THE 'NEUROLIBERAL' WELLBEING AGENDA - A TROJAN HORSE?

An enquiry into the potential space
for repositioning responses to wellbeing
intervention strategies as intrapersonal resistance

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Abstract

There has been a reported increase in the number of children and young people (CYP) in England identifying as having mental health issues. The most recently commissioned national survey (NHS Digital, 2018) identified prevalence rates of 1:8 5-19 year olds having at least one mental disorder. When published, this created alarm across the media resulting in the reporting of a 'crisis' in CYP's mental health, which impacted public perceptions of student wellbeing. As a consequence, the mental health narratives within education, (in respect of the 'affective turn') intensified, leading to an increase in wellbeing intervention strategies and school-based practices. However, despite a raft of intervention measures in educational settings, CYP's mental health issues appears to be growing exponentially, with waiting times for referral to services like CAMHS getting longer. When CYP are seen by clinical services, this often involves treatment interventions that include medication and psychological therapies. This research enquiry involves a search for 'gaps' and 'spaces' outside of the current wellbeing narrative, which seeks to reposition explanations for reported 'mental health disorders' as intrapsychic defences, a response to threats around the core identity. The research enquiry critically assesses the constructs of the Wellbeing Agenda around four specific themes. (1) Representation of mental health in CYP - through an evaluation of the 2018 report findings and assessment of what this says about mental health issues in CYP. (2) Alienation - CYP are experiencing the same types of alienation found in adult populations working within monopoly-capitalist economies, created by education marketisation which in turn creates mental distress. (3) Resilience - the implementation of wellbeing strategies that use concepts based upon positive psychology are harmful and dehumanising. (4) Resistance - using a combination of sociological and psychological theories of resistance 'intrapersonal' resistance is explained, as a means to defend against intrusive wellbeing measures that seek to use resilience as a means to 'fold back' resistance. The approach taken to this issue is 'pure' research (Patel and Patel, 2019) utilising applied Resistance Theory as method (Matias, 2021). The critical evaluation has been completed using a modification of Evaluative Inquiry (Fochler and DeRijcke, 2017). This evaluation has reflected Bacchi's (2016) comments relating to political ontology and the 'positioning' of problems to serve specific political agendas, in this regard the neoliberal trope of 'personal responsibility'.

Key Words: Affective Turn, Alienation, Neoliberalism, Resilience, Resistance, Wellbeing

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CONTENTS PAGE

I. List of Abbreviations

A LEVEL – Advanced Level

ALS - Action Learning Sets

APA – American Psychological Association

APPG – All Party Parliamentary Groups

AYPH – Association for Young People's Health

BACP – British Association for Counselling and Psychotherapy

BBC – British Broadcasting Corporation

BDD – Body Dysmorphic Disorder

BESA – British Educational Suppliers Association

BMI – Body Mass Index

BMJ – British Medical Journal

BTEC – Business and Technology Education Council

CAMHS – Child and Adolescent Mental Health Services

CPAG – Child Poverty Action Group

CQC – Care Quality Commission

CYP - Children and Young People

CYPMHT – Children and Young People's Mental Health Team

CYPMHW – Children and Young People's Mental Health and Wellbeing

DAWBA – Development and Wellbeing Assessment

DfCSF - Department of Children, Schools and Families

DfE – Department for Education

DH – Department of Health

DSM - Diagnostic and Statistical Manual of Mental Disorders

ECM – Every Child Matters

EHWB – Emotional Health and Wellbeing

EI – Emotional Intelligence

(EI) – Existential Isolation

ESA – Employment and Support Allowance

ESP – Education Support Partnership

EYMHC - Early Years Mental Health Committee

FAD – Family Assessment Device

FE – Further Education

fMRI – Functional Magnetic Resonance Imaging

FOIR – Freedom of Information Request

GCSE – General Certificate of Secondary Education

GDP – Gross Domestic Product

GMHM - Global Mental Health Movement

GP - General Practitioner

HBSC – Health Behaviours among School Children

HE – Higher Education

IAPT - Improving Access to Psychological Therapies

ICD – International Statistical Classification of Diseases

ID – Indices of Deprivation

IPT - Interpersonal Psychotherapy

K-SADS – Kiddie Schedule for Affective Disorders

MBI – Mindfulness Based Interventions

MHFA - Mental Health First Aid

NCSR – National Centre for Social Research

NHS – National Health Service

NHSP - National Healthy Schools Programme

NICE – National Institute for Health and Care Excellence

NSPCC – National Society for the Prevention of Cruelty to Children

OECD – Organisation for Economic Cooperation and Development

OFSTED – Office for Standards in Education

OLT – Object List Theory

ONS – Office for National Statistics

OPCRIT – Operational Criteria Checklist (for Psychotic Illness and Affective Illness)

PASS – Pupil Attitudes to Self and School

PATHS – Promoting Alternative Thinking Strategies

PCT – Primary Care Trusts

PDM – Psychodynamic Diagnostic Manual

PE – Physical Education

PHE - Public Health England

PISA – Programme for International Student Assessment

PQ – Parliamentary Questions

PRP – Penn Resiliency Programme

PSHE - Personal Social and Health Education

RCGP – Royal College of General Practitioners

RCP - Royal College of Psychiatrists

RCPCH – Royal College of Paediatrics and Child Health

SDQ – Strengths and Difficulties Questionnaire

SEAL – Social and Emotional Aspects of Learning

SEN – Special Educational Needs

SEWB – Social and Emotional Wellbeing

SSfE - Secretary of State for Education

TaMHS - Targeted Mental Health in Schools

TUC – Trades Union Congress

UCL – University College London

UK NSC – United Kingdom National Screening Committee

UN – United Nations

UNICEF – United Nations International Children's Emergency Fund

WEMWBS – Warwick-Edinburgh Mental Wellbeing Scale

WHO – World Health Organisation

INTRODUCTION

'...by focusing on the individual student's specific behavioural, educational or emotional problems, there is strong inclination to divert attention from the inadequacies of the education system itself and what bureaucratic, cultural and economic conditions caused the necessity of applying these constructs originally'.

Apple (1990:135) *Ideology and Curriculum*

II. Introduction

The subject of this thesis is contentious.

Whilst it can be argued that all research should disturb and trouble knowledge, in order that advancement in our understanding can be made, it is nonetheless important that 'established' wisdoms and contemporary practices are routinely scrutinised and held to account. It is essential, as researchers, that we pose questions to policy, interrogate instruction to action and critically analyse data presented as 'evidence', especially if this evidence subsequently shapes and forms operational performance and even more so, when it is framed in the discourse of 'evidence-based' 'best' practice as a means of 'gatekeeping'.

This approach is necessary to ensure that, much in the same way medical science uses clinical governance to review decision making and evaluate effective recovery; education is providing the same depth and rigour in critical reflection of its practices and underlying assumptions. It should be able to demonstrate that the provision of teaching and learning is beneficial to everyone that engages with it. In the case of education, this is especially important as it is the only mandatory apparatus for the delivery or a range of emotional, psychological, social, spiritual, academic, socio-economic and environmental knowledge and skills that shape the lives of children and young people.

Furthermore, there has been a call for social science researchers to engage in what Denzin (2017:9) refers to as *'...ethically responsible activist research'*, which he claims impacts positively on the lives of those that are socially oppressed. This is the antithesis of the *'...audit culture of global neoliberalism'* which he persuasively argues *'...marginalises critical enquiry'*, promotes social inequality and sustains pervasive, social injustices (*ibid*:8). Within his research agenda he identifies specific goals that should be a focus in the pursuit of any ethical research, namely, to ensure that oppressed voices are central to the inquiry, to identify

potential places for emancipatory change to happen, to use discovery to improve oppressed peoples' situation or circumstances and to influence social policy decision making by voicing criticisms of current practice. A critical aspect of this type of enquiry is to position questions around policy and practice that are not necessarily being asked by others. Denzin calls for action within research that not only interprets or reinterprets the individual's experience, but actively changes it, in ways that *'...resist injustice*' (*ibid*:9). What is demanded here is not passive acceptance of the pre-constructed neoliberal world view; used as a parameter with *'...narrow models of objectivity'* (*ibid*) but research questions that enquire about difference between and within 'normalised' educational standards that exist to service the hegemon. What the research that encapsulates social justice requires is courage, it should seek to broker new truths, to undermine, disrupt and dissemble oppressive practice, it should strive to reveal and expose 'agentic' forces that militate against the raising of consciousness. Further, it should seek to engage in an emergent framework of discovery, using what Denzin terms a new *'...moral criteria'*, by focusing on social justice, empowerment and change (*ibid*:10), regardless of whether such inquiry historically, has been perceived as subversive.

It is within this spirit of enterprise that my research has a deliberate intention to provoke and agitate. It is directed at unsettling the sediment of 'agentic' practice by voicing criticisms of current policy and its application. It will seek to question some of the foundation principles around which much of the current wellbeing policy agenda is located and illuminate areas where 'accepted' truths can be problematized. This is in an attempt to both reassess and reinterpret the interpersonal terrain relating to the wellness of being in an educational context and to try to redress the discursive policies and provision around framing wellbeing interventions. Most importantly, this thesis has at its core 'resistance'.

III. The Current Debate

In the last decade there has been an unprecedented focus on issues surrounding the mental health and wellbeing of CYP. Most recent national survey figures available from NHS England (2018) suggest that around 12.8% of 5-19 year olds have 'some form' of mental disorder, with 8.1% of this figure representing disorders of emotion (such as anxiety and depression). This is the perceived 'truth' which has been further elaborated by Levecque *et al* (2017) to include a substantive proportion (51%) of PhD students who are believed to be at risk of developing a mental health disorder whilst undertaking research. It appears then, that at every level of

education, from primary to university, there are developing concerns around mental wellness.

These concerns have positively correlated with a rapid promotion, growth and development of the overarching Wellbeing Agenda and an increase in what many researchers refer to as the affective or therapeutic 'turn' in education (see Craig (2009); Ecclestone (2007); Ecclestone and Hayes (2008); Furedi (2004); Harwood and Allan (2014) and Timimi and Maitra (2006)). Overall, this emergent approach across the wider educational landscape has moved towards the metrication of human emotion, underpinned by the belief that felt responses and mental processes are in some way measurable and thus malleable. Whilst many researchers have embraced the focus on affect in education (see Dernikos *et al* (2020); Massumi (2015) and Niccolini *et al* (2018)), citing the position that the affective turn opens transformational spaces to shift the discourse around educational interventions. Zembylas (2021) refers to ways that the affective turn can lead to new opportunities for 'micro-political' resistance. There has been concern expressed by some that this focus on affect is locating children as psychologically susceptible and socially manipulable (Williamson, 2016).

This thesis will focus on the constructs, representations and interpretations of the reported 'crisis' in the mental health of CYP. It is contentious because it 'resists' the 'creep' in privileging the Wellbeing Agenda within educational contexts, which arrived without any critical consideration or analytical assessment of its appropriateness and efficacy. Nor of its potential to exploit and reinforce what Freire (1972) calls 'submersion' – where individuals are prevented from achieving consciousness of their actual oppression, due to an entrapment within their current oppressed context, in which they are reinforced to believe they have no alternative choices or autonomous potential to change their situation and are forced into passive acceptance. This is especially true when coupled with what could be argued as manipulative programs that appear to be benign, like 'welfare' (wellbeing) which Freire (*ibid*:149) argues *'...distract the oppressed from the real causes and solutions to their problems'*.

IV. Approach

In examining these contemporary themes, and by taking a multidisciplinary approach, this research will seek to reinterpret the current debate through a critical lens of applied theory. The debate itself relates to whether there is an actual increase in CYP mental health issues, with many people believing that diagnosis for disorders such as depression have substantially increased, whilst others would attribute the perceived increase in CYPs mental health issues are arising from changes to policy, educational reform and increased media and social media focus. This research will offer a different perspective from within two complimentary disciplines but will seek to unify both in a 'singularity' of agreement on a constituted form of resistance. The initial focus will be on issues surrounding the emergent topography of the Wellbeing Agenda in a Post-16 education setting. This will include reference to changes after *Transforming Children and Young People's Mental Health Provision* (GB. Green Paper, DfE, 2017) and the significant impact this has had on practice.

The term 'crisis' has been used in citation because my thesis will endeavour to construct a series of arguments that will reframe the issue, moving away from the psycho-biologically constructed perceptions of 'mass mental health decline'. The current debate can arguably be positioned around a belief that the number of CYP with acute mental illness is rising. This is because across national policy landscapes, reports, publications and practice, this is what educators are being told. Instead, it will consider an alternative proposition to argue that what is presenting in schools is not a 'crisis' of mental ill health, *per se*, but a form of psychological resistance. This is positioned in a uniquely intrapersonal domain. It is a response that is neither deliberate nor necessarily conscious but is brought about as a consequence of potentially damaging interventions enacted within the Wellbeing Agenda. The explicit focus will be on the examination of places and spaces that can cause alienation and the 'forced' remediation of 'resiliency'. In this respect it will seek to 'resist injustice'.

It will consider the impact of wellbeing policy; the implementation of psychotherapeutic measures to 'manufacture' wellness and the rise in medication for mental health issues in CYP; within an agenda that in its current form, could be refracted as inherently pernicious. Not least because it manifests as an emancipatory, liberating and empowering escape from mental ill health when it can be reframed as both alienating and dehumanising, serving only to 'normalise' suffering and entrap CYP into a cycle of therapeuticisation. This research is

antithetical in this context because, rather than embracing the new currency of wellbeing in education as a panacea to address perceived mental ills, with its arsenal of counselling, mindfulness, therapy and medication solutions, my convictions (and observations) have led me to question deeply the motivations of such programmes, the position from which they operate, the agenda that they ultimately serve and, in considering how teaching professionals have been forced to adopt and implement these measures without critical judgement, how this 'false generosity' concomitantly makes 'sub-oppressors' of us all.

To summarise, I intend to examine the perceived rise in mental health issues in CYP, questioning what evidence there is to support the assertion that mental illness is indeed increasing. This is in order to assess whether there is a mental health crisis, or a crisis of another kind. To address this issue, I will consider a range of variables that include potential changes to diagnostic criteria, the rise in 'self-reported' disorders, the change in reporting and recording of mental health concerns and the change in patterns of medication within the age range specified. I aim to illustrate how the debate can be reframed using both psychological and sociological principles, based on narratives of resistance because I believe that what is being witnessed is not a rise in mental health disorders, or even pathologies. I argue this is instead a manifestation of suffering and misery created through education practice that is emergent in a distinct, intrapersonal form of resistance. This occurs as a result of the alienating experiences within education and through interventions to impose 'wellbeing' measures and strategies, such as the mental health awareness campaigns discussed by Saltmarsh (2016). This leads to the individual's internal construct of their lived experience being compromised. For example, in the application of resiliency training, that takes the CYP's reactions to social injustices like; poverty, inequality, lack of opportunity, low socio-economic status, disadvantaged living situations, digital poverty, family dysfunction, parental issues (illness, mental illness, substance abuse and unemployment), poor access to services and insufficient resources and translates this to a psychological 'frailty'.

I advocate that, due to the nature of neoliberal educational policy, mental distress is materialising as profound psychic harm, created by the interaction between academic expectation and wellbeing intervention. The degree of mental suffering occurring is presenting as damage to the 'core self'. The internal level of harm is so significant that the outward representation of the internal discord presents as psychological 'resistance' to the

distress being created, manifesting as a rupture in emotional function, rather than a biochemical neuropathology and thus it is impervious to treatment with medication that claim to alter physiological function. This will necessitate a dual reading of resistance from two different perspectives in complimentary disciplines, as a means of 'troubling' current practice.

V. Theory as Method

In Matias' (2021) work *The Handbook of Critical Theoretical Research Methods in Education*, on p.V of the front matter there is a quote which reads '*For education researchers, may your research never be limited by a method*'. I like this quote very much.

Matias puts forward the view that rather than 'theory' being used as a structuring framework to locate epistemology, ontology and agency within research, (which she refers to as '*narrowly conceived'* (*ibid:*1)); she identifies that theory can be more '*expansively employed*' (*ibid*:1) by creating possibilities to widen and invigorate educational research from a social justice position. She argues this can be achieved through expanding methodological imagination. In terms of theory, the relationship with method is complex. Theory operates in most research, somewhat like a scaffold that supports the building of a house. Implicit in the 'framework' of beliefs that precede the build are the researchers' fundamental ideologies about the nature of reality and what constitutes knowledge, whilst ignoring the fact that the scaffold also shapes the nature of the house that can be built.

Referring to the practice of methodological 'gatekeeping' as a 'hidden curriculum' within educational practice (*ibid*:2), Matias suggests that this focus on empiricist and 'scientific' data generation through quantitative and qualitative methodologies is designed to satisfy the presumption of 'validity'. This, she argues, reinforces the dominant hierarchy which carries with it an agenda of 'othering'. Matias makes this point by emphasising that a narrow focus on empiricism *'...delegitimises theoretical education research in ways that 'silence' theoretical researchers*' (*ibid*:3). This is important because much of this 'silencing' is of women, black and ethnic minority groups and other 'marginalised' peoples who conduct research (*ibid*:3). In this regard, adherence to strict methodological practice could be seen as a way of maintaining oppression, systemic racism and sexism. Moreover, Matias has highlighted that by failing to consider theoretical research as a method, it will potentially *'...destroy the possibilities and*

intellectual imagination for research itself' (*ibid*:5). She further illustrates her point by asking who theorists like Freire, Dewey or Giroux '*ever interviewed'* (*ibid*:3) suggesting that by current research standards, their work would be conceived of as 'lacking validity' due to unsuitable research methods. In this regard, it can be seen that certain methodologies and approaches to research using 'traditional' methods of empiricist practice to 'claim' the 'scientific' high ground, serve only to reinforce existing and dominant oppressive epistemologies.

In Patel and Patel's (2019) work on exploring research, they state in their conclusion that:
'Research is a voyage of discovery; a journey; an attitude; an experience; a method of critical thinking; an activity caused by instinct of inquisitiveness to gain fresh insight/find answers to questions and to acquire knowledge' (p.54).

I resonate with this description as the research journey that I have undertaken during this dissertation has been to reframe a debate of contemporary importance around the mental health of CYP within an educational context. From the initial planning stages I wanted this research to be a cognitive challenge of my ability to understand and work with applied theory. I resisted the temptation to complete quantitative research, as I had done in my masters and undergraduate degrees (questionnaire, experiment and content analysis). I also wanted this to be as much a challenge to my intellectual ability in creative thinking as it was to my skills in articulation and reasoning. In their description of the range of research types and their purpose (which included historical research, simulation research, longitudinal research and quantitative and qualitative research), they identify 'basic research' which they also term 'pure' (p.49). The description they give to this type of research is that it is conducted *'...for the sake of enhancement of knowledge'* and *'...with the intention of overpowering of the unknown facts*' (p.49). This research is often the type undertaken when formulating new theories.

As stated initially, the research in this thesis is not conducted using typical methodologies. Whilst there has been a systematic approach to the generating of information, (which will be explained later in the section), the remit for this research was to construct a persuasive argument to illuminate and evaluate a matter of current concern. This locates the approach taken as 'pure' research. This research can be argued to be critical in its entirety, because it takes a counter position to the established and widely accepted view in statutory educational

settings of the function and purpose of the Wellbeing Agenda. Further, it can be identified that my positionality would naturally incline my innate bias to an acceptance of the 'face value' explanations of a substantive increase (referred to by Harwood and Allan (2014) as a 'spiralling' mental health problem) in CYP, especially given my declared psychological positionality as being biologically and cognitively founded.

Patel and Patel (2019) further argue that the aim of research is to *'...find out the truth which is hidden and which has not been discovered yet*' (*ibid*:49). They break down research into four general categories of 'finding out' which they relate as being to; '*test hypothesis*', '*determine frequency'*, '*portray characteristics accurately'* and finally '*gain familiarity with phenomena*' (*ibid*:49). This thesis looks to focus on the last category which is to examine phenomena in order to gain '*insight*' (p.49). They regard these types of research studies as 'exploratory' or 'formulative'. Working from within the psychodynamic approach for much of this dissertation, I found the inclusion of 'insight' appropriate as Freud (1937a) determined that insight was an attempt to access material which has been repressed into the unconscious. The emergence of this matter from the unconscious afforded recovery; in this regard, the metaphor of uncovering, making visible that which had been hidden and exposing that which is obscured from awareness, are all appropriate for this endeavour. An example of exposing that which is obscured can be seen in the construction of students' negative mental wellbeing which has been evaluated on the basis of absenteeism, academic performance, overall achievement, punctuality, engagement and the impact of education targets; but not on the effects of the implementation of the Wellbeing Agenda itself.

The approach I am therefore taking to complete this thesis is as a theoretical researcher. The work will be framed in the application of 'pure research' and will utilise a multidisciplinary reading of applied Resistance Theory. A major decision taken in relation to the research, as already stated, was not to conduct primary data research. This was because the 'unconscious' resistance that is conceptualised within the psychodynamic approach is not directly accessible and so cannot be 'measured' or 'tested'. There was no value in asking students to answer questions on their mental wellbeing as this could not access their unconscious states, according to psychodynamic theory, this can only be achieved through therapy. I did not engage teachers in the research for the same reason, but there may have been value in conducting research to identify what their thoughts were in relation to the causes of CYPs

mental health issues which may be a direction for future study. However, at the onset of the research, I completed a brief statistical analysis on access rates to the college's internal counselling services which did not support the statistical profile of 1:8 recorded in the NHS survey (see *Appendix 1*). The analysis of results is not fully representative, as it does not differentiate students who have diagnosed clinical disorders (for example with eating disorders where the college is responsible for monitoring adherence to their Eating Disorder Meal Plan (EDMP) and also with Schizophrenia and Bipolar Disorders) with students who have made a 'self-referral' for issues like anxiety. It is intended only as a 'snapshot' of the historical context of the college's involvement in referral to counselling (not clinical services) in the build up to the 2017 legislative changes. Referrals are now made through 'Wellbeing Services' and are most usually made direct to CAMHS and external Tier 1 services. The referrals are diverted through clinical service with CAMHS liaison and the children's social work Crisis Team. However, much of the critical assessment made could also be representative of issues within other settings.

Whilst the 'theory' is the 'method' within this research, as indicated by Matias (2021), it was still necessary to create structure and a system of working through and analysing the secondary data information, resource and studies that were used to generate the arguments articulated within this thesis. I elected to follow a structure of Evaluative Inquiry (Fochler and DeRijcke, 2017). This technique examines the process of academic work as it is 'constructed' through individuals, groups and networks which cooperatively generate knowledge (DeRijcke *et al*, 2019), usually through an on-going programme. It is typical for this type of research to be conducted within what Parsons (2009) refers to as CLIPS (Communities of Learning, Inquiry and Practice). However, I have elected to appropriate this strategy because importantly, there is an emphasis on evaluation as a process that contributes to knowledge. DeRijcke *et al* (2019) argue that much research is 'linear', starting with a research question or hypothesis, conducting an experiment to gather quantitative or qualitative data and then creating a conclusion. Evaluative Inquiry promotes research that *'...makes visible the complexity of actual practice and its engagement'* (*ibid*:178). They further suggest that evaluation through analysis is stronger if it is competed by an *'...engaged analyst working within'* (*ibid*:178) rather than someone analysing material in external detachment. In this regard, I am an 'insider' researching the application and implications of the Wellbeing Agenda within my own institution, whilst being conscious of the impact on CYP that this agenda can have.

Researching in this way has allowed me to ask questions that cannot be responded to within my own setting.

DeRijcke *et al* formulate a useful explanation in their application and interpretation of Evaluative Inquiry, namely that *'...recognising evaluation itself as both an analytical and strategic project, the analyst thus moves from objective observer into the role of engaged evaluator, not only engaging in an evaluation of quality, but also in the analysis of the broader political projects of accountability with which it is intertwined'* (*ibid*:178). This evaluation of the evidence of mental illness in CYP allows for a positioning of the findings against the political context in this regard. This context also considers the mandatory requirement of wellbeing policies and the statutory requirements of practice within compulsory education settings.

The evaluation itself covers three phases which are exploration, data collation and analysis and reporting (p.179). In this respect, the exploration was in finding out how the 'crisis' in CYPs mental health was generated and to consider the development of the Wellbeing Agenda in response to it. The data collection involved engagement with a range of secondary sources in examining to what extent the advocacy of a spiralling mental health problem could be ascertained. At this stage, there was also the collating of what DeRijcke *et al* refer to as *'themes and pathways'* that present themselves as the evaluation deepens (p.179). These emerged from the data sources, which looked at repetition and recurrence of aspects that supported or refuted the research questions proposed – which asked 'to what extent' as a value judgement of assessment (to a greater extent, to a lesser extent or not at all). This depended on both the volume and quality of the data that was examined. DeRijcke *et al* suggest that as these pathways emerge, it is at this point that there is a connection between 'academic' and 'societal domains' (p.179).

A strength of using Evaluative Inquiry is that it allows for different types of data generations from a range of other techniques and strategies, for example in the group project undertaken by DeRijcke *et al,* they use 'generative dialogue' (p.179) to discuss findings with colleagues and other stakeholders. However, they indicate that a host of other methods, including images, schematics and multimedia could be generated within the evaluation. They suggest that the outcomes of research using the Evaluative Inquiry approach allows for *'...conceptualising scholarly work not in terms of a linear diffusion of knowledge, but rather as*

an emergent effect of an unfolding, multidirectional research process' (*ibid*:179), but the emphasis is on the deep engagement with material and assessing its individual contribution to the research question, especially when using secondary data. This gives access to a wider core of research knowledge than just primary data research, which can be insular (in respect of the scope of findings). This threefold pattern of exploration, data collation and analysis were used as a contained approach within each of the four chapters.

A further strength of using the Evaluative Inquiry is that this more detailed focus regards the evaluation itself as part of the production of knowledge, not just as a by-product of the research results. An example to support this point is the work in Chapter 1, which considered the results of the NHS Digital (2018) survey. The findings specified that there had been an increase in the number of CYP with mental illnesses and cited statistics of 1:8. This survey was from a respected source and is heavily cited in multiple other publications. However, I carried out a detailed evaluation of the survey's process and composition, examined how it was conducted and the claims to evidence that were being made. I also analysed the technical information provided (including the statistical assessment of levels of confidence). I then conducted an evaluation of its validity and reliability, looked at reports relating to its publication (including media and other communication from the researchers tasked with undertaking the survey) and made comparisons with the earlier NHS surveys to assess trends. The findings where then compared to school populations using the most recent statistics available, to assess the specific incidences of purported mental illness in CYP that were representative of numbers of actual children in real terms. This was to see if the cited figures of 1:8 could be supported and could be argued to constitute the escalation of numbers that warranted the use of the term 'crisis'. The findings, even using 'taken to be true' inferred numbers from the survey (not including the plethora of problems found within the methodology) did not numerically represent a 'crisis'.

I am mindful here of Bacchi (2016) who suggests attention should be paid to the many 'dimensions' implied by political ontology and cautioned researchers to consider the way representations of 'problems' in policy are constituted as 'real' (p:2). A further example of the benefit of using Evaluative Inquiry was in assessing a range of contributions to Resistance Theory, before deciding to use Holland and Einwohner's (2004) model. The justification for the choice of this model was that it positioned a range of different types of interpretations of

resistance, which made it versatile and flexible across multiple disciplines. It is in using Evaluative Inquiry that I was able to modify the model to 'see what would happen'. In this respect, the model opened new 'pathways' and allowed an interrogation of the model to discover 'insight' that may impact practice, which is in keeping with the values of Evaluative Inquiry.

A further reason for selecting Evaluative Inquiry was given by Preskill and Torres (1999), who suggested that using this process enabled individuals and organisations to investigate issues that were important to them, using systematic analysis. As a psychologist, this issue matters to me professionally, within my practice and within my institution which implements the Wellbeing Agenda. A further reason for electing to focus on an Evaluative Inquiry is that *'...it makes it possible to articulate positions, roles and values that are often subordinate to dominant currents in academic practice and that are often silenced in traditional evaluations'* (DeRijcke *et al* 2019:180). This suggestion of 'silencing' links to comments by Matias (2021) and also Primdahl, Reid and Simovska (2018) who identify that such discourses around health within education are enmeshed within what they term 'overt and covert meanings' (p.724). This relates to what is regarded as 'reasonable' within applications to both curriculum and practice. They further specify that *'...certain matters may be routinely or deliberately excluded, particular topics never seem to be broached...just as much as some people involved in education aren't always willing or able to speak about what is'* (*ibid*:724). This would seem to suggest that there are restrictions around practice (and practitioners) in what discourses they are permitted to engage with. This links to the point made in the initial introduction to this thesis that questions the creation of the wellbeing agenda and the lack of critical engagement with its implementation.

DeRijcke *et al* further suggest that Evaluative Inquiry identifies the evaluation itself as being part of the generative process of knowledge making (p.180), rather than just an assessment of the data outcomes. The fundamental components of my research statements were to question the 'taken to be true' within educational setting. For example, it was 'taken to be true' that there was a mental health crisis in the college, that psychological treatments, therapies and referrals to CAHMS were the most effective way to deal with these mental health issues, that all staff needed training in Mental Health First Aid to manage the spiralling mental illnesses in CYP and that, without question, CYP had a range of mental illnesses and

disorders, in vast numbers, which only the Wellbeing Agenda could address. Parsons (2009) has also commented that Evaluative Inquiry involves *'...an intentional process of framing questions, systematically gathering information relevant to the question and using information to draw credible conclusions that can shape practice'* (*ibid*:44). She specifies that Evaluative Inquiry can be done by an individual and highlights that it is appropriate to gather information that is relevant and pertinent *only* to the question, which means there is latitude to create boundaries to focus the search for specific research that address *only* the issue raised.

In terms of the process of research within the Evaluative Inquiry, I constructed schematics to locate the areas that I wanted to evaluate which would start to critically assess the discourse around mental health in education and the clinical narrative of the prevalence of mental illness in CYP. This was driven in part by both the 2019 changes in the Education Inspection Framework (EIF) which had a significant focus on mental health provision in schools and the *Transforming Children and Young People's Mental Health Provision* (GB. Green Paper, DfE, 2017) which was the driver for the changes in practice. Concepts were then plotted around the schematic and searches for a range of literature to expand these points began. Searches were extensively conducted on academic journals through the universities STAR catalogue and open access resources. The largest challenge was finding any material that questioned the current narrative on wellbeing.

Once material had been found, it was systematically evaluated by following a table format that meant that the same details were collected from each source. This was completed contemporaneously as the research was read. This included the source, date and author details. In some instances, I researched more about authors to find out their position, especially if the material I examined were interview contexts. The work was summated by bullet points into key areas and direct citations were included at this point. There was also a section to consider the relationship between the materials I had read, for example where it corresponded to or was in conflict with other research. I also identified where material was referenced by other researchers. The final section related to my thoughts, feelings, remarks and ideas that emerged during the reading process. This was where I also noted down themes or ways that I thought material connected. An example of ideas that emerged from this process was the concept of 'embodied resistance', which developed from comments made

across multiple research studies with each making a small contribution to the 'larger' picture of the physical body, as both a site of and means to resist.

A feature of evaluation within my research on the secondary sources was to use a Convergent-Divergent-Convergent approach to narrow in and expand out on key areas that developed from themes and patterns within the studies. For example, in looking closely at their references lists and sourcing research that had been used to argue opposing points or where points had been made that were of relevance to my research questions. To complement this, I used notes on extracted key points and reviewed these at regular intervals to see if additional information I had found changed the contribution that they made to my own research. A further conscious decision was taken not to include any sources that could not be supported by either a theory, or additional research. I flagged these as 'orphan studies' and did not include them within the thesis. This was because I could not find additional sources to corroborate. The notes also assisted in looking for differences and similarities in the information that had been summarised, evaluating this in terms of the contribution it made to the critical question, what additional concepts or angles the data contributed to the overall picture and where the information was positioned in relation to other material. This created the 'themes and pathways' described by DeRijcke *et al,* (see *Appendix 2* for examples of schematics and research notes).

There are limitations in using Evaluative Inquiry and I am mindful that the trade-off in working with a strategy that has a significant degree of flexibility is that the parameters within which the research is conducted are subjective and value based. The analysis of the secondary data sources was interpretive. This means that a different researcher may not assess the material in exactly the same way. Whilst key information (for example the authors own assessment and analysis of their findings) was reproduced directly and so was reliably summated (faithfully reproduced), the relationship, associations, comparisons and contrasts between the different sources utilised, the inferences I took from how research was mutually supportive of themes or acted to foreground key concepts was indicative of my own beliefs, values and positionality, which affected how the representations were privileged.

A further issue with the method when used to evaluate programmes (rather than policy) is the lack of consensus on what determines both value and success criteria. For example, the approach tries to move away from performance metrics (e.g., examination results). Further,

Holtrop, Hessels and Prins (2020) have stated that *'...what is of value and to be valued is not fixed'* (*ibid:*2), in the above example, the level of improvement, the rate of engagement and the development of skills that the CYP may have achieved are not 'present' directly within the metrics of the exam grade, but may have intrinsic value. The aspects, artefacts or attributes that are regarded as 'valuable' may also change over time, dependent on the needs of the organisation or institution at different junctures. They also state that *'...the focus on 'value trajectories' opens up the concept of academic value and moves away from the focus on citation of scores to finding dense and vital activity around research themes and ambition'* (*ibid*:2). In expansion, Crittenden (1981) has argued that many models of evaluation erroneously assume a set of '*normative criteria of evaluation'* which includes performance metrics that is assumed to be 'equally relevant' to all groups (p.179). In Evaluative Inquiry, there is flexibility to determine value trajectories for organisations, institutions or even individual groups. A consequence of this is that it makes comparison of performance across sectors problematic.

Another limitation of Evaluative Inquiry according to Holtrop, Hessels and Prins (2020) is that the contributions of different factors are often difficult to precisely quantify and cannot necessarily be extricated or measured discretely, largely because the parameters are constructs and they are not strictly controlled within the process of research. This is especially true when evaluative action is assessing aspects like organisational culture or ethos. This is also especially true for subjective domains of affect like 'wellbeing'.

In terms of the approach to evaluation taken in assessment of the secondary sources, there were other models that could have been used as this is an education-based research thesis, for example, Fetterman (1999) Empowerment Evaluation; Partlett and Hamilton (1972) Illuminative Evaluation; Scriven (1977) Goal Free Evaluation; Stake (1967) Countenance Model and Tyler's (1949) Objectives Model. However, many of these models require on-going evaluation of in situ learning programmes. They may also require set objectives to be in place at the onset of the programme. Further, none of these models take the evaluation process itself as part of the value base within the research. Other issues were considered prior to selection of Evaluative Inquiry, for example some models, like Stake, requires consideration of the antecedents of action as historical aspects and searches for incongruences in transactions between evaluators, whilst Fetterman's model is best utilised with mentorship,

apprenticeship of other coaching or guided support programmes as it has self-assessment as a specific objective. I considered using Partlett and Hamilton's Illuminative Evaluation, but this again required a programme to be implemented as the two foci of the model are on the Instructional System and Learning Milieu, which were not present within this research.

VI. Framing Positionality

Griffiths (1998) has identified that framing positionality in research should include reference to an individual's ontological, epistemological and human agency assumptions. This elaborates personal constructs on the nature of reality and lived experiences, the nature of knowledge (or what can be known) and the extent to which agency, choice and decision-making capabilities can be attributed to individuals as autonomous actors. These factors become challenging to discuss when working within the discipline of psychology, which has a breadth of research relating to personal identity and processes of mind encompassing all of these sociological and philosophical aspects (such as free will versus determinism, the meta-constructs of knowledge through schematic plasticity and the interpretation of 'real' through sensory synthesis). This is especially true if the psychological paradigm is based within clinical domains. Much of the research within these fields is written from the etic approach described by Griffiths, intended to be 'culturally neutral' and written wholly for a scholarly community of like-minded practitioners.

Whilst it is important to remember, as Carr (2000) has identified, that research cannot be 'value free', much etic research is produced with no overt 'authorial voice'. In this regarded, the majority of research I have been exposed to within my academic career (and covering three previous degrees) had no statement of positionality or reflexive intent, as this was not an expectation of the type of research published within the cognitive and clinical neuroscience approaches. Therefore, the biographic inclusions seen within published articles inside of the social science disciplines (in exploring the personal beliefs and constructs of the researcher), are unusual to see within the clinical sciences. In context, a very limited amount of research within this thesis, (where it has been drawn from clinical journal sources), contains any reference to researcher positionality. It may contain information about the occupations or employment of the researchers (such as their universities and clinical field of expertise), but there is no reference to the three assumptions outlined here by Griffiths.

Further, discussions around the nature of reality, agency and knowledge become more problematic from within a discipline where fundamental beliefs about these issues span paradigms which are consistently at odds, even within the field. For example, the biological/medical/cognitive approaches within psychology have very different modes of research, reporting and validation methods than does the humanistic/psychodynamic approaches. Traditionally, research fields within psychology such as cognitive and clinical domains have taken a positivist approach; relying on fundamental scientific principles such as nomothetic laws, using replicable and controlled quantitative data methodologies that lean towards observable and measurable external phenomena. This enables researchers to make 'truth based' claims on the nature of the 'real' that are empirical and falsifiable (Rhodes and Conti, 2011).

In this respect, my background locates me within a positivist approach as much of my working practice has been around an 'evidence-base' of scientific research relating to diagnosis, treatment and therapies for clinical disorders. However, I acknowledge a degree of '*pragmatic contextualism'* (Pynn, 2015) within my personal approach as I accept that 'claims to truth' or knowledge are context dependent, based on variables such as time, historical period, cultural values and semantic accuracy (the lexicon used to describe the phenomenon). An example of this semantic accuracy can be seen in the discussion around definitions of key terms used within this thesis such as mental wellbeing, resilience and resistance. Moreover, definitions of mental health have changed over time, transitioning from a theological explanation to a psychological claim to knowledge, as the function and process of mind and brain became better understood. Some illustrations of where a positivist approach has been used within this thesis can be seen in the inclusion of research sources based on positivistic methods, such as MRI scans, EEG readings and laboratory-based experiments giving inferentially quantified data. An example is the material used in support of changes in adolescent brain function and in the establishment of baselines brain output for the measurement of behavioural responses. Further, a positivistic approach can be attributed to Social Baseline Theory (Coan and Sbarra, 2015) used to expand the discussion on the impact of alienation and the therapeutic approach within education. Another example of where this positivistic approach can be seen is in the critical appraisal of the methodology used within the NHS Digital Report (2018), which was assessed on the basis of its methodology to illustrate weaknesses in its knowledge claims.

An emergent issue in the completion of this thesis has been a personal move away from this positivist position. This can be seen in the critical assessment of the definition and diagnosis of mental wellbeing issues and their interventions, within the non-clinical environment of educational settings. It can also be seen in the consideration of psychodynamic aspects of behaviour (which challenges what 'truth' can be 'known'), along with a fundamental shift in acceptance of the claim to knowledge in the construct of clinical disorders. These have been personally challenging to accommodate. The deliberate choice of an alternative psychological paradigm, to illustrate how the selective and abstractive use of psychological theory and concept has been manipulated by successive governments, (as a way of maintaining the neoliberal trope of 'individualism and self-improvement') was chosen for a specific purpose. Arguably, this was to construct an alternative interpretation of the current mental health 'crisis'. Notwithstanding, it is also prudent to consider this is a critical approach to take of the existing (and dominant) discourse within education at this time. As Secules *et al* (2021:38) highlight *'...positionality is particularly complex because of the multifaceted ways in which identity impacts research'*. My personal background and identity as a psychologist have influenced the subject of this research. The area of mental health prevalence in CYP; the research questions proposed, the approach to critically interpret current educational practice based on biological/medical paradigms within psychological theory and also the range of psychological arguments, drawn from different domains all speak to my personal position. This has been developed further by the consideration of resistance and alienation, which are not areas I have previously traversed. The psychological approaches chosen to complete this research have been with the express intention of illustrating how the 'type' of psychology that is used can impact the outcome, to illuminate the 'co-opting' and distortion of theories and approaches within the discipline. In particular to illustrate what Rose (1998:34) describes as the capacities of the psychology disciplines to '*penetrate*' other fields and to lend its vocabularies in ways that infuse and '*implant its constructs and judgements'*. Whilst I remain faithful to my discipline in the belief that psychological intervention is beneficial to many struggling with profound mental health challenges, which I have seen at first hand. I am also conscious of the impact that the application of psychological theories and practice can have when it is misused to serve political ends and I remain disquieted by the complacent (and complicit) approach taken by many within the field.

V.II Research Positionality

Formulating a statement of positionality for this research has been challenging.

Holmes (2020) has suggested that positionality is designed to 'locate' the researcher in three different ways, it should position them relative to the subject under investigation, the research participants and the research context and process (*ibid*:2). This thesis contains no active 'participants' directly involved in the collation of either quantitative or qualitative data, expressed as research 'results'.

Guidance literature and 'models' of positionality to support EdD students in dissertation writing overwhelmingly locate positionality as an 'emergent' process that is reflexively 'discovered'. This emergence comes from considering the dynamics that exist between the researcher's engagement and interaction with participants and the processes of methodological design and reporting (see Jacobson and Mustafa (2019); Secules *et al* (2021) and Sochacka *et al* (2009)). According to Merriam *et al* (2001), *'...positionality is determined by where one stands in relation to 'the other'* (*ibid.*411). As there is no 'overt' other, this has required a different type of engagement and reflexive consideration of my own position and an examination of decisions and choice made in the research process. For example, there are 'others' whose personal experiences are 'represented' by statistics, surveys and published work from organisations, practitioners and researchers that I have included within this thesis. Therefore, a more nuanced consideration of positionality is demanded.

An example of guidance on positionality statement writing can be seen in Jacobson and Mustafa's (2019) *Social Identity Map* which provides a 'positionality' diagram. This identifies several key dimensions such as gender, age, citizenship (for example naturalised or migrant), ethnicity, ability and class. This is with the intention of overtly signalling the researcher's attributes. They state the benefit of completing such a map derives from the creation of an *'...explicit and intentional space for researchers to reflect on themselves...*' (*ibid*:7), with an express focus on what they term the 'explicit awareness' of a range of social, political and cultural dynamics of power (*ibid*).

Further, Secules *et al* (2021) in research examining positionality statements have commented that the purpose of these statements can be broken down into three key areas; namely that they function to (A) *Acknowledge Practice* (57%) (to establish trustworthiness and research

quality). (B) *Establish Transparency of Self Attributes* (28%) (personal demographic information, previous experience and professional experience or understanding to lend voracity to research practice) and finally, (C) *Contextualising Methodology* (15%) (creating a layered context for the research questions, methods and approach, again to imply research competence) (*ibid:*22). It is important to also recognise that according to Griffiths (1998) *'…bias comes not from having ethical and political positions, this is inevitable – but from not acknowledging them'* (*ibid*:133). In the process of reading, the individual become positioned inside the text – in the same way, someone describing themselves in terms of their positionality locates themselves within the narrative that they write, suggesting as Usher (1996) does that individuals' '...*values and prejudices are implicated in what they create as knowledge'* (*ibid*:128). Thus, failing to disclose individual positionality is regarded by Opie (2004) as 'unethical' and by Sikes (2004) as an unacknowledged 'bias'. However, not all researchers agree that positionality is important in academic writing, for example Okeley (1992); Patai (1994); Peshkin (1988) and Robertson (2002) regard positionality as a mechanism that can encourage narcissistic and indulgent preoccupation with self as a defence against bias; with VanMaanen (1989) describing positionality as something akin to a 'confession' and Kobayashi (2003) as 'self-obsession'. An example of this negative perception is seen in Cousins (2010:9) who defines that *'…moral authority is claimed either through an affinity with the subject or through a confessional declaration of difference and relative privilege'.* Important to remember is that according to Garfinkel (1967), rather than having 'true' knowledge of their own research intentions, researchers retrospectively construct justifications for decisions they have taken, which means to some degree these become referential and self-fulfilling actions.

In respect of 'self attributes', I identify my 'position' and acknowledge my biases as being a white, cisgendered female, over 50 years of age who despite having been in a professional health and education role for over 30 years, (including as a teacher in F.E for nearly 20 years) identifies very much as working class, due to my parental background. I am the only member of my family to go to university and achieve a degree. I grew up in an economically deprived area of Nottinghamshire within a mining family which placed little value on education. My grandfather once said that education (beyond school) was "*not for us*". My political view is therefore left-leaning and I advocate strongly for social justice and the impact of poverty on wellness. Living in a coal mining area during the miner's strikes (between 1984-1985) meant

I saw first-hand the hardships families in my community faced, such as pooling food to ensure that children were fed. These personal attributes inform and influence my processes, given St Louise and Barton (2002) view that *'...much historical, political, social and cultural factors position people from birth'* (*ibid*:3) and are therefore not 'chosen'. This suggests that even 'conscious' decisions made around the research may not have been autonomous. For example, the election to utilise psychological theories that move away from a biological basis (which was made with the intention of expanding the debate around wellbeing), could have been influenced by a conviction that socio-economic factors contribute to illness, as I had seen during the year long strike watching many deeply divided families fall apart; so this may have meant a reluctance to accept sources that provided evidence for a biological cause of mental health issues, which are under-represented in the thesis, for example in reading self-harm as resistance and not 'illness'.

This more nuanced reading may be found in considering Merton's (1972) suggestion of Insider/Outsider doctrine. That of considering which 'groups' a researcher may or may not belong to that gives accessibility to knowledge and experience by 'status sets' (*ibid*:22), which are similar to the attributes identified by Jacobson and Mustafa. Merton identifies that the researcher can exist in multiple groups as insider and outsider by virtue of their attributes, which may 'intersect' with the research participants (e.g., nationality). He further advocates that status identities can both preclude the joining of certain groups (i.e., it would be impossible to 'belong' to a group consisting of CYP because of my age) but they also allow mutability in others, this is where 'attributes' are not 'fixed' for example by political view.

Taking the Insider/Outsider doctrine as a basis for my positionality, the picture here is more complex. The subject of my research is the perceived metal health crisis in CYP within education. As a woman of 50+, I am an outsider as the CYP group which is the focus of the research constitutes those who are aged 5-18 years (compulsory school age). However, as an EdD candidate, I am part of the inside group of being a student and experiencing pressures and tensions in meeting academic expectations to satisfy an awarding body to achieve certification. I therefore have sympathy with the high stakes testing that CYP are exposed to in mainstream education and understand the stresses and pressure they encounter. Further, as a teacher in an F.E college in the Yorkshire and Humber area, I am an insider as my research context is educational settings. I work daily with CYP who are both in an area of high economic

deprivation, falling within the top 10% of England (Indices of Deprivation, 2019) and into a statistically high group by age for potential mental wellbeing issues (16 -19 years). I am also an insider in terms of my occupation within an educational setting with CYP, many of whom are subject to wellbeing interventions. I am an insider in being required to implement the policies and practices enacted by government in relation to the Wellbeing Agenda, particularly in the practical application of strategies and policy initiatives at the settings level and am well placed to see how they impact practice at the 'chalk face'. I am aware of the tracking, monitoring and intervention practices we are required to provide as part of the wellbeing remit, linked to our own personal performance and appraisal reviews. However, I am also an outsider as I do not directly or personally feel the impact of the strategies I am required to implement (for example referral to CAMHS) with the CYP I work with.

My current professional status and academic qualifications are as a teacher of Psychology, Health and Access to H.E (Health Professions, Nursing, Teaching and Science), where I deliver a range of units on mental health, diagnosis, treatments and therapies; professional practice in health; clinical governance and clinical audit; research methodology and psychology. I am therefore part of an outsider group as I have broader knowledge of mental health related issues than the group I have elected to research (CYP). My first qualification is a BPS accredited degree in Cognitive Neuropsychology and prior to teaching I worked in a residential clinical health care setting with people who had a range of acute mental health conditions (Tier 3 and 4), so I have insider *and* outsider knowledge of the diagnostic and treatment programmes used in clinical practice. Mohammed (2001) has identified it is possible to be an insider and an outsider *simultaneously*. Further, I have both personal and family experience of mental health issues, so this would locate me as an insider in considering the wider impacts of diagnosis, treatment and medication for mental illness for people 'subject to' clinical intervention.

As a BPS member, teaching practitioner and examiner I have a thorough understanding of the discipline of psychology and am passionate about the subject in all of its range and variety, so this gives me insider status in theoretical understanding of the paradigms and approaches within psychology used in policy decisions making. However, I have developed a greater understanding of the negative influences of psychology and now align myself with a critical psychology approach, which locates me as an outsider to many clinical practitioners, including

inside education and within my own department. This has been a particularly challenging position to occupy and has caused incongruence in my view that helping people with mental health issues can be at the same time beneficial and potentially harmful. I have personally seen how individuals with chronic clinically diagnosed mental disorders, such as schizophrenia, bipolar disorder and eating disorders have been helped to overcome profound difficulties with function and managing daily living. This experience has made me alert to the 'labelling' of individuals with 'issues' that are far removed from the types of illness and treatment I have previously witnessed. Also, I am currently training to become a BACP accredited counsellor (in the final year of a three-year programme), so I have insider status of receiving counselling, both personally (as required by the programme) and through supervision; but am an outsider in the delivery of counselling support for mental health to other people as part of my required placement hours, many of whom are young people over the age of 16 years.

This exposure to critical aspects of psychology and psychiatry has also forced me to negotiate and redefine my own perceptions about their wider application and practice. In this regard, the exercise of conducting this research, especially in reading work by theorists such as Parker (1999, 2007), have meant that I have had to question my fundamental underpinning beliefs in the most profound way.

Lastly, I have considered Jacobson and Mustafa (2019) point that *'...by identifying and deeply thinking about our race, class and age, we may begin to see how larger systems of privilege and oppression play out in our work'* (*ibid*:11). This is crucial in the co-location of the self within the research process and in considering oppressive socio-political influences within the group that forms the basis of my research (as demanded by Denzin). I am aware of my own privilege in terms of my knowledge, attributes, prior educational attainment and current academic endeavour. I am also aware of the privilege my occupational and professional status gives me as an experienced teacher, psychologists and counsellor – as an insider and outsider. I am also cognisant of approaching the topic as both a practitioner and 'agent' for governmental policy implementation and intervention. Therefore, I have sought to research in a way that incorporates principles of social justice by examining the potential for oppressive practice within the wellbeing framework and the interventions that I am required to deliver. Bendix-Petersen (2016) has elaborated that theoretically, individual educators are free to

reject neoliberal policies and refuse to implement practice that compromises their beliefs and principles, *'...in practice, the extent to which individuals can exert choice over whether to accept or resist such policies may be limited by a range of factors'* (*ibid*:7).

V.III Originality

According to Baptista *et al* (2015), the nature of 'originality' in doctoral research is not easily articulated and has no universally agreed definition (*ibid:*57). They comment that there is very little 'undiscovered', truly original or 'novel' knowledge; at best, most researchers seek to redefine, reposition, realign or redress existing concepts, theories, arguments or ideas. They suggest it would therefore be better to consider how a researcher can build a space within which to 'locate' an argument or, alternatively, articulate how a conversation emerges and identify where they could 'join in' (*ibid*:55).

The European Universities Association (2010) indicated that 'originality' could more reasonably be considered as innovation of approach or creativity in application. Clarke and Lunt (2014) have also suggested that the 'nature' of originality differs between disciplines and fields, with STEM areas often being regarded as 'original' only with extensive quantitative data confirmation, peer review and assessment of suitability for publication. In contrast, they argue that the social science and humanities fields regard originality as being more linked to expansion of existing knowledge within the discipline. Moreover, within the social sciences, originality does not just relate to research product, but also in the process or methodology utilised to achieve the outcome (Baptista *et al*, 2015:57). Lovitts (2005) expands this definition further by suggesting that 'original' contributions can be regarded as making an 'incremental' step of accumulation in the knowledge base, through reinvigoration by novel approaches, for example by the questions asked, the interpretation of an idea or the implementation of new methodologies. In this respect, Baptista *et al* contest that originality very much exists within the interaction between 'old and new' (2015:58).

The approach that my research will take in quantifying 'original contribution' is to consider the aspect of creativity and innovation suggested by Pope (2005) who identified it as *'...the capability to make, do or become something fresh and valuable with respect to others as well as ourselves'* (*ibid*:11). This definition is important as it indicates that change should happen not just in the impact on the discipline of the research being conducted, but with the impact

of the research on the researcher themselves. This links more widely to Bennick-Björkman's (1997) definition of creativity as being defined through its infusion with novelty and relevance, identifying that the 'creative' process is an intrinsically 'human' dimension. Further, Frick, Albertyn and Bitzer (2014) have suggested that the creation, innovation and delivery of 'incremental changes' to the disciplinary knowledge base is not without 'risk', therefore doctoral researchers need courage to pursue studies that expands knowledge and 'disrupt' established thinking.

Within contributions to research there are different aspects that should be considered, for example some research strands include; devising or expanding a new theoretical concept, revising an existing conceptual framework, applying established theories in a novel way, carrying an argument forward in a new direction or application, adding to other researcher's thinking or utilising a new methodology, cohort or setting to test existing theories, hypotheses or findings (Badenhorst, 2021).

The original position that this research will occupy is to 'join the argument' and extend the relationship between 'old and new' readings of 'resistance', from a multidisciplinary perspective. This is to reposition and make space to reinterpret the current debate around the perceived mental health crisis of CYP within education. This will be achieved by refocusing the issue through a sociological perspective, to explore how contemporary readings of resistance as motivated measure of political, external opposition to suffering can reframe the mental health debate. This is an attempt to reduce the privileging of favoured psychological approaches like the biological model. This will be through an expansion of the established conceptual framework provided by Holland and Einwohner (2004), to identify how including a category of *Reactive Resistance*, would create 'pockets' to enable the current behaviours seen within many CYP, being interpreted as 'wellbeing issues' and 'mental health concerns', to be successfully argued as constituting micro-political resistance.

This assertion can be rationalised by drawing strands from the work of a range of researchers including; Brekhus (1998) (observing the 'unmarked'); Cloward and Fox-Piven (1979) (resistance as endurance); Cohen (2004) (living as opposition); McClaren (2002) (the body as a site of resistance); Scott (2018) (the sociology of nothing); Wagner (2012) (micro-political resistance); and Ybema, Thomas and Hardy (2016) (the construction of resistant self-identities). This innovation adds 'space' within the framework to reinterpret resistance forms

of behaviour, not currently acknowledged in their categorisation of *Not Resistance,* to recognise an emergent form of intrapersonal protest. This argument has been further strengthened by also introducing a new category to the framework by questioning if the action produced through resistance had change 'potential'. Including this category served to 'make visible' styles and types of resistance that currently are restricted to only recognising consciously commissioned acts. This expands the scope of resistance, hinted at to some degree in Holland and Einwohner's category of *Unwitting Resistance*, but thus far restricted in scope by not including unconscious acts of omission.

A further contribution this research will make is to engage with a deliberately alternative psychological reading to address issues within the Wellbeing Agenda, in order to demonstrate how selective abstraction of concepts and constructs from within the discipline are chosen specifically by the neoliberal education agenda to promote the *status quo*. In using the psychodynamic perspective, it will both critique the current explanations of mental health from a biological approach and further, offer explanations as to how internal 'resistance' will mean that psychotherapeutic strategies for intervention based on forced 'normalisation', (put in place by educational institutions and wider mental health service providers), are likely to fail. This will entail the consideration of wider interpretations of resistance, as a psychological deflection and defence against a 'therapeutic' assault. This will utilise the work of Barabasz *et al* (2016) (subject and object energy); Emmerson (2013) (vaded ego-states); Messer (2002) (therapy as ego-agitation) and models of therapeutic resistance including Greenson (1967) and Mahalik (1994). This contribution is important as, considering an alternative psychological perspective through which to refract wellbeing interventions, rather than the positive, biological and clinical psychology paradigms currently utilised, means that the intervention approach itself becomes part of the problem. Especially when it pathologizes behaviours, introduces 'talk' therapies and resorts to medication to ensure compliance. This positioning is novel because it focuses on the wellbeing interventions themselves as generating resistance. This provides new insights into the impact of wellbeing measures being used routinely across education sectors, especially in the 'blanket trawling' for mental wellbeing indicators across all CYP within many settings.

In short, the contribution of this research will be to 'make visible' the small contradictory spaces that exist between the vehicle of statutory monitoring and the mechanisms of

mandatory intervention, within the interpersonal and subjective domain of individual mental wellbeing. It will examine potential implications for individuals who are subject to this process and offer an alternative view of mental health issues in education as a subversive political action instigated as 'psychic salvage' against the alienation that is felt. A further contribution this research will make is to consider the application of theories of alienation (Elliott (2000) and Helm *et al* (2019), *State Trait EI Model*) in understanding how interventions within the Wellbeing Agenda can increases a sense of alienation and trigger ego-defence mechanisms, triangulating with the work of Barabasz *et al* (2016) in transference of subject and object energy and Social Baseline Theory (Coan and Sbarra, 2015) which considers how alienation can be created through a process of ungrafting, further triggering psychological resistance. This work adds to the research literature in providing novel insights into multi-disciplinary collaborative spaces around resistance, transiting between the internal and external environment, conscious and unconscious intention and private and public effects of micro-social and intra-personal action. It also pulls resistance theory outwards and inwards in contemplating both the sites and types of resistance. These inclusions all have implications for practice if the starting premise is positioned to accept that wellbeing interventions, rather than positively improving CYP experience of education are potentially causing alienation, which is giving rise to resistance.

This could be further expanded to explain that the creation of this 'protective ego state' is enacted to both minimise the emotional harm being inflicted and to undermine the alienating system that perpetrates the harm. Streeck's (2016: 263) concept of '*social entropy'*, has suggested that capitalism will eventually *'...consume and destroy its own foundations'*. In this regard, the urgency with which the Wellbeing Agenda is being radically enforced suggests that there is a sense of concern pervading government. The current 'crisis' in mental health, if interpreted from within the marginalised spaces between monitoring and intervention, can shed light upon the attempts by government to minimise its impact on economic efficiency. Interventions are not happening due to a sense of moral outrage over the endemic stress and tension that CYP are subjected to, but from the 'panic' around a diminishing and 'diminished' future workforce.

As stated, the research direction will move away from the underpinning biological psychology of the detection, labelling and treatment of mental illness. It will briefly examine the

components upon which the current wellbeing narratives are based and critically examine why these are, at best, unhelpful and at worst, psychologically harmful. This will be with a focus on therapy intervention and 'resilience', which is a major component of the positive psychology theory underpinning much of the Wellbeing Agenda as a primary political focus, whilst giving no critical consideration to the economic and social injustices it is proselytising children should become 'resilient' to. Therefore, I will advocate that this is both detrimental to CYP's mental health and psychological integrity, due to its capacity to create alienation. Notwithstanding, to enforce such an approach can be perceived as irresponsible, unethical and not at all in keeping with the ethos of social justice, described by Denzin (2017).

As stressed at the outset, this thesis has at its core 'resistance'. This will be exemplified not only in the engagement with a range of constructs relating to resistance, but it will also demonstrate resistance to the current enforced approach to manage wellbeing issues formulated in educational contexts. Also present is an attempt to 'resist' the orthodoxy of academic protocols in respect of the structure, format, framework and expectations of doctoral writing. It is hoped, in the spirit of Denzin (2017), that there is courage to be critical and provide a persuasive, well-reasoned and illuminatory argument to cast light onto a parallel discourse around an issue of contemporary importance within current practice. What is absent, however, is the stricture and constraint that inhabits proscribed parameters and protocols around academic work, the adherence to methodological aesthetics and the pursuit of 'data'. It is also imperative to consider, when assessing the context of doctoral writing, that Giroux (1983:17) suggests *'...methodological 'correctness' does not provide a guarantee of truth'*. He further advocates that, within research, attention is focused usually on theory as a mechanism of contextual framing. Woodrow (2000:5) has commented that theories are often used in research *'...in vain more often than in value'* and as such there also needs to be consideration of what specific interests' theory serves and how theory itself can be used, methodologically.

IX. Research Questions

In concluding this introduction, it is important to consider how the questions it seeks to address can illuminate not only the current educational debate but examine the impact on educational provision within institutions in terms of legislative changes and policy directives. This is important because these changes have had a direct impact on professional practice

and autonomy which has both political and social justice implications. These emerge from being forced to enact procedural change, based on decisions derived from information that can be perceived as both ill-advised and spurious. This is further illustrated within the theme discussed earlier as a need to 'resist' a momentum that has become relentless. At any level of compulsory educational practice, it is not possible to step outside of the Wellbeing Agenda as identified by Saltmarsh (2016). There are no spaces, in the delivery of educational services at a mandatory level, where resistance is tolerated. Recognising, monitoring, recording, tracking and intervening in CYP's mental welfare is now a statutory obligation within compulsory education and practitioners can be personally liable if they fail. From primary to F.E levels of education, there are no central domains or periphery margins were subverting the Wellbeing Agenda is an option. Arguably, this has the impact of effectively nullifying the claim of an 'evidence' base within both policy and practice around the wellbeing polemic, but further of imposing a 'statutory silencing' on any voice that resists what could be regarded as an oppressive mechanism of intervention.

The research questions posed here reflect my positionality in being constructed from the point of view of an educator; wanting to further understand the consequences of the practices and processes I must implement which has led to an examination of the underpinning narrative on wellbeing. They have also been positioned from my location as a psychologist, to examine the expansion of the 'psy' disciplines into education, to consider the impact of their effects on the lives of CYP and to consider if they are helpful or potentially harmful. In this regard, this thesis follows four specific threads which are Representation, Alienation, Resilience and Resistance.

1. In respect of recent media coverage relating to increases in concern for mental wellbeing, what evidence is there to suggest that diagnosed mental disorders in CYP are increasing? (Representation)

This question will consider how the debate around the mental health crisis has been created. It will examine how it is understood, what it constitutes and how it has been constructed. 'Crisis' suggests an exponential increase, therefore the definitions of mental health have to be considered: for example is there a genuine increase in the prevalence of mental illness in diagnosis, or an increase in reported incidents; has there been an increase in recognition of existing conditions, a change in definition of what constitutes a condition, a change in

parameters or boundaries in the way a condition is defined, a change in private or public perception of the condition or a change in the recording or reporting of incidences?

2. To what extent can it be argued that educational settings are creating mental illness in CYP? (Alienation)

The U.K has one of the longest compulsory schooling periods in the world. Children are therefore subjected to the impacts of education policy for many years. During that time CYP are exposed to what Althusser (1970) terms the *'ideological state apparatus'* that uses *'technologies of affect'* to regulate and control behaviour in line with capitalist principles. These methods result in a focus on neoliberal values of personal accountability and responsibility, entrepreneurialism, self-improvement and competition which are emergent in marketisation; with failings attributed to individualised mental frailty or lack of resilience. The question will examine whether schools themselves can be viewed as being responsible for the steep rise in reported mental wellbeing issues, in the way that they employ technicist approaches to the management of wellbeing in education which it could be argued, create anxiety and alienation. Bendix-Petersen and Millei (2016) have suggested that whilst psychology disciplines have been actively embraced by educators and utilised within schools to manage CYPs emotional and social conduct, there is limited consideration to how this also operates as a form of 'regulation' (*ibid*:6).

3. Could it be argued that the Wellbeing Agenda is predicated upon control rather than care? (Resilience)

The issues relating to perceptions of mental health in young people are nuanced and complex. It has been claimed that there is a substantive increase in the number of CYP who are presenting with mental illness. Further, that the cause of such mental health issues has been related to individual neurobiological deficits that can and should be treated using pharmacological and other psychotherapeutic interventions. Rose (2013:14) has suggested that the prevalence of mental health issues can link to failures of mental health professionals to consider *'...the extent of their troubles'.* Isin (2004) invites the term *'neuroliberal governance'* where the neurosis created by market force consumer-based capitalism is framed in the mask of personal depression relative to biological function, as these individual psychopathologies are more benign, palatable and manageable than the threat of whole class

anxiety. CYP are actively encouraged to expose their inner mental states for assessment, through a battery of inventories and psychometric tests which creates an internal locus of self-scrutiny, where CYP are compelled to manage their own 'neurosis', in the form of 'resilience training' or medication to eradicate undesirable symptoms of affect. This question asks whether this exposure is for the benefit of the child or for the sake of the state. This question will therefore seek to examine if the origination of the current Wellbeing Agenda is founded upon humanism or capitalism.

4. What evidence is there to suggest that the reported 'crisis' has emerged in response to interventions created by neoliberal education policy to manage perceived mental health issues? (Resistance)

This question will allow engagement with a range of themes around the 'crisis' that is related to education policy, practice and priorities. This is to see if an alternative position can be examined which could argue that what is manifesting as mental ill health is actually resistance, created by the latent impact of external forces of education policy and the pressure to enforce a happiness agenda within the wellbeing remit; as a reaction to the dehumanising, alienating and marginalising practices employed in the current 'culture of wellbeing' within education.

To conclude, it is necessary to consider the underpinning premise that drives this research ambition. This can be articulated with reference to Giroux (1983:106) who suggested that *'...what is needed is a notion of alienation that points to the way in which un-freedom reproduces itself in the psyche of human beings*'. This comment has given impetus in proposing an alternative reading of the current mental wellbeing discourse, that there is a relationship between the prescribed 'internalisation' of individual oppression in alienation and the 'legitimacy' of prescribed therapeutic interventions deployed to supress awareness of it.

Research questions 3 (Resilience) and 4 (Resistance) have both questioned the underlying motivations and ethos of wellbeing practices within educational contexts. These research questions have emanated from the practical applications of the Wellbeing Agenda that have been implemented within my own institution from a raft of internal policies and procedures. They are questions, not assumptions, as they are not hypothesised. The questions have

positioned the research as an inquiry of 'to what extent'. Indeed, for both questions the overwhelming and unilateral adoption of the wellbeing narrative prompted colleagues to ask why I was "bothering" to research this issue at all.

These policies and procedures have included the Fitness to Study Policy and Mental Wellbeing Policy documents, extensive staff training on approaches to student mental health issues, changes to academic demands as part of the provision of wellbeing care, documentation and reporting procedures through electronic record keeping and the role of job appraisals/H.R demands in the management of staff responses. In this regard, there is bias within the focus of the question based on my personal experiences of operating its practices. Pannucci and Wilkins (2010) have given an extensive outline of research bias and processes to manage these impacts, arguing that no research can be free of bias, rather they question to what extent the bias has *'...prevented the proper study design and implementation'* (*ibid*:619). In this regard it is appropriate to consider where bias could have become problematic within the research conducted.

As the research undertaken here did not generate primary data, much of the more common biases they allude to, for example in study methodology and design (Flawed Study Bias), sampling (Channelling Bias), participant engagement (Selection Bias), interpretation of data results (Information Bias) and consideration of extraneous and confounding variables (p.620) are not relevant. Of more benefit is work by Baldwin *et al* (2021) who consider the potential biases within secondary analysis. They report issues around cognitive biases such as Confirmation Bias (focusing on evidence consistent with personal beliefs) and apophenia (looking for patterns in random data) (p.1). However, they also point out that much of the work needed to ensure a lack of bias and transparency in reported studies should be conducted before the investigation takes place, which includes pre-registration of data access, multiversal analysis, hold-out sampling and trial analysis on datasets (p.3). Whilst the potential issue of biases is noted, the methods suggested do not relate to this research as it was not possible to identify studies prior to the research taking place due to the nature of the questions proposed, however some issues from their recommendations were incorporated, for example the research here is not hypothesis driven and the work does not require the satisfaction of statistical analysis to achieve its stated aims.

When starting to approach work on questions 3 and 4, I looked at the work of Lisi (2016) and identified one way to try and minimise bias was in producing a conceptual framework within which to locate work that I researched, which was later transposed into a table that indicated key themes and sources as part of the Evaluative Inquiry. These were kept in comprehensive handwritten notes, schematics and annotations as a large range of different resources were found. This also included 'embracing' the multi-dimensional aspects of my positionality and acknowledging that my own understanding, working practice and professional background would inform my choices. I endeavoured to minimise bias and remain open-minded during the research phase in two ways. Firstly, by looking at the current position and identifying if I could see gaps in practice. These were in the form of inconsistencies, irregularities and questions that were not satisfactorily answered (for example in one training course I asked why students declaring mental health issues were not required to produce 'evidence' of this, when staff in the same institution were required to produce extensive evidence which included mental health assessments through occupational health services, confirmatory medical evidence and in some cases medical records and prescriptions). This resulted in my questioning more fully what was missing and what had not been included which is why the thesis has recurrent references to gaps, pockets and troughs. As stated, having a psychological (and clinical) background made me suspicious of these factors.

Other ways that I attempted to remain open minded was in pursuing evidence from examples that were given in secondary data sources, this involved not only extensive reading from citations in resources where counter arguments or criticisms had been specifically included within the work, but also in regularly reflecting on where recurrent themes or points were made that related to work already covered. One example is the motif of fabric used as a device to examine resistances. An example of operationalizing this process is how I utilised research conducted by Naz (2021) which I read when considering research question 4. Within the research Naz analysed the 2019 changes to the EIF in using it to analyse the presence of a neoliberal discourse within inspection practice. As a result of this, I worked back through different EIF inspection frameworks and analysed them to see if this was an isolated example, including examining what issues there were politically at the time the amendments were instigated. This included extensive and time-consuming research and summation around the different iterations of the EIF. This was used to draw conclusions that there was a history of political anxieties around wider behaviour being enacted through EIF changes that mirrored

closely government priorities in an attempt to exert social control. Lisi (2016) has further identified that in research that creates emergent and inductive reasoning, it is important to remain vigilant for patterns or themes of data, whilst being conscious of Baldwin *et al* (2021) call to prevent apophenia. In this respect, I created a 'rule' whereby I had to be able to triangulate multiple examples or illustrations of a point or theme that emerged from within the secondary data, before I would include the point in my thesis. This meant that multiple studies were read and recorded, but were not included, even if they produced points that I felt in agreement with.

CHAPTER 1: A MENTAL HEALTH CRISIS - REPRESENTATION

Introduction

Asking anyone who works within a mainstream educational context; whether that be a primary school, F.E college or university, if they feel the focus on CYP's mental health issues have increased in recent years, will almost certainly yield an affirmative response. National and local policy and change to practice within education has created the perception of a mental health 'crisis' engulfing education which has resulted in the belief that vast numbers of CYP are afflicted with a range of severe mental health conditions and disorders, from depression and anxiety to dysmorphia and self-harm. This has, they will attest, been reported extensively in a variety of press and wider media, giving the impression that CYP are in the midst of an epidemic of severe mental illness. For example, SecEd (2020) had a graphic identifying that '*1:6 children aged 5-16 have a probable mental health disorder*'. Given that there is a current U.K compulsory state provision of schooling for around 8.89 million children (BESA, 2021), this represents a figure of over 1.48 million, which would actually be higher, give compulsory school age is now 18 years and the age range of 16-18 is emotionally and physically challenging for many young people. This chapter seeks to examine the representations of mental health in CYP in England and explore the nature and evolution of the perceived 'crisis', offering an assessment of the current forces and tensions, its levers and drivers, to try and determine its possible antecedents and assess to what extent such a crisis may exists. My own positionality has meant that I have been somewhat sceptical of these claims; having worked with individuals who have been diagnosed with complex mental health issues, the behaviour I have witnessed in the CYP that I encounter, (with a few notable exceptions), have manifest as high levels of anxiety and some distress, but with little evidence of clinical psychopathology. Indeed, I have been surprised by the types of discussions that I have heard take place between 'wellbeing' staff surrounding CYP in relation to their 'mental health'. From a clinical position, the language being used by educators, especially 'Mental Health First Aiders' is concerning. This includes the numerous CYP who have been referred or are awaiting referral to CAMHS within my own institution. Therefore, I acknowledge that other educators may hold a different view.

In terms of the lexicon of clinical terminology used to describe CYP within school context, Harwood and Allan (2014) have commented on the increasing psychopathologising of CYP

within education in relation to how clinical discourse are used to articulate children's experience of learning in a continually psychologised pedagogic context, which includes the diagnosis and medication of specific conditions like ADHD and anxiety and the settings role as 'proxy' therapists. Of main concern is the continuity with which groups already disadvantaged face further inequalities and injustices as a consequence. In particular, they reference black and ethnic minority children (see the following section), those from a low socio-economic background and boys who are more likely to be impacted for behavioural management interventions for autism and ADHD. A key aspect is not that educational settings are reactive to support students and pupils who are experiencing mental health, learning or behavioural issues, but that they are *proactive* in the identification and referral in terms of placing CYP in the path of clinical and psychological services through CAMHS and therapeutic practices like counselling within the educational institution.

Further, they argue that rather than creating a positive outcome for children, this strategy serves to create a *'...displacement of education by medicine and the reproduction of exclusion and inequality'* (*ibid*:7). Harwood and Allan's main argument is that education has taken second place to the medical and psychological needs of the child, given that *'...care, medicine and policing as well as educational knowledge enact the child in different and not necessarily complementary ways'* (*ibid*:7). This example can be supported in the discussion given on race and psychological interventions which follows. This section will also highlight the tensions that are endemic within pedagogic practice, as teachers navigate the role of providing education and management of affect. They further argue that educators should demonstrate more criticality in reflection on the duality of this role and its implications for the child. This is especially true given the 'proliferation' of the mental health issues CYP are now presenting with (p.8). Harwood and Allen also comment that consideration should be given to *which* CYP are being diagnosed or treated with different conditions and in what ways such trends in diagnosis can be seen to be significant (p.8).

An example they give includes the very 'public' medication queues in schools as children with 'pathologies' stand in line to receive their pills. This is a stark image of 'othering' for these children, who are unable to manage their own medication because of their age (in terms of safe storage) but, who as a consequence of this activity, are 'constructed' by staff and peers as having a 'disorder' (p.1). They describe this process as being *'...captured in the diagnostic*

gaze' (*ibid*:1). Harwood and Allan express a concern that children have become constructed through the pathology that entraps them in this gaze, arguing that the priority of their education has been replaced by the practices of mental health management. They also suggest that the increasing pathologizing of CYP has become attached to issues of school-failure, absenteeism and poor performance. As with Behrouzan (2015), Harwood and Allan have identified the appropriation of a clinical lexicon in which the discourse of pathology is used to articulate lived experience of CYP, whose behaviour is described in terms of their potential symptomology. They argue this is a top-down imposition of labels which acts to the child's detriment in shaping the interactions and relationship that peers and adults will have with them, which effects how children are constructed as 'ill'.

Examination of mental wellbeing is a sensitive, complex and contentious issue, especially when this is linked to CYP. Whilst media have presented to the public that there has been a rapid and expanding mental health 'crisis' within CYP, much of the 'evidence' upon which this is based has not been appropriately scrutinised or evaluated, especially in the reporting of 'headline' information, for example the shortcomings in the NHS Digital Survey methodology and extrapolated findings examined in this chapter. An example to illustrate this point can be seen in Wille *et al* (2008) who critically assessed a range of self-report data in their research to consider the degree of 'impairment' of mental health in children (deemed not to meet diagnostic thresholds for formal diagnosis of a condition, but who exhibited 'emotional distress'). They found that the self-reports made by children in the sample (aged 7-17 years) on their level of distress and 'impairment' of function were not correlated with reports made by parents on the same questions. The research showed a *reversal* of trends, especially relating to gender, by parents from the children's findings. This means that there is limited concordance between how children view or report their own emotional distress and level of 'impairment' and the perception of their parents on their level of mental health. This has implications for the NHS Digital Survey which included a substantial number of parental reports on children's mental health in their analysis. The subsequent rapid changes made in education policy and practice to address this 'crisis', (for example the NHS Digital Survey of 2017 and the *Transforming Children and Young People's Mental Health Provision:* (GB. Green Paper, DfE, 2017) has meant that any refusal to accept the dominant narrative on the 'state of wellbeing' creates tension. It could be argued that in this regard, the discourse around mental health has itself become '*etiolated*' (Scott, 2008).

1.1.1 The ‘ CYP’

The group of children and young people who are the subject of this thesis are referred to, for brevity, as ‘CYP’. This is not intended to imply that they are an entirely homogenous group, there are significant differences in the lived experience and realities of these young people, however there is some degree of heterogeneity between them as they have a range of characteristics in common. They all belong to a collective of people who are of statutory school age (5-18 years), all within some form of education, apprenticeships or training and employment in England. They are also engaged within education in a range of settings and contexts, which could include; academy schools; free schools (university technical colleges and studio schools); faith schools; foundation schools; community schools; grammar schools; special schools; city technical colleges; independent schools; state boarding schools; young offender institutions; hospital education; home school; sixth form colleges and further education colleges (Gov.UK, 2023).

Additionally, the CYP all experience the impact of education policy that shapes and determines what and how they should be taught. CYP within education in England are also subject to wellbeing and safeguarding policies and strategies, a range of education initiatives in health promotion and social functioning and all are subject to procedures for intervention in attendance, academic achievement and school behaviour. Although all CYP are educated within a school environment that is shaped by its wellbeing agenda, not all are impacted in the same way. There is evidence to suggest that some groups of CYP are more likely to be targeted for interventions than others. The following assessment will examine the role of schools in referral of ethnic minority CYP and in particular Black males. The NHS primary and secondary mental health care providers record referrals for their services as being from within ‘education’. However, they do not specify the setting type, so the distribution of referrals by education providers is not fully transparent. Further, the CYP’s experiences of education will be very different, as the schools they attend are also located within varied local authority areas, with different demographics, geographical regions, socio-economic stratification and education provider status (i.e., Academy chains).

The focus of this thesis will be on CYP in England, as the majority of data in relation to mental health statistics are mostly obtained through sources like NHS England and Public Health England (PHE) (now U.K Health Security Agency). Additionally, as detailed in this chapter,

datasets available from health providers of mental health services do not generally provide statistics that relate to race, ethnicity, religion or culture. Most statistics identify the age (which varies between different reports, even from the same provider), gender (restricted to male and female) and occasionally geographical location.

Within the CYP group there also exists a range of differences relating to their individual circumstances, experience, lifestyle, life expectations, aspirations, family situation and relationships (including with friends, peers, teachers and other education, health and wellbeing professionals). This range covers individuals who, within their school context may have different; ethnicities, cultural background, sexuality and gender, learning support needs, disabilities, illnesses, physical disorders, family and financial responsibilities. They may also have different family constituency, they may be in local authority care, with foster families or be estranged and living alone. This brief outline illustrates the vast array of contextual circumstances that can be potential sources of impact on CYP's mental health. This suggests that CYP differ significantly and their personal circumstances create individual and unique lived experiences.

As suggested, most epidemiological data relating to CYP in respect of mental illness does not report discretely on mental health, as data collected (for example through NHS) is clustered with learning disabilities and autism. Currently, there is no way to distinguish just the mental health component from the figures, which means it is difficult to draw inferences from the data. Further, as stated, statistics for CYP in respect of race and ethnicity are not accurately collected by NHS England or NHS Digital; data is recorded mostly by age and gender, on account of the data for ethnicity being *'...imprecise due to the small number of respondents'* (Baker and Kirk-Wade, 2023:14).

Their recent report on mental health (House of Commons Library) provides a summary breakdown on current mental health data. This presents a snapshot of key trends in mental health across England but does not exclusively cover the age range specified as CYP in compulsory schooling (5-18 years). However, it can give indicative information that contextualises CYP experiences of mental health issues. The recording of prevalence rates for common mental health disorders was given for 16-24 year olds as males (10%) and females (28%), the highest by some margin, with the average for all female ages being (20%) (Baker and Kirk-Wade, 2023:5). The most common types of disorders reported were General Anxiety

Disorder (5.9%) and Depressive Episode (3.3%). Others not specified registered (7.8%), this included conditions like PTSD, bipolar disorder and eating disorders (*ibid*:6). A measure given that related to ethnicity looked at common mental disorders reported within the last week (but for all ages, so not just CYP) which identified Black and Black British (23%), Mixed and Other (20%), Asian and Asian British (18%), Whiter British (17%) and White Other (14%) (*ibid*:7). This suggests that higher incidences of reported (not recorded) mental health issues were received from ethnic minority groups. However, as can be seen, this categorisation is blunt and incongruent in developing an understanding of mental health profiles by ethnic diversity. Additionally, common mental disorders were also calculated by employment status, identifying that the economically inactive (33%) and unemployed (29%) recorded the largest figures, full time employed (14%) was the lowest (*ibid*:8). This also obscures the picture of mental health distribution as there is also likely to be a skewing of the measure for employment status by gender and ethnicity.

Interestingly, rates of PTSD and Bipolar Disorder were also recorded as highest in 16-24 age range, with males (4%) and females (13%) and males (3%) and females (3.8%) respectively. Further figures identified that in measures of both self harm and suicidal thoughts, 16-24 year old (females) showed the highest rates (20%) and (10%) compared to males reporting (6%) for both types (*ibid:*13). The report also identifies that white ethnic groups (especially females) were (20.1%) more likely to have a probable mental health disorder than other ethnic groups (9.7%) (*ibid*:14). However, the report was compiled using statistics collated during the Covid-19 pandemic, which created distinct challenges for mental health due to lockdown constraints. This is acknowledged in the report and is believed to account for a significant spike in adult reporting of mental health concerns.

The statistics identify that females between the ages of 16-24 record the highest value across every measure in relation to mental health. However, it does not specify their ethnicity, so this could incorporate females from a range of cultural groups.

A landmark report by Kapadia *et al* (2022) has detailed a range of inequalities in accessing mental health services for ethnic minority groups. They echo the point that monitoring of accurate service use by ethnic minority groups in national data sets is poor, leading to 'missed opportunities' to assess the level of inequalities in services delivered (*ibid*:4). Their review identified extensive barriers in accessing services for these groups. Barriers to access included

logistical and operational problems; for example, a lack of translator services or availability of information in different language formats (i.e., for digital services); failures in G.P services to refer appropriately and disparities in referral in services between Black and White groups, (especially for services like IAPT). Where referrals were made, fewer sessions were offered to Black service users for treatments like CBT, compared to White groups. There were also persistent inequalities in compulsory admissions to psychiatric facilities, especially for Black groups. They reported that individuals with Black, Mixed and Asian ethnicities were more likely to be treated differently to White counterparts when using inpatient services; they also 'faced harsh restraint' within the settings and were more likely to be placed into isolation (*ibid*).

In respect of CYP, they identified similar inequalities but recognised additional contributing factors including a distrust of health service providers and health professionals, due to perceived injustices relating to the treatment of Black African and Caribbean groups (especially by young black males). They further reported that CYP from Black ethnic groups were less likely to be referred to CAMHS through G.P services, but more likely to be referred through social services, criminal justice or education settings (*ibid*). Whereas White groups received higher referral rates from primary care, were in treatment for longer and were more likely to self-refer. The report also found that where referrals were made, for example to IAPT services, ethnic minority groups were less likely to remain engaged with services.

The issues of race and ethnicity within mental health services in the U.K relate to a range of factors including; the assessment and diagnosis of disorders; referral routes for admissions to services; potential treatments for mental health issues and the evaluation of services from the user's perspective. An example of these factors can be seen in Ahmad *et al* (2021) who examined data from the Millennium Cohort Study to assess the relationship between mental health in CYP and their ethnicity.

The data generated suggested concurrence with Kapadia *et al* (2022), showing there was a higher prevalence of mental health issues in CYP from a Black and Asian background, compared to White British CYP. Ahmad *et al* (2021) cite a range of studies to support that mental health issues may be worse in these populations, not due directly to ethnicity, but from the additional factors experienced because of ethnicity. For example, Reiss (2013) identified CYP from Black and ethnic minority groups are more likely to also experience

socioeconomic disadvantages and Jivraj and Khan (2015) expressed that CYP from these groups are more likely to face social adversity, such as living in socially deprived areas with limited access and range of support services. Priest *et al* (2013) add that CYP from Black and ethnic minority groups are also more likely to experience marginalisation and be subject to discrimination and racism. This is important as Berger and Sarnyai (2015) state racial discrimination creates a heightened and prolonged physiological stress response. They postulate that *'...discrimination activates key regions of the salience network....salience dysregulation may be a result of chronic discrimination and may make the individual more susceptible to other stressors....a common pathway with mental disorders involving salience dysregulation such as psychosis and schizophrenia'* (*ibid*:9). This research examined the impact of an increased allopathic load on the neurobiological stress responses in the Hypothalamic-Pituitary-Adrenal (HPA) and Sympathetic-Adreno-Medullar (SAM) axes, identifying how exposure to discrimination, through racism, affects brain physiology and biochemistry. It could also be used to explain why higher levels of stress are seen within these ethnic groups and why there may be increased incidences of psychosis, especially within Black ethnic minority groups. These finding also link to the work of Fanon (1986) discussed in Chapter 4.

Similarly, Tolmac and Hodes (2004) identified that these same findings are reflected in admission rates for adolescent Black youth (including Black African, Black Caribbean and Black British). This showed that individuals from within these ethnic groups are overrepresented in psychiatric units, especially for involuntary detention under the *Mental Health Act* [GB. Department for Education, 1983] (see *Academies Act (2010)*) including sectioning for diagnosis of psychotic disorders. However, they further suggest that the diagnosis given were valid and reliable when using DSM-IV criteria, under both the OPCRIT checklist and K-SADS inventory (Non-Affective Psychosis). This study is important as it concurs with wider studies that Black groups (especially males) were more likely to be diagnosed with a psychotic disorder than White groups (irrespective of gender) (Koffman *et al*, 1997) and six times more likely to be detained in mental health facilities (Davies *et al*, 1996). They attribute the higher level of admission of Black ethnic groups with psychosis as being a result of social adversity, poor socioeconomic situation and high exposure to stressors. Tolmac and Hodes dismiss the notion of bias within the diagnosis, based on the process of research involving 'blind' rating by clinicians, where ethnicity was not identified. They also noted a feature of the compulsorily

detained group specifically was their recent migration (within 10 years) and for some individuals, refugee status.

Barnett *et al* (2019) have also supported the findings that Black Caribbean and Black African ethnic groups were significantly move likely to be admitted to psychiatric facilities with compulsory detention than White and other ethnic groups. Their analysis located the increased risk as being down to contact with criminal justice services, higher likelihood of social disadvantage, increased incidences of psychosis, higher risk of violence and distrust of health services like G.P practice. Barnett *et al* make an important point regarding intersectionality in respect of potential risk of admittance for psychotic and non-psychotic disorders. This is because explanations of risk are 'confined' to ethnicity without considering a wider, more complex interplay of factors such as disadvantage, poverty and barriers to access for services. Importantly, they specify that psychosis alone as a symptom is not sufficient to compulsorily detain someone. The findings also do not satisfactorily explain why there are readmissions for individuals from Black ethnic minority groups after diagnosis and discharge. What Barnett *et al* suggest is that some of the potential risks related to admission could be explained by the person's experience of care whilst detained.

Supporting this position, McKenzie and Bhui (2007) presented a 'snapshot' study of NHS and private mental health facilities and learning disability units which also found disproportionally high admission rates for Black African and Caribbean service users (21% of patients) against White British and White Other groups. They also found that individuals within these groups were more likely to be involuntary committed. Their findings also reported that treatment for individuals from these ethnic groups were less likely to be based on psychotherapy and more likely to be psychopharmacological, often with coercion. They argued that treatment pathways were more likely to be influenced by a service user's racial group, than by their specific diagnosis, suggesting that the process was institutionally racist.

Referral routes are also subject to racial disparity. Daryanani *et al* (2001) have highlighted that the gathering of ethnicity data within services is a contributing factor to poor assessment of service access for ethnic minority groups. Linked especially to the limiting 'groups' given to categorise ethnic information. Further support for this position can be found from Dogra *et al* (2012) who have reported that difficulties with 'categorisation' of ethnicity is that they 'stand as' a proxy for wider socio-economic and socio-geographic and environmental issues,

like poverty, deprivation, disadvantage and poor housing. Also, factors like migration itself (especially if traumatic) compounds differentials for mental health issues from context, history, experience and expectations. Daryanani *et al* further concur that a bias operates for referral of adolescents with mental health issues to CAMHS, dependent upon their ethnicity, with the nuance of the concerning 'issue' implicated in the route chosen. For example, White groups are more likely to be 'medicalised' and referred through a G.P or specialist practitioner, whilst Black ethnic groups are referred with educational issues, through schools and colleges and Mixed ethnic groups through social services, as there is an increased likelihood this will be linked to deprivation and socioeconomic factors. An illustration of this can be seen in Rutter *et al* (1974) who advised children in schools are more likely to be regarded as 'difficult' or 'deviant' with problematic behaviour. This is reflected in exclusion rates for some groups, i.e., Black-Caribbean children represent (7.3%) of exclusions from school, disproportionate to the (1.1%) within the school population (Osler, 1997). This gives clear indication of the school's role in engaging ethnic minority groups within the Wellbeing Agenda.

Additional evidence in respect of referral routes is found in Corrigall and Bhugra (2013), who also confirmed that the disparities which exist within admission to adult psychiatric support services for different ethnic groups are mirrored in adolescent mental health provision. Their research also concluded that Black ethnic minority male adolescent groups were at higher risk of admission to psychiatric facilities than their White counterparts. This rate applied only to psychotic disorders, not to other mental health issues. Further, a rate for risk of admission for Black males with other types of non-psychotic disorders was very low. The risk of admission with non-psychotic disorders was high for Black females (who were over-represented) when compared with White females. The study also found variance in rates for admission with psychosis in Asian ethnicity adolescent groups, which was higher than for White adolescence. British Indians were seen as low risk for admission on psychotic and non-psychotic disorders, having the overall lowest proportional prevalence rates and risk of any group. As this group had very small numbers, Corrigall and Bhugra suggested that calculation of compulsory detention was too small to specify. Their study suggested that there was not a systemic ethnic bias within the application of the *Mental Health Act* [GB. Department for Education, 1983], had there been, it would be expected to see similar numbers for compulsory admission for

both psychotic and non-psychotic disorders. So, the picture is more complicated than just potential systemic bias within the application of referral and admission processes.

Edbrooke-Childs *et al* (2019) also concluded that Black and ethnic minority group CYP were more likely to engage with healthcare services like CAMHS through compulsory, not voluntary routes. They also found that CYP from Black and ethnic minority groups were less likely to be referred for mental health services through health routes, instead they were referred through education and social care routes. One explanation given was that Black and ethnic minority parents were less likely to register for primary care services (like G.Ps) whereas children were exposed to compulsory schooling, which may explain the levels of referral coming via education providers. Vostanis *et al* (2013) identified that British Indian and Indian ethnic minority CYP were less likely to engage with formal mental health services like CAMHS but used informal support for example through the family, which could account for the low rates seen in Corrigall and Bhugra findings. A further point made by Skokauskas *et al* (2010) suggests that CYP from minority ethnic groups were more likely to prematurely terminate treatment for mental health than White ethnic groups, which supports the findings from Kapadia *et al's* (2022) research.

An implication of early termination of engagement was researched by Morris *et al* (2021) who found that feedback via Patient Reported Outcome Measures (PROMS), a measure used by service providers to assess patient experiences and outcomes (included treatment success) where significantly underrepresented from Black and ethnic minority groups. These forms are required by CAMHS to measure the impact of interventions on service users who engage with provision. The lack of data from these groups leads to inaccurate assessment of service efficacy, *'...leading to biased estimates of improvements and leading decision makers to draw false conclusions'* (*ibid*:57). This impacts (and skews) data relating to Black and ethnic minority mental health monitoring, preventing the types of improvements in practice being made for Black and ethnic minority service users that were suggested by Kapadia *et al*.

One explanation for differentials in referral routes for ethnic minority groups can be accounted for by Jackson *et al* (2022) who examined to what extent adverse childhood experiences (ACE) was correlated with police contact for adolescents. They concluded that CYP exposed to cumulative ACEs before the age of fourteen increased the likelihood of police contact, which then increased the risk of engagement with the criminal justice and probation

services and subsequent referrals on for mental health issues. This is important because increased involvement with the police did not have to result in arrest to have a negative impact on health outcomes for adolescents. Why this research is relevant is that policing in the U.K is 'racially disparate' (i*bid*:2) meaning there is a higher likelihood of adolescent from Black ethnic groups being stopped and questioned, cautioned and /or warned/arrested. The findings identified that higher levels of ACEs increased the risk of unfair treatment by the police and within the criminal justice system for adolescents, especially from Black minority groups.

Exposure to ACEs was further considered by Viner *et al* (2006) in examining risk factors, patterns of vulnerability and protective factors in Black and ethnic minority CYP in England. The findings challenged the practice of viewing risky behaviour as a 'single syndrome' (attributable to one specific factor), especially in assessing mental health in Black and ethnic minority CYP. The study considered a range of ACE factors including, smoking, gender, ethnicity, alcohol, drug taking behaviour, physical and mental health and social support from family and peers. Viner *et al* observed that attributing common factors in explaining risk related health issues for Black and ethnic minority CYP can create misleading stereotypes. For example, attributing drug use to Black young people, when a range of factors such as family and peer support, religion, culture and country of birth all create nuance in risk patterns and preventative effects. A further example to illustrate this point can be seen in Best *et al* (2001), who report that rates of smoking and drinking are lower in Black and South Asian CYP than in White CYP populations. These lower risks were associated with strong family social support. This could arguably suggest there are cultural differences that influence risk behaviour in CYP which are not necessarily related to ethnicity.

These preventative effects were further examined by Bhui *et al* (2005), who suggested that adverse ACEs do not automatically confer risk status onto ethnic minority CYP. They investigated protective factors in negating poor mental health in CYP from ethnic minority backgrounds in a London based study, focusing specifically on cultural identity (including acculturation and friendships). They identified that strong multicultural friendships were associated with better mental health in ethnic minority groups, along with establishing 'integrated cultural identities' (*ibid:*299). Therefore, cultural identity, rather than just ethnicity, was seen as an important factor in determining mental health and wellbeing.

Disparities in referral routes linked to social disadvantage was examined by Ayodeji *et al* (2021) who suggest that racism should be incorporated into the range of ACE that CYP can experience. This is not just for CYP from ethnic minority groups who are personally subject to direct and overt racism and discrimination, but also through the reporting of racial violence within the media, which they argue can lead to a type of PTSD. (This would seem to correlate with the earlier findings from Baker and Kirk-Wade, who reported the highest incidence of PTSD was found in 16-24 year olds). Ayodeji *et al* further report that the prevalence rates for CYP with mental health issues from Black ethnic groups was less (5.6%) when compared to White CYP (14.9%). They argue that this is not necessarily because Black ethnic CYP suffer less, but because they are less likely to report mental health issues and engage with services through primary care routes. This could be accounted for by a reluctance to engage with services that are perceived of as systemically racists, or possibly because of the stigma associated with mental illness for some cultures, or from more practical issues like language barriers. Their study concurred with findings reported here that identified contact points and points of entry for CYP with mental health services, confirming that CYP within White groups are more likely to be 'medicalised' through primary care services, like G.Ps whilst CYP from Black ethnic groups were 'problematised' through education provisions, social services and criminal justice routes.

Much of the research around race, culture, ethnicity and mental health has focused on experiences of Black ethnic minority males and White and White Other females. However, the research cited within this section has highlighted that there are mental health concerns around Black ethnic minority females, especially within adolescence (Corrigall and Bhugra, 2013). Spates (2012) has highlighted the many implications of excluding female Black voices in the psychological debate around mental health and race. Using Code's (1991) argument suggesting that knowledge guidelines have been shaped by white males, whose explanations and presentations of mental health issues (for example in the creation and updating of the DSM) are 'taken to be true'. Spates argues that this 'appropriation of knowledge' (*ibid*:1) is oppressive, as it is used as a mechanism for creating (and maintaining) power and control. This construction of knowledge from a White male gaze means that the specific social stressors that impact Black women and girls are neither considered nor understood. Largely, Spates argues, due to the creation of early psychological knowledge as addressing only White male psychopathology (for example, many of the disorders in the *Statistical Manual for the*

Use of Institutions for the Insane (APA, 1918) (precursor to the first DSM-I (1952)) focused on conditions like 'shell shock' (PTSD), as a result of observations of resettled male armed forces personnel after the first world war (Grob, 1991). Spates also suggests that most contemporary psychological approaches to mental health take a 'Eurocentric' position (*ibid*:4) which fails to recognise ethnic and cultural differences in Black African, African American and Afro-Caribbean groups.

Black feminists have sought to redress this omission by foregrounding Black women's resistance. Spates identifies that the multiple forms of discrimination that Black women face, such as structural inequalities, systemic racism, cultural differences and the historical positioning of Black women's experiences has forced them to 'reinvent' themselves (p.4). Spates comments *'...over time Black women have discovered they play several different roles to survive. Multiple role-playing is exhausting and extremely stressful, and it has physical and psychological consequences for the individual'* (*ibid*:4). She cites an extract from Feagin and Sikes (1995) interviews with Black women entrepreneurs which states *'...we can never be ourselves all around'* (*ibid:*1). This context identifies the intersectionality of Black women's experience of both their 'Blackness and femaleness' (*ibid*:4). These issues have implications for Black women's mental health. Spates argues for Black women to be empowered and to see themselves as 'victims of society' (*ibid*:5) rather than questioning their own mental facilities, arguing that this would substantially remove layers or stress.

Neal-Barnett (2003) has indicated that women within different ethnic groups deal with stress in different ways. White women tend to garner external support for mental distress such as from family and friends, whereas Black women are 'immersed' within the stress (p.6) in an attempt to control it, what Donovan and West (2015) refer to as the Strong Black Women (SBW) stereotype, which can lead to further psychological ill health.

Further, Donovan and West (2015) have used Intersectional Theory in a study of female Black college students to elucidate how the identities of Black women are created through multiple social situations and contexts. They identify that ethnicity; race and gender combine to create a range of psychological and physical health issues. They argue that the binary of 'strength and caregiving' (*ibid:*385) within the SBW stereotype is pernicious. This attributes extensive levels of 'resilience' in Black women to cope with trauma, stress and oppression through personal traits like independence, emotional containment and strength (*ibid:*385). This

creates the impression that Black women do not need support, as they are 'capable'; therefore, they are less likely to be assessed as psychologically distressed or referred for support, whereas their White counterparts are often viewed as 'fragile' and in need of intervention, care and support.

Research has suggested that many Black women identify with this stereotyped view (see Harrington, Crowther and Shipherd (2010) and Woods-Giscombé (2010)). Donovan and West go on to argue that this situation is often unsustainable for many Black women, leading to depression. Their findings demonstrated that students in the study who held a high level of the SBW stereotype were positively correlated with higher levels of stress and depression. They concluded that holding a SBW stereotype may preclude Black women from seeking help and support, meaning they were more likely to '*suffer in silence'* (*ibid:*392). However, the internal tension that this position creates means that Black women are placed at greater risk of serious mental health issues. These findings also support research that outlines the difference in referral rates (and routes) to mental health services like CAMHS for Black and White female ethnic groups.

Another important point is made by Romero (2000) who identifies that Black women and girls who maintain the belief of SBW would have *'...difficulty starting and staying in therapy due to the ambivalence around acknowledging the need for help and around focusing on self-care'* (*ibid*:392). West, Donovan and Daniel (2016) have added that Black minority women who have a strong belief in the SBW stereotype are more likely to internalise and 'mute' (*ibid*:395) their emotional reactions to stress due to societal expectations of behavioural responses that demonstrate stoicism and self-sacrifice. Black minority females are not regarded, societally, as vulnerable, but as being strong, independent and resilient. Adhering to these stereotypes, Nicolaidis *et al* (2010) suggest, can create a barrier to accepting a diagnosis of depression and seeking treatment. West, Donovan and Daniel continue by stating that maintaining this position over time will create negative physical and psychological reactions to stress because the ability to deal with stress effectively is compromised, they referred to this as the Stress-Coping Disruption Model. In other words, attempting to supress the stress response will lead to its exacerbation.

One example of how 'suffering in silence' can have a pernicious effect on the mental health of Black ethnic minority females is to consider research by Farooq *et al* (2022) who examined

self-harm rates in adolescence by ethnic group, using age range 10-19 years for data in England, from 2000-2016. (These were for actual hospital admissions for self-harm rather than reported incidences). The highest rates were in the White ethnic group for adolescents. They also found that an increasing proportion of CYP for ethnic minority groups had self-harmed in the period specified. A key finding was the level of social disadvantage for many of the ethnic group CYP represented, but also an inadequate level of psychosocial assessment. They further cite that levels of self-harm are seen as an indicator of psychological distress. It was also closely linked to lower educational attainment, poor employment prospects, mental health issues and an increasing potential for substance abuse. In terms of other ethnic groups, increases were seen more in Black minority groups, proportionally more females than males, (this group also registered the highest level of deprivation and social disadvantage). The South Asian and White Other ethnic groups also showed increases in self harm behaviour over time.

Explanations for the increases have been given as potentially better reporting and recording of ethnic minority health service support. Farooq *et al* also postulate that help-seeking behaviour for emotional or mental distress from within the ethnic groups specified may account for the increases recorded. This research suggests that Black ethnic minority females were at an increased risk of self-harm, which is an indicator of emotional distress. It could be argued that this is a response to the strain that is faced in maintaining the SBW stereotype against discrimination, adversity, deprivation and economic uncertainty. This could be illustrated in the findings from Al-Sharif, Krynicki and Upthegrove (2015) who commented on difference in self-harm and suicide behaviours between ethnic groups. The U.K has extremely high rates of self-harm and suicide (Schmidtke *et al*, 1996). Their review identifies that there is ethnic disparity in the rates of self-harm and suicide in the U.K, in particular self harm levels for Black females (Borrill *et al,* 2011).

In expanding understanding further, it is useful to consider contributions from Pickard (2015) who researched self-harm in women and its motivations. Suggesting that the act occurs across a range of context and circumstances and is prompted by factors such as; regulation of affect, in managing emotional responses; revenge, as an act of retaliation; protection, from potential future harm and as a mechanism of deterrence and finally, a means to exert social or interpersonal control (*ibid*:76). She further expresses that self-harm can be conceived of as either a self-directed end, or an other-directed end as a trigger to act. Pickard cites a specific

example in other-directed ends which applies to female acts of self-harm generally and for Black minority ethnic females especially, in terms of current discrimination and historic marginalisation as being 'Other-punishment' (punishment of the Other) *'...for women who feel anger and rage and want to be aggressive and violent...self-harm can offer a safe way of expressing such emotions and impulses, when violence towards others is deemed unacceptable. This function of self-harm correlates with the experience of being attacked....as it becomes like a symbolic weapon, turning anger towards others inwards on the self, while yet communicating anger to them'* (*ibid:*80). What is particularly significant here is that Pickard identifies such acts should not be deemed as pathological, but as a sign of *'rational agency'* (*ibid:*81).

1.1.2 Adolescence – A Brief Context

The claim that adolescence is a time of tumultuous change, strain, anxiety, pressure and conflict is not new. Kramer (1959) and Macaulay (1899) writing about adolescent changes from a historical perspective include references to descriptions of adolescent emotions and behaviour dating from Greek and Roman civilisations that are recognisable in modern CYP, *'...children no longer obey their parents....the end of the world must be approaching'* (Kramer, 1959:1) cites a Mesopotamian scribe writing in pre-Christian history around 1800 B.C and *'...it was a favourite amusement of dissolute young gentlemen to swagger by night about the town, breaking windows, upsetting sedans, beating quiet men and offering rude caresses to pretty women'* (Macaulay, 1899:69). Socrates wrote concerning adolescent youth being disrespectful to their elders and indulging in luxury, referring to them as 'tyrants' (Fridenberg, 1965). These descriptions would just as easily describe behaviours seen in contemporary gang culture (Boyer, (1978); Gottlieb and Ramsey, (1964)). However, Teeter (1988) identifies that the construct of adolescence as a discrete life stage was not popularised until the early 19th century, largely because of concerns relating to youth behaviour emanating from the onset of puberty.

Young people entering puberty experience not just physical changes, but emotional, social and psychological transitions that change their interpersonal terrain. Whilst this typically refers to the biochemical hormonal changes that occur to generate maturation, researchers, most notably Hall (1904), identified this psychological and emotional turmoil as '*storm and stress*', a time when young people emerge from adolescence into early adulthood and

attempt to negotiate their own space, place, position and value base as independent individuals, separate from parental influences. Hall identified three key areas from which this change derived; parental conflict, disruptions of mood and higher degrees of risk-taking behaviour.

Although much research exists that seems to support the view that emotional dissonance occurs during this life stage, (see Allen and Sheeber (2008) increase in mood disorders; Bailen *et al* (2018), assessment of emotional changes in adolescence; Barrett *et al* (2007) emotional complexity; Gross (2014) changes in subjective self-identity due to physiological impact of puberty; Heller and Casey (2016) rafted changes in biological and social impacts in adolescence and Larsen and Diener (1987) fluctuating emotional stability), it is by no means universally acknowledged, as many adolescents experience little conflict or strife during puberty. Further, some claim that social and environmental factors have significant degrees of influence on adolescents during this phase. Arnett (1999), for example, suggests emotional turmoil occurs more frequently in individualistic rather than collectivist cultures. Similarly, Schlegel and Barry (1991) found less effect in preindustrial cultures compared to western developed nations. Other critics like Mead (1928) focused on the ethnographic differences in adolescent experience, whilst Petersen *et al* (1993) suggests that at any given time, only around one third of all adolescents in puberty experience depressive moods. Larson and Richards (1994) also explored ideas of emotional volatility in adolescents, Buchanan and Holmbeck (1998) identified that college age students were more likely to experience insecurity, anxiousness and depression than younger children. Molloy *et al* (2011) examined negativity of self-image in puberty and Hollenstein and Lougheed (2013) suggested disruption was 'probable', but not 'inevitable'.

More recent research has been possible due to advances in technology, for example Casey *et al* (2010) lend support to the 'storm and stress' hypothesis from imaging studies in the brains of adolescence, which identifies an imbalance within the Subcortical Limbic Region (Amygdala) which they explain as a lag in development against the Prefrontal Cortical region, as a neurobiological explanation for the mechanism of this phenomena. What this means is that, during adolescence there is a 'mismatch', a lack of synchrony between the function of the Amygdala, which regulates arousal and emotional responses and the Prefrontal Cortex which controls planning, cognitive function, problem solving and decision making. In more

recent studies, for example Meeus *et al* (2016) and Maciejewski *et al* (2017) both reported findings consistent with earlier studies, that suggest there are significant emotional disruptions in adolescence, resulting in the deterioration in a range of emotional indicators, which can lead to *anxiety*.

This initial introduction is important because it establishes two specific points. Firstly, that there is an acceptance that the transitional period of mid-adolescence is characterised, for many young people, as a time of emotional upheaval and strain, with the tendency for many to experience anxiety. Secondly, and pertinent to the focus of this dissertation, as Arnett (1999:324) hypothesises, *'...adolescents experiencing 'normal' difficulties may be seen as 'pathological' and in need of 'treatment'*. This is supported by Westen *et al* (2011:311) in that adolescence could be *'mistakenly pathologized'* and Schraml *et al* (2012:74) who advocates that strain and stress in adolescence *'is expected'*. This indicates that researchers acknowledge there will be a degree of upheaval during adolescence, manifesting potentially as anxiety and mood shift.

What is unclear is whether 'normal' behaviour and affect have been 'pathologized', as Arnett suggest, or if the perceived 'crisis' in adolescent mental health is something altogether different, distinct and beyond those culturally referenced maturational norms. This section is intended to highlight that there are recognised and accepted changes in emotional stability in significant numbers of CYP at the time of adolescents that has been lost from the current narrative and seemingly replaced as 'wellbeing issues'.

1.1.3 Defining Mental Health

In a climate where any individual expressing alarm at the intensifying intrusion of therapy services into mainstream education is regarded with suspicion, it is perhaps important to initially establish what is meant by the term 'mental health'.

The World Health Organisation (WHO) defines 'mental health' as *'...a state of wellbeing in which the individual realises his or her own abilities, can cope with the normal stresses of everyday life*' and *'...can work productively and fruitfully and is able to make a contribution to his or her community'* (WHO, 2004). 'Mental disorders' are categorised as presenting symptoms, comprising disturbances in 'normal' function and equilibrium (*ibid*, 2004). This needs to be further clarified, as the American Psychological Association (APA) uses the terms

mental health and mental disorder differently. In the APA definition, mental health includes emotional wellbeing, freedom from anxiety, capacity to establish relationships, but also *'...good behavioural adjustment*' (APA, 2020). It describes mental illness as *'...any condition characterised by cognitive and emotional disturbance, abnormal behaviours, impaired function'* (APA, 2020). This broader definition is problematic because it does not allow differentiation between physical conditions like Alzheimer's disease and for example, PTSD. Both could be identified as satisfying all three criteria. However, Alzheimer's disease has measurable impacts on brain tissue; therefore, they should not be similarly classified. In effect this causes confusions between the brain / mind distinction.

This is a point made by Banner (2013) who has criticised the call by some psychiatrists to have classifications for mental disorders reconfigured as physical diseases in an attempt to gain parity with observable conditions of brain deterioration. Researchers have historically identified that issues with the definition of mental disorder has led to problems with value based associations of regulation rather than diagnosis, indeed successive DSM publications have changed the definition of mental disorder i.e. removal of 'harm' and further, there is some disagreement between clinicians on what differentiates mental disorder from mental distress (see Bolton and Bhugra (2020); Gert and Culver (2003); Klein (1978) and Tellas-Correia (2018)). The key definitions given here have been selected because the WHO publishes the ICD 11 and the APA publishes the DSM V. These are the two main diagnostic manuals used to categorise mental disorders by clinical professionals.

Where there are problems with these definitions is that the use and meaning of the three terms (four if you include 'mental conditions' as a replacement for mental disorder) have become conflated to mean the same thing. Further, there is no agreement between clinicians to unify opinion as the definitions have become 'popularised'. This has led to confusion in discussion around mental health, which is now interpreted as 'mental disorder' by many as the terms have become interchangeable. This is especially true of discussions within educational context where there is a lack of expertise in clinical practice. Additionally, colonisation of the term 'mental wellbeing' is used ubiquitously by the burgeoning assortment of therapists, consultants and specialist services promoting a plethora of mental health provision into education. This seems to have embedded itself into the collective consciousness and now appears to encompass a benign representation of any aspect of the

'mental state'. It can therefore be suggested that part of the difficulties around discourses of mental health are the lack of consistencies in the use of language and concepts. This is an issue as Kinderman (2014) expresses the disease model of mental health operates through the 'coercive' use of affective labelling as a discriminatory marker of 'illness'. This can be seen as an example of where 'psy' disciplines function to support the neoliberal agenda.

1.1.4 The Crisis Emerges

To enable a clear picture to be established on where the current 'crisis' in mental health seems to have emerged, it is useful to consider when 'crisis' as a description for CYP mental health gained currency and what heralded its arrival. According to Fongay (2015) during 1990 there was no single mention of CYP mental health issues in newspapers in the U.K. In 1995 there were 9 specific articles carrying information that related to mental illness in CYP, most relating to waiting times for services, this rose to 996 in 2015. This suggests that in the 10 years from 1995–2015, reporting of the issue gained momentum, but prior to 2015, there was no talk of a 'major crisis' in CYP mental health terms. Fongay (2019) has more recently been cited as stating *'...in fact, reports of a rise in mental health problems are for the most part, exaggerated*'. He further comments that there is a '*popular perception'* relating to mental health issues in CYP as being '*more troubled'* than previous generations (Murphy and Fongay, 2012:3), citing evidence from a range of surveys, but notes that factors other than an *actual* increase in the prevalence of clinical disorders might be having an effect. Increases are identified as *'...providing further indications of a <u>possible</u> rise in mental health issues'* (*ibid*:3). Bor *et al* (2014) in research on international studies using systematic review found no evidence of an increase in clinical mental health issues in children, finding only an increase in internalising of symptoms in adolescent girls. Pitchforth *et al* (2016) made similar findings in research conducted in a review based on data available between 2000–2014, recording no significant changes in levels of mental health issues for adolescents. This would suggest that clinically diagnosed disorders have not increased exponentially.

It is around 2015 that national media coverage started to reference mental health issues in CYP more directly, a significant feature of the reporting format was a change in rhetoric, with the use alarmist terminology like 'crisis' and 'epidemic'. Therefore, within the public psyche, this escalation was sudden. There was very little before 2014, but a substantial number of reports on mental health problems in 2015-17, which only served to amplify concerns. A small

selection of representative newspaper headlines demonstrates, in simplified form, the escalation of much of the media language used in coverage of mental health issues across platforms such as *The Guardian, The Independent* and *The Times* during this period:

'*You are not alone: Student stories of mental health'* Page (2014)
'*Mental health problems for college students are increasing'* Holterman (2015)
'Teenage mental health crisis' Bedell (2016)
'Quarter of a million children receiving mental health care in England' Campbell and Marsh (2016)
'Calls for mental health action over 'intolerable' child mental health crisis' Marsh and Boateng (2018)
'Government 'sleepwalking' into deepening mental health crisis' Busby (2018)

It has not been difficult to establish that, based on the identified amplification of reporting within the national press, there is perceived to be a 'crisis' in mental health within school age CYP. This led to an increase in parliamentary questions being asked around CYP's mental health services from a broad party of MPs. This has been revisited at several points across the research period. In early 2016 Liz McInnes MP (January 2016) asked Nicky Morgan (SSfE) '*What estimate she has made of the number of children in schools with mental health problems and what assessment she has made of the capacity of schools to appropriately support those children?*' In the same month, several MPs including Ben Howlett, Julian Knight and Dr Sarah Wollaston all raised questions relating to government policy and intervention for mental health issues in schools.

Further multiple questions were found from a range of MPs and government officials, across the political spectrum, asking about child mental health provision, support and services across varied geographical locations, educational levels and party ordnance, frequently recorded in parliamentary reports. This would seem to suggest that the concerns are both deeply held and widespread (see *Appendix 3* for a complete list of questions).

This pattern has persisted as questions and debates in the House of Commons have been given over to discussing issues of CYP mental health. Topics include questions on detection of mental health, delivery of intervention strategies, funding, access to services and 'special group' consideration (for example looked after children) which suggests that it has occupied much parliamentary focus. A recurring question has been exemplified in requests by MPs, notably Simon Hoare (February 2017) who asked, '*What steps are being taken to prevent mental health illness and provide mental health support for children and young people?*' and

Paul Blomfield MP (March 2019) who asked, '*What recent assessments had been made over the adequacy of support in schools for children and young people's mental health and wellbeing?*' So, it can be argued that this issue has longevity, as the questions that are being asked and responded to have changed little within this time frame.

One way to assess where current political interest lies is to engage with parliamentary debates and minutes of Select Committee and APPG reports. This can give a context for what parliamentary questions have been given coverage and what is being talked about. I felt it would be useful context to see if any changes in the frequency and duration of discussions in the House of Commons mirrored the increase in the interest from national media that has already been discussed. Checking *Hansard* archives, it was discovered that prior to 2015 very limited references were made. Examples include Timpson's announcement in the House, relating to the commissioning for service delivery in the *Voluntary and Community Sector Prospectus* (October 2014), identifying that for the first time, (in Theme 3), children's mental health would be a separate category. This would subsequently mean children's mental health provision, through tendering and commissioning, would be discretely represented and therefore discretely reported. The focus here was mostly on improving the identification of disorders in childhood and improving collaboration and commissioning efficiency and effectiveness between agencies. Prior to this question, in research from 2010, no specific reports were found.

In February 2015, there were questions raised about the availability of inpatient beds for child mental health issues; it is here the term *crisis* was used for the first time, but in relation to the inability of NHS services to provide local stay beds for Tier 4 services (local access to in-patient services). A similar debate was conducted around the same issue, in March 2015, but the majority of this related to approving spending. In March 2015, Norman Lamb also announced the publication of a report commissioned in September (2014) '*Future in Mind*' and gave a brief overview. In July 2015, Henry Smith MP asked a question relating to mental health support for young children, responded to by Minister Alistair Burt. In October 2015 there were general questions in the House relating to funding for CAMHS. What emerges here is that 2015 seems to be a watershed year for the discussion of and subsequent interest in 'mental health problems' in schools framed as a 'crisis'.

Prior to this point, I could find no debates in the House of commons relating specifically to mental health of CYP as being critical, acute or at epidemic levels; those debates that were found were tied closely to learning disabilities or behavioural disorders, for example Autism (January 2010, April 2010 and July 2010). In a general enquiry of the topics debated and written questions in the House up until 2015, I was unable to establish any evidence of a 'crisis' in CYP's mental health being discussed. The term 'crisis' was used; but only to define the lack of service provision for CYP in finding adequate care placements. These findings have therefore suggested that, as with the media reporting of mental health issues in CYP, these were not major concerns directly addressed by government, certainly in any awareness of an *unfolding crisis*, much before 2015.

1.1.5 The Crisis as Public Concern

Attempts to ascertain the presence of a 'crisis' around mental health issues in CYP throughout this research have proved extremely challenging. Consider just one example. For the most part, numbers of CYP in compulsory education has risen year on year. In 2020 (most recent available data) for England it was 8.89 million (BESA, 2021). In the preceding few years from 2015, the number increased on average, by around 110,000 students per year (taking into account the 121,395 peak across 15/16 as the statutory leaving age in schools was raised to 18 [G.B: *Education and Skills Act*, c.25, (2018)]. This identifies the number of CYP registered as being in full or part time education, under the age of 19 years, in England. This figure will be revisited shortly. What follows now is a brief analysis of the NHS Digital (2018) report; in later sections broader aspects relating to the perceptions of increased numbers of reported mental health conditions will be assessed.

As a response to governmental concerns about mental health issues in children, the NHS Digital (2018) report, (from the 2017 national survey), was commissioned to assess the current mental health climate of CYP in England. This is important because the report is regarded as the 'best evidence' to support the argument that mental health issues in CYP are increasing. Therefore, this report represents the foundation document for the government's recent CYP mental health legislation and intervention policy, providing the 'evidence base' used to assert that mental health in children has deteriorated in increasing numbers over recent years. The NHS Digital website describes the survey as *'England's best source of data*

on trends in child mental health' (NHS, 2018), due to its scope and size, but also as there were preceding surveys (1999 and 2004) where analysis of trends would be possible.

Later reports such as the Briefing Paper *Mental Health Statistics for England: Prevalence, Services and Funding* (DfE:2020) has relied on data from the NHS Digital (2018) report. Of interest in the document is the comment that rates of mental illness reported are measures of *'...self-reported mental ill health and not diagnosed clinical cases'* (2020:7), with local prevalence (for targeted intervention in funding and services) based on *'estimates'* from patient surveys. Data from this report shows that for 2018/2019, the total number of CYP in contact with NHS mental health services (11-15 years) was 293,434 (9%) and (16-19 years) 234,363 (9%), so CYP (11-19 years) were the largest group contacting mental health services at (18%). However, admission rates to services for these two groups were 1,401 and 4,922 (collectively representing just 2% of those in contact). These figures of 'in contact' with services also included learning disability and autism services, meaning the actual mental health component would be considerably lower (2020:12). Crenna-Jennings and Hutchinson (2018:7) reported that only around one quarter of referrals to specialist mental health services were *'deemed inappropriate'* with the most common reason for rejection cited as the condition not being serious enough to trigger the threshold (*ibid*:7). This suggests that individuals contacting or being referred to services subsequently were not deemed to need the service once assessed, which may be one explanation of why admission to services was seen as low.

Other reports such as CMH (2021) *Mental Health Fact Sheet* contains statistics from studies styled as *'the facts'* – which use data from the NHS Digital (2018) report, which had clearly identified that figures gathered were estimates and projections. The CMH report also contains data from other sources such as NHS Digital (2020) Follow-Up Survey, EPI (2017) and ONS (2020a). The ONS data states suicide is a leading cause of death aged 20-34 years. The CMH use this information in a misleading way as the fact sheet states that the information relates to children and young people; suicide is not the leading cause of death for people under the age of 19, (as statistics report this as an adult mortality), so this figure is sensationalist as it intimates that suicide is prevalent in *children*, which will serve only to exacerbate concerns. Further, the reports make statements of 'facts' but fail to acknowledge the limitations and tentative claims of the research cited in evidence. These types of report anchor the claims of

a mental health 'crisis' into public consciousness, whilst omitting to reference the data was generated by self-report, estimates, generalisations and extrapolation. For example, *The Children's Society* (2021) website states 1:8 children *have* a mental health problem. There is no citation for this figure, if it is the NHS Digital Survey (2018), then these figures are not given as *actual* calculation of clinical diagnoses as no clinical data was gathered during its compilation, only self-report data and so it is misleading, serving only to promote the perception of significant numbers of children being in a mental health crisis.

1.1.6 The NHS Digital (2018) Report

The NHS Digital Survey of 2017 (and subsequent Report (2018)) has been compared with the earlier NHS surveys of 1999 and 2004 as 'evidence' that mental health issues are rising exponentially. However, looking at the three surveys it can be seen that the sample used in 1999 was limited to (5-15 year olds), in 2004 to (5-16 year olds), but in 2017 it was expanded to include (2-19 year olds). By any definition, 19 is an adult and there is no mention of the percentages of respondents who were this age at completion, or if they were still in education at this time. Further, increasing the sample parameters is likely to see a corresponding increase in the reported phenomena by ratio alone. It should also be considered that the 2004 report heralded no such alarm in CYP mental health when it was published, there was no mention in the report of 'crisis' or in the subsequent media reporting of the survey, even though the incidences it recorded were higher than the preceding 1999 report.

It would therefore be useful to consider the findings in more detail than has been reported in the media. In the technical information relating to the survey, it specifies 18,029 CYP were *'...asked to take part',* it later counts these as 'addresses issued' not as actual respondents (2018:3) but it specifies an achieved response rate of 52%. It is therefore not clear if the actual sample size (9,375) constituted participants or households. Somewhat later in the report (p.43) eligible households and those agreeing to take part were reported as amounting to 9,117 CYP. It further stated that for these households, full or partial interviews were achieved, with *'...one or more participants in the household'*. This is important because for a number of the individuals included, parents were interviewed, not the child (falling under 16 years of age). Further, it is still not made clear how many individual participants responded altogether, it is not unreasonable to assume these could be multiple child households with one parent reporting on two or three children within the age categories allocated. It specifies there were

8,602 parental interviews conducted overall and 3,595 teacher's reports received (which highlights there is already duplication). This means that, in a multi-child household, potentially, there could be a parental interview for three children, (under 5 and under 12), an interview with a young person (over 16) along with two teacher reports on the younger children. This means that, technically, six lots of data could emanate from one household. The respondents were incentivised to take part (with gift vouchers) and it is unclear whether the participants in the 'dress rehearsal' mentioned were taken from the same sample, so effectively they could have completed the process twice.

These points illustrate some of the difficulties in establishing detailed information to ascertain what the current mental health situation of CYP is in England. Moreover, it is interesting that reports were not taken from G.P services, CAMHS or hospital diagnostic services, which could have been accessible to NHS researchers. Why this is problematic is that, as stated, this recent NHS Digital survey has been the foundation policy document for 'evidence based' strategy interventions and to a larger degree represents the best evidence for the 'crisis' which the early media reporting had recorded. Of note is that the report itself in the accompanying technical data clearly states that *'...none of these increases necessarily mean that children now have worse mental health than they did before'* (*ibid*:7) and '...*low wellbeing and dissatisfaction indicators are closely associated with mental health – they are not the same as a mental disorder'* (*ibid*). However, at no time were any of these points mentioned within the findings reported by the media. Further, the headline figures that were reported were *extrapolated* from the findings of the participant cohort and given as *estimates* of numbers of CYP with reported mental health issues nationwide, which were subsequently recorded as *actual* numbers of CYP suffering with acute mental health conditions. This is concerning when the self-report data generated effectively relies on 'face value' and assumed accuracy.

Whilst it is acknowledged by the survey that large scale sampling on issues around mental health is problematic and some level of confidence values and adjustment factors were given – (also creating difficulties with interpretation of data), it remains that a significant proportion of the assessment tools used have issues. The list included, SDQ, DAWBA, FAD and WEMWBS. In the 2017 survey, the SDQ and DAWBA were used *'...to assess whether each child showed evidence of mental disorder'* (p.30) based on reports from parents and teachers for all children under 16 years old, but by asking the 17-19 year olds directly. Whilst the survey responses

were assessed and rated by, no doubt well trained clinical professionals, the point remains that they were rating *post-hoc* self-report data from non-clinical specialists – who may, or may not have understood the terminology or implications of the survey report questions they were completing. So it is somewhat irrelevant that the level of data analysis; subsequent to completion, whilst rigorous and including weighting does not detract from the fact that the questions on the survey amount to '*Do you have a mental health issue*?' and for some respondents, relied on the parents giving a subjective view of their child's mental health state, which is likely to have been confused with their emotional or behavioural functioning. Only 17-19 year olds were able to answer directly based on their own feelings, which itself is not without problem (see Chapter 2).

Considering the data set that was accessed for the survey, at no point does it suggest that responses were correlated with known mental health or behavioural disorders for the households concerned. This could result in a parent identifying that their child has 'depression' where a GP/Clinician has not confirmed this as a diagnosis, based on their child feeling 'sad'. This is also reflective of Wille *et al* (2008) research that identified discrepancies between CYP and their parents' reporting of their mental states. Also, given that each successive survey has increased the target pool by incrementally increasing the age of the individuals eligible to take part, it is to be expected that the number of reports of mental health concerns would be proportionally higher than the preceding survey, or that the latest survey showed higher levels than the first conducted in 1999. It was omitted from the media reporting that in the most recent survey, there was an increased age range variable in group metrics ((1999) 5-15 years=10 year, (2017) 2-19 years =17 years). This alone could have accounted for the increases reported, suggesting that in fact there may well have been *no* increase at all, if the earlier 1999 data gathering protocols on age had been applied. It is highly unlikely, had the trends remained consistent with 1999 rates, that interventions put in place subsequent to the survey, would ever have been initiated.

Moreover, the sampling frame of NHS Patient Registers used for the 2017 survey excluded anyone not registered with a GP in England, which creates further limitations for groups of individuals, for example families not registered at one local practice, any number of individuals who have migrated areas or who were not initially registered at the time. It also precluded individuals who had not agreed to share data. A final point worthy of note, prior to

addressing the inclusion of this report in the research, it also states explicitly in the introduction that *'...it should be acknowledged that prevalences are only estimates'* (p.8).

So, to return to the value of contribution that can be gleaned from this report, at the beginning of the section I identified that statistics indicate there were (as of July 2021) 8.89 million CYP in education. Reasonable assumption would therefore permit the 'crisis' in mental illness that is being reported must be affecting a significant number of these individuals with chronic and acute diagnoses of disorder, assessed by expert clinicians according to NICE approved criteria based on the ICD diagnostic indicators. In the NHS Digital (2018) report (detailed above), which has been labelled as 'best' evidence to support the reporting of a crisis, it has stated that rates of mental illness in 5-15 year old children (age range present on all three surveys from 1999, 2014 and 2017) had increased from 9.7%, to 10.1% and 11.2% respectively. This is an increase of only 1.5% in eighteen years, by its own calculation, based on estimates derived from self-report data from around 9,117 individuals, founded largely on the observed opinions of parents and teachers (not clinical practitioners) and extrapolated to be representative of 8.89 million CYP's mental health. This represents around 0.1% of the specified target population. Further, it clearly indicates in the outline of the report that the groups assessed in 11-16 year olds (14.4%) and 17-19 year olds (16.9%) *met the criteria* for having a mental disorder when *retrospectively* assessed against the ICD 10, they did not *have* a mental disorder. Headlines also did not identify that of the 11-19 year olds surveyed, (25.9%) also had a life limiting long term and chronic illness (Sadler *et al*, 2018) which is known to have comorbidity with mental distress.

Whilst any CYP with emotional distress is concerning, a stated increase of 1.5% in eighteen years is hardly indicative of a crisis. Given that, on a population stated at 8.89m (but not representing just 5-15 year olds) it would reflect a real-world increase of 133,350 CYP additionally reporting mental concerns. To put this into perspective, in England there are 23,018 primary, secondary, special schools and PRU settings, for children 5-15 years, (excluding Independent Schools) (BESA, 2021). This statistically represents an average percentage increase of 5.79 children, per school, based on the stated value of increases in mental illness rates. This equates to an increase of less than 6 children per school.

This suggests that the perceived and reported 'crisis' is actually founded upon extrapolation from a sample of less than 10,000 individuals out of over 8.89 million other school aged CYP,

based on questionable data generation methods, where the survey authors themselves have indicated not only that this should not be interpreted as evidence for an increase in mental illness, but further that reported measures of low self-esteem and dissatisfaction; which is mostly what the data captured, should not be interpreted as such. It also explicitly states that the measures given are only 'estimates', and not actual *recorded* incidences of clinically defined mental health disorders and conditions.

Attempting to locate data on clinical diagnosis of anxiety and depression in CYP in the U.K has been hugely problematic in this research. Trends in hospital admission rates for CYP found in *Hospital Admission Statistics* published by PHE (2019) showed there was an admission rate due to mental illness of 97/100,000 per population (10-14 years) in 2017/2018. The rate for the same age range in 2013/2014 was 103/100,000 population, so this shows a *decrease*. There were 261/100,000 population (15-17 years) in 2017/2018. The rate in 2013/2014 for the same age range was 260/100,000 which shows a *minimal increase* of 1/100,000. This highlights that there was no significant increase in admissions rates for CYP to hospital for mental health conditions (PHE, 2019). Further, the rates on the same report for self-harm in the age groups (0-17 years) between 2013/2014 and 2017/2018 shows only a 4/100,000 increase (from 177 to 181 per 100,000). Suggesting there was no significant increase in mental health admissions in CYP. This correlated with findings from Jack *et al* (2019) publishing in *the BMJ,* who examined prescription rates for CYP for antidepressants. They identified that in 2017, estimates of clinically diagnosed rates for depression in CYP were 0.3% of 5-10 year olds, 2.7% of 11-16 year olds and 4.8% of 17-19 year olds. This reflected around 200,000 children, in total, of 5-19 year olds. This is also not suggestive of a 'crisis' in terms of increased prescribing as a correlate.

Jack *et al* also found that there was a trend of increasing antidepressant prescribing patterns in the years (between 2009–2015, although not concurrently). This was supported by an increase in the reporting of depressive symptoms in CYP but was counterweighted by a decrease in the number of clinical diagnoses for depression in the same period. This creates a confusing picture but denotes no 'crisis' in CYP in terms of clinically diagnosed (and treated) mental illness.

1.1.7 Defining the Data on Crisis

In defining the data, it is important to consider the context that situates the increase in emotional distress (the labelling as mental illness is still contested) to establish why there was an increase in the reported incidences at this time. As indicated, the trigger for change in the 2017 Green Paper was a consequence of the OECD PISA (2016) report which identified low levels of happiness in CYP in the U.K. This was the precipitating event but could arguably be described as the culmination of a series of socio-economic and educational policy changes that impacted CYP which was then reflected in the OECD survey. Following the banking crisis of 2008, the U.K had been in a period of extreme austerity which saw increases in tax, a raft of public spending cuts on services (estimated to be around 9.5% of all department budgets), (Ormston, and Curtice, 2015) and a coalition government of the Conservative and Liberal Democrats. The austerity measures created public protests concerning loss of services to health, social care and welfare (i.e., U.K Uncut). This included the implementation of the 'benefits cap', which limited the amount a person receiving benefit could claim to the average household income in their area, after tax (irrespective of their circumstances). Changes also included modifications to the Spare Room Subsidy and students saw an increase in university fees from £3,000 p.a to £9,000 p.a (*ibid:*3).

This had the effect of pushing more people into poverty and unemployment, as from 2011 rates rose significantly (to a peak of just under 9% in December 2011), but remaining above 7% until mid-2014 (Statista, 2023). Additionally, the years between 2010-2015 saw changes in education including the introduction of more testing at KS2, changes to the national curriculum and to GCSEs and AS/A Level qualifications, removing some coursework components, changing re-sit opportunities and making the content more challenging (DfE, 2015). These circumstances could have been one reason why the PISA survey results for U.K schoolchildren were so low, despite all global nations being impacted by economic instability.

The NHS Digital survey is based on self-reported information, the technical report states that to be recorded as having a mental health disorder, *'...the individual had to meet the criteria for one diagnostic category for at least one emotional, behavioural, hyperactivity or other disorder around the time of the interview'* (2018:30). For clarity, using the ICD 10, 'one diagnostic criterion' for example in diagnosing mood or depressive disorders could include '*talkativeness, a decreased need for sleep and irritability*' (*ibid*:30). This could arguably

represent any typical teenager. Additionally, abstracting *one* symptom as a 'qualifying criterion' to represent a clinical condition would effectively mean it would be extremely difficult not to be identified as having a disorder, given especially that Buchanan and Holmbeck (1998) have already identified that college age students (16-19 years) were likely to experience high levels of insecurity and anxiousness. A further criticism of the survey results can be levelled in that questions relating to Body Dysmorphic Disorder (BDD) were asked, but this disorder does not appear in the ICD 10 diagnostic manual. This could have had an impact because as Bor *et al* (2014) identified, young girls are more likely to raise issues in relation to body image. It is not clear what proportion of responses this relates to; however, it identifies that for this component, the DSM V was substituted. Why this is an issue is that U.K clinical services use the ICD and there are inconsistencies between the ICD and DSM in other areas such as the representative categorisation and criteria for a range of clinical disorders and not least (as discussed), an agreement on what defines mental disorder. First (2009:382) has also indicated that within the 176 diagnostic categories shared between the DSM and ICD, there is only concordance in one specific disorder. So, categories may differ even for disorders with clearly defined parameters.

An example of where parameter changes can have an impact is seen in Sanders *et al* (2019) who illustrated that increases in trends for conditions like ADHD showed a marked increase after 2013, which was not due to increases in prevalence, but due to changes in the DSM V migrating age ranges at which symptoms were assessed, from being present before the age of 7, to being present before the age of 12. This had the impact of showing a spike in numbers that was not due to increased cases, but instead due to a change in the age of onset criterion. This is relevant because much of the statistical 'evidence' for increases in mental illness is from sources that group this together with services for learning needs, conduct and behavioural disorders.

A further important point to make is that key data providers like PHE, NHS and ONS England do not collect data on prevalence rates for clinically diagnosed mental disorders like depression however; they do collate data on indictors from self-reported measures on anxiety and depressive symptoms (Hagell and Shah, 2019), which specifies that population surveys on CYP include *'...measures that indicate symptoms of depression or anxiety even if they do not provide a diagnosis'* (*ibid*:119). It also specifies that measures of mental wellbeing vary by

age range in population surveys and by the indices and measures used which are not standardised across research. Therefore, what is needed to more effectively reference a composite picture of mental health in CYP is better reporting and recording of clinical diagnosis and recording of access to mental health services by age, type of referral and specific disorder. This would potentially give a very different national profile.

A feature of data reports on CYP mental health investigated for this research show a use of 'tentative' language around claims of increases in mental health statistical rates such as; this *may* indicate an increase, this *could* be indicative of, it is *estimated* that and is *likely* to show an increase. However, these are not reported accurately in the media which reference only extracted data as 'fact' to support the constituency of a 'crisis'. For example, in the media reports identified from newspapers at the beginning of the chapter, none reported the methodological issues with the NHS Digital Survey, nor did they use the cautions from within the survey data that the findings did not represent increases in clinical incidences of mental disorders. This would suggest that media reporting is inaccurate as it does not reference the context of the findings in commentary. This can have to effect of sensationalising headlines as seen in the examples given earlier. It could be argued that this is perhaps because at stake are significant vested interests from organisations, agencies, companies, institutions, businesses, consultants, professionals and clinical specialists who have a stake in the Wellbeing Agenda being promoted.

1.1.8 Assessment of Clinical Evidence

The findings from the NHS Digital (2018) report seems to be indicating that there has been an increase in incidences of reported mental health issues in CYP, but it has already been established that individuals needed to present with only one aspect of the diagnostic criteria from the ICD to be 'recorded' on the survey as 'having' a mental health issue. Further complications arise in the consideration or what is reported, recorded and diagnosed. These have again become conflated with 'fuzzy boundaries' identifying trends in self-reporting and self-labelling with mental health issues that are then attached as permanent labels. Often bypassing the involvement of medical or specialist clinical services altogether. Chapter 3 will identify further how an individual can receive a label (and become medicated for) mental health issues that are self-reported.

It is therefore important to assess whether there has been a significant change in the number of young people being diagnosed with clinical mental illness, not 'mental health issues' that are often subjective assessments based on self-report data narratives. In the systematic literature review previously cited by Bor *et al* (2014) to see if child mental health problems were increasing, they set out to measure changes in mental health in a selection of cohorts across time using comparative studies of CYP up to the age of 18. From the 19 epidemiological studies examined across a range of countries; for young children there was no reported worsening of mental illness found. For some studies, improvements in mental health were seen, most typically where a range of psychometric self-report indictors were used i.e., Health Behaviours among School Children (HBSC, 1982). Bor's research is important as the meta-analysis examined a range of clinical studies conducted using a variety of self-report indices (so there was not an instrument effect) to determine if 'reporting' of mental wellbeing issues was actually reflected in an increase in mental health disorders. Five of the studies included were carried out in the U.K and Scotland (representing nearly 25% of the sample). The remaining research covered the U.S.A and western European counties including, Finland, Sweden, Denmark, Netherlands, Germany and Iceland. There was also data inclusion from two studies in China. Their conclusion found that research in these countries, when critically assessed, did not support an increase in diagnosed mental health conditions in the populations studied (one study alone being a sample size of over 10,000). Bor *et al* also found discrepancies in the reporting trends between CYP and their parents, showing limited concordance in what parents' thoughts about their children's mental wellbeing and what the children reported for themselves, supporting the findings of Wille *et al* (2008). Suggesting that incidences of clinical recording of specific mental health issues had not risen in the representative study populations within the research from the different countries, expressing that *'...for children and toddlers, recent cohorts did not exhibit worsening of mental health symptoms, for adolescents, the burden of externalizing problems appeared to be stable* (*ibid*:611).

For adolescents, they concluded that there was no increase in externalising problems of mental health for either gender, but that there was evidence of an increase in internalising problems in females that had the potential to lead to poorer mental health, but these were not causally associated. This suggests that, whilst a range of identified variables from within the study could increase the risk of mental health issues (i.e., anxiety) this was deemed to be

for a range of reasons. These included earlier onset of puberty in girls, the influence of social media, but more crucially, the encouragement to talk about mental health more openly and to report any incidences of unhappiness or stress, as a form of 'mental health concern'. Of significance, there was no reported increase in mental health problems overall, comparable to previous years, but there was an associated higher overall risk. Wiklund *et al* (2012) found similar in also reporting that girls expressed the feeling of pressure to perform academically more often than boys, which could be a contributory factor to the gender differences expressed. What this would imply is that there was no verifiable increase in actual diagnosed mental illness or disorders in CYP at this time.

This can be further supported by NHS Digital (2019a) who identified that for the first time in 2016/2017, inclusions were made separately for CYP within mental health services and that for the year 2018/2019 it reported that 241,926 CYP under the age of 19 years accessed secondary services in England, which comprised mental health services, learning disability and autism support. This is problematic because users could be accessing multiple services due to comorbidity (having a learning disability and mental health issues) but further, the NHS survey identifies that some individuals *over* 18 years can still access children's services, but may not be in education. This is relevant because whilst these figures may represent distress for the individuals concerned, the numbers identified are not representative of a 'crisis' at the levels previously reported as being *within* education.

As Harwood and Allan have suggested, the impact of the pathologization of children within school contexts has encouraged concepts of CYP as 'ill'. However, they also consider the change in parameters of development in terms of what behaviour constitutes a 'normal' child. They refer to this as *'...navigating a narrow passage through the increasing proliferation of mental disorders'* (*2014*:3). This relates to the pathologizing of some behaviours and to the categories within the diagnostic manuals (DSM-V and ICD 11) attributing disorders on the basis of behaviours which could simply refer to 'normal' childhood aspects (like irritability, poor sleep and excitability). The classification as 'disordered' could be determined by the trajectories of children's development (itself a psychological construct) and their progression through 'milestones' of behaviour which have become symptom 'hurdles' to be overcome. The issue that they raise specifically with medication is that children's ability to partake in school activities is *contingent* upon them being medicated, in order that they are more

focused, less disruptive and easily managed. This has led Harwood and Allan to talk about the discussion by pharmaceutical companies of 'paediatric patients' who exist *only* within an educational context during the school term (p.4). This has implications for how society should view the 'medication' of children, with disorders that, seemingly, only affect the child for 40 weeks of the year. Harwood and Allan ask why the increased medication for children in school terms (which is absent during holiday times) is not being challenged or questioned by educators. A simple response might be that it benefits the *schools* to have children medicated in this way.

These type of anomalies are examples of the call that Harwood and Allan makes to educators to become more critical. Further asking how psychologization can continue to be so dominant when there are clear inconsistencies in the construction of mental illness and behavioural disorders, which does not consider further critiques of the classification of diagnosis in manuals like the DSM-V (see Cohen, 2016). This has led them to conclude that schools are *'...sites where mental illness occurs, but also sites involved in the diagnosis of mental disorder'* (*ibid*:5). They further suggest that *'...schools have a significant bearing on the culture of mental disorder'* (*ibid*:5) which can explain the 'spiralling' rates of mental illness in CYP (p.7). This is reflective of Conrad (2007) who suggests that non-medical issues can become pathologized in CYP (for example not sitting still in class) (p.8). This means in effect, that the 'paediatric patient' is constructed through the intersection of school regulations, behavioural policy and teacher expectations. This suggests that *'...schools play a key part in the psychopathologization of behaviour'* (*ibid*:8), being a major force in the creation of some children as pathological, Harwood and Allan argue that schools are intimately 'connected' into the architectural framework of diagnosis.

The intention of this section was to consider a range of points raised in Research Question 1, to assess how mental health is understood and constructed and to determine if there is indeed an increase in 'acute' mental health issues constituting a crisis in CYP as reported in the media. What has been suggested is that there are no more CYP suffering from diagnosed mental disorders like depression, reported in the most recent epidemiological survey (NHS Digital, (2018)) than there were in 2004, the date of the previous comparative survey, other than would be expected as a percentage increase commensurate with an expanding school aged population and the reclassification of 17-19 year olds as school age due to changes in

school leaving legislation. This is supported by Schraer (2019) who identifies comments from Prof. Tamsin Ford, one of the developers of the 2017 NHS survey who states that the increase from 1999-2017 was *"...smaller than we thought"* and *"...it's not huge, not the epidemic that has been reported"* (2019). Earle (2016) writing in *The BMJ* had questioned whether there was an actual increase in prevalences of mental illness in CYP, stating it was the subject of '*much debate*'. This debate is current.

There appears to be a significant gap between the number of CYP saying they have a mental health problem and the lack of any corresponding diagnosis made through a clinical service. Prof. Tamsin Ford has suggested that the increase identified within the survey may be due to children being encouraged to report distressing emotions as mental health disorders. At best, Schraer concludes, the evidence to support a rise in mental disorders is contradictory.

Where there has been an overwhelming increase is in the number of reported incidences of mental health concerns being driven by education providers. They have raised awareness of 'mental health issues' in schools where CYP are actively encouraged to self-assess, self-report and externalise their internal mental health narratives, for example NHS Digital (2018:27) states contact with professionals for mental health in CYP aged (5-19 years) was at (66.4%) which comprised mental health specialists (25.2%), primary healthcare specialists (33.4%), with education support services (22.6%), but showing teachers were the highest contact source at (48.5%). This highlights that mental health referrals from an education setting are driving the current demand for services. (Referrals through education will be considered further in Chapter 3).

What can therefore be argued is that there has been an increase in the recognition of mental distress, due to expanding information and specific interest groups promoting awareness of mental wellbeing. What has also occurred at the same time is the conflation of definitions and meanings around mental health and the 'de-professionalising' of identification and assessment of mental disorders, which are now routinely 'self-assessed' in non-clinical settings. This has been tied to the changes in definitions and loosening of clinical diagnostic criteria that will be examined further in later chapters (see Cohen, 2016). For example, in Horwitz and Wakefield's (2007) discussion around inflated depression rates in the U.S.A being attributed to a removal of diagnostic context, such as the changes in the diagnostic thresholds

of the DSM V with the removal of the '*Bereavement Exclusion'* (Friedman 2012), which have cast doubts on the figures cited for actual incidences of clinical depression.

1.2. Current Context

A useful background to the research is to consider the contexts relevant to current thinking around the issue of mental health in education in respect of the perceptions of 'crisis'. The 'media panic' has quickly evolved into a 'moral panic' that now occupies a disproportionate amount of public perceptions around CYP's mental health, which has served to somewhat hijack the narrative around wellbeing. What has been created is similar to Barrett's (2019:7) description of the introduction of CAMHS services as linking to *'...alarmist media focus on declining family values'*. An almost unilateral focus and prioritisation on wellbeing (and safeguarding) has resulted in deeper, more fundamental problems on a host of other educational issues being somewhat displaced from public awareness. For example, persistent geographical and regional inequality, accountability, academisation, the progressive marketisation of schools, changes to the curriculum and changes to the inspection frameworks rarely makes the news.

Furthermore, it is a crisis that has, in its construction, eclipsed concern around wider and more complex socio-economic problems that underpin much of the manifestations of 'negative mental health' that are currently being considered, for example the impact of poverty and wider socio-economic inequalities (see Boardman *et al* (2015); Bradshaw and Keung (2018); Deighton *et al* (2019); Jakovljevic *et al* (2016); Knifton and Inglis (2020) and Lund *et al* (2014)). A point identified by Catherine McKinnell MP (2017) in her comments to the house *'It seems to me that there is little point in the Government mandating compulsory mental health education in our schools while they actively undermine pupils' mental health'.* During which she challenged the government around the 'zero-sum game' of pitching academic achievement against wellbeing.

The focus of this chapter has been to primarily assess how the current 'crisis' has developed and how the issues that inform it has been framed. It will therefore be useful to consider key contexts that have helped to shape different perceptions and understanding of this 'crisis'. Briefly, the positions that will be addressed are from within an education and mental health (clinical) perspective. These have been selected as later chapters will argue that it is education

settings themselves that are driving the increase in mental health statistics. The interplay between education and clinical practice are therefore important perspectives to consider. Omitted, by reason of space and scope, are contextualisation of the debate from psychology (as an operational perspective) and from sociology (as a theoretical perspective). There are other critical perspectives that could have been included, such as a philosophy of education position and educational policy analysis, both are relevant and valid and could, for example, have provided useful insight into the recent surge in school intervention programmes. The parameters of this research relate to how the 'perception' of a mental health 'crisis' has evolved and how the ensuing interventionist panic has amplified and galvanised policy changes that have a direct impact on practice and as will be illustrated, cyclically reinforce the notion of 'crisis'. The further examination of educational policy analysis to examine political drivers as to whose interest is served by changes to the policy agenda would have been a worthwhile endeavour, but as indicated, the focus here is to ascertain and establish a profile of the current debate across compulsory educational practice. It will also seek to specifically outline the operating parameters for practitioners, in particular within mental health and educational fields.

1.2.1 Contextualising an Educational Perspective

Since the publication of *Transforming Children and Young People's Mental Health Provision* (GB. Green Paper, DfE, 2017) there have been substantial changes introduced to policy, practice and procedure within all educational institutions, organisations and agencies that are involved with service delivery to young people (discussed further in Chapter 3). Prior to the publication of this document, the provision of service for CYP in education was facilitated most usually through either the SEN or pastoral care route with teaching or support staff, via an internal referral pathway.

If there were concerns for the CYP's mental health, then recommendations would be made for them to contact their GP who would potentially then seek a referral to CAMHS or other mental health professionals. Schools and colleges could offer support once specific mental health issues had been identified and give logistical and practical strategies, for example guidance and advice in coping with exams, preparing children for moves between school and college (induction activities and taster sessions), a pastoral support network and a nominated teacher or tutor may have been allocated as the 'first point of contact' along with information

sharing with other members of staff. 'Buddy Systems' and 'Peer Mentoring Programs' were available in many schools, so a coordinated approach to monitoring and support was adopted. However, these were, at this time, outside of the clinical process and implemented only after a diagnosis had been established.

There was wider engagement with health-related issues; through the academic and broader curriculum for example healthy eating initiatives, PSHE lessons, PE and awareness of bullying campaigns. Qualified first aid staff would be available on site in the event of any medical emergencies or health difficulties. The school nurse visited periodically, delivering a range of health services (like vaccination), initiatives and programmes (like Choices and sexual health). This was likely to be a uniform experience of providing for wellbeing in most mainstream institutions. Provision for teaching and learning, timetable structure, delivery of services and behaviour management policies were often amended to reflect any potential student needs like bathroom breaks or eating at set times. Specific issues around mental health, prior to September 2014, were not regarded as particularly separate from other SEN provision. This is an important date because this was the first-time government had considered children's mental health issues as discrete from SEN and other health or behavioural provision, with the establishment of the CYPMH Taskforce (DH, 2014a), a collaborative review body constituted by the Department of Health, NHS England and other stakeholders, with the explicit purpose of assessing provision of services for CYP in respect of mental wellbeing.

In recent years, a range of government commissioned reports and research has investigated the provision of mental health services in schools and colleges, for example *Closing the Gap* (DH, 2014b); *Future in Mind* (NHS England, 2015); *Counselling in Schools – a Blueprint for the Future* (DfE, 2016); *Are we Listening* (CQC, 2018) and *Failing a Generation* [GB. Green Paper, House of Commons, 2018] driven by much of the public concern around the 'mental health crisis'. This culminated in the *Transforming Children and Young People's Mental Health Provision* [GB. Green Paper, DfE, 2017] which outlined mental health provision and statutory requirements for mandatory mental health action by compulsory education providers. This included a nominated Mental Health Lead staff member in every institution and provider, establishing close working links with allocated mental health support teams specialists from within clinical practice, a new mental health partnership for 16-25 year olds, a reduction in waiting times for CYP referred on to be less than 4 weeks (from referral), an improved

understanding of mental health issues with on-going training and support for educational staff and access to initiatives like Mental Health First Aid workshops and mental health 'tool kits'.

There has been a constant updating of government policy in relation to mental health related issues, but many of these notifications were issued as Departmental Briefing publications that were given as 'best practice', but were *not* designated as statutory requirements for provision of services. For example, the government issued non-statutory departmental advice relating to *Counselling in Schools a Blueprint for the Future* (DfE, 2016) which laid out a number of proposals and initiatives for managing wellbeing and mental health support, including PSHE lessons, using internal or external counsellors, raising the profile of mental health in schools and promoting staff awareness. It also suggested that referrals to both internal and external agencies should be prioritised in terms of urgency. Further examples of commissioned policy research relating to guidance on mental health provision, by organisations such as NatCen, can be found in Marshall *et al* (2017); Marshall and Smith (2018); Parkin *et al* (2019) and White *et al* (2017). From my own perspective, I have seen the changes in interventions in 'wellbeing' over the last twenty years within one setting, from being a personal tutor with pastoral care responsibilities where mental health issues were extremely rare and positioned as post-diagnostic adjustment and support, to having significant numbers of CYP assessed under 'fitness to study' policies linked to wellbeing where numbers requiring modified programmes, additional support and adapted examination measures was running into the hundreds.

One such notification of non-statutory advice was *Mental Health and Behaviour in Schools* (DH, 2018). This paper states there is no requirement for standalone provision of mental health in schools, but cautions that statutory responsibilities under the [GB. Equality Act, 2010] must be managed as some mental health issues would qualify as disabilities. This seemed to be somewhat at odds with the strident position and intention of action embodied within the *Transforming Children and Young People's Mental Health Provision* [GB. Green Paper, DfE, 2017]. Research by Brown (2018:21) has indicated that 56% of primary schools and 44% of secondary schools do provide some mental health support to children; with the number higher in colleges and institutions of F.E. This is in addition to the support offered for CYP with SEN provision needs. Strategies that were adopted and specifically reported as being used by schools included deployment of external counselling services, 1-2-1 pastoral support

with school staff, anger management classes, small group self-esteem building activities, Resilience Training, Play and Art Therapy, 1-2-1 therapeutic based session with support staff, external trips and visits i.e., Forest Schools and Farm Experiences and comprehensive Nurture Programmes. In addition, some schools had established positive home liaison, specific wellbeing sites around the buildings and there was a focus on promoting exercise and healthy eating (*ibid:*21).

A further notification within the document outlined school's responsibilities to manage mental health issues outside of statutory SEN provision, but most notably, it also set out how schools could identify individuals with mental health issues and recommends that schools should 'screen' for mental health using mechanisms such as the SDQ and Boxall Profiles. Whilst it states explicitly in its introductory list of key points that *'...school staff cannot act as mental health experts and should not try to diagnose conditions'* (2018:5) in section 4.15 of the same document it advises staff should be able to *'...document evidence of the symptoms causing concern'*, *'...understand the criteria that will be used by specialist mental health services*' and *'...use a clear process for identifying children in need of further support'* (*ibid*:24).

In the same document, reference is made to liaison with the Mental Health Support Teams that were identified in the *Transforming Children and Young People's Mental Health Provision* [GB. Green Paper, DfE, 2017]. However, the use of indices in schools to 'assess' mental wellbeing as a diagnostic function, as mentioned above, should be of concern. As explicitly stated, school staff are not qualified mental health professionals and thus are not competent in determining what qualifies as mental ill-health behaviours in CYP. Of more concern, however, are the directives encompassed within the new statutory guidance *Relationship Education, Relationships and Sex Education, and Health Education in England* (DfE, 2019a) – implemented from September 2020, which updated the curriculum around relationship education for all mandatory school settings, where it is to include children being taught to recognise mental health issues in *each other*.

As part of the Wellbeing Agenda, changes to statutory requirements in delivery of recognition, assessment, intervention, monitoring, support and management of CYP's mental health issues has seen a significant focus not just in expectations of school and college practice, but in developing relationships with external agencies, changes to working relationships with colleagues, parents and young people and in responses to inspection regulations. So, for

educators, the 'crisis' is formulated as the fear that they need to ensure every young person who could potentially have a mental health issue is correctly identified. In attempting to achieve this outcome, a range of assessments and measures have been put in place to 'test' for wellbeing issues (such as the inventories and indices mentioned earlier), many with such arbitrary measures and poor consistency and validity, that achieving anything other than a positive indicator for mental health issues would be a challenge.

In summary, the 'crisis' that exists for educators, in terms of mental health, appears to be one of recognition and detection of mental health 'problems' and referral to clinical services. Where every CYP who displays emotional responses that are anything other than 'happy' or positive, must be immediately referred on for mental health support, or the professional will be regarded as 'failing' in their statutory responsibility. This is despite the fact that there is a recognised and established understanding that adolescence is a time of emotional turmoil and distress. It could therefore be suggested that 'normal' pubescent behaviour is being 'pathologized' as Arnett (1999) has cautioned. These represent similar experiences for staff within my own institution, where the burden of recognition and reporting of 'mental health issues' falls on academic and support staff and further, forms part of the surveillance for performance management indicators, as the completing of information on virtual platforms produces reports that identify data activity on key pastoral pages that are monitored by senior leaders.

1.2.2 Contextualising a Clinical Perspective

The inclusion of a clinical perspective was important to me as I wanted to investigate the potential impact on practice from changes in educational procedures, to ascertain if there were discernible differences as a result of policy direction within the Green Paper. The perceived mental health crisis within education has implications for clinical practitioners, front line staff whose role is to manage the needs of individuals with presenting mental health concerns, NHS England, regional and local Primary Care, Integrated Care Services, Trusts and Foundation Trusts, commissioning groups, specialist consultants, mental health specialists (nurses, counsellors) such as CAMHS and front line referral services like GPs – who collectively take the view that there has been an increase in the number of CYP seeking help for mental health issues, largely because they manage front line provision at direct point of entry to service for mental health. For these individuals, agencies and organisations, the crisis is

framed within the context of service provision and the inability to supply services to meet increasing demand and targets.

In the 12 months up to the end of 2018, in England there had been 460,000 referrals made by schools and colleges to CAMHS for CYP (amounting to 183 students per school day (Henshaw, 2018)). Of this number, approximately 200,000 received some form of treatment. These are individual referrals, but do not take into account multiple referrals of the same young person over that time, or referrals of the same individuals from multiple sources. This figure is unsurprising when education professionals such as Dr Margot Sutherland (Centre for Children's Mental Health) refer to schools, colleges and universities as *'...front line mental health services'* (F.E News, 2021).

The Education Policy Institute report (Crenna-Jennings and Hutchinson, 2018) also showed that over the last 5 years referrals to children's mental health services increased by 26%, but the school population had increased by only 3%, which suggests a larger proportion of children were seeking help disproportionately to the increase in pupil numbers, but it does not suggest that the number of diagnosable disorders had increased, only the referrals for assessment. In the NHS Digital surveys previously discussed, the published results show only a small increase in the number of children reported as having mental health disorders. Mental disorders were reported as 9.7% (1999), 10.1% (2004) and 11.2% (2017). This represents, nationally, an increase of 0.4% in the first 5 years and an increase of 1.1% in the intervening 13 years - so not substantive on its own; representing an increase of 1.5% in the 18 year period. The NHS Digital (2018) report itself resisted using the term 'trend' to describe the increase, largely deeming figures to be stable but proportionally appropriate. Considering also that, the numbers of children in education has an average annual incremental increase in the 100,000s. The survey expressly states that there has been an increase in the demand for specialist services, but this has not necessarily been reflected in the increase in overall rates of diagnosis and detection of mental health disorders.

Whilst this is indicative of an increase in mental health referrals, this does not seem to correspond with the 'crisis' level that has been alluded to in media and government policy decision making. This would seem to suggest that there is not a 'crisis' in the experiencing of mental health, but a 'crisis' in the number of people being referred of self-referring for assessment by mental health professional services, from outside of the clinical environment,

(most notably by schools). Unfortunately, due to the nature of clinical services, individuals must be seen before they can be assessed, so what these statistics are illustrating is, that whilst referral services have exponentially increased, the number of CYP going on to be actually diagnosed and treated has only increased proportionally, with the expected increases in school populations, so diagnostic number have remained stable and consistent over time. What this suggests is that there has not actually been an increase in the number of CYP being additionally diagnosed with mental health disorders (see earlier section).

Previously outlined figures released by NHS Digital (2018) and the most recent national statistics available (at the time of writing), indicate the number of referrals to CAMHS by schools was 34,757 in 2017-2018 (RCPCH, 2018). According to the NHS Digital (2018) survey, of the 48.5% children who had contacted professional mental health services for support, 71.1% had been referred through education, whereas only 25.3% had been referred through mental health specialist services, where medical practitioners had deemed the referral appropriate. This suggests that the 'crisis' in demand is largely being driven by education providers.

Where there has been a 'crisis' in terms of mental health practice is in the provision of funding, commissioning, staffing and delivery of services for mental health care. For example, there are significant failings with CAMHS in terms of operational and structural performance and service. In an NHS report *Future in Mind* (NHS England, 2015) the service itself identified an overly complex system of commissioning protocols that was not standardised across either NHS Trusts or Local Authority areas. This included access to a range of services; the provision of specialist services, out of hours appointments and budget transfer were also variable from region to region. There were delays in passing information within and between providers, gaps in recorded information were frequent and data that was recorded was not consistent across Trusts. There was variability in the *per capita* spend on mental health services between Trusts. A recent *Children's Commissioner Report* (2019) (*Early Access to Mental Health Support*), identified large variations in funding between CAMHS budget allowance for spending on mental health in CYP, noting that the statistical range of provision between the top and bottom 25% of providers varied between £1.1m and £177,000, causing them to comment that there was a *'...a postcode lottery for child mental health services*' (*ibid*:4).

An EPI (2018) report also stated that there was a marked difference in regional waiting times against the government's target of 4 weeks, with waiting periods ranging from 1 – 188 days in different regions around England. A CQC (2018) report *Are we Listening? Review of Children and Young People's Mental Health Services* describes the referral process into CAMHS as *'...complex and disjointed'*, suggesting that various departments within the service have failed to take a *'...joined up approach*' (*ibid*:4). (In 2017, CQC rated many CAMHS services as being either requires improvement (39%) or inadequate (3%) for safety of CYP p.17). However, it fails to identify that the backlog in waiting times is often for individuals referred through educational settings who are not exhibiting clinical symptoms (Tier 3 and 4) but meeting the 'baseline' assessment thresholds for intervention through school-based initiatives (Tier 1).

There has also been criticism levelled at staffing and resources for front line services, with conservative estimates suggesting there is a national shortfall of mental health nurses in the NHS workforce, with an estimated 20,000 vacancies within mental health services amounting to around a 12% reduction in posts against 2009 figures. Further, training courses for mental health nurses have continuously under recruited by around 11% against other allied nursing fields (NHS, 2017). Full time mental health nurse numbers have fallen by more than 7,000 between 2010 and 2018 (15% fewer) and there are 170 fewer trained doctors working in mental health services than in 2010 (FullFact, 2017). Although categorisation of working 'within mental health' is not straightforward due to NHS England classifying Trusts as Mental Health Trusts if they have over 50% of their outpatient work categorised as within a mental health service. There are around 52 such Trusts, but numbers are fluid because they can be re-categorised, (for example from a Primary Care to a Foundation Trust) dependent upon their patient services. What this means is that numbers of mental health staff can appear to fluctuate due to their Trust being reclassified, rather than because they have not recruited or failed to retain staff.

There are also concerns over the number of mental health consultants, with an overall deficit of 700 (13%) in numbers of Consultant Psychiatrists, (the RCP have announced reductions in trained clinicians of 6.3% in Child and Adolescent Services, in the past four years (RCP, 2018)). Surprisingly, NHS England have declared that they lose on average 10,000 staff a year from mental health services, whilst much of this churn will be due to 'natural wastage' (for example retirement) there is still a marked loss of qualified staff. Further, there is an identified shortfall

of Educational Psychologists (a recent government initiative has been announced to recruit more as numbers have dropped by 13% between 2010 and 2015 (DfE, 2019b)). There has also been a reduction in School Nurses (recording a loss of 16% in staffing (RCN, 2017)). A subsequent issue has been identified by the British Medical Association (BMA, 2018) report *Lost in Transit* which has identified that funding that should be reaching the frontline of CAMHS services is being diverted to other service like acute hospital care, because the commissioning services have not ring-fenced the budget specifically for mental health services (see Earle (2016) and BMJ (2017)).

Most notable is the fact that there is no standardised threshold for accessing treatments, with each separate NHS Trust determining its own level of severity for a disorder before it would make a referral for treatment from the initial assessment, causing many CYP to be refused services because they failed to meet the baseline thresholds, for example *'...more than half of CYP with mild to moderate or moderate to severe mental health problems do not meet CAMHS thresholds*' (STEM4, 2019:6).

What this situation does speak of, in respect of the experience of clinical professionals, is a 'crisis' in the constituency and provision of services, rather than a 'crisis' in the number of CYP with an actual mental disorder. What emerges is a picture of a service provision that lacks cohesion, is chronically under-staffed, under-funded and struggling to manage a process that lacks any consistency in fundamental standards and accountability across Trusts and Local Authority Services. Therefore, it is not helped by the mounting referrals from schools for individuals who have 'wellbeing' issues rather than mental illness and there is some concern amongst practitioners that CYP with chronic mental health disorders are effectively losing out on access, resources and provision of services where genuine, chronic or acute illnesses persist. From the point of view of clinical services, the 'crisis' is one of inundation of individuals who have been referred, that neither meet the threshold for diagnosis nor need treatment. What John *et al* (2016) refers to as *'...the medicalisation of unhappiness and normal human experience with the resulting over-diagnosis and over-treatment'* (*ibid*:3315).

1.3 CYP and Agency

Beeker *et al* (2020) adds to the debate surrounding the medicating of children as a contested space that oscillates between the 'best interest' of the child in their entitlement to treatment

and care and a form of potential child abuse or state sanctioned mistreatment. Commenting also on the construct of children's mental health as being perceived as a 'rising crisis' (p.13), Beeker *et al* suggest the picture around the diagnosis and treatment of children with perceived mental illness is both complex and nuanced, leading to an overall 'messiness' (p.13). This is especially true when the reactions of CYP, their families and other clinical practitioners and wider supporting professionals and others contribute to the 'psychiatrization' process. The study researched the positioning of children within the therapeutic process by considering an ethnographic case study examining therapy ideologies in considering how children in Poland made sense of their engagement with psy services through processes of acceptance and enablement to rejection and resistance. The research makes the distinction between top-down and bottom-up processing, top-down consisting of the diagnostic, labelling and medication processes (by clinicians) (as suggested by Harwood and Allen) and bottom-up, examining the impact of awareness campaigns, access to financial support, self-help groups and individuals 'seeking' recognition for specific behaviours or experiences (p.14).

The research undertaken by Beeker *et al* examines two specific cases of psy-practice involvement and assesses the political, social and cultural impact of psychiatrization, identifying how children engage in 'zones of circulation' (Lakoff, 2005) where psy-knowledge 'percolates' through impactful layers around the child, from sources that are both top-down and bottom-up. For example, from the awareness of parents and teaching professionals of 'types' of affective behaviour and 'normative' standards to the diagnostic practices of clinical practitioners who assess, label and medicate. In one study, the child, diagnosed with ADHD, rejects the label and did not engage in the psychiatrization process which carries on around him regardless of his interaction with the process. Resistance occurred through the child hiding medication, rejecting the 'label' and refusing to engage in group or therapy sessions, commenting that *'...he acted towards the psy-practices as something he needed to defend himself against'* (2020:19). The second study identified how a group of girls (calling themselves the Porcelain Angels) who experienced depression, fully embraced and engaged with services, medication and treatment; going further to 'promote' and advocate for others to engage with clinical services, through their blogging and social media accounts to become *'...vectors of psychiatrization themselves'* (*ibid*:21). The discussion talks at length around the relationship between the psy-disciplines, power dynamics in children's services, actors and

agents within the process and the functioning of the ideological psy-frameworks around education. Concluding that *'...top-down agents may encourage and mobilize bottom-up psychiatrization'* (*ibid*:22), especially if it mobilises the rhetoric of 'social justice' and 'antidiscrimination' (*ibid*).

Brady (2014) conducted research on children's perceptions of having ADHD which was undertaken using interviews with a small group of young people aged between 6 and 15, their parents (including by survey) and observations of clinical practitioners within CAMHS to better understand the layering and complexity of service provision around ADHD as *'...a concept, a condition, a label, and an experience*' (*ibid*: IV). Brady reinforces that children have a commonality in sharing a journey through 'childhood' but their experiences of childhood are unique and multivariate. She further asserts that children's lives are structured through a range of factors, relations and experiences but that ultimately, childhood is 'politically' and 'economically' situated (p.20). The research focuses on concepts of children's agency, the extent to which there are choices and constraints in their engagement with mental health professionals in the diagnosis, management and treatment of ADHD.

Brady identifies that in respect of agency, children can both negotiate their social contexts in a range of domains, within school, the family, the home and peer groups and further, that children are active contributors and reporters of their own health and wellbeing issues within the framework of their own meaning, demonstrating both rationality and competence in reporting and engaging in personal health concerns (p.252). This means that children should be regarded as having agency and autonomy in decision making around treatment and care. She also suggests that *'...health care professionals need to take the time to ask young people directly how they feel about both their diagnosis and the treatment*' (*ibid*:252) This also identified that children should be spoken to *'... separately from their parents, recognising that the needs of parents and children are not one and the same'* (*ibid*:252). This is to ascertain the child's views and positions, which may be different from the parents.

In Brady's research there is an expression of concern around the medicalisation of ADHD as a 'problem' rather than a consideration of the facets of behaviour that makes the composite of ADHD a way to understand how some children process and interact with their world (p.254). She argues the concern with a medicalised view of ADHD (especially when it is held by children themselves) converges as a 'deficit model', focusing on what it is perceived that a child cannot

do, rather than on the range of qualities and abilities a child possesses. These negative associations can and do impact children's self-esteem and self-identity. Importantly, Brady proposes that most seeking out of medical intervention for children was generated by *'...parental concern regarding the 'normal' development of their child'* (*ibid*:255) in a bid to understand their children's 'difference' to other children and the 'normative' behavioural expectations led them to look for explanations for these 'differences'. Brady further states that the dominant biological view is maintained for several reasons, including ADHD being predominantly framed within a medical discourse, the promise of medication to 'modify' children's behaviour in line with social 'norms', the 'legitimation' that parents (and children) obtained from both the medical establishment and the positioning of differences of behaviour being framed as a 'medical problem'. This was due in part to the degree of positivity that was exhibited upon receiving the 'diagnosis', especially in terms of exhibited understanding, tolerance and disciplinary latitude. The creation of the 'label' also gave access to a wider range of support for both children and parents, financially, in terms of resources within schools and in respect of engagement with education services. Moreover, there was a change in the opinions and beliefs around manifestations of behaviour *'...children and young people were no longer regarded as being wilfully* naughty' (*ibid*:256). However, she argues that this compromise does not come without cost, once a medical diagnosis within a psychologised framework has been given, the behavioural issues that exist as a 'problem' can only ever be understood through the lens of diagnosis and 'treatment'. In this respect, the metaphorical Genie cannot be put back into the tablet bottle.

An example of how this medicalisation of ADHD impacted children's self-perception is given by Brady in her account of the way children in her study described their condition. The explanations were 'biologically determined' and reflected the children's experience of engagement with clinical services (reproducing the lexicon of pathology) such as having *'...an 'illness', or 'something not working in your brain'* (*ibid*:258). Brady argues that this sense of 'functional' failure could have a negative impact of the children's understanding of self-identity. Importantly within the research, Brady differentiates between the children's perceptions of their diagnosis and their parents. For example, in parents indicating 'relief' at the label as an 'explanation' for their children's behaviour, which they viewed as 'less stigmatising' than being considered as 'failing' parents (p.258). Whereas children felt more stigmatised in changing perceptions of their behaviour form *'naughty to ill'* (*ibid*:258). The

findings also considered that these potential outcomes impacted the extent of disclosures the children were prepared to make around their condition for fear of being seen as 'mentally ill' (p.258). Brady termed these the 'psychosocial' consequences of receiving a diagnosis, which were linked to the child's degree of precarity. This was a consequence of diagnosis not felt or experienced by parents which led Brady to concluding that this may make children feel 'burdened' (p.258). She further suggested that a re-framing of ADHD away from the biomedical approach and into a psycho-social, environmental (and to some degree cultural) construct can help children in asserting agency and improve self-esteem (p.259).

Brady further identified that CYP developed their own coping strategies to maintain their health and well-being. This included the desire to have responsibility in decision making around care of their health and the opportunity to negotiate inputs and interventions in the management of their ADHD. In terms of medication in treatment, this led to an interesting 'split' around children referring to themselves in plural as a 'self' that was medicated and a 'self' that was non-medicated (p.259). Brady argues that the use of medications (like Methylphenidate) should have *'...made young people feel more 'normal', but instead it seems to have made them more aware of their difference'* (*ibid*: 259).

A point of concern here is the cost versus benefits analysis of the medication used to control some aspects of children's behaviour with ADHD. Children expressing a distinction of two 'selves' would suggest that they are experiencing changes in self-identity and Brady states in her conclusion that taking medication resulted in a feeling of an 'altered personality' (p.263). This is important because this may account for non-compliance with medication regimens. In her conclusion Brady also identifies the children's complex thoughts and feelings around medication to manage their behaviour. With many identifying that others received more benefit from them being medicated than the children themselves (for example teachers and parents) (p.264). Many expressed that medication was beneficial in educational contexts, by allowing greater concentration and an ability to better control impulse and remain calm, but also in enabling better communication with family and peers, with some reporting improved empathy. However, the children's primary driver for taking medication is that they wanted to 'fit in' and not be perceived by others as 'different' (p.259). The 'medicated self' that children described did correlate for many as a more positive experience, showing increases in self-esteem and more positive school and family relationships (for example in receiving more

positive praise for 'good' behaviour). Brady evidences this through a variety of data collection within the study such as written accounts, pictures and body language (p.261).

Brady makes several important points in her conclusion, firstly that perceiving children as having 'deficits' or 'illness' can negatively impact children's sense of value and self-worth. She further adds that many of the 'problems' in behaviour which children with ADHD experiences are located in their external environment and the adults that have care of them, for example in 'structural' and 'attitudinal' barriers (p.260). Managing ADHD from a medical perspective can deny children's agency, especially if their wishes are in conflict with those of their parent or carer. This relates to *'...children in society having been constructed as passive, apparently inculcated with parental norms and values, and not perceived as active agents, capable of shaping relationships'* (*ibid*:262). The means that children's contributions, parent's lay experience and non-medical opinions and beliefs are not valued (p.263). This means that, rather than being afforded autonomy, children are 'subordinate' to the beliefs and values of adults who deliver care. Secondly, Brady advocates that whilst a reliance on medicalisation and medication of ADHD persists, alternative solutions, and more emancipatory systems of management and care, will not be developed. Finally, Brady suggests that continuing to medicalise children with, essentially, a social issue deindividualize and disempower the child, limiting their agency and further *'...serves to depoliticize the issue'* (*ibid:* 267).

Within my own institution, there is limited agency for either CYP or staff in applying the Wellbeing Agenda. The policies that are used with CYP including the Fitness to Study, Wellbeing Policy and Mental Health Policy are rigorously applied and surveilled. Strict monitoring of CYP occurs from referral. Teaching and support staff are held accountable at every stage of the process in identifying, monitoring, tracking and recording information and are expected to attend regular review meetings with students and parents, where academic and wellbeing interventions are discussed with the panel and actions scrutinised.

1.4 Summary

This first chapter has considered Research Question 1 in addressing if there is any evidence of a mental health 'crisis' in CYP. It has illustrated that there are issues with the 'evidence' used to make this claim. The most 'reliable' of which has been cited as the NHS Digital (2018) survey identifying an increase in prevalence rates of CYP with mental health issues. This has

been evaluated in respect of the sample, methodology and issues with self-report data used because it is a foundation policy document for later intervention. The chapter has further highlighted that there is a problem with the language and terminology around discussions of mental health, for example the conflation of definitions and clarity of constructs of mental health.

It has also demonstrated that there are discrepancies in the reporting or prevalence and recording of clinical diagnosis, which are reported by the media as mutually interchangeable. For example, AYPH (Hagell and Shah, 2019) identifies that 1:7 CYP between the ages of 11-19 meet the criteria for a mental disorder, whereas prevalence rates of mental health 'problems' in 11-15 year olds increased by 2% (between 1999-2017 (in England)). This is an example of the issue discussed around the conflation of terminology relating to mental health conditions and disorders.

There are added problems in that much of the research around mental health in CYP has different age classifications and lacks consistency across reporting with some recording ages between 15-19, some 11-16 and some 15-24. This makes finding wholly accurate and fully reflective statistics on CYP's mental health difficult. Also, regular periodic data surveys may make changes to the way data is collated, which makes direct comparison and discrete extraction of data for key age ranges extremely challenging. For example, NHS Digital (2019b) have identified that the number of children accessing any NHS commissioned of funded community mental services in England during 18/19 was 377,866. However, the report cautions that changes took place in the way data had been calculated during this period and using the earlier measures would have equated to 297,832 – a significant difference because of the inclusion of Mental Health Services Dataset Values (the new directive), rather than locally recorded data from individual trusts (the existing method). This inflated the numbers because the mechanisms for collation changed; there were not 80,034 'new' cases.

Often, research conducted uses a range of self-report inventories and metrics that are not externally standardised, are completed as 'proxies' by someone else (i.e., parents) and are again difficult to draw comparisons between due to data reliability issues (i.e., Davidson (1998) '*Affective Chronometry*'). The chapter has also highlighted that the assessment of CYP as in need of 'mental health support' appears to be linked to the concerns identified at the outset of the chapter on pathologizing adolescent affect, which is deemed to be a recognised

emotional transition during this period of development as a problematic time of emotional flux resulting in expected increases in anxiety and strain. It has also identified that much of the cautionary caveats and warnings contained within the research findings are ignored or under reported, for example in the limitations of generalizability from samples, the nature and limited reliability and validity of self-report matrices and the use of extrapolation and estimation.

Also illustrated was the increase in reporting of mental wellbeing problems in CYP (not related to specific issues in diagnosis or existing clinical disorders) within the media which has given rise to the perception of a 'crisis'. At the same time there has been an increase in political interest which has seen an escalation of questions and responses in the House of Commons, the establishment of new APPG's (like psychology), with a working remit to drive the mental health agenda (see *Appendix 4* for details) and extensions on the work of Select Committees with a specific remit of mental health.

This section has also illustrated that the 'crisis' in perceived mental health appears to have a specific origination in escalation through mainstream media that became more prolific around a time sensitive window of 2015 onwards. Given the timings of the media escalation, one indication of what might have generated the perceptions of a 'crisis' is that much of the increased reporting around mental health can be correlated to the U. K's poor performance in the OECD (PISA) (2016) report, which for the first time included metrics on levels of wellbeing by ratings of happiness in children, a point that will be examined in Chapter 3.

In summary, this chapter set out to examine the thread of representation, aiming to identify how the 'crisis' in mental health in CYP has been reported and consumed. The conclusion drawn here is that there is insufficient evidence to confirm a significant increase in the number of CYP with diagnosed mental disorders. What has also been found is that there is no single data source that accurately reflects mental health statistics for CYP from 5 – 19 years of age in terms of discrete categories like anxiety and depression, therefore, attempting to ascertain the mental health of CYP creates a confusing picture. That being said, there has been a significant increase in the number of CYP reporting mental distress and seeking support. The following chapter will offer explanations for why this might be the case and deals with the thread of alienation.

CHAPTER 2: CAPITALISM, NEOLIBERALISM AND SUFFERING - ALIENATION

Introduction

The preceding chapter summarised the argument that linked to Research Question 1, relating to the assessment of evidence to consider whether CYP were experiencing an increase in the incidences of mental disorders. Whilst this was not supported, it was found that there had been a significant increase in the number of CYP reporting an experience of mental distress.

This chapter will consider how capitalism and in particular neoliberalism can create mental distress and how this can be used to consider impacts within education. Marx (1844) argues that the fundamental estrangement of individuals from their 'human essence' creates a type of deprivation that produces misery (see Byron, 2016). This is important because, it highlights that it is the oppression endemic within a capitalist system and the alienation that this creates, that adversely impacts human nature. The chapter theme will consider alienation as a possible cause of suffering, which can be reflected as emotional distress. This links to changes within neoliberal education policy that have led to the marketisation of schooling through as range of mechanisms. Historically, schools have traditionally been a site of social reproduction (see Bowles and Gintis (1976)) and what Althusser (1970) has termed ideological state apparatus. However, schools now operate under the same economic principles as businesses due to the expansion of private companies and direct capitalist practices of unregulated free markets and the accumulation of profit and as such, are exposed to the same inherent levels of oppression, exploitation and alienation associated with any capitalist enterprise. This chapter therefore concerns itself with Research Question 2; to what extent could schools be creating the mental health issues that are being reported.

The intention of this chapter is to use a range of existing research to try and create a link between the supra-structure of capitalism and CYP's subjective psychological experiences, manifesting as alienation. The impact of a capitalist economy on health and wellbeing for many is experienced as degrees of suffering and there is the potential for the relationship between economy, education and misery to explain the 'epidemic' of distress currently being reported. Whilst Chapter 1 questioned the accuracy in representation of the current phenomena promoted by the media and interested groups (as clinical mental health disorders), evidence does suggest that there has been an increase in the levels of distress being reported and referred, especially within an educational context. Knight (2014) has

indicated that increases in affective responses (such as misery and anxiety), are created when experiencing the powerlessness that accompanies the oppression and alienation inherent within a capitalist economy. He suggests that under capitalism mental and physical wellbeing are compromised, but the challenge is that *'...the problem is only visible at an individual psychological level; the social causes of the problem are concealed'* (*ibid*:1). This problem could be presenting now because schools have, more than at any other time in their recent history, become marketized and subject to the influences of capitalist systems and practices in their active operations. For example, Lewis and Pearce (2020) consider the impact of marketisation on standards of care in schools by suggesting that children's 'value' is measured now only in terms of educational outcomes that supports the institutions success rates. Hicks (2015) identifies that marketisation of schools in England has led to increases in educational inequality, also research by Brunila (2011) on 'the link between marketisation and therapisation', Dean *et al* (2021) on 'implications for social justice', Pratt (2016) 'the commodification of school achievement' and Säfström and Mänsson (2021) 'democratic deficit in marketized education', (see also Brancaleone and O'Brien (2011); Furedi (2010); Hill (2004) and Ward (2019)).

Knight's research is important because it can be applied to emphasise the covert nature of the Wellbeing Agenda as a 'Trojan Horse'. Whilst it appears to be a benign initiative to promote, manage and maintain personal wellbeing; the agenda can be viewed as complicit in creating anxiety, alienation and internal distress through its focus on 'resilience'. This point is supported by Firth (2016) who suggests that current anxiety is created through precarity and indebtedness, so policy is mobilised to promote 'security' (*ibid:*122) which is manifest as wellbeing, resilience and therapy interventions. This is not to enact emotional safety, but to distract from the diminished capacity to mobilise collaborative social support and action. Therefore, the neoliberal state structuring of affect is subtle and pernicious. This will be examined in Chapter 3. In this regard, it could be further suggested that the agenda itself represents the iatrogenesis described by Illich (1976), in its three-fold incarnation of clinical, social and cultural damage to the psychic integrity of an individual by means of unsafe and potentially ineffective treatments. It represents particularly the social iatrogenic aspect of a 'socially derived' health problem which Illich includes as increased stress levels, increased medical dependency and the *'...awakening of new and painful needs'* (*ibid*:46). The 'medicalisation' of living described by Illich when applied to CYP's experience of education

also resonates very closely with the concerns outlined by Arnett (1999) that 'normal' adolescent behaviours and tensions could become pathologized. This is also emphasised in the medical dependency encouraged by the Wellbeing Agenda and links to the treatment of children in education with damaging psychotropic drugs to facilitate resiliency. A theme examined in the next chapter.

2.1 Defining Neoliberalism

This chapter relates to capitalist economic principles within education, being established through the political force of neoliberal policy in the marketisation of schools, as being responsible for the process of alienation in CYP. It is therefore useful to consider how these terms will be used and what they will describe.

At its most basic level, economic capitalism is a practice often referred to as 'laissez-faire' (leave-alone), which is a policy of no interference with free market forces which operate via a mechanism of supply and demand transactions, where individuals, organisations and companies work to accumulate wealth. It is premised on the private ownership of capital assets (rather than land) which can be sold to make profit (including one's own labour). It emphasises the rule of law and prefers that state participation is confined to administration (taxes, duties) and law and order (policing and security) (Jahan and Mahmud, 2015). However, embedded within the term is a weight of political ideology, focusing on the work of Marx and Hegel. Therefore, when the term capitalism is utilised, it is necessary to consider its wider application, for example Knafo and Teschke (2020:1) discuss two distinct threads in Marxist thinking that relate to *'...the laws of motion of capitalism conceived as a system'* and a second reading centred on *'...the focus on social relations and the centrality of power and class struggle'* (*ibid*:2). Whilst Marx never used the term 'capitalism' in his writing, he did refer to capital, he considered people who advocated for wealth accumulation to be capitalists. Capital according to Marxist ideology is explained as C-M-C (Commodity-Money-Commodity); the process through which profit is accumulated and the circuit of consumption maintained, (in its basic form capital is money) (Giminez and Kuhls, 1999). A Marxist reading of capitalism will be examined later in the chapter. The second definition identified by Knafo and Teschke (2020), the focus on social relations and struggle are especially applicable to education.

In simple terms, neoliberalism, a word originally popularised by Hayek (1935) is a political philosophy and ideology founded upon capitalist thinking that claims to understand the relationship between human nature and economics, arguing that the maximisation of human 'flourishing' can be achieved by the maximisation of profit and growth. However, the use of the term neoliberalism is problematic with Venugopal (2015) suggesting that *'...neoliberalism is everywhere, but at the same time nowhere'* (*ibid*:165). Mudge (2008) has considered that the term neoliberalism is an over utilised but 'ill-defined' concept identifying that there are inconsistencies in the application of the terminology, a lack of consensus on an absolute meaning and even a failure in identification of the term as defined by an ideology, a concept, a theory or process, a political form or economic category. It is therefore seen, according to Venugopal, as a *'...controversial, incoherent and crisis-ridden term'* (2015:165). He has also illustrated that the meaning of neoliberalism changed considerably between the 1970s and 1980s. Moving from a construct of economic theory, emerging from what he describes as the Freiburg Ordoliberalism School and the Chicago School which focused on counter-Keynesian economic principles surfacing in the West German economic revival after the Second World War. To the use of the term to describe, *post hoc*, a cluster of specific changes made by states around a loosening of regulation and taxation, a privatisation or previously state-owned assets and a diminishing of the support given through 'welfare'. This transition moved beyond a change to fiscal and monetary policy in order to improve trade and industry – rather it solidified as a *'...political, ideological, cultural and spatial phenomena'* (*ibid*:168). He has therefore argued that neoliberalism can also be regarded as a *'doctrine'* (*ibid*).

Expanding further, Venugopal (2015) attempts to define neoliberalism in his comparison on the use of the term between the early 1970s and late 1980s, namely that, prior to the 1980s, it was used 'esoterically' by economists to define a specific type of free market, whereas post 1980, the was used exclusively by social scientists and political analysts and is no longer the preserve of economics. What he suggests here is that the 'neoliberalism' had become a 'signifier', whereby the term has accreted meaning by attached associations. So, the word neoliberalism can only be understood through its aggregation of concepts. He also asserts that describing something as neoliberal is generally applied by 'others', in that individuals, organisations, political actors and institutions do not 'proclaim' themselves as 'neoliberals'. It is to this extent that Venugopal argues neoliberalism is more useful as a *'...rhetorical tool and moral device for critical social science'* than as a term to describe real world economics

(*ibid*:189). Suggesting that the construct of neoliberalism is now most utilised to discuss issues of power and ideology (*ibid*:169).

In terms of an economic reading of neoliberalism, it can be seen to supports fiscal policies that 'liberalise', which includes open markets that are not subject to regulation, a rejection of any form of state control or 'nannying' and a strong support for private property rights and individual commercial or corporate interests (Thorsen and Lie, 2006). It rejects state ownership of utilities and services like education and healthcare and where these are publicly owned, it defends reductions in public spending within these areas, advocating they should still be subject to market forces. It emphasises entrepreneurialism and individual responsibility over 'civil society or citizenship', public good and social security or state supported welfare programmes. Neoliberalism sees competition between individuals as not only desirable but essential. It identifies individuals that do not work as 'unenterprising' and they are regarded of as 'ineffectual'. As neoliberalism is perceived of as a doctrine, it is regarded as a means of social control to facilitate the economic principles of capitalism. However, neoliberalism expands further to incorporate a range of wider influence, for example Dawson (2013:4) expresses that *'...neoliberal economies are those which encourage increased marketisation by enacting policies favourable to capital'*. This is important because Connell (2010:23) suggests a hallmark of neoliberalism is to 'create' markets were none previously existed, rather than just operate within an existing market for trade purposes. He includes here privatisation of previously held *'productive state assets'* specific examples given are utility companies and transport (*ibid*:23). As stated, aside from creating markets, a neoliberal approach is also to resist constraint and regulation, minimise rights of employed workers, which includes hostility to trade union membership and also reduce taxation to 'stimulate' growth. Harvey (2005:7) has argued that enacting this trifecta creates a 'neoliberal state' which is more than just an 'economic approach'.

Dawson further identifies that the spread of neoliberalism has become tied to institutions such as the International Monetary Fund (IMF), the World Bank, the European Bank and the European Financial Stability Fund (2014:6). This is important because countries and organisations that engage with these institutions are forced to implement policies or reform in order to successfully receive aid or support. Therefore, it can be argued that there is an infusion of neoliberal ideology that moves beyond the financial transaction or economic

programme. This is exemplified by Dawson when he suggests that *'...the strength of neoliberalism exists not in its material occurrence but rather in its theoretical take up and dominance'* (*ibid*:7). Advising further that there is a danger inherent within neoliberalism which positions itself as a 'realised reality' rather than an 'ideology' (*ibid*). A final point that is made relates to neoliberalism casting the individual as a 'rational, agentic actors', and therefore 'entrepreneurial' as the confines of rationality extend *only* to economic decision making. The issue here is that in positioning the individual as an 'economic' decision maker, it maintains the fallacy of the meritocratic and 'level' playing field and also ignores inherent inequalities in opportunity and access. On a final point, Dawson concludes that rather than neoliberalism's strength being in its economic process, it is found within its impact at the individual level through collusive power relations (*ibid*:6).

An expansion of this concept of neoliberalism as a phenomenon can be seen in Brohman's (1995) view that individuals are perceived of as 'atomistic', bound together only by the dynamic forces of the market (*ibid*:297). This creates what Brohman refers to as 'isolated creatures', a homogenous collective of 'rational' individuals, existing exclusively within the actions of economic trade and exchange, but stripped bare of historical and cultural identity, meaningful social relations and personal political ideas, beliefs and opinions. Brohman further argues this simplistic view seems to ignore the economically complex pattern of factors that exists between the process and production of capital and the individual actor. Also echoed here is the fact that 'rational' action is defined in narrow terms of being the 'pursuit of profit'. This focus on what neoliberal idealism deems 'rational' relating to *'...equilibrium, equations and formal models based on assumptions of individualistic exchange relations'* (*ibid*:298) precludes attention and focus on behaviour that is not deemed to be 'rational'. This means that pro-social or cooperative behaviour that promote social justice and inclusion are largely devalued. One specific criticism is that this leaves no mechanism to explain trends that link to behavioural factors that defy '*...models of economic logic and rationality*' (*ibid*). For example, goods produced at low fiscal cost but high environmental cost which would shape consumer purchasing decisions.

Inherent also within neoliberalism is the presumption of a capitalist elite class that is willing to 'trickle-down' and variant factors that affect this economic shift; for example, avarice, human beliefs about wealth, class differences and 'family' enterprises, organisations or

institutions which operate outside of 'normal' marketplace relations, i.e., in choice or trading partners or employment and recruitment practices. Brohman goes on to identify a range of criticisms of neoliberalism that includes a neglect of power relations, for example politico-ideological factors, an omission of values and meaning, neglect of environment and sustainability and reliance on positivistic models of enquiry (*ibid*:300). He concludes by stating that a major issue with neoliberalism is that it embodies a '*...narrow type of economism'* (*ibid*:314). This argument is reflective of Bowles and Gintis (1993) critique of *homo economicus*, focusing on 'economically rational' choice making that is reductive in minimising the multifaceted and complex real world decision process.

A strong critique of neoliberalism is provided by Fine and Saad-Filho (2014) in identifying assumptions and presumptions that inhabit its rhetoric. For example, they express doubt that an accurate ideology of neoliberalism can ever be defined, that any set of policies could constitute neoliberalism or that it could even *'...specify the native of contemporary capitalism'* (*ibid*:2). They articulate problematic issues with contextualising 'neoliberal thought' as an entity, ranging from consideration of the complex constructs that coalesce around its definition, for example the rhetoric (ideology), the intellectual (scholarly) and policy elements that determine its form (*ibid*:3). Arguing that what is understood as 'neoliberalism' is not consistently stable over time, context, issue or place. The example they give is 'freedom' which is not an intrinsic creation of neoliberalism but relies on state provision and coercion of specific statutory rights, such as property ownership. Ergo, neoliberalism relies on freedom to operate, but it does not create the freedom it needs and it can be construed that to survive once established; it must restrict freedoms to maintain its existence. This is seen in neoliberalism association with authoritarianism, strong 'law and order' to prevent public discord and its suspicion of democracy, which is sees has the potential to denude its conditions of practice. They conclude by describing neoliberalism as an 'assault' on the poor and on progressive values.

A further critical view is given by Cornelissen (2020) identifying neoliberalism as pernicious in that its influence negates the ability to contemplate any alternative economic approach. He further identifies neoliberalism as a threat to democracy, by positioning it as offering a stark choice between *'...economic development and democratic self-governance'* (*ibid*:349) implying that it is not possible to have both. Brown (2015) has suggested this is manifest by

the 'emptying' out of democratic content from states, institutions, agencies and organisations. This is surreptitiously achieved by the replacement of genuine accountability and participation with 'managerialism' and competitive pressures. Cornelissen advocates suspicion of neoliberal ideals by suggesting that *'...neoliberalism, both in its ideational and practical dimensions, hollows out democracy and renders it powerless to mount an alternative hegemonic project'* (2020:351). Biebricher (2019) has extended this point further by stating that neoliberalism's objective is to reign in democracy as it is a fundamental threat to the neoliberal project, because there is the potential for pressure to be brought to bear for redistribution of wealth, for interventions within the market and for the needs of specific interest groups to be prioritised.

The reading of neoliberalism that is utilised within this thesis is represented by Jessop (2013:65) who suggests that neoliberalism has become *'...more a socially constructed term of struggle that frames criticisms and resistance than as a rigorously defined concept that can guide research'*. The direction of the thesis examines the impact of marketisation on education and the effect of alienation this creates, interpreting the response this produces as resistance.

2.1.2 Marketized Schooling

Teague (2010) quantifies the neoliberal ambition to marketize schools as not being a series of discrete and unrelated reform to improve performance and academic achievement, but rather a wholesale reconstruction of provision within schools that are configured around internal and external market relations (*ibid*:9). Accordingly, Whitty and Power (1997) identify that the DNA of neoliberalism can be seen within the marketized education system as it focuses on a decentred and deregulated provision of schooling, disassociated from the practical tasks of developing critical academic skills, to creating insubstantial activities of 'learning' that contain no intrinsic properties other than that which provisions *'... exchange value determined by the market'* (*ibid*:14).

These reforms fundamentally shift the potential directions that schools' development can necessarily take. One such shift is the removal of control from local authorities, communities (through engagement and governorship) and parents by the transfer of control to private organisations, corporations and agencies (for example academy sponsors). This process is

evident in the *Education and Adoption Bill* [GB: Department for Education, 2015] which forced 'failing' schools with poor Ofsted ratings to become academies. This is despite recently released figures suggesting that the cost to the Department for Education of re-brokering failing academies ran into billions (Boustead, 2019). For example, £31 million given in 2019-2020 alone to support academies, which is in addition to academy debt being written off every year (£10 million in 2020-2021) (House of Commons, 2022). Major criticisms have been made concerning academy schools, including poor management of finance, excessive salaries to staff managers and executives, limited investment in school infrastructure and estates and poor pupil outcomes. Despite being publicly funded, academies do not have the same level of accountability as maintained schools (see West and Wolfe, 2018).

Teague (2010) has commented further that this allows the new school controllers to shape education not just from a practical, business position, but also from an ideological one '*...since 1979, the choice based mechanisms were not merely policy moves designed to create internal markets, but were also attempts to restructure school provision and schooling to enable the process of marketisation and the transfer of schools from public to private ownership'* (*ibid*:21), (see also Ball, (2004) and Whitty, Halpin and Power, (1998)).

Teague has provided a useful commentary on the impact of marketization as a consequence of changes in schooling being visible in four key areas; firstly, the market in school provision, which allowed for redevelopment of buildings, subletting of land and buildings and the granting of licenses and also control of teachers' pay and conditions of service (2010:24). Secondly, market in school services which related to outsourcing for services like training, HR services, maintenance and estates work, catering, clerical services, recruitment and consultancy services (such as inspection readiness). He argues this influences the 'alienating relations' as these services, along with the control of teacher pay and terms of service, influence how schooling operates (*ibid*:25). Thirdly, market in school materials, which covers a host of factors like teaching and learning resources, IT, technology and eLearning, classroom equipment and material, training and financial accounting and management services like H.R (*ibid*:26). This area of marketisation is especially an issue as many of the 'materials' that are 'purchased' are from the school owners themselves, creating what Teague refers to as a 'distorting effect' in serving commercial interests, rather than delivering quality of education provision.

Finally, he identifies the market in school building, which links to new builds, refurbishments and maintenance that were often in partnerships with private building initiatives (such as Private Finance Initiative (PFI) and the Public Private Partnership (PPP) (*ibid*:27). The necessity to use only 'qualified builders' (in terms of accreditation for tendering) has meant that again, many of the organisations already involved in school provision, services and resources often tender and are successful, maintaining commercial interest. For example, the *Bright Tribe Multi-Academy Trust* founded by Mike Dwan, who awarded contacts for school services including catering, maintenance and cleaning in a school in Colchester that was part of his MAT to *Blue Support* and financial service through *Equity Solutions*, both organisations in which Dwan had direct financial interest (Mansell and Boffey, 2016).

It could also be argued that the creation of public league tables with CYP's results has expanded the province of marketisation and market activity by expanding competition between schools to attract students. In addition to changes in school structure, management and organisation, funding and resources; the Academies Program and the subsequent *Academies Act* [GB. Department for Education, 2010], enabled all schools to choose whether or not to academize. In doing so, it also loosened much of the regulation of schools, for example removing the requirement for teachers to have Qualified Teacher Status (QTS) and the need to deliver the National Curriculum. Further, academy chain governance and administration does not form part of the Education Inspection Framework (EIF), reducing even further academy accountability. As local authorities and other private providers (including schools that choose to market themselves to others) also offer a range of services, along with academy owners and sponsors, schools now operate in a climate where profitability is a major concern.

This important summary of changes around schooling outlined by Teague (2010) illustrates that the alienating forces and pressures, along with the social relations found within capitalism are present within the educational context of school, leading to estrangement between management, teachers, support staff and students, which has led to a disintegration of overall school cohesion and cooperation. For example, he comments *'...the educational needs of many pupils are sacrificed to the measurement of the school's success in the terms laid down by the government's market reforms'* (*ibid*:149). Accordingly, education has become 'devalued and distorted' as schools align to 'commodity production' and 'making a

profit' (*ibid*:153). More importantly, social relations become replaced by economic relations which leads to *'...private possession being satisfied at the expense of human need'* (*ibid*:154).

Teague draws a distinction between market models that are used to define alienation (notable by Tooley (2002) Light Regulation Market and Brighouse (2000) Regulated Market) by suggesting both models consider alienating forces that exist externally to the social individual. Conversely, in Marx's original theory, forces that alienated were perceived of as relating to internal social relations. Why this is important is that Teague has indicated the 'entrepreneurial' capitalism of Marx's experience and the 'monopoly' or corporate capitalism of the current day have changed the economic context, but have not fundamentally changed in the process of alienation they create, which links to the impact of the marketisation of schooling on CYP.

2.2. Personal Entrepreneurialism

Ecclestone and Hayes (2009) have theorised that 'therapeutic' education, with its focus on wellbeing and happiness, undermines education in favour of 'learning' in what they argue has moved towards *'...imposing happiness and well-being and coaching people in the right way to achieve them'* (*ibid*:144). This 'right way' is the neoliberal trope of personal responsibility and entrepreneurialism. This therapeutic turn in education is neither progressive nor benign (*ibid*: xii). Whilst Ecclestone and Hayes do not draw explicit parallels between neoliberal education and the remit of the Wellbeing Agenda, they state that the concept of the diminished self enables government to focus on the individual traits of poor esteem, vulnerability, frailty and its subsequent associated 'lazy' behaviours typified by demotivation and apathy. This fundamental error in attribution locates wider social ills like structural inequality, poverty, unemployment, poor housing and lack of social justice or opportunity to 'internal psychological states' for which the individual is then held both accountable and responsible (*ibid*:12). There are criticisms of Ecclestone and Hayes work, notably Downes (2018) who provides a systematic rebuttal to the key aspects relating to an agenda of emotional wellbeing in schools, mostly to its role in preventing early-school leaving. Citing support from EU Council Recommendations (EU, 2020) against Ecclestone and Hayes points relating to; therapeutic intervention, the privileging of wellbeing over curriculum, state regulation of emotional subjectivities and the 'culture' of vulnerability. Downes provides a step-by-step critique of points made. In relation to the area specifically covered by this thesis,

he suggests that teachers should be '*...adopting a well-being and mental health promotion and stress prevention approach but not a therapeutic one*' (*ibid:*153). This is a valid point, but what is not addressed is that 'promotion' will have a consequence for 'referral'. It is naïve to assume one can exist without the other. Downes states that such promotion would not lead to an individualisation of pathology, but this seems to be the natural outcome of promotion of mental health, in that it will foreground where mental health is absent, so the action contains within it the original argument made by Ecclestone and Hayes. Further, Downes' arguments draw extensively on EU supporting policy, which may no longer carry the same level of currency, subsequent to the U.K's withdrawal from the EU in January 2020. Further critiques of Ecclestone and Hayes work can be found in Hyland (2009) and O'Donnell (2013). A feature of some of the critique I observed was in their failure to understand the politicisation of wellbeing interventions, which were considered from the psy disciplines approach addressed by Millei and Alasuutari (2016).

Van Den Bergh (2012) writes about the neoliberal ideological goal of individual responsibility, self-improvement, and self-actualization. He cites this as individuals having to consider themselves a constant work in progress on the road to the 'best possible self'. He identifies that individual are encouraged to become *'...self-referential beings, exhorted to create themselves without any real basis to take the plunge'* (*ibid*:9). Neoliberal values reassure individuals that they are free to 'be themselves', when they are in fact required to construct wholly artificial identities of the 'happy consumer' (*ibid*:11). He further suggests that social control is achieved not in spite of individual self-determination, but because of it (*ibid*:12). The Wellbeing Agenda feeds into this discourse through the referential 'self-help' and 'self-improvement' narratives that promulgate the technologies of self (Reveley, 2016). This personal branding is problematic because it leads to the colonisation of the subjective mental states as 'products' of capitalism. Indeed, Fisher (2009) comments that *'...to a degree unprecedented in any other social system, capitalism feeds on and reproduces the moods of populations'* (*ibid*:35).

As capitalism structures society, so too do the structures that it designs reflect capitalism. In this regard, architectures within capitalism like education, law and health are primarily established to ensure that monopoly-based capitalistic values are not compromised, by incorporating and embedding systematic correspondence to its own dominant ideology. This

means that at their heart, their underpinning function is to maintain the integrity of capitalism through surveillance, reinforcement and regulation. The actual function they serve, in educating, healing and dispensing justice, is a secondary requirement. For example, the policy directive (identified as guidance) entitled *Plan Your Relationship, Sex and Health Curriculum* (DfE, 2020a), states that *'...schools should not under any circumstances use resources produced by organisations that take extreme political stances'* which specifically includes anti-capitalist material. However, this same directive also explicitly states that schools should not use resources that oppose the right to freedom of speech. This is a clear example of the 'illusion' of freedom and of the political interest being served in maintaining the *status quo*.

Recent changes such as this have caused a decline in the U.K rankings on freedom of speech reported by *Article 19* (2022); from 161 countries the U.K is now positioned 31, (placing the U.K behind all other G7 nations). The U.K ranked score is 82/100 on a range of 25 different indicators of free speech. This figure is 2 points above the threshold for countries to be considered 'restricted' (80) rather than 'open'. Crucially, one key indicator is cited on how free individuals are '*to teach*' (Jones, 2020). It is also witness to the closing of spaces within which to resist; speech, it appears, is certainly not free. This potentially signals a necessary transition to more intrapersonal types of resistance (examined in Chapter 4). A point elaborated by Webb (2018:109) who suggests that within aspects of academia there is a *'...search for boltholes and breathing spaces within the system*'.

2.2.1 Locating the Wellbeing Narrative within a Neoliberal Context

Issues surrounding mental health are a key focus of the Wellbeing Agenda. However, there should be concern around the prevalence of methods to detect and diagnose mental wellbeing issues in education and of the increased use of intense and aggressive types of 'post-panoptic surveillance' (Page, 2016) (see also Rose *et al* (2017) and Sinclair and Holden, (2013)).

As stated, Althusser (1970) outlines this use of surveillance in considering education as the dominant 'ideological apparatus' of the state. In this regard it is responsible for indoctrinating CYP into the capitalist relations of production and the preparation for their own exploitation. Althusser voices this in terms of schools *'...cramming individuals with daily doses of nationalism, liberalism, moralism...'* (1970:154). He also uses the term 'vulnerable' when

referencing how children have ideology '*drummed*' into them by schools. However, in this context Althusser uses vulnerability to suggest naivety, suggestibility and a lack of critical capacity. This seems incongruent with the vulnerability identified within the wellbeing remit which implies the inability of a child to meet expected outcomes, psychological frailty or to be at risk of harm.

This is concerning as the PHE (2020) report on child vulnerability *'No Child Left Behind'* includes references to '*worklessness*' as a potential vulnerability, which would seem unlikely when framed within a mental wellbeing perspective, but less so when considered from an economic one. What is of further interest is the diametric opposition of these two explanations; for Althusser, vulnerability comes in the inculcation of children into the capitalist ideology and their failure to be aware of their own exploitation and oppression. For education, vulnerability comes in failing to be inculcated into the state apparatus of intervention that aims to eliminate critical conscious awareness of the nature of exploitation and oppression. It could be argued that the 'greater harm' is endemic within the latter.

This surveillance has led to a focus on aspects of affect including anxiety and the more problematic issue of depression, problematic because of the change in conceptual use of depression from a clinical disorder, to representing the antithesis of 'happiness'. Currently schools are proactive in identifying individuals that may be experiencing any kind of mental distress; a range of vigilant 'experts', 'specialists' and 'supporters' are available to 'detect' signs that someone might be suffering from mental illness (see Lines, 2002). Current school practice requires that such observations are reported and recorded; this monitoring then triggers meetings and conversations for referral to intervention services like CAMHS. A NatCen (2017) survey found that out of (2,780) responding schools, 99% stated that they routinely screened for mental health issues in children, 24% said this was targeted where there were 'concerns' raised by staff, but 15% stated they screened universally as a 'trawl' to see if they could detect 'underlying' issues of concern.

Similarly, recent guidance from the DfE (2020) *Relationships Education, Relationships and Sex Education and Health Education*, (p31) state that children will be 'taught' to recognise mental health issues in each other and report them to a teacher. It is therefore apparent that internal, psycho-emotional states have become the subject of sites for intervention from the expanding neoliberal Wellbeing Agenda, which has now 'recruited' CYP to effectively

'diagnose' each other. It could be argued that the last containment barrier of the self has been displaced, in terms of delineation of intrapersonal (and intrapsychic) boundaries (Rose, 1990). This position, more importantly, realises a confluence of issues in terms of policing and surveillance of wellness and resilience as a tool; fabricated to measure conformity to neoliberal ideals and values. In particular, there is a focus on the 'mental frailty' of CYP as placing them either at risk or in danger, from an ever-increasing number of 'disorders' with which they can become labelled.

2.2.2 Psychiatric Hegemony

An important summary on the impact of capitalism on CYP in education has been put forward by Cohen (2016) within the aptly titled *Psychiatric Hegemony*. Cohen suggest that the reason for the increase seen in rates of mental health issues in children is not due to actual increases in illness of the mind (a theme explored in Chapter 1), but a need by neoliberalism to shape children's character at an earlier age than was previously necessary, the 'drumming in' referred to by Althusser (1970). This has seen an emergence of psychological interventions within what Cohen terms the 'education factories' (2016:115). He suggests that intervention in mental wellbeing by professionals is political and moral, rather than scientific and benevolent. This 'psychological surveillance' has been established in order to control and manage CYP behaviour. Mills (2014b) has commented that such surveillance is not for signs of psychological issues, but for behaviour that deviates from neoliberal ideals and normative values. *'...we could read psychiatry then as a form of surveillance, a means to convert the 'irrational' into the 'calculable' through diagnosis'* (*ibid*:214). Arguably, the role of the wellbeing professionals in schools is to reinforce neoliberal values, to enable children to determine their place within the existing social order, not to question their position, but to become *resilient* to its damaging effects.

Cohen provides support for this view by identifying that over its last three iterations, the DSM has progressively expanded the range of mental health disorders that children can be labelled with. It is interesting to note that DSM I (1952) and DSM II (1968) had little reference to school pathology (45 and 112 respectively) and very few identified mental health issues that impacted children, only 8 specific mental health issues were categorised as relating to children in the DSM II. A significant leap was seen with the publication in 1980 of DSM III with 37 identified 'mental health' conditions impacting children and mentions of school related

pathology had increased to 1,024 across a range that included school, play, games and teacher. This is important because as Cohen points out, the DSM III was published at the same time that neoliberalism was beginning to assert itself in western culture in the late 1970's.

In the most recently published DSM V (APA, 2013), these indicators had risen to 47 named mental disorders of children and 1,983 mentions of school related pathologies (Cohen, 2016:121). Thus, Cohen has located the increase in labelling propensities for children as being directly related to the need for neoliberalism to create pliant children that do not question the structural hegemony. It is not unreasonable to assume that educational institutions are therefore best placed to detect such 'school related' pathologies. Further, he dismisses any notion of personal incapacity or dysfunction and identifies that the designated categorisation of disorders within the DSM are fabricated and fallacious; symptomatic of the iatrogenesis discussed by Illich. Timimi (2010) has referred to the changes in diagnosis and treatment of children's emotional and psychological states as '*McDonaldization*'. He describes this as linking diagnosis and treatments with the vapid consumerism signified by fast food, in this form of 'junk treatment', there exists a convenient, quick, non-disruptive and simple pill which gives '*instant gratification'* (*ibid*:607).

Liegghio (2016) has studied CYP's construction of 'normal mental health' in relation to CYP in participatory action research with individuals diagnosed with a range of 'severe' mental health issues who had accessed mental health services. She makes an interesting point in commenting that the psychiatric labels of 'abnormality', discussed by Cohen, are attributed to CYP for whom emotional distress becomes a 'disorder' (*ibid*:111). The argument of this thesis makes a similar inference, Liegghio refers to this process as *'...the unmaking of a person and the making of a disorder'* (*ibid*). Given that measures of abnormality may clinically carry terminology such as the 'deviation from a statistical or social norm', 'failure to function adequately' or 'deviation from ideal mental health', I would concur with her position that 'abnormality' is attributed in the 'othering' of individuals who are labelled with diagnoses of mental illness that sets them apart from the construct of 'normal'. She describes this binary as a framework that regulates behaviour, which inhabits power relations focused around 'normativity' (*ibid*:112). She also suggests that CYP are objectified through an 'adult gaze', where aspects of CYP 's lived experience of wellbeing and distress are 'constructed' and defined in respect of an adult world view, which she contests leads to individual and systemic

discrimination (*ibid*). She further argues that problematically, mental ill health issues are constructed around medicalised, biological views of 'normal functionality' and impairment, which does not consider social and cultural influences, for example the socially prescribed constitution of 'good mothering' discussed by Singh (2004) in relation to diagnosis and medication of CYP with ADHD. Her argument is crystallised around the notion that definition and understanding of mental illness are defined from a position of mental wellness, viewed as a deficiency 'within' the individual CYP, this, she maintains, is used as a justification for interventions that remove or override individual freedoms and agency, such as forced medical treatment and detention.

Liegghio makes connection in her work to LeFrançois (2008) in suggesting that CYP lose both their autonomy and right to choices over their care and treatment. She also claims that the mental illness narrative has been effectively 'captured' by ableism and saneism, where CYP designated as mentally ill are not measured or assessed against their own constructs or beliefs about wellness or 'normality', but against an agenda imposed by adults from a position of 'normal', in whose gaze those labelled as 'abnormal' are already diminished.

Liegghio's research consisted of a photo voice methodology (Foster-Fisherman *et al,* 2010) where a sample of seven CYP (all accessing mental health services and some with more than one mental illness diagnosis), sought to answer the question '*What is normal mental health in children and young people?*' by discussing, in detail, their prepared photo collages of images they had taken. Emergent themes from the research included the problematic conceptualisation of 'normal' itself, the CYP counter-narrative on their perceptions with a view offered that 'normal' mental health was '*ambiguous and shifting'* (*ibid*:119) and context and observer dependent, but most importantly, the CYP offered resistance to the labelling of 'abnormal' and indicated that emotional distress should be incorporated into established constructs of 'normal' psychological function, so it was not seen as an 'abnormal' issue (*ibid*). Liegghio draws conclusions from her findings that the CYP in her study, firstly were not conscious of self-referential 'normality', only of how it was used as a position to create their 'othering' by *'... being compared and falling short of a preferred ideal'* (*ibid*:120).

A further conclusion Liegghio makes relates to the CYP position of mental health being *'...a matter of perspective and opinion'* (*ibid*), due in part to their experiences of their 'disorder' as

being constructed and reflected back to them from the adult professionals within their social and familial environment, for example within their education through poor performance in school (*ibid*). The third theme concluded with resistance that mental illness fell outside of 'normal' mental health, which was rationalised as all people experiencing mental distress, so the suggestion here could be interpreted as mental health being a continuum. This included the CYP reimagining the narrative around mental illness as being 'valued' as it indicated they had *'overcome hard times'* (*ibid*:121). This allowed the CYP to reclaim something back of themselves that had been 'taken' by the label they had been given. She concludes by suggesting that *'...a 'mental health issue' does not indicate an abnormal child'* (*ibid*:122) but represented *'...a normal child reacting and adjusting to the conditions of their lives'* (*ibid*). This positions the CYP as resisting the labels imposed and creating spaces to explore and position their own interpretation of the normal/abnormal binary. This moves away from the positioning of 'emotional distress' as a mental illness, which is a position I fully endorse. In some areas within the research, there is a lack of criticality around the findings given. Whilst Liegghio identifies in her analysis that many of the systems that position CYP into the psychiatrization process are oppressive and exclusionary, there are issues that are not addressed, for example she states that *'...psychiatrized young people could have very different subjectivities if their expressions of distress were constructed and treated as "appropriate" and even 'normal' responses to the difficulties they face in life'* (*ibid*:123). This statement fails to differentiate between types of mental health issue and severity of presentation. I cite two examples from my own clinical experience of a teenage girl with anorexia, who, at 170cm weighed under 32kg and eventually needed to be fed by nasogastric tube, as she refused to eat anything and a young woman with such severe OCD that the back of her left hand had exposed bone and tendon, where she used bleach and a metal scrubbing brush to eliminate germs. Whilst 'normal' may be described as a '*matter of perspective and opinion'* (*ibid:*120), it is still 'boundaried'. Their presenting pathology could not be identified as 'normal', for if it had been, no intervention would have been put in place and, presumably, neither of these young women would have gone on to recovery. Whilst I concur that emotional distress and anxiety should not disqualify the CYP in Liegghio's study from participating in their own recovery and having their opinions and preferences considered and valued, nonetheless, clinical practitioners, such as psychiatrists, are often the 'last resort' when mental illness has become so severe, that it has become a threat to life.

Whilst it can be argued that most U.K clinical practitioners do not use the DSM, but instead favour the ICD, this is also problematic as most disorders represented in the DSM are found within the ICD. Although there may be variation in the diagnostic pathways, Tyrer (2018) identifies that clinicians using the ICD have more discretion in diagnosis than the DSM allows. This means that there are less rigorous adherences to the diagnostic indicators needed than in the DSM. He also identifies that the WHO has a stated intention of reducing mental health prevalence; a way to do this is to widen the parameters of definition and diagnosis, so more people can be targeted for intervention (see *Appendix 5* for critique of NICE diagnostic criteria).

Olivier (2015) emphasises this when he identifies that 'normal behaviours', like daily hassles, disappointment, frustration and disorganisation have become symptomized as mental health issues and categorised as such; for example, the ICD-11 index which include 'inability to concentrate' and 'forgetfulness' as part of the diagnostic criteria for depression. This is important as it means that surveillance of such matters can give rise to a CYP being faced with interventions for mental health issues, where potentially no such disorder exists. This is because pathologizing problematic behaviours can enable neoliberal societies to manipulate and control subjective experiences to set agendas using interventions, for example through targeted wellbeing strategies. This would seem to support the findings in Chapter 1 which found no increase in the diagnosis of clinical disorders in CYP, despite the mechanisms of diagnosis (like the DSM and ICD) being structured to allow an ease of diagnosis to manage social conformity.

2.2.3 Examples of Targeted Wellbeing Strategies

The evaluation of Emotional Health and Wellbeing strategies (EMWB) within education is extremely important as it lays bare the relationship between the school and its purpose in structuring the emotional state of CYP. This being to adapt, accept, conform and obey through the disciplining of emotion, (which would presumably entail careful management of any signs of disequilibrium, inability to cope or lack of engagement). It reinforces further the school as supporting agents of the capitalist architecture. This links to research on the technologies of emotional regulation and management deployed within schools, for example in programmes such as NHSP, ECM and SEAL. More recent strategies include PATHS, MBI, PRP and the Healthy

Child Programme (see Benham-Clarke *et al* (2022); Gillies (2011); Murphy (2006) and Ng *et al* (2022).

Hayward (2009) identified that the NHSP represented the '*rise of an emotional needs culture'* which problematizes emotional health in the EHWB agenda. This in turn became a policy driver which shaped educational responses. Why this is an issue is that in 'framing' the problem, the policy becomes a technology of governance of emotion and affect. Hayward argues that in the 'problem' identification, there resides an array of assumptions, presumptions, suppositions, causes and proposed remediation. However, there are also gaps, omissions and silences in representation of 'normalised' emotion that act as markers to identify CYP who do not meet the behavioural benchmarks and labels them as being at risk or vulnerable. These 'gaps' can foreground oppressive practices by adopting abelist, saneist, sexist, racists and genderist standards of emotional function that can marginalise minority groups, who may disproportionally be impacted by wellbeing interventions.

This leads to a 'backgrounding' of socio-economic aspects like disadvantage, poverty and inequality which Haywood (2009) identifies are missing from the policy text on the NHSP programme. She identifies that this has led to competency models that focus on looking inward for solutions to psychological deficiencies, whilst failing to challenge systemic inequalities and culturally positioned responses. An arguable example is that the NHSP policies locate poverty as a consequence of poor emotional wellbeing, not as a cause of it. This is supported by Mills (2014a) who has indicated that *'...poverty more generally creeps into psychiatric discourse'* (*ibid*:197) (but more perniciously, into diagnosis). This leads to the 'identification' of wellbeing or mental health issues often being decontextualized, as Mills may argue, by failing to acknowledge the psycho-politics of lived experience, when *'...psychic oppression and trauma are interlaced with the socio-economic'* (*ibid*:216).

This perspective also limits solutions to being personalised and individualistic interventions for CYP. This leads to what Burman (2009) suggest as *'...the suppression of variation, which endorses conformity and denies actual struggle / conflicts of interest'* (*ibid*:141). Whilst many of the strategies identified were products of New Labour policy initiatives (see Chapter 3), which focused on social and emotional literacy; new and evolving policy strategy such as mindfulness and resilience have a more exclusive focus on interpersonal contexts, leading to the suppression of 'undesirable' emotional responses. So, these newer strategies are less

interested in the management of behaviour, than in restructuring the mechanism of cognition. Barker and Mills (2018) have identified that the therapy discourses within the wellbeing remit locate structural and systemic inequalities as '*resolvable*' with managed interventions that are myopic; focusing *'...almost exclusively, on the need for improvements in an individual's emotional literacy, self-esteem, social skills and family dynamics'* (*ibid*:651).

A specific example of Burman's denying of struggle and suppression of variation has been examined by Procter (2013) in assessing the SEAL programme (DfCSF, 2008b) which was a curriculum designed to manage feelings, promote emotional awareness and self-regulation. The SEAL curriculum defines the teaching of emotions in an educational context and the expectations of how children should both manage and express their emotions in a 'literate' or 'intelligent' way. Procter focuses on 'angry boys' and how they are shaped and defined within the SEAL curriculum. Certain emotions, like anger, are identified as being undesirable emotions to express, CYP are 'educated' to identify the expression of such emotion as being shameful and inappropriate. Procter explores how children labelled with specific emotions have their behaviour interpreted in different ways. This affective label has the power to change and construct the child's interactions with others. Therefore, *'...identities get 'stuck' to children at school'* (2013: 505), leading to spatial segregation.

Procter further advocates that because the focus on behaviour in schools is to 'manage emotion'; there was a lack of focus on the reasons why the boys were displaying anger, rather than the behaviour that the emotion of anger caused or created. The spatial associations that Procter makes link to proximity and distance; calm and 'safe' spaces, social isolation and a withdrawing or moving away from others because of the expression of anger. Children are reinforced that anger is a 'bad' emotion. In this regard they are less likely to exhibit anger, even in a situation where it would be an appropriate response. Children are therefore being shaped to be placid, docile, passive and compliant 'automata', devoid of affective range.

This labelling manifests in children taking up the vocabulary of exclusion, referring to children being withdrawn to different locations because they have 'anger problems'. There is an expectation that 'angry' children will not be included, will sit somewhere else or will be physically distant or removed because they have been *labelled* as angry. The more recent move into resilience and mindfulness progresses this exclusion further, as it is less about Procter's concern with managing emotional regulation (like anger) but extends to children

alienating themselves from their own patterns of affective reaction and response. Moreover, it is an example of where labelling used within schools creates 'problematic' behaviour which is then repositioned as a mental health issue attracting intervention, as an 'accepted truth'.

The increased attention given to the policing of emotion and affect is an example of what Knight (2014) refers to as 'public secrets' that function to maintain the social hegemony. These are facts that are known, but unacknowledged because doing so may create divisive emergent agendas and pockets of resistance. Knight suggests that the current public secret is anxiety, which is manifest as mental anguish or distress. This is defined by Knight as a sense of hopelessness. Why this is a problem is that the current narrative in wellbeing focuses on making changes *within* the individual, in 'building resilience' to address anxiety and it is this aspect which is driving the current agenda, for example the MBI and PRP. This is divisive because it fails to consider any socio-economic or geo-political aspects of lived human experience as a cause of stress, tension or unhappiness. It prefers instead to focus exclusively on individual mental frailty in terms of internal biochemistry and biology. This links to Knight's proposal that aspects of personal management discourses (like time and anger management and improved 'self-branding' such as self-esteem raising) have permeated thinking about what constitutes mental wellness and; driven by the psychological and emotional self-help industry, conspires to shape subjective conformity to neoliberal ideals, whilst giving the illusion of individual self-control and improvement (*ibid*:5).

An important aspect to further consider is that for most educational practitioners, the content of the Wellbeing Agenda is never critically explored within a political context. Therefore, there is no dialogue around the potential 'direction of effects' that the Wellbeing Agenda could have created. Insomuch as the agenda is not just measuring existing phenomena but is potentially responsible for creating the phenomena it is claiming to measure. What is also important to consider is that mental health is impacted by the strains, tensions, stresses and competing demands of an education system that has been radically marketized. This requires close attention to be paid in constructing a narrative that identifies how neoliberal education policy specifically and capitalism in general, can itself 'cause' the mental distress considered in Chapter 1, which are subsequently being measured and treated. For example, Timimi (2010) has argued that fundamental structures within neoliberalism have created what he terms a *'...narcissistic value system that creates an ethos of winners and losers'.* (*ibid*:696).

This is important as he defines this system as 'atomising' individuals who are compressed into insulating, isolating (and alienating) individualised spheres of existence. This serves to reduce affiliation, responsibility and obligations to wider social communities. This narcissistic imperative has resulted in children existing in a *'...psychological vacuum, pre-occupied with issues of psychological survival'* (*ibid*:695). He argues the consequences of this leads to increased feelings of vulnerability and alienation, due to lacking a sense of personal value and worth, but also the dissociation of belongingness, a lack of connectivity and social integration with others who are viewed as 'obstacles' and 'competition'.

What now follows is an illustration of how alienation can create mental distress in CYP by reflecting how capitalism itself creates mental ill health. This is in order to support the position that, wellbeing services are a means of maintaining the existing hegemony and are colonised by 'psy-professions' who are complicit in remaking socioeconomic inequalities into personal pathologies. This appropriation of personal misery and distress created through social contexts is contrived to position mental ill health as a consequence of personal deficiency. Fisher (2009) has stated that *'...mental health is a paradigm case for how capitalist realism operates. Capitalist realism insists on treating mental health as if it were a natural fact, like weather*' (*ibid*:23). For Timimi (2010), the ensnarement of children within this system is indicative of the unhappiness and misery ostensibly 'measured' in metrics of affect. Culpability lies with the value base of the social system within which children develop and grow. However, responsibility is reflected onto the child by viewing the emotional distress this creates as weak personal psychopathology which needs 'medical intervention'. Thus, *'...by providing convenient ways to subcategorise discontent and behavioural deviance, biological psychiatry gives government new ways of regulating the population'* (*ibid*:696). Later chapters will evaluate Levine's (2013) description of a *'...curious revolt'* (*ibid*:2) in assessing the resistance offered by CYP who are diagnosed with 'mental health' issues under the guise of 'wellness'.

The perspective taken in this section has challenged my position on the emergence of mental health issues. Prior to this research, I favoured a biological explanation for mental health issues because I had experienced working with individuals who had life affecting diagnosis of mental illness that they required extensive help in managing. Some of these individuals had complex, acute and challenging behaviours. Through the diagnostic process there was very

limited attention paid to other factors, as the focus of centre staff's work was post-diagnostic recovery, with a view to the person being discharged. Whilst I accepted that many individuals that we worked with had difficult personal relationships, family situations, environments or practical challenges like homelessness or substance dependency, which contributed significantly to their mental state; what was not recognised at this time was the bias inherent within the diagnostic process itself. This was rarely questioned and it was 'taken for granted' that the diagnosis of 'bipolar disorder' or 'schizophrenia' was correct. It is not my experience that individuals were 'blamed' for their 'condition', the 'labelling' of the disorder for clinical staff was more about determining what the best course of treatment was for ameliorating the distressing symptoms for the person. However, I now accept that the systemic structure of social relations for many of these individuals was not taken into account for their recovery. This is especially true for individuals who returned to the centre periodically, when they were unable to manage their symptoms outside. Some would stop taking medication and relapse. For many it was a question of whether the distress of their disorder was more tolerable than the side effects of the medication they were taking.

2.3. Capitalism as a Cause of Illness

Whilst the argument positioned by this thesis relates to mental distress as a consequence of alienation and resistance, it is important to briefly expand on the evidence that suggest capitalism can be the cause of both physical and mental illness. These are to illustrate that capitalism is inherently engineered to create illness and indeed, has no facility to prevent it. Also, it is to counterbalance the narrative that *'...adult mental health issues begin in childhood or adolescence'* (DfE&DH, 2017:8). This section argues that adults labouring within a capitalist economy are likely to suffer mental illness *irrespective* of whether they experienced mental health issues as a child.

Researchers like Weinstein (2015) have commented that there must be more careful focus on the link between what he terms the material and the mental, understanding how the suffering created by capitalism seriously impacts mental health. Studies such as Davies (2015); Sagall (2013) and Wilkinson and Pickett (2010) all relate to the inherent inequalities in capitalist society creating mental strain. The effects of this type of suffering manifests through work absenteeism, low morale, somatic illness and general malaise which illustrate how societal organisation can lead to strain, subsequently degrading and diminishing the human

psyche. Moncrieff (2018) as a practicing psychiatrist has talked about *'...holding back a tidal wave of misery'* (*ibid*:307) in identifying the life positions and social conditions of many of her patients. She recognised that to deploy explanations for mental illness which are confined to the reductionism of biochemical imbalances, fails to explain why, as Wright (2014) suggests, societies that have less poverty and inequality, correspondingly have less misery and fewer mental health issues.

Olivier (2015) relates to a range of suffering under capitalism from economic and physical to psychological and emotional senses of pain, loss, injury, hurt and harm. He cites Van Haute's (2013) concept of *'...the patho-analytic principle'* which suggests that by examining evidence of individual psychopathological traits, it can reflect the psychological state of the wider population.

In respect of illness and capitalism, there are implications in failing to consider what Scheper-Hughes and Lock (1986) have termed the vector effects of capitalism (socio-economic factors like inequality and poverty) when regarding illness as just a disease of the body, which reifies sickness. This would be both a type of false consciousness and, they argue, a form of self-alienation. This results in a failure to see illness within its wider context. This was a warning explicitly mentioned by Yuill (2005) who cautioned that the impact of social organisation on alienation would potentially be lost if alienation was reduced to personalised 'repairs' of affective aspects of individual consciousness, (which is currently being seen in the Wellbeing Agenda). They reference the types of strain and tension inherent within societal and labour relations, for example unhappiness, anger, worker alienation and social isolation, as maximising illness potential. What Kovel (2019) refers to as the *'...ubiquitous neurosis caused by alienation'* and the *'...colossal burden of neurotic misery'* (*ibid*:69). For Kovel, the neurosis he describes will be examined later in Chapter 4 in relation to Freudian principles created by the conflicted self. (The themes of alienation and neurosis are closely related in psychodynamic theory).

2.3.1 Illness as a Socially Patterned Defect

Fromm (2002) (using a psychoanalytical approach) locates the origins of mental illness within a capitalist economy as inhabiting the modes of production, arguing that a split occurs in the nature of humans because of the alienating operations of labour they are forced to

undertake. Also recognised was the focus on individuality, self-reliance and independence favoured under capitalism, which rejected collectivism, solidarity and group responsibility in preference for aggressive and pitched competition within and between individuals. These similar features can be seen in the earlier example of marketized schooling, where competition between individual CYP and schools are created and encouraged. This leads to a dichotomy between the intrinsic human needs to relate, affiliate and cooperate and the skills necessary to be successful within a capitalist economy as a 'personal entrepreneur'. This is due to the complexity of human needs and desires that seek intellectual and creative expression, rather than simply the meeting of basic requirements like sleep, thirst and hunger (Maslow, 1962). It also reflects the '*...narcissistic value system'* envisioned by Timimi, important because this type of value system also *'...shapes the way we conceptualise children and their problems'* (2012:413).

Fromm (2002) recognised five important psychological needs for mental wellbeing, including relatedness, belonging and a sense of identity as important aspects of the human condition that require satisfaction. These are required to be met at all stages of life, including childhood and adolescence. He suggests that where just one of these psychological conditions was not met, this would create '*insanity*'. Further, even if these core conditions were met but not in a satisfactory manner, this would result in neurosis (*ibid*:66). Matthews (2019) has claimed that *'...the deterioration of mental wellbeing is a standard response to wage labour in monopoly – capitalist societies'* (*ibid*:55). Identifying that capitalism not only has the underlying potential to create the conditions for mental health issues to arise, but more importantly, has no facility or capacity to *prevent* it.

Fromm has further suggested that a cause of mental distress, despondency and dissatisfaction is caused through what he termed 'socially patterned defect'. This relates to a phenomenon where multiple individuals in a given society or group share the same psychological strain, to the extent that this is no longer recognised as atypical, abnormal or even individual. Such a group could be constituted from CYP who are exposed to schooling. This is important because an adverse indicator of such phenomena is that mental degradation becomes 'normalised'; so, individuals cease to be aware of toxic environments. This would be effective in explaining how CYP in schools could experience the same levels of strain and distress but not perceive this as atypical. Fromm (1944) further expresses this as a failure to

experience unhappiness (which would prompt action) due to the submergence of negative emotional responses in the mutually shared experience of the group, blunting emotional awareness. As indicated in the preceding paragraphs, a sense of relatedness and belonging are essential for healthy mental function, so this would be met, as the individual feels part of the group due to their shared experience of misery, but it is met dysfunctionally, because the situation is oppressive and damaging, (so the need has not been met appropriately). Therefore, this is a group malaise, rather than an individual neurosis. Fromm's belief was that a society could itself be 'sick' and mental illness could be deemed as a 'collective response' to social degeneration.

This interpretation of 'failing to feel unhappy' as a cue to action also illustrates that a 'forced' feeling of happiness works in the same way, limiting triggers to act. Importantly, Harris (2022) identifies the individual's sense of alienation and detachment is evidence that their psychological needs, such as belongingness have not been realised, which indicates that their social environment is pathological. This feeling of 'forced' happiness can be explained with reference to positive psychology practices, which will be examined in Chapter 3. I have used Fromm in this context as it provides a useful explanation of how cohorts of CYP could experience emotional distress which has become normalised, it further explains how alienation can occur as the 'authentic' state is incongruent to the social feedback being received within the group. It is also useful in positioning a psychodynamic explanation for mental distress, which could create a somatic ill health response, for example an enhanced stress reaction. Although there has been historical criticism of Fromm's position from researchers (see Maccoby (1996) and Marcuse (1956)), there has been contemporary application of his theories, (see Brookfield (2002)), alienation within an adult education environment; Cortina (2015), a review of existential humanism; Grillo (2018) Fromm's theoretical perceptions of habitus; Sakurai (2018) examining interpretations of 'autistic personality' as separate from autism and York (2018), the contemporary rise of fascism and the impact for mental health).

2.3.2 The Inherent Strain within Capitalism

To consider how capitalism (and marketized schooling) may create suffering and mental strain, Ferguson (2017) has stated that *'...we live in a society that is based not on meeting human needs first but that is driven by the need to accumulate profit'* (*ibid*:3). He further

considers that where fundamental human needs are not met, this causes a sense of alienation as human desires are repressed, sublimated or distorted. Much of this he relates to the repositioning of mental health into a medical paradigm which has shadowed the trajectory of neoliberalism. This would indicate that relating mental illness to constructs of personal abnormality is politically expedient. This serves to disguise or mask the relationship between both class and socio-economic factors in the creation of ill health; it also deflects the endemic unhappiness and misery created under capitalism. This failing to recognise unhappiness is embedded within Engels' (1893) suggestion of false consciousness, where the realities of domination, subordination and oppression are concealed behind the construction of social relations, creating what Little (2019) refers to as distortion errors and blind spots in consciousness. Therefore organisations, institutions, agents and policies that control and shape thought, beliefs and ideas create a hegemonic framework, vested in the *status quo*, whose function is to generate and preserve false consciousness and prevent resistance. This can be seen in the deployment of the medical and psychology related disciplines that are critiqued in much of the work of Cohen and Ecclestone and Hayes.

Sell and Williams (2019) have referred to the vector effect of capitalism, in their concept of structural pathogenesis (*ibid*:5) due to its adverse effects on human health. Moreover, where no resistance to such oppressive situations occur, or where resistance is supressed, Ferguson (2017) states that internalisation of the misery, pain and distress created is more likely to happen, leading to a sense of alienation. This is due in part to feelings of helplessness and powerlessness, caused from the location of mental illness as being solely intrapersonal. This designates the person into the role of 'victim' of their individual psychopathy and biochemistry, as well as generating feelings of powerlessness and loss of personal agency in becoming an 'object' of and 'subject' to medical and psychological intervention. Ferguson summates the problem relating to these therapeutic interventions as being *'...about changing the way you see the world, rather than changing the world'* (*ibi*d:5). This focus on 'changing the individual' world view will be examined in Chapter 3 with the assessment of character education and affect, linked to the Wellbeing Agenda and the impacts of positive psychology in its drive for 'resilience'.

This resonates with the point made earlier by Ecclestone and Hayes in assessing the 'right' way to feel. Ferguson further examines ways that Marxian thinking links to Freudian

psychodynamics by outlining that as society represses and distorts the individual's needs and desires, neurosis will be manifest. Capitalism is driven by an imperative to profit and accumulate, which increases alienation and amplifies oppression and subservience. This creates atomisation of social support at the same time as it increases and intensifies competition. It is, therefore, not difficult to understand why Baran and Sweezy (1966) have claimed that capitalist systems fail to provide the necessary foundations for a society that is even capable of promoting the mentally healthy development of its citizens.

A key feature that has been identified in this chapter is that capitalism can be viewed as the causal force in the dissembling of physical and psychological health. It can be regarded as a locus of suffering and a root of mental ill health, for example in the dual pressures of alienation brought about by 'powerlessness' and the individual's own perceived *'...complicity with exploitation'*, (the socially patterned defect outlined by Fromm) Olivier 2015:6). What Olivier advocates is that a significant degree of strain caused to the mind and body is inherent to labouring within a capitalist economy, because the individual endures a range of psychological damage, created through processes like depersonalisation, commodification, competition and regulation. In contrast, he regards 'unselfish capitalism' as existing in countries like Denmark, Sweden and Finland. He suggests that significantly more compassion and community are present within their culture, where there is a more ethical and even use of derived GDP, for example higher than average amounts are given in support of the sick, infirm and unemployed. Important was his desire to be consistent, by focusing comparisons of use within exclusively westernised, developed economies which was in an effort to prevent economic or infrastructure bias. What this identifies is that it is not just capitalism that underpins suffering and distress, but the *type* of capitalism that can determine by what varying degree. This point would also seem to be reflected in the PISA surveys which place Nordic countries like Finland and Denmark in the highest-ranking league positions in international comparisons of education, both academically and in terms of wellbeing.

Olivier draws on a range of research (including Federici (2013); Klein (2007); Parker (2011); Salecl (2010) and Verhaeghe (2014)) to support his critical argument on the suffering caused to individuals within a capitalist society, he further includes a breakdown of work by Hardt and Negri (2012) to establish what he interprets as the new social topography. This is constituted through individual subjectivity; the 'indebted', created by financial organisations,

economic policy and fiscal management. The 'mediatised', created through the domination of social media, marketing and the ideology of 'choice'. The 'securitised', manufactured through the insecurity, fear and panic orchestrated through the casting of the 'other', against which we need protection, surveillance, safety and enguarding. Finally, the 'represented', which are argued to have been formed from the 'depoliticised', created through what they regard as 'corruptions of democracy'. Whilst there are criticisms of Hardt and Negri, (see Mouffe, 2012) for example in relation to the definition of 'common', Charles (2017) has expressed that *'...a concept of the common should be seen as an understanding of production centred on affect in neoliberalism'* (*ibid*:15). This is relevant here because Hardt and Negri state that there exists no space 'outside of capital'. Capitalism has wholly infused and shaped the life fabric and thus is dependent upon colonisation of the 'affective' processes in 'cognitive capitalism' to exert control. This is indicative of Mills (2014b) point of colonisation around the psy disciplines shaping and construction of mental illness as personal and affective, which fails to consider social and systemic inequalities, she comments that *'...in its translation of [this] distress into psychiatric diagnostic categories, psychiatry also alienates and colonizes'* (*ibid:*221).

To Hardt and Negri's list could be added the 'medicalised'; individuals who have been measured against biased clinical assessment frameworks, derived from parameters and boundaries whose demarcation is set by neoliberally defined 'norms' in order to ensure individuals are controlled and conform to prescribed subjectivities. For those individuals who fail to meet these criteria, a range of interventions to facilitate their rehabilitation of continued social and economic compliance is created. This can be through cognitive behavioural programmes, resilience and inoculation training, tranquilisations, sedation and psychological 'numbing' that works to subvert the emergence of critical consciousness. Olivier adds that it is against this new terrain of the socially constructed subjective self, that resistance must be enacted.

What has been made clear is that emotion is the new currency of neoliberal policy in the control and management of individual compliance. Further, Knight (2014) has identified that neoliberalism seeks to repress dissent and non-compliance by repeating cycles, whereby strategies of resistance that are formulated become negated by changes to policy and practice that absorbs and subsumes them. He cites historical factors like misery, boredom

and deviance as examples where this has happened. What this suggests is that there are constant crises within capitalism, these are minimised by changes in neoliberal policy around what are termed *'newly dominant affects'* that emerge (*ibid*:1). What this means is that policy and practice are reconstituted to minimise resistance strategies. Resistance, dissent and subversion do not emerge when 'dominant affects' continue to be a 'public secret'; they only need to be managed when they become publicly *conscious*.

Knight has identified the current public secret is anxiety, which has been made publicly conscious in the reporting and recording of mental health statistics, (seen in the media panic discussed in Chapter 1). It follows that significant levels of intervention and control will be put in place to prevent this from becoming an organised strategy of resistance and further to subsume it by mobilising and maximising strategies of 'containment'. It could be argued that this is to ensure anyone who is considered resistant can be enmeshed in the interventions that will 'recondition' their behaviour. Changes made to the diagnostic criteria encompass more individuals who can then be 're-educated' through 'resilience' programmes that reshape their mental subjectivities. These are executed through close measurement and surveillance, prompting wellbeing initiatives that follow on from a diagnosis, disclosure or label. It is within this context that the Wellbeing Agenda can be positioned as a political initiative to manage the newly dominant effect of anxiety. This containment is facilitated by psychotherapeutic interventions through the labelling and reprogramming of resistant behaviours. However, as Rose (1999:219) has suggested *'...for alienation grounded in the form of economic organisation, therapy could only be a palliative'*.

2.4 Hegemony within Educational Structures

A useful illustration to assess how the alienation found within capitalist systems translates to education can be found in Kingston (1986) who explains that a lack of academic success in schools, low commitment and perceived negative behaviours like being off task, having a disruptive or poor attitude are the consequences of neoliberal education policy under capitalism, rather than the cause. In this respect, Deacon (2006) has outlined that schools developed '*moral orthopaedics'* to facilitate what he termed '*disciplinary technologies'* (*ibid*: 83). This can be mirrored in the *'disciplinarization'* of schools referred to by Foucault (see Deacon, 2005:85) and the 'ideological state apparatus' of Althusser (1970). This related to structural processes and systems within school that reflected the systemic hierarchy. Where

individuals or schools are seen to 'fail', stricter discipline and harsher academic requirements and/or more punishing regimens of testing are introduced. Marx would argue for these factors to be seen as evidence of the alienating and oppressive forces within education, where children are seen as 'producers' of what Everhart (1983:32) identifies as '*exchange not use value'*. Therefore, the prime directive of these institutions and organisations is to manipulate pedagogic practice, create modes of surveillance and reports of potential resistances. It further augments disciplinary, interventionist and restorative practices which monitors and regulates adherence to neoliberal values.

An example of such values in education is seen in Allen's (2014) work that aims to dispel what he termed the 'myth' of meritocracy, prescribed within the 'self- improvement' of 'personal entrepreneurialism'. Most notably that ability + effort = merit, or that achievement and the ability to make 'progress' is premised on the simple notion that working hard and following the 'rules' will produce equality of opportunity. More truthfully as Allen points out, is that meritocracy functions to maintain and legitimate inequality (*ibid*: 7). For example, in presuming an initially level playing field upon which ability and effort can be deployed and the assumptions implicit in the propensity of ability and effort to be both levelled out and levelling. Allen suggests that meritocracy in effect reinforces inequality but also 'diffuses' displeasure. In this regard meritocracy serves the function of closing spaces for resistance, by creating the illusion of fairness whilst at the same time militating against any progressive changes.

It can therefore be argued that if education in general and schools in particular are organised along the axes of capitalistic values, (as Althusser suggests), then inherent within their design will be the same alienating and oppressive tendencies seen in its prime originator. In this respect, Brosio (2006) describes the impact of neoliberal education values as a *'...gale of creative destruction'* (*ibid*:ix) which seeks to harness and control every aspect of thought, behaviour and action that might potentially threaten the goals of neoliberalism. Suggesting that rather than schools being places of freedom, education, creativity and discovery, schools *'...have become compulsory workplaces for children'* (*ibid*:ix). He identifies that the 'democratic imperative' has been replaced by its pale impersonator, the 'neoliberal imperative'. The consequence of which is a transition from an egalitarian ideal of choice, freedom, representation and accountability to a system that creates the illusion of choice and

freedom, encased stringently within parameters that function only to preserve and maximise the interests of the controlling elite. This serves the same ends as the myth of meritocracy discussed by Allen. It also allows for generalisations to be made from the earlier work here on the impacts of capitalism on health and wellness in terms of alienation and suffering. If schools are indeed 'workplaces for children', then they 'labour' at the task of learning and face the same dehumanising and alienating conditions.

A key component of education as an agent of neoliberalism is the replacement of what Martinez and Garcia (2015) reference as the 'public good' or sense of community with 'individual responsibility'. This relates to concepts of schools as being places of creativity and nurture within the community. This change in the social relationship is both destructive and divisive because it relocates the cause and response to societal inequalities and injustices from a collective social concern to a personal problem. This effectively means that systemic inequalities and artificially manufactured disparities, created through deregulation, privatisation, marketisation and the reduction in public expenditure found within education is now the province of the individual to navigate. They argue that the 'new' social contract between government and the people repositions and redefines their relationship, privileging corporate need over individual and social welfare. What this represents is a new reality for individuals where the removal of government responsibility for its citizens' education and welfare necessitates individuals now be wholly responsible for themselves. So those experiencing illiteracy and illness must find their own solutions to education and health inequalities, along with the burden of being identified as 'failing to try' or 'lacking motivation to succeed and improve'. Moreover, as already addressed, these deficiencies are framed in a neoliberal narrative as resulting from inadequacies, frailties, lack of effort, limited ability or failures in motivation within the individual, rather than injustices and inequalities in their lived environment.

As noted, Van den Bergh (2012) writes extensively around the concept of mental health being framed as individual shortcomings in *'...the duties of vigorous self-fulfilment'* (*ibid*:6). He expands this further by outlining that it is no longer adequate to rely on social bonds and collective shared values, what is now required in these '*postneurotic times'* (*ibid*:7) is to demonstrate self-reliance, expansion, the ability to excel, succeed and to 'display' oneself. However, the consequence of this shift is that rather than having an anchor of core values

and connection to create stability, the individuals find themselves 'apart' and adrift. So, under the neoliberal drive for individuation, people have become 'commodified' and exist, accordingly, in a self-referential, self-determining, self-actualising and self-realising state that again creates the illusion of freedom, but at the cost of self-alienation (*ibid*:9).

Researchers such as Apple (2001, 2013); Ball (2013, 2016, 2018) and Ross and Gibson (2006) have explicitly referenced how neoliberal policies in education 'reforms' have created multiple tensions, identifying how education has been both marketized and commodified. For example, in the move away from 'free' to 'fee' paying education, the switch to private rather than public programs and initiatives, the deprofessionalization and deskilling of teaching and lecturing, the politically selected curriculum and the removal of educationalists from autonomous decision making to low trust status under high levels of surveillance (see Page, 2016). Most notably they identify that contemporary education policy only meets the needs of the individual student as long as it maximises profit, for example through academisation. Ball (2018:28) talks about *'...the maze of policy hyperactivity*' in English schools, describing it as 'incoherent' where he states that derivative policy decisions 'lurch' from one prejudicial solution to the next with increasing inconsistency. He also suggests that education practice has been reduced to a range of *'performance outputs'* (*ibid*:28) which represent '*economies of student worth*' (Ball, 2013:16) but which fail to account for a variety of systemic inequalities.

Further, the impact of this marketisation and commodification has created a change in the function and purpose of schooling. This has seen an emphasis on generating students who are competitive, rational, increasingly productive, effective, skilled and entrepreneurial individuals who can add economic value and who are, more importantly, resilient to *'...enable nations to be responsive to changing conditions within the international marketplace'* Robertson (2000:187). What this also creates, more crucially, according to Ross and Gibson (2006), are students who do not challenge or question the hegemonic structure, but merely accept their place within it.

Of further importance in this process is that students who are not successful, who fail to compete, are unable to innovate or develop skills at the necessary level are deemed to have some personal lack, deficiency or inefficiency in motivation and effort. Responsibility is placed with the student, for not working hard enough, for not being well motivated, for being ill-

disciplined in their approach to study, for not attending and for not attenuating. Also, with the teachers for being ineffective, undedicated or incapable and with the 'failing' schools, for squandering public finances, wasting resources and recruiting staffs that are inadequate. As discussed, this concept of personalisation is a feature of neoliberal policy, which is then quantified with 'evidenced-based' judgements of poor examination results and low league table placement, which subsequently 'justifies' unilateral intervention, (Ross and Gibson, 2006).

This has led Lipman (2004) to comment that this pervasive culture leads to a focus only on why individuals or individual institutions are deficient. It fails to consider the inequalities inherent within the destructive culture of high stakes testing, a narrow curriculum, the A-C target focus, league table positions and withdrawal of public sector funding. It also illustrates that changes in requirements within the labour market; for the type of jobs that are available and who will undertake them, drives a revision of the subjects and content specified within the school curriculum, for example an explicit focus on reading, oracy and maths. This has also led to an increase in teacher mental health issues. Jerrim *et al* (2020) reported that around 1:20 teachers in England identify as having long term mental health issues. Gray *et al* (2017) relates that teachers across all educational settings have reported high levels of job stress, burnout and low job satisfaction. The ESP (2019) survey correlated with this, showing that 72% of educational professionals describe themselves as 'stressed' and 33% reporting average working weeks of more than 51 hours, with many recording physical and psychological impacts, such as insomnia.

Within schools, Verhaeghe (2014) has identified that for children, certain traits are desirable whilst others are discouraged and undervalued. For example, articulateness, flexibility and risk taking or reckless behaviours are valued as 'entrepreneurial'. Seen in the overt focus on meritocracy (see Allen 2014), where worth is earned, there is similarly an emphasis on competition, striving for perfection, ambition, resilience and an often overdeveloped drive to excel. Whereas traits like teamwork, cooperation, kindness, community focus, superordinate goals and championing social justice are dismissed as undesirable and lacking ambition. This emphasis on achievement also anchors a sense of self-identity and self-worth to economic and professional/academic success. This serves to loosen social bonds with others, who are

seen as competition to be overcome and beaten. This has the impact of weakening wider social affiliations, leading to a further sense of alienation.

2.4.1 Positioning Alienation

Gereluk (1974) has advised that it is preferable to use the term 'schooling' and 'policies for schooling' rather than education as there is no agreed epistemological definition of what constitutes education, as it is dependent upon a range of political, historical, cultural and socio-economic factors. As this chapter examines the impact of alienation in schools as a contributing factor to the growing concerns of CYP mental health, it is important to consider this point. Gereluk further comments that the use of the term 'alienation' is also problematic. Working from within a Marxist perspective, he suggests that the term is used to 'conveniently' reference the range of student behaviour seen in resentment, apathy, absence, rebelliousness and also illness. He is critical of research that does not use alienation with 'conviction' by considering the ontological or epistemological stance, but rather uses alienation as an objectively 'self-evident' construct. These themes are reflected further in research around alienation that considers the impact of schooling, for example in specific definitions of Fromm (1962) relating to 'estrangement', Illich (1971) regarding 'dehumanisation' and Holt (1964) with the 'impoverishment' of the child, where he identifies children as being 'starved' of emotionally connective relationships.

Gereluk's primary objections to the use of the term 'alienation' is that it aligns with the individual theorists own ontological positionality. A point that is reflected in my own interpretation of the definition and location of alienation as a construct, which he implies that if not explicitly stated – is tantamount to dishonesty. He argues that the researcher's own perspective will influence the use and application of alienation as an explanation for the impact of the processes of schooling. For example, a criticism of using alienation can be construed as being a subjective feature inhabiting the viewer's conception of 'reality' and not at all existing in the 'real' world, (being merely a hypothetical concept). It could also be regarded as a 'disposition' within individual CYP, a subjective manifestation of CYP's 'inability' to cope with the demands of schooling, or alternatively as a 'feature' of the process and function of schooling itself as a *'...character of the situation, institution or society'* (1974:39). Gereluk heavily criticises the psychological approach to alienation *'...explaining troubled behaviour as a recourse to consciousness'* and arguing that it is folly to 'start' with the

'...individual as their primary data' (*ibid*:40). Gereluk's argument resides in his belief that 'consciousness' if understood only as a property of the individual, is limited and reductive. He states that alienation can only be understood when read as *'...an ensemble of relations with a history*' (*ibid*:44) and so cannot 'reside' within consciousness.

To substantiate this claim, Gereluk uses Lefebvre (1968) views on dialectical materialism to consider the relations that students make (both between themselves and with the organisation/institutions) which are then reintegrated into the socio-historical (and to some degree socio-political) context of schooling. He reinforces this argument by utilising Mészáros (1970) constructs of alienation using the first order mediations (active relations to the social world of affiliative 'others') seen as a 'systematic configuration' of reproduction and second order mediations (entities that facilitate structural relations that 'mediate' control of these interactions) such as technology, bureaucracy and academia. This suggests that alienation is created by the second order mediations regulation of activity in producing the first order mediations. This can be seen as the school imposing 'forms' of activity' which regulate the purpose of the social interaction. Gereluk identifies this as *'...the purpose for which the child is engaging in schooling is not to satisfy their own needs but is completed to satisfy the institutional requirement'* (1974:47). This is especially true when the second order relations are fulfilling the needs of the market (*ibid*:48). Thus, alienation can be seen to be created by the structural relationships within the value exchange, rather than within the individual or as a feature of the school itself.

Gereluk's contribution is important for two reasons. Firstly, it necessitates that a statement of my own ontological position is imperative. Therefore, I disagree with his position as, in criticising the 'starting point' of alienation as being 'with the individual' there are two aspects that become problematic. Gereluk is limited in his scope in refusing to consider alienation as an issue relating to personal consciousness. This is because, in dismissing the psychological perspective, he fails to consider aspects of alienation within the interpersonal relationship with 'self' and focuses only on alienation from external social entities. Further, consciousness exists as a function of mind and whilst aspects of this may be mediated through relationships with others, a significant amount exists within the 'inner dialogue' examined by psychological perspectives like the cognitive and psychodynamic approaches. As an example, a person can

experience self-alienation whilst being engaged in positive and meaningful external relations with others, for example he states:

'Alienated students are never alienated 'in their own right'. They were only alienated and students insofar as they stood in certain relationships to other people and objective circumstances – in a social institution at a point in its history' (1974:45).

This also does not explain how alienation can be felt after the CYP has left school – if the alienation was only a function of the interaction between their 'status' (student) and 'location' (being in school). My ontological position regards alienation as being a product of the interaction between a range of social actors, including the *self* – but it does not locate the 'cause' of alienation as a psychological deficiency residing within the person (as Gereluk's criticism had suggested), but as an 'effect' on consciousness of experiencing incongruence in positioning relationships – alienation is, in essence – a *felt* reaction that subsequently impacts emotional and physiological responses to external pressures and forces. Thus, Gereluk's own argument regarding an 'ontological assumptions' can be levelled back at him. Secondly, and where I concur with Gereluk, is in his suggestion that most research does not make explicit its ontological position on alienation and, often, is only articulated in terms of CYP's emotional state, failing to consider the precipitating events; alienation comes from 'somewhere' – in this thesis it will be positioned in relation to the resistance created by wellbeing interventions within the marketized school, creating a focus on prescribed individual subjectivities. I further concur with his view that medication and therapy would be unsuccessful in treating the effects of alienation

2.4.2 Alienation in an Educational Context

It can be argued that schools have, historically, been sites of alienation and therefore, alienation as a concept contributes 'nothing new' to the CYP mental health discourse. Sidorkin (2004) has expressed that students become alienated because they neither '*consume nor exchange*' that which they produce in schools and further, the works they produce are *'useless objects*' that serve no purpose and have no extrinsic or intrinsic value or function, in this regard they are merely *'learning to be schooled'* (*ibid*:252). Sidorkin also makes a crucial point that alienation in schools is a feature of a modern, industrialised society, arguing that the longer formal education takes, the higher the likelihood of a student feeling alienated

(*ibid*:255). He identifies that early schooling was exclusionary and seen as a privilege for children of the wealthy elite who were educated in order to make a fluid transit into their established social position, through public school, university and then a family business, the military or the aristocracy. Thus, they were not alienated, as the cultural values the school embodied mirrored their lived experiences and expectations. It is only with economic and political expansion that increased knowledge demands were placed on the labouring classes, who required more expansive skills and better training to undertake more technically demanding work. To support this position, Sidorkin cites the systematic changes to the school leaving age as a reflection of expanding industrialisation. These have increased progressively from ten years of age before 1870, to eleven years in 1893, thirteen years in 1899, fourteen years in 1918, fifteen years in 1944, sixteen years in 1972, seventeen years in 2013 and eighteen years in 2015 (Gillard, 2018). Interestingly, it is from 2015 that significant reporting of mental health issues in CYP have been identified, therefore it could be argued that Sidorkin's view is an accurate reflection that extended periods of compulsory schooling have created alienation.

Importantly, Brunila (2011) sees the marketisation and therapeuticization of education as being closely connected as the 'market oriented' aspects of policy in conjunction with therapeutic methods of intervention and governance creates an overt concern with psychological wellbeing. This is because individuals who are schooled must now demonstrate 'measurable outcomes' in order to react to global economic pressures (*ibid*:422). Brunila further advises that a feature of marketized schooling is an overburdening of 'emotional work' as CYP are required to develop an 'agile mindset' relating to mobility, obedience and flexibility (*ibid*:429).

In further expansion, Hall (2022) has contributed to the argument that schools alienate students by considering that schools (and thus education) exists only to meet the demands of developing *'human capital'*, through the process of '*generating value'* articulated by schools as traits of 'employability' (*ibid*:30). This further supports Sidorkin's view that students in school produce 'useless objects' that do not contain 'value', but are merely transactional vehicles used to manifest activities for achieving a 'work ready' status. This is further substantiated by Frost (2012) who has identified that current educational policy making models of creating 'entrepreneurial individuals' are wedded to underpinning economic

competitiveness, by introducing a 'commercialisation' of the schooling system. Noula and Govaris (2017:223) would also ascribe to this position, as they identify that the nature of activities of learning demanded by schools in creating entrepreneurial employees means that CYP have no intrinsic understanding of what they are learning in school, as the tasks required do not nourish their creative or discovery drive, but only serve to satisfy economic imperatives, thus pupils are also alienated from the work they produce and from the purpose of its production. Reflecting further Sidorkin's position on much of schooling output as being 'useless objects'. It is unsurprising then, that Jensen (2019) has indicated that *'...education is in the cross hairs of capital's concerns'* (*ibid*:187).

A further position on alienation, (such as Charlot (1979)) suggests that education cannot be viewed outside of a psychological lens, as the process of schooling is a key factor in forming the personality. This personality shaping is engineered through the application of political, social - and more recently – economic normative values. Montreozol *et al* (2017) have offered support for this view by observing that teaching, as a 'political act' *'...establishes psychological structures of dependence, idealization and renunciation in its psyche, forming an individual who follows the interests of the ruling elite*' (*ibid*:24). Montreozol *et al* further advocate that the marketisation of schools has 'commodified' education, not only positioning the student as consumer (and consumed), but the restructuring of many educational institutions around academisation means that schools are now, essentially, sites of competition and profit.

The link between young people and alienation in education is well established, writers such as Adorno (1973); Friere (1972); Keniston (1965); Lefebvre (1971); Lukács (1971), and McClaren (1986) have examined youth disaffection in relation to school alienation based on sociological studies of CYP in the 1950s and 1960s. Frymer (2006) talks about post-modern capitalism creating *'...a steady decay of uprooted foundational norms and dislocated ethical narratives'* (*ibid*:101) which he attributes to both a 'cultural and existential' crisis, which he suggests does not just affect the traditional 'working class child' but that impacts even CYP regarded as privileged by 'class, gender and race' (*ibid*:106). He argues this is because it is personal rather than class identity that is in crisis, a crisis of the 'self' which is linked to the 'systematic' alienation of schooling from education. He has argued that this is due to an underlying 'culture of consumption' within schools that creates *'...continually circulating desires and fantasies of status, power and happiness'* (*ibid*:108) within a system of fallacious

meritocracy. This adds a further dimension in considering alienation as suggesting that schools are alienated from education, CYP in schools are alienated from the process of schooling and from their peers and that a consequence of these types of alienation is an estrangement, or fracture, from their own concepts of self. In this respect, alienation cannot be viewed without recourse to the 'individual and personal' rather than just the structural and public, contrary to Gereluk's view.

In respect of schools as an agency of alienation, as has been asserted, if school is 'work for children' and structural aspects of capitalism like competition, marketisation and commodification are inherent within its processes, then it can reasonably be assumed that the stress and tension previously explored should be visible within technologies of education. Seeman (1975) identified six ways that theoretical aspects of alienation could be re-envisioned and utilised as an explanatory framework. He identifies that the psychological concepts of alienation as estrangement from self and the sociological aspects of alienation that he defines as being attributes of the socialising system, are constantly at issue and are difficult to unify. These included perceptions of *powerlessness* linked to social control; *meaninglessness*, which relates to a lack of understanding of the complex and ambiguous social order and institutions, as well as an inability to derive sense or meaning from interaction. Also, there is *normlessnes*s, which relates to difficulties in conceiving of and curating normative standards of behaviour when measured against societal expectations. This links to the final categories of *cultural estrangement* from societal values, *self-estrangement* (which incorporates *social isolation* and relates widely to concepts of loneliness, alienation and self-esteem). The former relates to a failure to recognise cultural aspects of the first three categories, for example culturally specific 'dominant' norms and deriving meaning from cultural practices that may be alien to an individual, such that they manifest in this fourth category (*ibid:*92).

Taking these concepts further, Hascher and Hadjar (2018) apply them to a school context in considering alienation as a specific response to an individual's environment and experiences (*ibid*:174). For example, they identify that alienated behaviour can lead to *'...disengagement and superficial approaches to learning'* (*ibid*:175). In much of the behaviour within schools alienated responses can be identified using Seeman's framework. For example, powerless can relate to lack of choice in academic subjects and level, vocational or academic, streaming of

children in respect of teacher expectation and level of academic support for learning, especially if this relates to children with SEN. Meaninglessness can be linked to school routines and restrictions, for example dress codes and behavioural requirements, as well as a lack of purposeful curriculum, activities and resources that do not relate to aspirations and occupational choices. This can also relate to school bureaucracy such as target setting, monitoring and review of achievement, reinforcement practices and safeguarding protocols. Normlessness can be positioned against understanding prescriptive social codes of conduct and expectations, for example to the marginalisation of children with challenging behaviour and the rigorous enforcement of studious and diligent behaviours in class, like sitting quietly and raising the hand to speak. (This includes conforming to school prescriptions for completing and submitting work, writing in specific types of ways and formats with particular kinds of instruments). Finally, self-estrangement and social isolation is clearly evident in exclusionary policies, like isolation and disciplinary practices such as exclusion, suspension, and detention which prevents participation and an ability to affiliate with peers. For example, Ball (2016:209) identifies the '*postcode lottery'* of school exclusion identifying that ethnicity, social class and location determine the levels of school exclusion, with areas like the Northeast and Yorkshire having 8/10 of the highest exclusion rates in England. (See also Arnold (2012); Davis and Watson (2010); Dutro (2009); Graham *et al* (2019); Margalit (2010); Pantazis *et al* (2006); Ridge (2002); and Walker and Crawford (2008) for discussions on children's lived experiences relating to exclusion, poverty and other factors).

Further, Hascher and Hadjar (2018) consider that alienation can relate to a sense of 'uncomfortableness' of failing to belong or see merit in what is being undertaken. They correlate this with feelings of alienation as the learner perceiving discrepancies between their actual and preferred experiences. They go on to distinguish contributions from Tarquin and Cook-Cottone (2008) that links symptoms of alienation felt by students as manifesting in affective factors such as hopelessness, dissociation, emotional numbing, avoidance and depression. It is not unreasonable to incorporate anxiety into this raft of indicative symptoms. What this suggests is that experiences in education that are alienating could result in symptoms that present as mental distress. Wider research has reinforced this relationship between psychological 'wholeness' and physiological function and process (see Bartlett and Coles (1998); El Ansari *et al* (2013); Hernandez *et al* (2017) and Stewart-Brown 1998)).

Seeman's concept of alienation can be applied to consider aspects like estrangement in the commodification of qualifications; where the results obtained by young people are used to promote and propel the specific institution in respect of league table position and improved reputation and status, but where the CYP's individual grades may not be sufficient to satisfy conditions for admittance to schools/universities of their choice. Further, in the alienation from the creative energy necessary to sustain human essence, which can be seen in the repetitive and formulaic prescriptive practice, constant testing to examination requirements in singular modes of written questions of content from a curriculum that is dull, lacks meaning and is potentially culturally specific. For example, Savage (2017:155) references the '*economisation of curricula'* not to develop learning or induce creativity, expression or passion, but to dovetail into employment practice with a focus on 'employment led learning' emphasising soft communication skills, interpersonal attributes like timekeeping, attendance, reliability and efficiency, which now forms part of the Education Inspection Framework.

This is further reinforced by Patrick (2013) who comments that learners are taught they should be responsible, adaptive and successful, prepared to reskill where necessary, strive to achieve and show progress. It could be argued that education as rounded and critical engagement with intellectual or academic challenge has been replaced by an economic value system of learned skills and aptitudes that are practiced to produce outcomes measured solely by examination and testing, in order to create economically competent labourers (Mokyr, 2001). Insight into the effect of neoliberal governance on CYP in respect of economic imperatives is evidenced by Bonnett (2009), who draws a distinction between the 'selves' constructed as commodified entities within the mechanisms of entrepreneurial development and the selves which should naturally evolve from *'...their sense of their own existence'* (*ibid*:358). This enforced development of self through the lens of economic proficiency can create dissonance and alienation when it is incongruent with existential self-development.

A similar perspective is taken by Tarquin and Cook-Cottone (2008) who indicate that these feelings of alienation can be manifest in symptoms of mental ill health, like distress and anxiety. This discourse of affect has been given both pre-eminence and privilege in the monitoring of subjectivities within the Wellbeing Agenda. Indeed, a founding principle has been the necessity to force dialogue around emotions and feelings. It is therefore useful to examine work by Boler (1997) who has considered a framework for discourse around

discussions of emotion, specifically in education. These suggestions are of contemporary importance to inform the current debates around wellbeing and the marketisation of emotion. She has constituted this framework to include Rational, Pathological, Romantic and Political discourses of emotion (*ibid*:205). Boler makes a crucial distinction here, in that there has been confusion in the linguistic recounting of emotion within wellbeing contexts.

A further shift has occurred in the language used around emotion in education from the 'rational' discourse of the sciences and 'romantic' discourse in the arts and humanities, to a discourse of 'pathology', which takes as its starting point both a *'...normative model of emotional equilibrium'* (*ibid*:205) and that we are *'...passive victims of our emotional responses'* (*ibid*:214). There exists a duality that problematizes any discussion of emotion, in taking a pathological approach as its starting point, which is at odds with what, linguistically, can actually be achieved. Boler highlights that the naming of emotion suggests there is a singular, mutually constructed, universally 'felt' experience which distinguishes the nuances of the sensory experiences. For example, in recognising and articulating the difference between feelings of happiness, joyfulness, glee, gladness, optimism and cheerfulness. However, emotions are subjects of affect and are constructed ideographically. Further, expression serves to represent verbally, not the 'felt' emotion itself, but how we *'...speak about emotions,*' which are tied '*...by logical relations to* [existing] *beliefs and mental concepts'* (*ibid*:210). These are, in turn, structured by the language we choose to express ourselves. It is therefore not possible to articulate the actual emotion, only to express an interpretation that represents what is being felt.

This work is important because she speaks of the missing discourse of power in educational contexts, making the point that the schools' role is not to highlight or challenge inequalities, rather it is to *'...adapt the individual to the existing system'* (*ibid*:211) and it is in this regard that the politics of emotion is of primary importance. The context of Boler's work focuses mostly on a critique in the emergence of emotional intelligence and emotional literacy in schools, (in programmes like SEAL). It also engages with a range of other works, most notably Prescott (1938) repurposing of the 17th century term 'labile' to refer to a level of 'over-emotionality' (1997:213) which Boler interprets as meaning a response to anxiety created by the inequalities the individual experiences:

'The text explicitly acknowledges that a central motive for "disciplining" emotion is to balance discrepancies between desires produced within capitalism and the "reality" of unfulfilled needs that causes frustration, maladjustment and conflict. Nationalism and capitalism hence reveal their dependence on emotional equilibrium'

(Prescott (1938) cited in (Boler, 1997:212)).

2.4.3 Alienation from Education

When evaluating how alienation can be created in schools, a purposeful starting point is to consider the argument made by Freire (1972) who has likened the experiences of students in education to a 'banking system'. This is where the act of educating mimics the depositing of money (knowledge), to produce a level of return (certification). Importantly, these knowledge transfers and the inter-personal and socio-political context within which they take place are what he argues largely create and maintain the ideology of oppression. Focused primarily on the *'...projection of ignorance'* (*ibid*:58) that follows this model, the system thus reinforces the student's alienation because it prevents the pursuit of creative inquiry, which drives towards awareness, liberation and the awakening of consciousness. Further, it locates the teacher in the role of dehumanising agents. Freire suggests that the banking concept, by necessity, regards individuals as *'...adaptable and manageable beings*' (*ibid*:60). This is because in the struggle for the learner to contain the 'dispensed' knowledge formulated by the academic curriculum, (privileged in its construction of only partial and distorted truths); the less cognitive space is given to develop a sense of critical consciousness.

As indicated, schools' function primarily to preserve the *status quo* as *'...the more the oppressed can be led to adapt to a situation, the more easily they can be dominated'* (*ibid*:60). In this respect, two themes become emergent, Freire discusses a dual mechanism of maintaining oppression that is used to reinforce continuity of domination, what he terms a '*social action apparatus*' (*ibid*:64), referred to as 'welfare' but that is repurposed here as 'wellbeing' because it seeks to serve the same function. Moreover, this 'benign' face of 'humanitarianism', which produces a visage of 'individualism' and vested concern for wellness, could be reinterpreted as a covert veil behind which interventions and actions occur to 'reintegrate' individuals into accepting their own oppression; in this instance, by the development of 'resilience'. It looks to purpose the 'adaptation' necessary to ensure a

continued state of unconsciousness and a compulsion to digest and regurgitate only knowledge that has been provided by 'approved' agents. It coerces an acceptance of the partial and dehumanising world view and insinuates compliance from individuals whose behaviour or attitude fall outside of the prescribed norms of the 'well society', creating a willingness to be rehabilitated by adjustment of their own psychopathology. Freire has warned that, the necessity for dehumanisation upon which the system of oppression relies has had the effect of turning individuals into 'automatons' and whilst *'...the educated man is the adapted man, because he is a better 'fit' for the world'* (*ibid*:63), he cautions that the disequilibrium and objectification of individuals inherent within this system of education, effectively disconnects them from their own consciousness, which leads to alienation, which, he assert, will lead to suffering and *'...the spectre of reaction'* (*ibid*:66).

Following on from this, Sarup (1978) has suggested that institutions of education engender dehumanisation because organisationally, they are predicated on capitalistic principles of competition and an inherent acceptance of the structural hegemony, therefore processes and systems become alienating for the individual in both a psychological and sociological context. He identifies that the operation of schooling in terms of modes of production means institutions are no better than factories, *'...schooling is a form of indoctrination to fit children passively into acceptance of an ideology that keeps them 'democratically in place''* (*ibid*:138). Asserting that children are *'rewarded'* with '*ritual certification'* if they accept the world view, or more importantly, do not conspire to resist it. Perhaps the most important point is that modern schooling creates the 'norm' of Seeman's constructs in the metrication and measurement of every type of output, behaviour and action. Leaving Illich (1970:40) to conclude that, *'...once they accept that 'value' can be produced and measured, they accept any kind of 'ranking*''.

2.5 Summary

This chapter set out to consider Research Question 2, in assessing to what extent educational settings could be regarded as creating the mental health issues being reported in CYP. The impact on CYP's physical and mental wellbeing, in relation to alienating experiences within educational settings, can be considered as support for the position that the mental strain being reported in schools is a consequence of neoliberal education policy. In particular, the aspects relating to manifestation of affective control and behavioural regulation seen in the

technologies of emotion deployed in school settings. This was contextualised against a patterning of illness and dis-ease endemic to capitalist culture.

These findings also support a reframing of the debate around mental wellbeing as less a means by which CYP can achieve emotional stability and happiness in the easement of personal distress, but more as a divisive measure to ensure that capitalist ideology is not undermined. This is achieved by the manipulation of individual's emotion to regulate, repress and repel dissent, resistance or subversion. This can further illustrate the precarious nature of the relationship between the politics of subjectivity and capitalism's dependence on producers and consumers accepting this regulation, but also that this lends substance to the arena of student mental health as an interesting field for resistance.

The Wellbeing Agenda operates according to the principles of neoliberalism, by considering how it supports the notions outlined in this chapter on personal entrepreneurialism, responsibility, self-improvement, individual psychopathology and 'resilience'. Yuill (2005) views that *'...alienation weaves through everything in life'* (*ibid*:128) which correlates with Hardt and Negri's position that there are no 'spaces' outside of capital. All components of modern life are infused with exploitative energies that alienate the oppressed across a range of contexts, including the playground. This chapter concludes that due to the alienating nature of contemporary school experiences, it is probable that much of the mental distress reported within schools, are a product of its systems, policies and processes. This is relevant as the next chapter will offer an account of the Wellbeing Agenda as being 'fetishized'.

CHAPTER 3: THE WELLBEING AGENDA – (RESILIENCE)

Introduction

The preceding chapter focused on the impact of changes within educational organisation, policy and practice that has led to a marketisation of schools, which now operate as a microcosm of wider capitalist society. Included within this argument were the ways in which 'learning' within a 'neoliberalised' school rather than just 'labouring' under capitalism can be inherently damaging. In particular this focused on a range of factors like neurosis, dehumanisation and the inherent demands on the body and mind, including the distress caused by alienation from both community and self. The present chapter will consider Research Questions 3, in assessing to what extent the Wellbeing Agenda, generated to improve CYP's physical, emotional and mental health; could be regarded as behavioural control rather than benign intervention. The thread this constitutes is therefore linked to concepts of 'resilience'. What this chapter will essentially argue is that the Wellbeing Agenda has become 'fetishized'.

The rationale for including a focus on resilience is linked to changes I have seen in pastoral practice in the twenty years I have been in further education. I approach this from both a position as an educator, required to work with CYP with strategies to 'improve resilience' and as a psychologist, familiar with the works of Seligman from his contribution to mental health studies examining learned helplessness (Overmier and Seligman (1967) and Seligman (1975)). The positive psychology 'movement', established by Peterson and Seligman has created a manual (Character Strengths and Virtues, 2004). It lists taxonomy of six core virtues of wisdom, courage, humanity, justice, temperance and transcendence, which produced twenty-four strengths including bravery, patience and persistence. In order to 'assess' the virtues, the Values in Action (VIA) Survey is included in the handbook which is used in many contexts, including education, business and the military. Criticisms of the publication can be seen in a range of research including Banicki (2013); Martin (2007) and Miller (2019).

When considering resilience, it is important to understand how the recent preoccupation with children's mental health has emerged. Stress, anxiety and emotional upheaval in late childhood and adolescence are an established premise. As discussed in Chapter 1, Hall (1904) identified the tumultuous adolescent state of 'storm and stress'. However, the previous

chapter also suggested that management of CYP wellbeing, in the form of technologies of affect could be seen as an example of the 'newly dominant affects' explored by Knight (2014). The reporting of mental distress has exposed the 'public secret' of high levels of anxiety, created through a range of education policy linked to technologies of affect and control of subjectivities. Therefore, the wellbeing strategies that have been created could potentially be identified as an example of the methods of 'containment' and 'submergence' that prevent resistance; mobilised when public secrets become 'known'.

The present chapter will give a brief introduction to the concept of wellbeing and trace its origination as a discrete agenda from the late 1990's. It will look at the emergence of wellbeing as a policy response to the perceived increases in 'antisocial' behaviour that coincided with comparative international rankings on CYP's performance (PISA). It will further consider how positive psychology has shaped the agenda to reflect neoliberal values focused around 'resilience', before considering the interventions used in 'regulating' for 'wellness'.

3.1. Formulating Wellbeing

Within institutions of education there has historically been a focus on the pastoral care of CYP, (as outlined in Chapter 1) which addressed the enrichment, safety, security and health concerns around CYP. It is only within the last two decades that explicit references to 'wellbeing' in an educational context has become formalised and linked to specific intervention policies. For example, Wright and McLeod (2015) advise that the frequency of use of the term 'wellbeing' was stable and registered low numbers over the period 1930 – 1980, but this rose dramatically during the latter 1990's and continued to accelerate upwards, spiking sharply in the late 2000's. They argue this reflected the acceptance of the term, embedding the concept as a normative value, which linked to *'...the colliding effects of therapeutic culture and neoliberalism'* (*ibid*:4). This research focused on the nominal use of the term, but not on the meaning associated with it. So, in this respect, the findings are somewhat decontextualized. The issue in research around wellbeing therefore, resides as much within the complex associations of subjectivities, semantics, epistemology and purpose, as in the ascription of concepts to notions of what it means to have health and wellness. Of further concern is the recent trend in education towards using a 'wellbeing' narrative to foreshadow a specific focus on mental health. Carlisle and Hanlon (2008) have identified that a focus on wellbeing acts only as a 'distraction' away from ingrained structural inequalities

and promotes morally contentious notions of happiness and goodness that link to individual and personal frailties (which could reflect the 'traits' included within the Character Strengths and Virtues). They further suggest that the Wellbeing Agenda *'...buys uncritically into the consumer culture of Western economies*' (*ibid*:1), a point which reinforces the entrepreneurialism of the self, discussed in the preceding chapter.

Much in the same way that the terminology relating to 'mental health' is slippery and ephemeral, Watson *et al* (2012) have said there is *'...little consensus of what constitutes wellbeing'* (*ibid*:3), claiming that due to its contested nature, wellbeing is *'...dense and unarticulated'* (*ibid*:6). This is because the concept of wellbeing is interwoven with theories and constructs from diverse disciplines such as psychology, health studies, anthropology, philosophy, law, ethics and sociology. Therefore, formulating one universal meaning with a unifying narrative explanation is problematic.

One example of this complexity in constructs of wellbeing is to consider its definitions. For example, Dodge *et al* (2012) have suggested that a clear definition of the term remains 'unresolved' and this is echoed by other researchers they cite (i.e., Ryff (1989) and Thomas (2009)). Even within one discipline, such as psychology, Dodge emphasises the range of definitions that allude to wellbeing, which relates to concepts from within different theoretical approaches. Examples of this range of concepts include autonomy, quality of life, functionality, flourishing, flow, multidimensionality, equilibrium, homeostasis and eudaimonia. If such confusion and disagreement occur within a single field of research; this highlights the disparities to be found between different disciplines – what Humphrey (2011:2) describe as *'...fuzzy and intangible concepts'*.

However, Watson *et al* (2012) conform to the opinion that there has been an uncritical view and unopposed rise in the inception and implementation of wellbeing practice and application within education settings. Further, they advocate that 'wellbeing' is just another concept and in this regard, it is appropriate that it should be deconstructed. They draw important inferences in relation to the confused nature of 'wellbeing'; rather than focusing on a perceptual form of holistic health, the focus is on what Ecclestone and Hayes (2009) advocate are strategies of interventionist therapy in pathological symptomology; not as an underpinning philosophy of 'making whole'. In furthering this view, Watson *et al* (2012) also make the assertion that the popularisation of the terms 'wellbeing' has made it ubiquitous

within policy, what they regard as *'...denigrating the debate'* (*ibid*:28), leading to a *'disenfranchisement*' of individuals from their own bodies and the control that they exert over it. This is also indicated by Wright and McLeod (2015), who stated that the pressure of mounting policy initiatives surrounding wellbeing have become *'...so commonplace and widespread that they can mean both everything and nothing'* (*ibid*:2). The issue here is not that a focus on wellbeing is wrong, but that the conceptual use of wellbeing to create policy is misappropriated. It could be positioned that the Wellbeing Agenda is actually empty of care in respect of CYP's health and psychological functionality; but that it is occupied with the 'wellness' of the neoliberal project. This is reflective of Risq's (2013) critique of the IAPT programme using a Lacanian concept of 'lack', referring to the governmentalism at the centre of the therapy service.

Risq identified that most of the therapist's time is taken up not with providing services to individuals seeking mental health support, but with completing extensive amounts of paperwork to document and evidence what has taken place, in order to meet a range of internal and external clinical outcome targets. She indicates that much of the work has become mechanistic, suggesting that the work of showing you were doing the job was more important than doing the job. Risq uses Lacan's concept of 'disavowal' to illustrate these tensions, illustrating that *'...we were all part of a system....one in which we were being asked to subscribe to something whilst at the same time undermining it'* (*ibid*:2). Risq creates a sense of how the important work of supporting individuals with profound mental health issues was of secondary importance to the 'bureaucratized spaces' where operational management took place. This work is important because Risq worked as a clinical psychologist within an NHS IAPT programme, which is the 'end product' of many of the referrals through CAMHS.

Watson *et al* (2012) also identify that the creation of a 'distinct' policy around CYP's wellbeing is a relative new agenda (i.e., SEWB). They link its inception to Blair's New Labour government of the late 1990's, arguing that their preferred agenda deliberately followed Objective List Theory (OLT). Watson *et al* describe OLT as a 'capabilities' approach based on economic principles like freedom, dignity and agency (citing Sen, 1985, 1993 and Nussbaum, 2000). OLT focused on a range of ten functional '*aptitudes*' like sense, imagination and thought, affiliation, control over one's environment and bodily health. What is interesting here is that

these are the very aspects that Marx and other theorists (e.g., Dewey, Montessori) regard as being 'at risk' of diminishment under capitalism.

The OLT approach also contains components from other philosophical and economic theories in a type of affective 'amalgam'. For example, OLT also includes concepts drawn from Rawls (1988) (right over good), Honneth (1992) and also Hegel (1991) (ethical living), Mead (1913) (intersubjectivity), Kant (1900) (moral reasoning) – seen in Gough and Doyal's (1991) concepts of 'flourishing'. Additionally, Kant's work is directly related to the quality of life research described by Veenhoven (2000) in his four-dimensional approach that included Life Appreciation and Utility of Life (see Watson *et al*, 2012:20). They also suggest that the OLT approach to wellbeing was taken because the practical application would allow for *'ordinalisation'* (*ibid*:79). This means an operationalization of actions that can produce rankable responses using ordinal data (Stevens, 1946), in other words, numerical or statistical data that could be generated from inventories and questionnaires. For example, the SEAL programme is based on the five dimensions of affect in Goleman's (1995) aspects of *Emotional Intelligence*, measured as a 'quotient' which could be plotted statistically on normal distribution curves and clustered according to difference in standard deviation. This method of 'emotional accounting' mirrors the competitive tropes of capitalist enterprise culture.

However, notwithstanding the criticisms of both the SEAL and EI programmes, (Coleman (2009); Downey (2013); Horton (2010); Humphrey *et al* (2007); Murphy (2006); Roberts, Zeidner and Matthews (2001) and Wigelsworth *et al* (2010)) there are also criticisms that Watson *et al* make in respect of the Wellbeing Agenda itself being founded upon OLT principles. These include the notion of 'elitism' that encapsulates a range of 'privileges' and in qualifying what aspects should be included, in any definition of 'fuzzy' concepts like 'living rightly'. The point they make relates to the impact of the majority culture influence in establishing the dominant 'normative' values, against which all CYP are measured. Also important is the conflation at the onset of the formalisation of the wellbeing policy which arose at the same time as the *Respect Action Plan* (2006), skewed to a focus on 'anti-social behaviour'. This reflected a further preoccupation with the control of adolescent groups who were, seemingly, 'beyond control'. This is relevant because the SEAL programme was established upon the underlying notion that CYP were potentially 'untrustworthy' and in need

of policy direction that regulated and instructed them on how to behave (socially) and relate to one another (emotionally). It is with the emergence of SEAL that *'...the approach to emotions would come to be modelled, taught and managed through the school curriculum'* (Watson *et al*, 2012:43). In this regard, it is not unreasonable to suggest that 'wellbeing' was founded not on aspects of compassion, but on aspects of control. It is therefore understandable that there is a level of 'distrust' factored into the objective aims of the practices it underpins. This policy also illustrates succinctly the concept of submergence and the containment of emergent dominant effects defined by Knight (2014), as the agenda is assembled using deliberately chosen psychological concepts that map closely to neoliberal values.

A crucial aspect of Watson *et al* research is the pinpointing of when the term 'wellbeing' entered the educational vernacular. They specify that the term arose to exist in its current form as a response to the *Child Wellbeing Report* (DfCSF, 2008a), produced during Brown's New Labour tenure. Specifically, the researchers who were commissioned were asked to identify where the term 'wellbeing' was used during interviews undertaken for the report. Respondents were then specifically asked about their understanding of the term. Thus, they record that *'...the research appears to have created, rather than simply observed, the debate about 'childhood wellbeing''* (2012:48). This also concurs with Wright and McLeod's (2015) findings of the reported surge in the use of the term 'wellbeing' around the late 2000's.

A further feature of the Wellbeing Agenda within institutions of education can be considered through the constructs of 'absence' and 'presence', relating to the misnomer that wellbeing as an 'agenda' creates. This is because there is no singular *concrete* 'document' or policy that constitutes the 'Wellbeing Agenda'. Rather, it exists as a collection of procedures and practices that figuratively make wellbeing felt through the presence of other mechanisms and services. It is constructed to 'emerge' from within the Ofsted inspection framework, government policy and briefing documents, education and health department guidance and institutions procedural documents. In this regard, the 'Wellbeing Agenda' is indistinctly formulated. Webb (2009) suggests that *'…we forget that there is, for representations, no actual 'presence' behind the term'* (*ibid*:103). For example, the 'children' who are referred to in each set of documentation are politically constructed and created through policy, which according to Webb focuses not on the interest of 'real' children, *'…the student that is actually*

present, but in the idea of the student' (*ibid*:14). What this representation of the 'real' achieves is to redirect focus onto the process of managing the current priority of wellbeing, which serves to promote the *'…presence of the political in the absence of the individual*' (*ibid*). It can be argued that a fair interpretation (using Deutscher (2005)) of this point would be that we are not protecting individual children's *actual* wellbeing; we are protecting the *construct* of wellbeing protection. This indicates 'fetishism', in the ascribing of care properties that should be attributed to human agency, which are falsely appropriated to objects. '*To identify a fetish is to expose the inadequate beliefs of those who revere it for what they believe it is capable of...'* (Dant, 1996:3). Agendas do not 'care'. This point was made by Risq (2013) to describe a fetishized approach to the services provided by IAPT. There was no necessity to show 'care' to service users in a human sense (cited often as a criticism of the service *'... "I felt utterly uncared for, I was treated like a number"'* (*ibid*:7)); as 'care' was endemic within the correct application of surveillance, monitoring and achievements of targets.

As expressed, whilst there is no singularly written or standardised 'wellbeing' policy, there is a ubiquitously 'visible presence' of related material, promotion, advertising, marketing, awareness raising and activities which gives the 'agenda' shape, leading further to a feeling of 'fuzziness and intangibility'. Brown and Shay (2021) have suggested that the U.K policy is simply to *'...sidestep the requirement to clearly define the term wellbeing at all, indeed the concept is treated as self-evident in every key document'* (*ibid*:5). This also causes an interfusion of 'nothing' becoming 'something'; the 'substanceless' creating the illusion of form.

Other commentators such as Bache *et al* (2016) have addressed issues around wellbeing, especially within educational context in the U.K as being devised as either 'Tame or Wicked' problems. They further reinforce that happiness and wellbeing are often used interchangeably in some aspects of policy. They define the wellbeing problem as 'wicked' because it has no easily definable solution. Critically, they argue that wellbeing 'problems' are unlikely to be easily managed as the nature of the issues around wellbeing exists in contested spaces, not least because the concept of 'ill-being' remains equally as indefinable. So, articulating the problem for which a solution can be found is not possible, arguing that the best that can be achieved is that the problem becomes cyclically 're-solved' over time and in different contexts (Rittel and Webber, 1973). They conclude by acknowledging the 'valid

concern' around the U.K government's 'governance' and the promotion of the metricised components of wellbeing as 'dashboard' style measures of affect. The re-solving in Bache *et al's* research can be used to deconstruct the 'un-re-solved' components of Dodge *et al's* position. For this reason, Brown and Shay (2021) also contest that wellbeing *'...falters in any state, other than a symbol'* (*ibid*:6).

3.1.2 The Metrication of Wellbeing

At the same time that New Labour were making changes to national education policy between 1997 – 2010, international measures of child 'wellbeing' were being recorded in a range of surveys and indices from a variety of influential organisations like OECD (PISA) (Educational Ranking Surveys), WHO, World Bank and others. Organisations were starting to record not only quantitative data with regards to school performance in subjects like Maths and English; but also socio-economic data relating to factors like risk taking behaviour, exercise, nutrition and access to material resources. The U.K scored poorly on these measures, with some headlines at the time reporting U.K children as being the lowest and poorest performing amongst the developed nations (OECD, 2006).

However, this issue cannot to be seen in isolation. It has been suggested that one reason the focus has shifted to consider policy intervention for mental health and wellbeing in CYP is as a result of further rounds of poor scores from international rankings. In the OECD (2016) report, a section on Children's Wellbeing (measured as levels of happiness) was included for the first time. The U.K was again ranked poorly (38th out of 48 participating countries), which was widely reported as U.K children being *'...amongst the unhappiest in the world'* (BBC, 2015). As has been suggested, the foreshadowing of wellbeing to become synonymous with mental health has driven public perceptions of rates of mental illness (Brown and Shay, 2021) in what has been reported as the mental health 'crisis' visited in Chapter 1.

The concern over mental health issues, (rather than social and emotional issues) in children was not framed as a critical educational narrative until this point. Prior to the publication of the OECD survey in 2016, a *Telegraph* article carrying similar headlines (Paton, 2012) '*British children 'unhappiest in the world' says academics'* had all but been ignored as the level of unhappiness was identified, in part, as being down to excessive testing, risk averse policy

decisions and enforced early education for children, *'…pushed into formal schooling at an increasingly early age'* (*ibid*). There had been a range of publications by professional bodies, organisations and individuals examining adolescent mental health (see Green *et al* (2004); Rutter *et al* (1970) and Rutter and Smith (1995)); third sector reviews (MHF, 2007); health based organisations (Kurtz *et al* 1994 and Wallace *et al* 1995); government departmental initiatives and reports focusing on aspects of mental health; (Audit Commission (1999) and NHS Health Advisory Service (1995) - which introduced the current 'Tiered System' in CAMHS and the House of Commons Health Committee (1998)) - but these were mostly concerned with epidemiology, diagnosis, prognosis or treatment of presenting symptomology and in many cases concentrated on conduct, behavioural or developmental disorders as the only areas relevant to the mental functioning of children. Upon reviewing legislation and specific government directives, it was not until February 2011 when the cross-government outcomes strategy '*No Health without Mental Health'* (DH, 2011) highlighted a targeted approach for mental health services for people of 'all ages', aimed at generating parity of provision and service with physical ill health, that discrete mental health provision for young people was on any specific 'agenda'.

Prior to the OECD (2016) report, legislation and policy relating specifically to children's mental health were at this time, not regarded as educational imperatives and for the most part were not considered outside of the wider SEN provision. There was a focus on emotional and social development, as has been identified. It was therefore considered that 'wellbeing' would seem to be addressed simply by regulating the ways in which CYP interacted with others. What changed to draw a sharp and sudden focus to specific mental health concerns was through the mechanism of the OECD (2016) survey using eudaimonic measures and the emergent metrication of 'happiness' that was linked as an 'indicator' of wellness. This led subsequently to a semantic repositioning of the value loading for 'happiness' to synonymise 'mental wellness', created by the 'normalising' and co-opting of affective language through the wellbeing discourse (Horowitz and Wakefield, 2007).

The use of language is a powerful signifier. Walker (2006) identifies that rather than language interpreting reality, language constructs reality, so it could be argued that the transition of sustaining binaries in recent years as a result of the wellbeing focus has contributed to the perceptions of changes in mental health states. As the binary relationship Happy ≠ Sad has

shifted to become Happy ≠ Depressed, so too has the meaning and value load carried by the term 'Happy', which must now assume the binary position of 'Not Depressed'. This precludes the possibility of experiencing unhappiness, sadness, gloom, misery, despondency, apathy or melancholy as a naturally occurring, healthy emotional state of being. The difficulty created is that the term 'depressed' has become interchangeable with any term connoting negative mood (Hegedüs (No Date); Horowitz and Wakefield (2007) and Wakefield and Demazeux (2016)). This is of particular interest because Greco and Stenner (2013) make the case for the politicisation of 'happiness', asserting that the etymology has been misappropriated by neoliberalism, in part to enable the management of both economic pessimism and worker expectations. In this regard they cite the premise that happiness has been used to *'...align subjectivities with economic imperatives*' (*ibid*:2) and thus happiness becomes another means of oppression that creates alienation.

CYP as well as being academically competent, employment ready, entrepreneurial and economically compliant must now also strive to become 'happy' and eliminate any signs of negative affect. Thus, failing to be happy now carries different meanings than just feeling sad. It creates a signifier of having a mental health problem. Therefore, what has changed is that feelings, in particular 'happiness', have ceased to be an emotional indicator of mood, but have transformed to become an economic measure of success and by association, a yardstick against which the line of international competitions and economic efficacy can be drawn. CYP are 'rated' on levels of happiness which has an expression of meaning falling outside of 'joyous affect', linking instead to a culture of 'toxic positivity'. Fisher (2019) cites the problem that a focus on overt positivity creates, as being *'...an ideology to prevent critical thought*' (*ibid*:3).

To enable an understanding of why wellbeing has become an emergent agenda, it would be useful to examine the rankings that came out of the OECD (2015) survey, which can be argued to have precipitated the emergence of the current 'crisis' in mental health. The government commissioned research by Jerrim and Shure (2016) to analyse the U.K's rankings in the OECD (2015) Survey which stated that, irrespective of ranking positions by comparative analysis to other countries, in real terms, the average educational performance of 15 year olds in England, Scotland, Northern Ireland and Wales on the three axes of maths, science and reading have not significantly improved since 2006. It reported that the result for low

achieving children in maths is the weakest of many OECD countries. The position in overall ranking for the U.K has changed, but this is due to the OECD average rates declining, rather than any improvement in actual educational standards of U.K based CYP. What the analysis does suggest is that differences in performance between children for the U.K ratings by range is larger than most OECD countries, with a disparity amounting to over 8 years of equivalent schooling (by value) between the bottom and top 10% of children's performance.

Criticisms of the PISA Survey aside, and there are many (see Yong (2020) *Two Decades of Havoc*), what this suggests is that in 9 consecutive years (and four PISA Surveys 2006, 2009, 2012 and 2015) changes to U.K educational policy have failed to deliver the improvements in educational testing that successive governments had desired. In particular, it has failed to make any headway in delivering improved educational outcomes for the lowest social-economic groups within the U.K (the bottom 10%). This suggests that overall, children in the U.K were seen as 'commercially vulnerable', failing to make headway in achieving the trinity of economic proficiency, entrepreneurial talents and employability competencies, believed to be reflected in the tests of maths, science and reading capabilities. Recently, Jerrim (2021) has identified in a report for UCL (Institute of Education) that the data used for U.K children in scores for maths on the OECD (2018) survey were based on flawed statistics, which means that the 'improved' ranking given to U.K children was incorrect and the results for that year should have reflect U.K students as only just meeting OECD average ranks, not exceeding them.

Singapore did not take part in the children's wellbeing section of the survey, but many of the high performing academic countries did, including China (42nd), South Korea (47th), Hong Kong (46th) and Japan (43rd). These countries were also some of the lowest on the happiness index measures. What is of interest here is that in September 2018, the Ministry of Education in Singapore announced a range of measures to substantially cut levels of testing in their primary and secondary schools to reduce the element of competition and minimise the frequency and duration of academic assessments. They have also announced that schoolbooks will no longer show the child's position in class or the level the child is working at. This is in an attempt to *'...dial back overemphasis on exam results'* which led to performance anxiety and stress, Chia (2018).

The combined picture from successive OECD reports has created the impression that children in the U.K are 'falling behind' their economic competitors in both academic competencies and emotional capabilities. In contrast to Singapore's action, the U.K government's response was a restructuring to more rigorous academic testing, starting with GCSE Maths and English that same year. A revision of GCSE and A Level examination and assessment placed a sharp focus on both changes to the grading system and a reduction in the type, number and level of assessment and coursework within the curriculum, for example by creating a linear two-year, end of period examination and by the removal of modules, as well as by making the content more challenging, (whilst removing re-sit opportunities). This made the examination of CYP in the U.K an even more high stakes environment; creating further assessments for CYP within the U.K who are already some of the highest tested children in the world (see Pierlejewski (2019) and Woolcock (2008)). This is indicative of a policy that intends to make children more economically competitive, it did not however introduce any strategies to improve wellbeing. Instead, it introduced strategies to 'build resilience'. In this regard, it could be argued that the Wellbeing Agenda was not conceived of to negate unhappiness, distress or anxiety. It could be positioned that it has been formulated to identify and 'purge' weaknesses in personality and mental frailty. This is an example of how the rubric of personal entrepreneurialism has seeped into policy.

The government's solution to the problem was effectively not to minimise educational practices that were complicit in producing distress (as Singapore had done), but to create programmes to identify those CYP who were unable to cope and 'force' them to become more resilient. Therefore, it can be suggested there was no desire to improve levels of wellbeing, there was only a desire to improve happiness because this was seen as a measure of resilience and thus a marker of performance. Importantly, missing from the educational dialogue is the distinction between 'happiness' and 'wellbeing'. It has become somewhat obscured that one does not serve as a 'proxy' for the other, insomuch as individuals may experience positive wellbeing but still experience unhappiness and report such if measured at that time. For example, Raibley (2012) suggests in his article '*Happiness is not Well-Being'* that it is *'...a necessary, but not sufficient condition for high levels of wellbeing'* (*ibid*:1105).

As already stated, there has been an upsurge in both the number of and interest in measures of happiness in recent years, triggered in part by the inclusion of wellbeing rankings by PISA

from 2015 which has led to a variety of follow up studies. For example, the Jacobs Foundation (2020) published a report on levels of children's happiness where the U.K was ranked 21st out of 35 participating countries. A UNICEF (2020) report card conducted research using 38 economically developed countries (defined as 'rich' in the context of the report) that identified levels of children's happiness placed the U.K 29th out of 33 countries (where data was available). The *World Happiness Report* (2020) ranked the U.K 13th out of all world countries as nation states (153) (using measures for adults). These ratings included per capita GDP, life expectancy and social support. Further surveys and reports were examined from a variety of institutions limited to those that had been reported in the U.K e.g., National Press, such as the *State of the Nation Report* (DfE, 2020b); Gallup (2020); the *Global Happiness Policy and Wellbeing Report* (GHC, 2019) and YoungMinds (2018). In all of these reports, the U.K fared worse than most western European nations.

The recent OECD PISA (2018) survey on happiness and student satisfaction located the U.K in 29th out of 30 places in OECD countries, ahead of Turkey which was placed bottom; and overall on all measures 69th out of 72 countries worldwide. This means that measures of intervention to improve happiness in the intervening three years since the 2015 report have again failed to record any positive changes. Of interest, in the most recent survey was the comparison with the earlier OECD (2016) survey report. For children in the U.K, satisfaction rates had fallen by around 0.50 points, identifying that children are less happy now than they were when reported on in 2015. It is also of interest to note that the countries performing poorly in these measures, were most often the countries identified by James (2007) as existing within 'selfish capitalist' states.

Further, the U.K was singled out in the PISA commentary *'...the drop in share of students who reported being satisfied with their lives was particularly large in the U.K – a difference of at least 13% points between 2015 and 2018'* (2018:16). Lobley (2020) identified other important aspects as being that U.K teenagers rating themselves as 'miserable' being 14% above the world average at 52%. It can be no coincidence that the number of children living in poverty in the U.K has risen by 38% since 2010 (Klair, 2019), at the same time that a decision was taken by the Conservative Coalition government to abolish the Child Poverty Act (2010) and abandon poverty action targets in 2015 (the same year that the PISA wellbeing measures were introduced). Projected figures from the Institute of Fiscal Studies highlighted that child

poverty was set to rise in 2020 by around 50% (Haddad, 2016). This could therefore predict that ranking due in the OECD 2021 survey may also fail to show an improvement.

More interestingly, the UNICEF report card entitled *An Unfair Start: Inequality in Children's Education in Rich Countries* (Chzhen *et al*, 2018) placed the U.K 16th out of 28 countries for secondary education, but with a preschool and primary school rank of (20 and 23), suggesting not only that there are inequalities in education across key stage areas, but that early years inequalities were the poorest rated of the three. It further identifies that the overarching significant factor in children's ability to gain equal access to education is the overall national context, related significantly to poverty. What this clearly identifies is that performance of U.K CYP in international measures was linked to systemic socio-economic inequalities, but the policy drivers within the U.K were still invested in locating poor performance in some form of personal lack and for wellbeing in particular, identifying failing as mental frailty, (caused by dysfunctional biological processes) for which resilience was the answer.

3.1.3 Measuring Wellbeing – The Influence of Positive Psychology

For brevity, the focus of this section will concern itself with how assessment and identification of perceived mental health issues in children are facilitated by the new 'measures of wellbeing' which have become a significant focus for psychologists and educators in recent years. This section will give a limited outline of the contemporary measures of CYP used in schools to assess 'wellbeing' and mental health. There is not the scope to examine a detailed assessment of all types of identification measures and inventories, but this 'snapshot' provides a basis for understanding how settings can identify and record wellbeing issues.

The rise in interest around matters of mental health and wellbeing has been exponentially driven by a variety of fields within the discipline of psychology, not least positive and personality psychology, which underpin much of the wellbeing framework. For example, work by Seligman (2011) *Flourish* and Csikszentmihalyi (1990) *Flow*.

The Positive Psychology Movement, originated by Seligman in 1998 has been a major influence in promoting the measurement and manufacture of wellness that are now familiar scripts within wellbeing policy U.K wide. Emphasising 'morality' and 'virtues', it sets out to focus on three key levels. The *subjective* level focuses on aspects linked to optimism like happiness, contentment and 'flow'; the *individual* level which covers areas including

strengths, virtues, interpersonal skills and perseverance, lastly the *group* level identifies civic duties and social responsibility, work ethic and tolerance. (The 'strengths and virtues' that form the basis of a positive psychology approach were discussed at the beginning of the chapter).

The *Mind Map of Positive Psychology* (see *Appendix 6*) gives further guidance on aspects covered in the 'teachings' on how to build 'moral character', which are referred to as 'scientific' and 'science based' in much of the written material. It is therefore argued that the assumptions and ideology of positive psychology serve expressly the neoliberal aetiology. Positive psychology has attracted much criticism, for example from Cabanas and Illouz (2019:1) who comment on the '*tyranny of positivity'* where happy selves are 'manufactured' by neoliberalism's drive for the personal entrepreneurialism identified in Chapter 2. They suggest that positive psychology has become a foil for neoliberal policy and a convenient means by which the personal responsibility narrative can be transmitted. For example, MacConville and Rae's (2012) work promotes the use of positive psychology in working with CYP, citing objectives for building resilience as developing flexible thinking, learned optimism, understanding and developing signature strengths and holding a growth mindset (*ibid*:15). Interestingly, they use a quote from Smiles which states *'...every youth should be made to feel that his happiness and wellbeing in life must necessarily rely mainly on himself and the exercise of his own energies, rather than upon the help and patronage of others'* (*ibid*). This reflects directly the 'personal entrepreneurialism' discussed by Van den Bergh (2012) in positioning mental wellbeing as the responsibility of individuals, when it is deemed to be lacking. This could also be seen to reflect Nolan's (1998) comments when he described the rise in therapies of 'self-esteem' as a *'...social vaccine promising to remedy a host of ills'* (*ibid*:173).

Cabanas and Illouz suggest that within positive psychological practices there is tendency to see personal situations or circumstances in terms of individual effort of merit rather than related to structural inequalities. This links to Mijs' (2018) identification of a 'paradox' created by inequitable societies not contesting the inequality, due to an ingrained belief that discrepancies in income are 'meritocratically' deserved. This has echoes of the deserving and undeserving poor of Tudor England. The focus on resilience can be argued to support Federici (2013) view that psychology has a history of *'...complicity and collaboration with Power'*

(*ibid*:7). The synthesis of psychology into education practice is therefore indicative of what Habermas (1987) terms a 'therapeutocracy'. This refers to a type of '*administrative violence'* (Culpitt, 1999:88). Rice (2002:21) suggests this has resulted in a *'...liberation psychotherapy discourse'* which has supplanted academic learning in favour of what Apple (2001) refers to as a focus on 'identity politics'. Allen (2014) appropriately refers to this type of practice as technologies of self that promote 'benign violence'. Pointing out that political force, like fabric, referentially 'folds back' onto the self in ways that relate to personalised design or individuated practice, seeming to create 'bespoke' situations and circumstances that support the development and progress of an individual to become 'better'. He references that in so doing *'...this disguises the operations of a malevolent power, obscuring a set of relations that forms the wider structure of feeling'* (*ibid*:3).

In the main, Cabanas and Illouz note that the success of positive psychology and its intention to personalise the search for happiness as the only worthwhile pursuit, creates a politically expedient narrative that harnesses the ideology of neoliberalism and effectively carries the momentum forward into practice. For example, they observe that the positioning of happiness within the wellbeing and resilience discourse *'...epitomizes the triumph of the personal society (therapeutic, individualistic, atomized) over the collectivist'* (2019:9).

However, the implementation of positive psychology paradigms within an educational context should be approached with caution. The focus on 'resilience' that emanates from within the approach as a desired 'outcome' to manage personal mental health and wellbeing has been considered further by Howell (2014). In her assessment of resilience training within the U.S (and increasingly wider) military, she assesses the influence of Seligman's theories in not only operating as strategies of training for war, but in a wider application of transposing its tenets to managing both precarity and austerity within a civilian and socio-economic context. In so doing, it minimises the cost of health care and support, for example in locating PTSD not as the consequence of a brutalising experiences within a theatre of extreme aggression and physical and mental trauma, but in identifying the individual as 'weak' in failing to develop mental fortitude to its damaging compound effects. This mirrors the neoliberal ideology of dispositional, rather than situational factors as causal derivatives of affective response. Howell questions the ethics and application of such psychological theories of resilience, focusing especially on Seligman's relationship with the U.S military, which

further critiques the role of the psy-disciplines like positive psychology in sustaining the hegemon. She refers to the training programme within the U.S military (Comprehensive Soldier and Family Fitness Programme (CSFF)) as an example of the application of positive psychology within a military context describing its implementation as *'...the largest psychological experiment in human history'* (2014:2).

In her analysis of the impact of resilience training, she comments that the programme has the potential of not only creating psychologically 'engineered' soldiers who have the capacity to engage in what she terms a 'never ending war' (p.2), but that it is clear the 'prototype' being used with military personnel is a clear 'pitch' (p.2) for the programme to be developed and deployed within civilian settings, which she expressly states include education. Howell also identifies that, as with many psychological practices in application, the premise upon which it is founded, as individual frailties in psychopathology (in the case of resilience, as 'failed' optimism) does not consider systemic and structural inequalities like poverty, racism and discrimination (p.6). Howell also concludes that the impact of positive psychology has effectively expanded the disciplines reach from just pathology, like depression, anxiety and PTSD, to the more pernicious preserve of claiming *'...dominion over our optimism too'* (2014:6).

A key feature of the appeal that programmes like CSFF holds is the idea that resilience and mental fortitude in adversity can be learned and instilled through training, creating what Howell cites as the ability of producing soldiers who can engage in 'persistent' and 'protracted' conflict (p.7). In her article, Howell also illustrates the trajectory of psychological theory and practice in supporting military and warfare ambitions and elaborates on its historical links, from the second world war through to the more recent 'War on Terror'. This highlights the impact of the training programmes effect of producing a *'...fantasy of indomitability'* (*ibid*:7) which is concerning as this conditions and reinforces soldiers' natural affective responses to war environments as being 'maladaptive' and 'unrealistic' (p.8). This is deemed to be a 'failure' in training for resilience which demands that those involved in conflict display optimism, positivity and determination. For example, training techniques within CSFF programmes which aim to teach soldiers to avoid 'catastrophising' in conflict situations to maintain functionality and, more importantly, to preserve military objectives (irrespective of the human cost) (p.8). Howell also challenges the ethos of the CSFF

programme by suggesting a feminist critique within the expectation that the training programme extends to families (most usually spouses and partners) of service personnel; demanding of these individuals similar mental training in resilience and fortitude and tasking them with 'unpaid' care, emotional and wider affective 'labour' (including sexual 'services') (p.7). She suggests this further removes the 'cost' of mental health management from the state and its agencies, to the individual and their private communities of support.

In the practices of 'resilience' training that Howell identifies are present within the CSFF programmes, there includes reference to mindfulness, meditation, gratitude, relaxation exercises and challenging negative beliefs (p.9). All of these activities are seen as present in the emotional management of CYP within school settings, so it can be argued that Howell is correct in her advocacy that resilience programmes have not only been manifest in military training to create 'invulnerability' of personnel to engage in a perpetual war scenario; but also to entrain affect in classroom settings to create children resilient to the impact of the alienating, competitive and depersonalising forces of education and wider socio-economic inequalities. She further identifies the more sinister components of this type of attitude training by suggesting that in the context or war and soldiering, *'...psychological resilience in the Army context should thus be seen not as a means for responding to violence, but as a means for expanding and producing it'* (*ibid*:9). This has profound and challenging implications for the concept of 'super soldiers' whose natural responses to hostile conflict, human loss of life and torture are replaced by artificially created thought patterns of invulnerability and indomitability, which Howell claims has 'weaponised affect' (p.9).

In terms of the 'proof of concept' (p.3) that Seligman has created within the resilience training programmes he helped to devise (for example the Penn Resiliency Program (PRP) (Gillham *et al*, 1990)) and others like the Global Assessment Tool (GAT) (Peterson *et al*, 2011), the 'experiment' that Howell alludes to within the CFSS (and using the GAT) has over one million participants annually and produces vast quantities of psychometric data that is used in analysis of trends and patterns in development of strategies to quantify, calculate and modify techniques of resilience (Lester *et al*, 2015). This is important for several reasons, the first is that, despite what Howell refers to as 'methodological promiscuity' (p.6) of the theoretical basis of the CFSS programme (a conglomeration of a range of psychological, spiritual, sporting, media, anthropological, sociological and educational concepts and practices) the

nature of the way these programmes are presented generates a veneer of rigour, reliability, veracity and credibility which serves to perpetuate the concept of resilience as being a *teachable* construct with an empirical and scientific pedigree. This is problematic as it serves to create a concept of resiliency having an 'evidence base'.

Secondly, as Howell identifies, there is an impact on the quality and delivery of services for mental health support to individuals if many aspects of mental illnesses like PTSD and depression can be regarded as preventable, through personal and individual agency, efficiency and motivation. Howell paraphrases Seligman and Fowler (2011) in suggesting that resilience programmes will change civilian health care provision away from treatment to prevention. She argues this creates the opportunity for health austerity, the diverting away of funding from services that are deemed to be within the individuals own control and responsibility to induce 'mental fitness'. This again can be extended to CYP in an educational context, especially when considering the calls outlined within the *Transforming Children and Young People's Mental Health Provision* (GB. Green Paper, DfE, 2017), for improved resilience and the reviews and implementation of the U.K Resilience Programme UKRP (e.g., Challen *et al*, 2011 and PHE, 2014).

MacConville and Rae (2012) also state the term *'...positive psychology is psychology adopting the same scientific methods'* (2012:18) which seems to reinforce the belief that positive psychology is 'evidence based'. This can be contested as there is little evidence that assessments of internal states can be measured empirically with any degree of validity. Seligman (2011) identified positive psychology as having a 'gold-standard' of how to assess wellbeing, stating that 'measurable' elements include achievement, engagement, positive emotions, relationships and meaning (Shean, 2015:18). It could be reasonably argued that engagement and achievement may be 'measured', by considering observable evidence and classification of grades in completing standardised tests. It is, however, not possible to argue for a 'scientific' measure of the remaining three with any degree of veracity. More recent research is focusing on trying to improve 'measures' on aspects of resilience such as 'positive experiences', for example Merrick and Narayan (2020) BCE Scale (Benevolent Childhood Experiences) uses ten indicators, including positive self-image, enjoyment at school and predictable home routines. Again, these are 'measures', but they are not necessarily 'scientific' and therefore the claim to provide 'evidence' is contentious. For example, some

'measures' can be interpreted in many different ways due to cultural subjectivity. It is also important to consider that Frege (1893) warns against 'psychologism' in the conflation of an objective 'truth' (a reality) and the 'perceptual truth' (a 'taken to be true') derived from the type of 'consensuses' that psychology can represent.

There are no shortages of models, frameworks or theories that attempt to measure, classify or categorise aspects of CYP's wellbeing. The proliferation of psychometric indices attests to the fact that many psychologists believe that wellbeing can be quantitatively measured and defined. As a consequence, there have been a raft of 'assessments' of mental wellbeing put forward from a range of organisations and companies, claiming to 'measure' wellbeing and from this, 'imply' degrees of mental health. (For example, one organisation, *GL Assessment* (2021) offers 50 different questionnaires for assessing mental health and wellbeing in CYP, including PASS and the Kirkland Rowell Survey – stating *'...the portfolio's simple scoring system makes it easy for classroom teachers to administer and support early identification of children's mental health needs'*). The term 'imply' is used because they are not specific diagnostic criteria from a recognised source (for example the DSM or ICD). What they do, in effect, is to ask the individual a range of questions, responses to which then form matrix calculations, (such as Likert Scales) that provide a numerical value. Indicators of unhappiness, anxiety or stress are then derived from these self-reports. Where there is an issue is that these subsequent results are used to determine if a CYP has an 'underlying' mental health issue. However, the major problem with many attempts to measure wellbeing, especially using psychometric implements such as these, is the reliance on the subjective nature of the self-report process or the process of observation and the level of affective chronometry, depending on the age of the child. Put simply, and a point over which she received much criticism, Sarah Vine (2016) expressed frustration in that *"...asking a 14 year old girl if she is unhappy is a bit like asking a dog if it would like to go for a walk".* Despite the problems inherent in using such measures, they are regarded by practitioners in education as both 'scientific' and 'evidence-based' when they could, effectively, be argued as neither. Nor are such measures 'weighted' to consider any baseline of potential adolescent emotional volatility, discussed in Chapter 1.

As indicated previously, in many institutions, rather than wait for individuals to seek help, educational settings use a range of measures so that CYP who might be 'at risk' can be 'sought

out' and referred to clinical services. The promotion of wellbeing in many schools recommends that universal testing of all children should be undertake to 'screen' for mental ill health. NatCen (2017:7) surveyed 2,780 schools and found 99% of all respondents had measure in place to identify pupils with mental health needs. A further number (24%) reported targeted screening of pupils in order to detect underlying mental health issues where concerns had been raised. However, 15% confirmed that they conducted universal screening to detect underlying mental health issues in all students, even when concerns had not been raised. *Mental Health and Behaviour in Schools*, (DfE, 2018) expressly states that it is the school's responsibility to manage mental health issues in CYP and requires schools to *'...instigate an assessment where there are any concerns about behaviour'* (*ibid*:12). These assessments are often completed initially using Boxall Profiles and Strengths and Difficulties Questionnaire (SDQ) which are advisory on the DfE guidance for schools (and form part of PHE Toolkit (see below)).

There are issues to consider when using the two questionnaires suggested in the guidance, for example in respect of the Boxall Profiles. The profile was designed for use by the same researchers who pioneered Nurture Groups (Bennathan and Boxall, 1998), a common practice in primary settings, it is therefore tailored to support work in this context. Its underpinning theoretical framework derives, in principle, from attachment theorist such as Ainsworth and Bowlby and as such, can be subject to the same critical assessments and underlying assumptions that beset the original theories and at worst, can only serve to assess aspects of behaviour that deviate from normative and culturally specific attachment behaviours. For example, Bowlby manufactured the term 'affectionless psychopathy' that he claimed developed within children from a failure to construct an 'internal working model' as a result of deprivation in primary care attachments. These terms are not found in any version of the DSM or ICD and therefore cannot be used to actually determine psychopathy or indeed abnormality in attachment, but their currency remains high in Early Years contexts. Both Bowlby and Ainsworth's suggestion of attachment types based on monotropy and maternal responsiveness have been criticised as ethnocentric (see Keller and Bard (2017) and Van Ijzendoorn and Kroonenberg (1988)).

Colley (2012) also highlighted that Boxall Profiles assessments are often undertaken by 'dedicated staff', who attempt to 'quantify' subjective adult perceptions where *'...an*

impression of a student's presenting behaviour translates the summary judgements of practitioners into numerical values' (2012:47). The Boxall Profile basically relies on interpretations of staff's 'intuitive' observations of children's behaviour. A further feature of Boxall Profiles is that much research focuses on the extent to which the profiles demonstrate concurrent validity (for example with the SDQ) and construct validity, by internal comparisons within its various sections (see Couture *et al*, 2011). However, this would be reasonably predicated, given that each of the sections would have been completed by the *same* 'dedicated staff'.

Further, as Doyle (2013) identifies, the Boxall Profile was originally standardised for 'normative measures' using a sample of 880 children, drawn from a specific local authority (Inner London) in 1984. It is questionable to what extent this can be time valid when used with children nearly 40 years later and in a range of geographic, ethnographic and socio-economic environments and circumstances, not least because the developmental 'norms' profiled (as a normal distribution and standard deviation from the earlier time period) would presumably skew contemporary data patterns (O'Connor and Colwell, 2002).

In order to support schools in 'testing' for wellbeing, PHE have published *A Toolkit for Schools and Colleges* created by a range of authors (Deighton *et al*, 2016) in collaboration with a variety of organisations including the Anna Freud Centre, Mental Health Foundation, UCL and the Child Outcomes Research Consortium. The toolkit contains a 'compendium' of psychological testing inventories and metrics to be used in schools that have been approved by the Department for Education to measure mental wellbeing in CYP. It claims that the measures have been '*validated*' (p.1) – however, it does not specify how and by whom. It does indicate that based on Ofsted making a judgement on Personal Development, Behaviour and Welfare, *'...school and college leadership teams have a strong rationale for assessing the health and wellbeing needs of their population and taking proportionate action to address their needs'* (p.4), again, it does not specify how this is to occur or what a 'proportionate response' would look like, but the insinuation is that schools who do not routinely test for wellbeing and thus mental health, are likely to fail the new 'deep dive' Ofsted inspection practices.

A brief search for mental health toolkits for use with children via *Google* returned a vast number of responses from a variety of providers, all promoting programmes, packages,

training and consultancy services, from a range of organisations, institutions, companies and consultants (e.g., YoungMinds, Mentally Healthy Schools, NSPCC, RCGP, Mental Health Network, Time to Change, Worth-it Wellbeing, RCPCH, National Children's Bureau and The Children's Society) are just some examples. Many of these organisations have contributed to extend the perceptions of children being in mental health 'crisis' and all with a considerable vested interest in sustaining this belief (for example YoungMinds offers its own operational framework). One such illustration is from *Our Kids Network* (2021) which has established an EYMHC offering screening and assessment services for mental health in children aged 0-6 years, which can be bought online. Under 'Screening' on its website, its first line states '*Significant mental health concerns can and do occur in young children'* (*ibid*). In the promotion of its universal screening services, it specifies that early years assessment can *'...facilitate access to timely services and support'* (*ibid*). This positioning of 'mental health and wellbeing' as a 'business model' is entirely in keeping with the marketisation of education discussed in Chapter 2. It has also led commentators like Coyne and Tennen (2010:8) to identify that the popularity of positive psychology is *'...driven by supply rather than demand'*, due in the main to what could be deemed a lucrative bandwagon that has been created for many academics, coaches and consultants as there is *'...so much money in the movement now'* (Smith, 2019). Further, it is interesting that Coyne and Tennen compares the fervour positive psychology creates to a religious 'cult'.

What is also problematic is that there appears to be a lack of critical interrogation around the inventories being used in schools, there seems to be just a passive acceptance of their veracity, it is, as Frege has suggested a 'taken-to-be true'. Also, the rise in the use of such measures seems inconsistent with previously reported mental health statistics in CYP (from Chapter 1), showing no increase in clinical mental illness or disorders overall, other than would be expected with proportional increases within the number of children in education. What should be happening therefore is a *decrease* in the level of testing that is going on. As suggested, it could be argued that it is the use of such mechanisms of measurement that has generated the 'crisis' levels that are being referred from within education into clinical mental health service, discussed earlier in Chapter 1.

3.2. Advocating Resilience

On 9th January 2017, Prime Minister Theresa May made a speech where she outlined the government's proposals in responding to what she termed the *'...burning injustice of mental illness'* (May, 2017). Within the speech she identifies statistics from a range of sources that outline an increase in the number of CYP with mental health issues, for example the trebling of reports of self-harm in women aged of 16-24 (between 2000 and 2014), stating this had grown proportionally to 1:5 young women. May also identifies the cost of maintaining mental health services to the economy as being around £105 billion. To address these issues, a list of proposals was detailed that aimed to ameliorate the current perceived mental health crisis, encompassing a wide range of sectors, settings, provisions, procedures and practice in the process. A significant proportion of these measures were aimed not at health, but at education. For example, in the creation of a programme of 'Mental Health First Aid Training' aimed at teaching staff to enable them to *'....identify and assist'* children with mental health concerns. Stated also was the intention for schools and colleges to work in close co-operation with mental health professionals (for example CAMHS). Further, an expectation was outlined that CQC and Ofsted would work together to examine provision of mental health services in both care and education, not just for institutions or organisations where children's health and social care needs were managed. This not only encompassed residential care homes, foster and adoption care services, but explicit was the consideration of inspection in schools now being assessed on the effectiveness of strategies for dealing with mental health issues, (as part of the Safeguarding and Wellbeing Agenda). This was incorporated into the Ofsted Education Inspection Framework revisions produced in 2019. Her final salvo was to announce the commissioning of the *Transforming Children and Young People's Mental Health Services* [GB. Green Paper, 2017]. The rhetoric used was stark, not least because in parts of the speech, there was a focus on the term *'helping young people...build resilience'* (May, 2017).

In the new Ofsted Inspection Framework (2019) reference to 'resilience' and 'mental wellbeing' is mentioned several times, (Sections 26 and 27). Interestingly, the term 'mental' wellbeing is the most used descriptor within the document (Brown and Shay, 2021). The reference to resilience is important because, in the following paragraph concerned with mental health in the workplace, May asserts:

'*Mental wellbeing doesn't just improve the health of employees; it improves their motivation, reduces their absence and drives better productivity too'.*
Theresa May (2017): The Shared Society: Prime Minister's Speech at the Charity Commission Annual Meeting**.**

The juxtaposition of these concepts is telling. The dictionary definition of the term resilience has two basic meanings, *toughness* (as an action or behaviour) and *elasticity* (as an object or substance). However, the APA cites resilience as being *'...adapting well in the face of adversity, trauma, tragedy, threat or significant sources of stress'* (APA, 2012). Implicit within resilience then, is that CYP will be given the capability to endure, suffer, bear, carry and withstand. Suggesting that what is required is a change to their internal psychological state, their self, their perceptions and conscious awareness of their own reactions and responses. Nowhere does it suggest that there should be a resistance to, defiance of, struggle against or obstruction of the external forces that create the conditions for which resilience is the necessary countermeasure. In this respect, it can be asserted that resilience is the changing of the individual, but not the changing of the circumstances, context, situation or environment within which the individual interacts. This appropriately reflects Ferguson's (2017) issue relating to not changing the world, but changing the world view, which represents a lack of government desire to address endemic inequality. Nowhere either, did it make any reference to social justice, reducing poverty or creating economic parity. The fact that the APA definition also specifically identifies that resilience is always against something pernicious and dangerous, should cause educators to pause and reflect upon what exactly it is within provision, that requires children to develop resilience; for in espousing one, it is not feasible to ignore the other.

In examining resilience further, definitions and comparisons of themes are given by Shean (2015) from six key resilience theorists (see *Appendix 7*). Shean identifies that resilience research findings have the potential to impact CYP in a range of modalities including psychologically, socially and emotionally. This is referenced to interventions in childhood resiliency as having the ability to impact both current function *'... but also their functioning in society as an adult*' (*ibid*:4). The theorists examined by Shean are all psychologists with the exception of Ungar who is a social worker. Shean's work cites both Luthar *et al* (2000) and Masten (2011) in claiming that resilience is not a '*trait*' that exists within the child. Ungar

(2005), the only resilience theorist mentioned to consider culture, context and social aspects of resilience, has called for a '*decentring*' of the focus on resilience as being 'inherent' within the child. In respect of resilience not being a temperament or disposition that a child is 'born with'. They do, however, all agree that it is a characteristic a child can 'develop'.

A further feature of research around resilience, as with the terminology relating to wellbeing and mental health previously discussed, is the ambiguous nature of not only the definition itself, seen in the range given in Shean's work, but also the inability to accurately quantify or measure the constituents of resiliency. This relates to factors that it may link to, such as risk, mechanisms of calculation and measurement and referential indicators of what might constitute 'vulnerability'. The meaning of resilience for Shean (2015) remains '*controversial*'. For example, one aspect considered is the *'...selection of outcomes that indicate resilience'* (*ibid*:29). Shean illustrates the conflicted nature of the possible measures to indicate a resilient individual as being based on '*psychopathology*' and '*competence*'. This is problematic for the reasons Shean gives, which includes considering psychopathology as an assessment of 'wellness' by measuring 'absence' of indicators such as anxiety and depression, but also for the significant ambiguity in what constitutes the 'competencies' which are being considered, measured and recorded. This also needs to be considered from two positions; firstly, that 'diagnosis' and 'labelling' of psychopathology is, as indicated, a contentious issue; but further that considering 'competencies' leaves the field open to decide amongst a range which could include emotional, social, academic, cultural, interpersonal and psychological. None of which can be singularly or discretely 'measured', let alone set as a 'benchmark' against which a child can be assessed to determine resilience as a measure of variance. This work further illustrates that the Wellbeing Agenda is mapped to neoliberal policy by the drive to position CYP as 'pathologically unstable', or 'irrational' possibly accounting for the inflation of referrals to clinical services and in promoting competencies that remain wedded to economic systems and processes. Shean comments that *'...unless some of the theories of resilience are tested, the concept of resilience lacks any real substance or utility'* (*ibid*:36).

Historically, the resilience frameworks utilised in schools have emerged from the six policy recommendations within the *Marmot Review* (2010). Specific related to the wellbeing focus was Policy Objective A; '*Give every child the best start in life*' and Policy Objective B; '*Enable all children and young people and adults to maximise their capabilities and have control over*

their lives' (*ibid*:15). One of the stated intentions of Policy Objective A is (3) '*Build the resilience and well-being of young children across the social gradient*' (*ibid*:22). For Policy Objective B (2) it is identified as '*Ensure that schools, families and communities work in partnership to reduce the gradient in health, wellbeing and resilience in children and young people'* (*ibid*:24). The delivery mechanisms to achieve (A) were stated as '*Provision of skilled key workers to target those with greater social and emotional needs'* (*ibid:*181) and for (B) was to '*Extend full service schools and provision of social, behavioural, psychiatric and other special needs support progressively across the social gradient*' (*ibid:*183). Interventions identified within the report reference only social and emotional learning (with explicit mention of SEAL programmes) which also comments that, *'...reviews of the evidence suggests that the effects of the programmes were variable, plus there are problems with the robustness of the evidence base'* (Stewart-Brown, 2006:192).

There is no discrete mention of any 'resilience' based training or intervention as a named initiative. Within the policy objective commentary, mention of resilience is absent other than as a reference made in the recommendations themselves. In some areas it could be argued there is a mismatch, as express mention of resilience in the recommendation section summary is then not revisited in the implementation and delivery guidance. Reference is made to interventions in schools based on mental health, healthy eating and physical activity as being effective (Marmot Review, 2010:107) with CBT explicitly stated, as an intervention for countering 'anxiety'. However, with comorbid conditions, such as anxiety and behavioural disorders, this was deemed as less effective with *'...long term outcome evidence lacking'* (*ibid*:107). What is of specific interest here is the point made on p.108 which suggests that intervention programmes within schools have *not* translated to better health in adulthood, as Shean had suggested.

3.2.1 Transforming Children and Young People's Mental Health*:* Green Paper (2017)

If the *Marmot Review* (2010) had set the agenda for affective intervention within education, the government's Green Paper *Transforming Children and Young People's Mental Health* [GB. Green Paper, 2017] mobilised it to prescribed specific changes in educations regarding the need for better mental health service provision. Its main objectives were that schools and colleges identified a Designated Mental Health Lead (DMHL) to oversee strategic operations in terms of provision for mental health services. This person would act as a link to provide

'...rapid advice, consultation and signposting' (DfE 2017:4). It also identified joint strategy management for services between schools and CAMHS, who would be working in partnerships with schools to provide intervention and promote mental health management. Theresa May announced a review of current mental health provision to be carried out by CQC into establishing better links locally with schools, colleges and mental health staff in liaison and referral through Mental Health Support Teams. Recent changes will see this expand from 59 teams to around 400 by April 2023 (DHSC, 2021) which will have the capacity to support around 3 million CYP. There are currently 183 active teams in over 3,000 schools and colleges covering approximately 15% of CYP within the 25 'trailblazer' areas, identified within the paper.

As a response to work from the CYPMHT (established in 2015), she also announced the launch of a pilot initiative to allow peer to peer support for mental health issues, along with *'...randomised control trials of promising preventative programmes'* with the aim of *'...giving schools the information they need in deciding which programmes are most effective for their pupils'* (Parkin, Long and Gheera 2020:10). The measures that schools could use in shaping its initial interventions were based upon the work promoted through the preventative programme's 'toolkit' provided by the Anna Freud Centre. *Transforming Children and Young People's Mental Health* [GB. Green Paper, DfE, 2017], also included mandatory Mental Health First Aid training for all secondary schools and colleges, which will be considered further. In addition, the Anna Freud Centre is also involved in delivering the *Link Programme* (implemented in 2019) to support the DMHL which in total has provided training for professionals in health and education amounting to 1,365 schools and colleges across 50 of 200 CCGs (AFC, 2021).

Many organisations, such as MHFA England and St John Ambulance are now offering training programmes for educational institutions to train staff in 'first aid' for mental health. For example, St John's Ambulance states that their two-day training courses will allow attendees to understand the *'...difference between a mental health episode, a crisis and a condition'*, also *'...psychosis, including delusions, thought disorder and hallucination'*. It also states MHFS should be *'...able to recognise the signs and symptoms of common workplace mental health illness'* (St John Ambulance, 2021). Of concern is that it does not offer instruction on how to differentiate emotional distress from mental illness.

As an example, the MHFA England 'instructors' course claim that delegates will leave with a knowledge of recognising warning signs for psychosis and crisis first aid for acute psychosis, including schizophrenia (MHFA, 2020). This is hugely troubling as schizophrenia takes some considerable time to diagnose appropriately, not least because according to the DSM there are five specified types, each with different presenting symptoms (as well as atypical symptoms) and a range of symptom classification, for example positive and negative groupings, that have to be present and active over specific periods of time (in months). The fact that is advertises an ability to 'recognise' symptoms is troubling as this could potentially give individuals' misplaced confidence to 'identify' and 'label' someone with a mental illness. Individuals may then take ownership of this 'label' and in future self-report as 'having' the disorder.

This is a potential explanation for the increase in reported incidence of mental health in education, rather than a record increase in mental illness in CYP discussed in Chapter 1. It is not difficult to comprehend where statutory requirements for teachers and support staff to 'monitor and report' on aspects of CYP's emotional and psychological lives, coupled with the false premise that they have been 'trained' to detect mental health issues could create a multitude of referrals to clinical services for perceived disorders like depression. If every child that displays distress, upset, sadness, loneliness, or more critically, unhappiness gets sent to see medical specialists, then this would singularly account for the substantive increase in the volume of referrals seen by frontline mental health services, but would also account for the failure to see a correlation in diagnosed mental health disorders increasing.

This could also be explained as students being 'diagnosed' in school, by teachers who are not clinical specialists and being referred on as *having* the diagnosis. This would also support the point made in the introduction from the NHS Digital (2018) survey that around 71.1 % of referrals to CAMHS had been through education pathways, whereas only 25.3% had been through mental health specialist services. Meaning more educational settings referred CYP on to CAMHS than did qualified medical specialists, who, presumably, could better discriminate actual mental health problems from stress or everyday negative feelings. This does indeed suggest that the demand is largely being driven by education in terms of the timeframe, based potentially on the legislative changes in the 2017 Green Paper.

A recent report (Scottish Government, 2018) highlighted the issue of problematic referral further, for GPs who identified that they *'...do not refer to CAMHS lightly'* (*ibid:*65) and do so only after other options for treatment, intervention or care have been exhausted. Whereas, with the new close working relationship required between schools and CAMHS, referral is made immediately *any* negative or troubling emotional situations (like unhappiness) arise for children. A GP in the survey commented that they only refer the '*pinnacle'* of patients presenting with serious mental health issues to CAMHS (the top few per cent). The report highlighted several important issues, firstly the high number of rejections that GP referrals receive from CAMHS, most usually identified as individuals not meeting the required baseline threshold for accessing service (around 62.5% deemed to be '*unsuitable*') (*ibid*:45). Secondly, GPs are feeling intense pressure to refer children to mental health services coming from parents and schools, but GPs felt there was a higher chance of success from making direct referrals via schools, rather than going through the GP route and are advising parents to refer through schools due to the new working partnership arrangements implemented by the legislation. In this way it could be argued the preferential partnership in schools is undermining actual clinical expertise from medical professionals.

Teachers were also asked to take part in the survey and they were reported as declaring that many referrals for pupils to CAMHS, on the basis or anger, anxiety, issues at home and self-harm were also rejected as not meeting the treatment threshold, or because CAMHS suggested other services might be more appropriate for the child, for example being advised to seek alternative (Tier 1 support). The report also calls for baseline threshold into CAMHS to be *lowered*, to allow 'easier' access for children being referred through schools. The terms used in the report are that CAMHS needs *'...a huge shake up'* and arguing for *'...fundamental reform'* (*ibid*:70) because it is not 'fit for purpose'. This would seem to be on the basis that it is unwilling to accept any referral for a CYP that the teachers believe they should. Tellingly, one commentator identifies referrals were sought due to a *'...continuing decline in mental health and educational performance'* (*ibid*:68). So rather than maintain the clinical determining benchmark for mental illness, derived through diagnostic criteria which are already set very low to achieve a diagnosis, the standard should be lowered to accept any referral from schools, almost as automatically meeting the threshold. This could indicate why CAMHS is seeing the unprecedented increase in reported cases from within education, identified in Chapter 1.

What is disappointing to note here is that at no point has anyone challenged the idea that the child does not have an actual mental health issue, as aspects like 'issues at home', whilst a concern, are not an appropriate reason to make a referral to CAMHS in the first place. This is exemplified by comments within the report from teachers, for example around one 5 year old child whose referral to CAMHS was rejected, stating that his academic work had diminished and he was distressed that he had *'...nobody to help him with his 'big feelings*' (*ibid*:68). Other indications given were that teachers felt angry, upset and helpless and that CAMHS were blamed for only wanting to take on *'...the severe cases'*, (*ibid*) but that is precisely the point. CAMHS exists to support referrals made for clinical cases of actual and chronic mental disorders with serious psychopathologies, certainly for Tier 3 and 4. CAMHS has no direct involvement with Tier 1 support services and very limited involvement with Tier 2. The majority of cases referred by schools are significantly more likely to fall even below these thresholds when being referred because a child, effectively, fails to appear happy, which is likely to be the reason why they are rejected referrals and do not meet threshold baselines to qualify for clinical intervention. The issue is that the school's definition of a 'crisis' is not the same definition understood by clinical professionals.

This is an unpopular position. However, it could be used to illustrates why the current view is that children are in 'crisis' with mental health issues and unmet needs. This has ominous echoes that education is shifting towards a situation where any social problem, stress, discomfort, unhappiness, behavioural difficulty, anxiety or even adolescent malaise is sufficient for a referral to a service where a threshold is set so low, it could mean that any and every child has the potential to be labelled as 'mentally ill' and primed for psychological or psychotropic intervention. To reinforce this point further, Recommendation 8 identifies that *'...in a well-functioning system, there should be no need for a rejected referral'* (Scottish Government, 2018). This effectively means that *every* referral would result in intervention, because *all* would meet the eligibility criteria to be deemed to be suffering from a mental health condition.

Craig (2009) has stated that the expectation of teachers to display the same depth of insight in respect of complex mental health issues as qualified mental health professionals is unreasonable and she cautions against making schools *'...the preserve of psychologists and mental health experts'* (i*bid*:19). Further, Craig (2007) has said that an overt focus on feelings

has the potential to undermine CYP actual wellbeing, not least because, as Yang *et al* (2013:287) state, *'...young adults might apply stereotypes to themselves, which may result in harm to their still developing sense of self and normalcy'*. This is due to what Graham (2015) cites as constructing an identity of self that equates to being 'unwell'. For example, *'...being 'sick' can provide a social identity that has a set of rules of engagement...it can be frightening to let go of symptoms if you do not know who you would be without them'* (Schwartz, 2017:2).

Further to the *Transforming Children and Young People's Mental Health* [GB. Green Paper (2017], schools and colleges are also required to prepare to teach a component of mental health awareness, in school via lessons in PHSE (Key Stages 1-5), in Post 16 education through induction, tutorial programmes, enrichment curriculum and subject specific curriculum i.e., Health. It also now includes preparation for Ofsted visits with specific reference to a 'visible' mental health presence, provision, promotion and delivery. Statutory guidance also came into force in September 2020 that required the explicit teaching of mental health at primary and secondary level, for example in *'...recognising the signs of mental wellbeing concerns'* (Parkin, Long and Gheera 2020:23), as well as types of mental illness like depression and anxiety. At Key Stages 4-5 children are expected to learn how to maintain 'personal wellbeing' which is identified in the Ofsted Education Inspection Framework (2019). Hursh (2006) has suggested that this is a key feature of neoliberal education policy, as the promotion of 'corporate' rather than 'social' welfare serves to arguably 'redefine' the operational relationship of individuals to society. For example, identifying that as societal responsibility for individual citizens diminishes, so the responsibility individuals must take for their own welfare, irrespective of ability, is increased. (A brief outline of changes in one Post-16 provider as a result of the Green Paper changes is given in *Appendix 8*).

Transforming Children and Young People's Mental Health [GB. Green Paper, DfE, 2017] saw the emergence and development of the mandatory responsibility of schools and colleges to provide mental health and wellbeing support for CYP and created statutory mechanisms through policy reforms, inspection framework, guidance documents and legislation. What is interesting to note is the continual expansion and intensification of measures of reporting and intervention in mental health matters that has been required of schools in the nine-year period from 2011–2020. It is also of note that, within this time frame, numbers of 'reported' mental health concerns have not fallen, but have substantially and exponentially increased,

(according to school referrals). This is despite the plethora of initiatives, working partnerships, funding contributions and interventions put in place over the last nine years. This creates a somewhat confusing picture as, never have there been more statutory surveillance, monitoring and intervention in the mental health of CYP, but conversely, never has the amount of mental health issues in CYP apparently been so great. Intuitively one would expect to have seen a decrease in mental health issues, given the significant amounts of intervention and prevention strategies to 'manage risk' that have been implemented. This suggest several possibilities: that the provision put in place is not effective in treating mental health issues if they are present; that the provision itself is creating or adding to the mental health statistics, in an ever expanding spiral where numbers can only continue to rise and never reach a ceiling; or that what is presenting and being 'identified' or 'measured' is not mental health problems at all, which is why the target based therapeutic approaches that have been implemented are ineffective. The issue seems to be that children being 'treated' for mental health issues are making no significant improvement. This could potentially be because the mental health issues do not actually exist as pathologies.

This statement intends to suggest that CYP do not have a diagnosable mental health disorder, but that they have emotional distress or anxiety. My position in this thesis advocates that the cause of this distress is psychological resistance, which will be covered in the next chapter. It is a fair argument to suggest that, given the context of the socio-political topography within the U.K in relation to austerity, a root cause of this emotional distress is poverty and social and economic factors, which can be seen as a tension within the research.

However, the thesis will establish a position that incorporates this view. The argument will suggest that the psychological impact of the wellbeing interventions is, in part, due to the incongruence between the CYP lived experience and the 'ideals' of mental wellness and positivity that the agenda incorporates, in this respect it does not make a distinction between external and internal causes of distress as Coan and Sbarra (2015) suggest. Further, it can be demonstrated (certainly within my own institutions) that the reported mental health issue affecting CYP are not exclusively impacting those with adverse financial circumstances. For example, the referral rates for the college's internal counselling services (see *Appendix 1*) identified less than 3% of students who used their confidential services were in receipt of financial support or free school meals from the college. The suggests that large numbers of

CYP, in particular adolescent White females, are reporting high levels of distress but this does not correlate with their economic environment. For example, within my own context, there are students with affluent, professionally employed and educated parents who report anxiety and are currently on the Fitness to Study policy.

This emphasis on managing the risk is also centred on the trope of 'individualism' spoken about in Chapter 2. For example, in the management of 'self' that is reflected in self-esteem, self-worth and self-confidence, what Lemke (2000) associates with self-assessment, self-management and self-governance as a way of meeting 'collective yardsticks' rather than a real focus on motivated care and concern for individual CYP's wellbeing. The fetishization described by Risq (2013). The use of the term 'wellbeing' as the thesis describes, can be perceived of as a 'Trojan horse'; it creates the impression of positive support and gives the illusion of empowerment, whilst at the same time 'creating' illness and reinforcing oppression.

3.2.2 Wellbeing Interventions

As part of the revision of policy around mental health, the government created a framework for school services *Counselling in Schools: A blueprint for the future* (DfE, 2016) which *'...provides schools with practical, evidence-based advice on how to deliver high-quality school-based counselling*' (*ibid*:4). Within the document was guidance on establishing and implementing counselling programmes, it further confirms that *'...one of the benefits of school-based counselling is that [CYP] do not need a clinical diagnosis to access it'* (*ibid*:8) which appears to confirm that the government's intention is for mental health support intervention to be delivered as 'treatment' within schools and colleges. Interestingly, Section 3.1 suggests benefits from counselling include *'...improved attainment, attendance, reduction in behavioural problems, as well as happier, more confident and resilient pupils'* (*ibid*:11). The guidance also states that it is a '*strong expectation'* that all schools should have counselling provision in place. Further, where reference is made to wellbeing, it is linked to resilience (4.3:12). This seems to imply that CYP that are not resilient or happy are in some way 'abnormal' and will require intervention. It also specifies counselling is beneficial for CYP having problems managing emotion, like anger (5.5:17). The majority of school-based counselling, according to the guidance, relates to issues of conduct and behaviour. This links

to Procter's (2013) work examining the construction (and exclusion) of 'angry boys'. It also suggests that the issue of improving 'wellbeing' is contentious, in that what it actually appears to mean is improving resilience to promote mental fortitude.

When considering the types of interventions that are available once a CYP has been 'identified' as having mental health 'concerns', there appears to be a vast range of potential 'therapeutic options' that can be accessed to help address these 'problems'. For example, the counsellingdirectory.org.uk offers an array of methods and treatments, from established options for therapy including; Rational Emotive Therapy, **Stress Inoculation Training**[1], **Solution Focused Therapy**, Personal Construct Therapy, Narrative Therapy, Cognitive **Behavioural Therapy** as well as the more traditional therapeutic options of Psychotherapy, Gestalt Therapy for example using the 'Empty Chair Technique' and **Person-Centred Therapy**. More recently developed treatments include Dialectical Behaviour Therapy (DBT), Eye Movement Desensitisation and Reprocessing (EMDR) and Dyadic Developmental Psychotherapy (DDP). Specifically with children, other available therapies include Play Therapy, **Creative Therapy** and Psychoeducation. This array of treatments can create potential confusion on what services CYP can access. Within schools, types of services would depend also on what the people employed as counsellors were trained to practice, resulting in diverse offers that could depend on the expertise and experience of the counsellor. This means that there would be no standardised approach to wellbeing support. So, for example, a child that has wellbeing needs may receive one type of therapy but may move schools where access to that same therapy is not possible.

Many of the therapies listed above are only available through commissioning, but CYP, especially older teenagers can use NHS services directly. The NHS website offers links, videos and online support material, including self-help books and specifically states that individuals can self-refer directly to support services *without* having to be referred through their GP via Improving Access to Psychological Therapies (IAPT) provision. However, to access the information the person searching must be registered with a GP and need to give the name of their GP. Once done – it directs the person to a link to select a service. This means that individuals can access therapeutic support *without* going through their G.P service directly. Thus, a system exists where a person can effectively be 'diagnosed', 'labelled' and receive

[1] Therapies in bold are available through my institution's own 'commissioning' services from external providers

therapy without having consulted a health care professional or clinician for an accurate diagnosis, but further can be recorded as having a mental illness by the educational institution where they study (see *Appendix 9* Stepped Care Model).

This may explain Pitchforth *et al* (2018) findings, noting that despite no increase in the number of self-reported scores on inventories measuring psychological wellbeing and aspects of emotional distress, there was an increase found in prevalence rates for long term mental health conditions over the period studied (1995-2014). This suggests that there is a discrepancy between CYP self-reports identifying that they are experiencing psychological distress and the rise in prevalence of clinical mental disorders. This is difficult to account for; other than to suggest that CYP are not self-reporting as suffering from a mental health problem, but are none the less being referred. Importantly the research does not say an increase in recorded diagnoses of mental disorders, just an increase in prevalence. However, it could be accounted for if the CYP in question had been referred for treatment, even though they may not see themselves as having a mental health disorder.

Where counselling therapy in schools is not successful in 'managing behaviour' to create resilience, a further option is medication. *The Pharmaceutical Journal* (Blow, 2017) identified that the number of antidepressants prescribed to CYP in England under the age of 18 years has increased by 12% in 12 months. (This included 10,595 to 12 year olds and 537 to children aged 6 years and under). This was for prescription medication to treat anxiety and depression between the period 4/15 and 6/16. This pattern has been reported widely in other countries, for example Cosgrove *et al* (2020) state high incidence of antidepressant use in American CYP, with rates of major depressive episodes increasing by 52% (between 2005-2017 in 12-17 year olds). They identify the drivers for this as the call to 'scale up' the diagnosis and treatment of mental illness by the GMHM and the demand for mental health screening in CYP, despite there being limited evidence of its effectiveness and accuracy. Lukmanji *et al* (2020) reports increase in antidepressant use in CYP in Canada whilst Wilkinson and Mulder (2018) reported increase in antidepressants in CYP in New Zealand as up by 21% (between 2008-2015). Of concern have been headlines in the U.K that identify children under the age of 10 years old being prescribed antidepressants. This amounted to around 597 children given Paroxetine and Venlafaxine (Marsh and Greenfield, 2018). A BBC FOIR identified that prescribing rates for SSRI and other antidepressant medication had seen an increase in rates in England up by

15%, Scotland 10% and Northern Ireland by 6%, Wales do not collect this data, so was omitted. On average the number of prescriptions in CYP rose from 290,393 in 2015-16 to 330,616 in 2017-18. The highest recorded rise was in children 12 years old or *under,* where an increase was seen of 24% (Newlan, 2018). It has been estimated that over 70.9 million prescriptions for antidepressants were given out across every age range in 2018 (in England alone) (BMJ, 2019) when the population of England is 56.5 million (ONS, 2021).

Jack *et al* (2019) in their previously identified research on antidepressant use in CYP takes figures from the Millennium Cohort Study (2017) survey conducted by Sadler *et al* that estimates depression rates are 0.3% (5-10 year olds), 2.7% (11-16 year olds) and 4.8% (17-19 year olds). Importantly, they also identify that recording of symptoms of depression are higher than clinical diagnosis for depression. They also report that overall, rates of prescription for antidepressants, especially SSRI's including Fluoxetine (Prozac), Sertraline and Citalopram have all increased between 2005 and 2017 and in some age groups had doubled in that period (12-17 year olds). Unsurprisingly, the research suggests that highest rates of medication for depression are in areas of high socio-economic deprivation.

There has been concern expressed about the use of antidepressant medication with CYP, for example Barthez *et al* (2020); Meister *et al* (2020) and Zito, Pennap and Safer (2020); who found CYP had an increase in negative reaction after taking antidepressants. Kagan *et al* (2020) identified CYP taking antidepressant often stopped use due to adverse side effects and a lack of effectiveness at reducing symptoms; this included only 18.5% of CYP identifying an improvement after starting treatment. Safer and Zito (2019) also found no benefit in CYP taking antidepressant and indicated a range of adverse conditions which included drug withdrawal, relapse and the potential for increased suicide risk. Fleming *et al* (2020) who conducted a Scotland wide study found CYP taking antidepressants fared worse educationally than CYP on other programmes of support. These deficits were seen in a range of issues like examination grades, numbers of suspensions or exclusions, absenteeism and later unemployment; so reported no long-term benefits of taking medication.

However, what has also been reported is the concern around rapid increases in the volume and quantity of medication given to CYP, for example concern around the GMHM's estimate of prevalence rates for the number of people being diagnosed as depressed, with suggestions that figures have been *'...distorted by commercial interest and psychiatry's capture of the*

movement' (Bemme and D'Souza, 2014:8). It has also been suggested that many studies identifying the benefits of CYP being given antidepressants have been sponsored by pharmaceutical companies (Hengartner, 2020). Whitely *et al* (2020:4) further identified that some '*influential mental health organisations'* and '*prominent psychiatrists'* challenged the 'Black Box' suicide risk warning given on many antidepressants that were then given to CYP. This suggests that there was knowledge that antidepressants were harmful, but that this information has been supressed or discredited due to vested interests. In terms of effectiveness, Boaden *et al* (2020) found limited numbers of antidepressants were either effective or well tolerated when prescribed for CYP, with several carrying an increased risk of suicide, as stated. Whitaker and Cosgrove (2015) have identified 'institutional' corruption in prescription trends, including an increase in depression screening of CYP people.

The UK NSC (2020) has made recommendations *against* questionnaire-based screening for depression in adults, including the use of 'routine' or 'universal' screening. The website explicitly states that screening for depression is not recommended as practice due to potentially *'...wrongfully identifying large numbers of people as having depression'* and *'...the poor positive predictive value of questionnaire-based screening' (ibid)*. It does not make reference to screening CYP, but it is not unreasonable to assume the same difficulties would be found in this type of screening, more so in that CYP are often unable to articulate internal emotional states fluently. Roseman *et al* (2017) also identified that there could be 'unintended harm' from screening for depression in CYP and that there were no control trials conducted to support their use.

Martinez (2005) advocates that *'...all mental health assessments and interventions are political'* (*ibid*:5), which suggests that any type of testing or diagnosis is undertaken as a political act. In this regard it is relevant to reconsider Reveley's (2013) point that strategies used by schools, in the form of wellbeing intervention programmes, are subject to 'capitalist imperatives' due to the colonisation of the psy disciplines in what he terms 'cognitive capitalism'. In particular they exploit capitalist driven affective dimensions that measure 'capacities' and 'dispositions' in self-audit, which are assessed against artificially conflated and politically engineered metrics of 'desirable' behaviours based upon neoliberal ideology (*ibid*:540). Suggesting perhaps that these devices are focused less on authentically redressing the inequalities inherent within the system that creates the stress and more on 'mindfulness'

and ‘self-awareness’ to distract individuals away from comprehending their own oppression or that of others in similar circumstances. As Knight (2014) would argue, ‘keeping the secret public’. This state of keeping individuals in ‘permanent vulnerability’ is also troubling for Reveley (2013) as it *‘...minimises the possibilities for resistance’* (*ibid*:544).

Mills (2014a) critically positions arguments around medicating CYP as creating a ‘*psychotropic childhood’*, where drug treatment and in particular the escalation agenda of MGMH and the WHO could be regarded as a source of ‘violence’. This can largely be seen in the overt focus on narratives of physiology around mental ill health causation and the reduction of *‘...socio-political complexities of distress to biochemical imbalances’* (*ibid*:201). Mills also records that the WHO *‘...position ‘distress’ as mental illness, and an illness like any other’* (*ibid*:194) which would seem to support that there is a lack of recognition between emotional distress as responsive affect and mental ill health. Seen further in reporting that MGMH has called for distress to be recognised as ‘*mental illness’*. It is therefore understandable that significant amounts of CYP are being described as having mental illness when they are more likely to be experiencing emotional distress.

As stated, this is important because the failure to consider distress within a socio-political, psycho-social and socio-economic context leads to the affective dysregulation caused by factors such as poverty, poor social housing, low income and unemployment to be reconfigured as personal failings. This narrative does not consider the range of factors that can impact CYP, for example within my own institution there are young people who are carers for parents or other adults with physical health issues (two in my current year who have parents with terminal illness); many have care responsibilities for young siblings. Many work in excess of 18 hours a week as they need to contribute economically to the household. Many live in areas of high deprivation and poor social or council housing, where they have no space to study or work and many experience overcrowding. A large proportion of students are entitled to free school meals or receive a bursary. Several also care for parents who have mental health or substance dependency. A large number have a parent or parents that do not work. In the last three years I have taught five students who are young mothers. Due to the rural area around the college, many struggle with transport. A number have families that rely on faith, community or charitable support, including food banks. Many of the schools in the surrounding area do not meet floor targets, so students come into college already challenged

to achieve at Level 3 studies. These examples suggest ways in which the personal constructs, interpretation and meanings attached to distress are negated and the iatrogenic aspects of engineered disorders denied (Mills, 2014a:200). It is also concerning because the distinction between mental illness and the mental distress that the burden of these lived experiences create is being lost.

The current educational approach to mental health issues, especially through the Wellbeing Agenda, is to focus exclusively on a biomedical model of health, whereby wellness can only be achieved through diagnosis of mental health issues and treatment with a range of psychological therapies and prescription medication, most notably drugs to treat anxiety and depression, including SSRI's. This effectively creates emotional numbing. It does not address the causes of anxiety and depression in CYP, it just anaesthetised against their effect. It illustrates further the concern relating to the pathologizing of adolescent behaviour considered in Chapter 1. Mills (2012) has further proposed that intervention with medication can constitute *'...violence against children in the name of treatment'* (*ibid*:445) in relation to how forms of medical intervention are conceptualised against 'normative' expectations of treatment and care. This final section provides context to Fisher's (2009) assertion that '*...it is not an exaggeration to say that being a teenager in late capitalist Britain is now close to being reclassified as a sickness'* (*ibid*:25).

3.3 Schools as Sites of Therapy

Barker and Mills (2017) have researched the '*interface of psychology and education'* that teachers across all educational settings and contexts are now required to navigate (*ibid*:638). This research is focused on understanding the role that educators have, not only in traversing the range of psychologised factors in educational contexts, such as mental health issues, administering medication, clinical diagnosis and engagement with care pathways, but also in the burden of recognition and referral that has emerged from recent policy changes. These changes are important as Barker and Mills suggests, due to the '*cultural shift'* this has created in practices of education, school policy and procedure and specific responsibilities of individual members of staff. The research focus examined the extent of staff knowledge surrounding the infiltration of the psy-disciplines into pedagogic consciousness and practice, but also the extent to which educators could be regarded as 'complicit' in the managing and maintenance of these psychopharmaceutical and psychotherapeutic approaches.

Their research was focused particularly on the diagnosis and treatment of ADHD. The findings from the single school case study indicate that to some degree, teachers in the primary context were reluctant to engage with psychopharmacological interventions or diagnostic practice of children's behaviour, they were however, accepting of psychotherapeutic interventions, suggesting that in relation to the psychologization of education, it is a question of degree.

Barker and Mills locate this approach as resistance, suggesting that the reluctance by staff to engage with the diagnostic or treatment process mobilised the needs to create alternative strategies for supporting young children. Many of the psychotherapeutic approaches discussed in their research are common to my own institution, such as mental health first aid, the establishment of counselling services and mental health literacy (*ibid*:643). Of interest in the findings was that the staff from the school under study did not appear to be influenced by the medicalisation narrative in defining or conceptualising children's emotional output. This is contrary to most findings in similar research, as Barker and Mills identify. Where there was direct reference to psychological services was in the acknowledgement of psy-expertise within the Educational Psychology services that schools outsource.

However, this issue is compounded by the policy and practice of 'diagnosis' for conditions (such as ADHD), which gives access to funding, special arrangements for assessment and additional resources *only* if it is made by a registered psychological professional (for example in my own institution, arrangements for extended time in examinations will only be sanctioned by the exam boards if accompanied by Educational Psychologists reports on performance based on psychometric testing, example include BAS3, Wechsler Assessment Scale, NEPSY II, Vineland Scales, ABAS Scales and Raven's Progressive Matrices). Further, their findings suggest that the staff had negative views of treating ADHD with medication or administering medication at school, despite the fact that the most common treatment for ADHD is methylphenidate (i.e., Ritalin and Concerta). Staff also reported a lack of training around medication and diagnosis of specific disorders and a view was held that medical professionals, rather than staff, should be concerned with diagnosis and medication (*ibid*:648). These are not the experiences from within my own institution, as stated, staff have extensive training on Mental Health First Aid, regular mandatory training updates are provided each year, staff at the college work collaboratively with front line CAMHS services

and counselling support for referral, staff are expected to monitor students' mental health and wellbeing and intervene, with a series of policies to support staff actions, including the Fitness to Study and Mental Health Policies. Further, the F.E staff are fluent in the medicalised language of the psy disciplines, discussion in pastoral support meetings use health service terminology and support for students within my own institution include safe storage of medication, liaison with CAMHS on specific care plans and drop-in support for students who need additional psychological help. College also liaises with the crisis team, where necessary.

Whilst their findings concur with earlier research (citing Malacrida, 2004), it is fair to suggest that the study may have resulted in different outcomes if the setting had been a secondary or a Post-16 context, given the issues surrounding emotional upheaval in adolescence identified in Chapter 1. For example, the significant number of students within my own institution that are under CAMHS for eating disorders and where the college wellbeing staff are involved in monitoring intake via EDMPs (Eating Disorder Meal Plans) along with issues like monitoring and providing support for self-harm (first aid providing sterile wipes, gauze and tape and a Sharps Bin). These issues are less likely to be seen in a prepubescent cohort. For example, rates of hospital admissions for self-harm in 2020/2021 for 10-14 year olds was around 220 incidents per 100,000 whilst for 15-19 year olds the rate was 653 per 100,000 per year (Nuffield Trust, 2022). Incidences for children under 10 years old were in single figures and the majority of self harm in the 10-14 year old group were at the upper age limit, suggesting that primary staff do not have to engage with the level of emotional distress found in later age settings.

Important in their findings is the indication that the school still used a psychotherapeutic intervention, albeit a 'preferred' method around behaviour control through Educational Psychology services, rather than by administering medication. Psychotherapeutic intervention was framed as 'structural' issues which still '*... focus, almost exclusively, on the need for improvement in an individual's emotional literacy, self-esteem, social skills or family dynamic'* (Barker and Mills, 2017:659). This is important because, locating emotional distress within the same bounded 'personal improvement' discourse has a similar effect of reinforcing the neoliberal narrative.

Singh (2004) expands further on the issue around medicalisation of children's behaviour by examining the role of prescription medication like Ritalin, for the management of ADHD. The

study spoke with women who discussed their experiences of caring for children with ADHD both pre and post diagnosis. Singh draws three emergent strands from within the research to encapsulate women's feelings, linked to responsibility, connection and anger, exploring the thoughts and emotions associated with the issues they raised. Singh identifies a concept within the research that she refers to as *'mother-blame-brain-blame'* (*ibid*:1194), where 'root causes' of the child's ADHD transfer from being 'inadequate mothering' to 'biological anomaly'. However, an undercurrent within the findings explored are the inferences of 'maternal fitness' (*ibid*:1199), that mothers with sons who have ADHD are both publicly scrutinised and sanctioned.

Singh links much of the findings to a feminist perspective, suggesting that mothers found some 'absolution' from blame if their sons were given a clinical diagnosis of ADHD; as the label of 'inadequate mother' was no longer applied by others to explain their challenging behaviour, or reactions from others internalised in reinforcing existing self-blame. However, this was not without cost, as Singh points out *'...ADHD diagnosis and Ritalin treatment encourage mothers to reconfigure their mothering in line with a biological narrative of behavioural causation and to judge maternal fitness against their ability to embed this narrative in their mothering behaviours'* (*ibid*:1202). Singh concludes that what transpires after an ADHD diagnosis is a different type of pervasive and pernicious influence over mother's internal construct. She concludes that *'... the problem is that a pill promotes medicalisation and an obscuring of the cultural components of both 'behavioural disorders' and 'good mothering''* (*ibid*:1204), adding that the use of biotechnical models obscures the influence of culturally and socially controlling forces in creating the need for which medications becomes the solution. She further identifies that the desirability of a biological label for the causes of ADHD and the provision of treatment are masks to what she terms *'...oppressive cultural ideologies of the good mother'* (*ibid*). In terms of this thesis, the same argument could be made that attributes emotions like anxiety to illness pathology serving to create similar oppressive ideologies of 'the good and bad student'. A feminist perspective is also still useful here, as the significant majority of students with severe emotional and wellbeing issues are female.

Malacrida (2004) also examined the impact of educators on the advancement of medicalisation in CYP and the roles that schools play in pathologizing behaviours typified as

ADHD. This is based on the concepts of educational staff being party to the *'…identification, assessment and administration of medication to 'problematic' children'* (*ibid*:61). She positions the argument that the introduction of medicalised language to define some forms of behaviour is what defines these children as being 'problematic', identifying that for most children their difficulties start only once they begin school. The medicalised language can be regarded as constructing the psychopathology of the 'illness' which they are subsequently labelled as having. Malacrida's research uses Conrad's (1992:211) model that identifies medicalisation occurs in three areas. These are the patient-physician relationship (interactional); this included using the medical lexicon to compartmentalise the symptomology and provide models of understanding. These levels of understandings were (conceptual), for example through the multi-axial approach taken within the DSM-V and lastly the wider adoption (and acceptance) of the medicalised approach at an institutional level to apply the medicalised principles in practice, often carried out as a 'proxy' by non-clinical practitioners.

The study focused on a comparison of opinion and practice around a medicalised view of ADHD, from school practitioners in both Canada and Britain. In short, it looked to examine if teachers and other educators working with children believed their ADHD to be a medical problem that needed to be treated with prescription drugs; or whether they felt it was not a medical issue and resisted pressure to undertake intervention by 'proxy'. In Conrad's model, the link between medicalisation and social control is made in terms of regulating and ordering children's behaviour to 'normative' standards, with the rationale that once behaviour has been identified, the attached label precipitates a range of interventions that become available to manage 'undesirable' behaviour in the classroom environment. Malacrida identified support for the view that in Britain, educators would be less likely to engage with defining ADHD as a medicalised 'disorder' or administer medication for a child with an ADHD label. However, given the date of this research this may not necessarily be reflective of contemporary practice in education. Barker and Mills (2017) found similar in their study of primary school teachers, in respect of an unwillingness to engage with medicalised practices of ADHD management (preferring instead to use psychotherapeutic interventions).

An important point that Malacrida makes in her research (using work from Castel *et al*, 1982), is the concept that medicalisation of children's behaviour through the mechanism of the psy-

disciplines can be seen as a pathologization of 'differences', which can lead to 'othering'. The expansion of behaviours that have become regarded as problematic (and so medicalised) is reflected in Cohen's (2016) work examining the increase in children's (and school specific) 'disorders' within successive DSM publications. This 'difference' is situated against deviations from both statistical and societal norms. Malacrida elucidates through Armstrong's (1983) position that the psychiatric 'surveillance' of children's behaviour in policing for difference, has encompassed features of generic behaviour that have become symptomized, but that could relate to any child. Similar findings have been illustrated in depression pathology (especially in adolescence) where behaviour such as tiredness, irritability and mood swings form part of the diagnostic criteria. This is especially important as diagnosis tended to be given after the child had started school, as the children were unable to meet the requirements of 'normal' classroom behaviours. However, behaviours that were being exhibited were 'normal' behaviours that children would enact – just not necessarily appropriate for the context.

In Malacrida's findings, she discovered that the majority of CYP in the British settings were not diagnosed through the school system and she explicitly states that educators were reluctant to put children forward for assessments for ADHD through the school, but encouraged mothers to pursue a diagnosis independently. These reflect Barker and Mills (2017) findings of similar reticence in primary school staff to engage with clinical specialists in either the diagnosis or medication of children for ADHD. However, it draws interesting parallels as educators are willing to engage in assessment, referral and involvement in treatment for CYP with anxiety and depression. Indeed, earlier statistics have illustrated that education is the largest source of referrals to front line mental health services. One potential explanation could be that CYP diagnosed with depression or anxiety creates less work, in terms of statutory provision, than do children statemented for educational support with ADHD. Of further interest was Malacrida's point that schools were more likely to utilise social control practices such as exclusion and isolation (as described by Procter (2013)) to provoke mothers to seek a diagnosis of ADHD, but many seemed reluctant to engage with the behavioural strategies that mothers implemented after diagnosis. This meant that little reinforcement and routine was established to support the children. Within my own institution, there are limited numbers of students who have ADHD/ADD diagnosis and in my personal teaching I have worked with three young people with the diagnosis within the last

three academic years. More common in my experience is autism. This may be for several reasons, initially, the student may not have a diagnosis, so this is not indicated on the electronic systems. Further, the young person may have developed strategies for managing behaviour, so it is less apparent. Alternatively, it may be that young people with ADHD/ADD opt for different routes into employment or education (for example more technical or vocational courses) and so do not access the range of courses that I teach.

In some educational settings, although not my own, there has been a move towards education that is described as 'Trauma Informed' practice, which arguably, is still a domain of the psy-disciplines. This relates to the co-opting of 'trauma' to describe any type of adversity, rather than physical or emotional trauma such as the experience of abuse, parental death or neglect. There is, I feel, a danger here in describing *any* adverse experience as trauma, which is unfortunately becoming confabulated with issues like school avoidance, learning disabilities and nervousness. This reflects the discussion in Chapter 1 around the use of the term 'depression' to describe feelings of unhappiness and is seen in the 'malaise' description identified in Behrouzan's work. Most usually, the concept of childhood adversity is contained within the ten ACE that were originally devised by Felitti *et al* (1998). The Trauma-Informed approach is being strongly promoted in schools and relates to adaptive teaching, learning and wellbeing strategies with a focus on ameliorating the impact of trauma on learning. This corresponds with improvements in emotion and behaviour in schools, so it is difficult to see how this is different from the SEAL programmes covered in Chapter 2.

The examples of Trauma-Informed Practice given by the Office for Health Improvement and Disparities identify that there is a focus on practitioners being aware of the impact of trauma, recognise the signs and symptoms of trauma and work to prevent retraumatisation (Gov.UK, 2022). It further reports that there are six key areas of trauma informed practice which includes safety, trustworthiness, choice, collaboration, empowerment and cultural consideration (*ibid*:2022).

Kelly-Irving and Delpierre (2019) have suggested that the issue with this type of programme is that it still does not address the underlying factors that have created the adversity, especially for aspects like socio-economic and structural inequalities. A child living in poverty is unlikely to benefit from any of the strategies identified, for example there is little 'choice' when there is financial hardship and schools have no authority to make changes to income

for families. Schools are unable even to decide who will receive school meals within their own institutions as it is decided by wider agencies like social welfare and the local authority. Courtois and Ford (2009) have also suggested that the type, nature and duration of specific types of trauma (like parental death or a vehicle accident) would have different impacts on the CYP than trauma emanating from long term familial neglect, which suggests that restitution through schools for trauma survivors means that the interventions would look very different, but these are not addressed in the practice guidance. O'Toole (2022) has further identified that the 'guidance' is open to a wide range of interpretation and highlights issues with the child's own interpretation of the events, but also that there is still a power imbalance between the CYP and practitioners and she suggests that there is danger in an overreliance on biomedical models of trauma, which sees the individual as 'victim'. In looking at the scope and impetus of the Trauma-Informed approach, I would argue that this is resilience training by any other name. O'Toole recommends that schools adopt the Power Threat Meaning Framework (Johnstone and Boyle, 2018) which is outlined in Chapter 5.

3.4 Summary

This chapter has sought to address whether intervention measures in educational settings have been used not to treat mental health issues, but to regulate and manage CYP's behaviour and affect.

It can be rationalised that the practices within the Wellbeing Agenda; which expresses that the individual's emotional states are now political currency, that 'happiness' is the expected state of existential existence, where direct intervention occurs and resources are mobilised for anyone detected as 'unhappy'; constitute just another form of oppressive practice, meted out in current policy by the inoculation training of resilience. The freedom to feel and experience is shaped by policy, where the emotion of sadness is prohibited as this state, seemingly, can engender contemplation, challenge and change. Also, that the identification of depression locates the site of dis-ease within the person, suggest that there is an 'abnormality of affect' which places the impetus for change on 'correcting' faulty beliefs, thus eradicating any vestiges of dissatisfaction or discontent whilst negating any potential for resistance. In Hendrick's (1994:47) research, he draws a parallel to the 'emergence' of the 'public secret' as *'...the socio-economic transition substituted the 'factory child' for the 'delinquent child*'. In considering wellbeing implementations as technologies of affect, this

analogy can be extended to suggest that the *'delinquent child'* has now been transposed to the 'neurotic child'. A young person, made sick by the system that enmeshes them, becomes so preoccupied with feeling there is no space for thinking. Fisher (2009) refers to CYP in the U.K as experiencing '*depressive hedonia'* (*ibid:*21) which he identifies as existing in a state of perceptual seeking of pleasure and happiness, (promoted through positive psychology and the wellbeing agenda) in order to manage the misery of capitalist realism. He argues further that the strain of being educated within a capitalist bureaucracy (and the tensions inherent in being both the consumer and product) is indicative of the reality of their oppression and exploitation and suggests this is why there are high levels of anxiety within an educational context. He suggests that the appeal of positive psychology is in the search for 'relief', identifying that *'...affective disorders are forms of captured discontent'* (*ibid*:84). What Fisher is suggesting here is that the focus on affect and subjectivity 'traps' individuals into a constant scrutiny of self to attenuate to their 'state of wellbeing'. The 'in the moment', 'mindfulness' of the 'now'. This serves to distract CYP away from the reality of their wider entrapment, within an unfair system. Whilst the reference to thinking and feeling is not suggestive of a unifying binary, the implication here is that CYP are channelled into excavating their psyche, to maintain the false consciousness of capitalist existence. Critical thinking, cynicisms and a solipsistic disposition threaten to undo the grip of capitalist realism, which would lead to awakening of the consciousness, it can therefore be suggested that critical thinking is not a desirable trait in CYP. This is because deep reflection can lead to a sense of dis-ease, which can create contemplation of wider unhappiness and tensions. The focus on positive psychology, as seen in Howell's example of a 'proof of concept' for building resilience emphasises 'gratitude' and a 'present in the moment' mantra to prevent contemplation and reflection. He argues that education creates *'...a culture that privileges only the present and the immediate'* (*ibid*:62).

The wellbeing response considered in respect of Research Question 3, would represent that the focus on 'resilience' as opposed to 'social justice' can therefore support the position that interventions of policy in wellbeing can be viewed as centring on control and compliance, not care and compassion.

CHAPTER 4: MAKING SENSE OF EMOTIONAL DISTRESS - RESISTANCE

Introduction

In the introduction to this thesis and in the research questions asked, I suggested that the high levels of emotional distress being reported as an increase in clinical mental health conditions was not actually a crisis in mental health, but something different; according to Freire (1972) and Levine (2013) it was reaction and revolt. There is no question that the incidences of *reported* distress have significantly and exponentially increased in the last decade and intensely in the years from 2015. In the preceding chapters I have offered an explanation of the destructive impact of capitalist marketization in education in relation to the creation of suffering through alienation and its impact on the mental wellbeing of those who are subject to it. I also suggested that neoliberal education reform was culpable in the creation of emotional distress. I can here appropriate the work of Zuboff (2019) to expand the remit on surveillance capitalism to include the close and constant tracking, recording and monitoring of mental health within institutions of education and the wellbeing remit of resilience. This is effectively to 'spy' on individuals who are not meeting neoliberal expectations of entrepreneurialism and labour market suitability. In other words, students and pupils are surveilled by their peers and education practitioners, to watch for deviation from accepted behavioural norms. A series of psychotherapeutic interventions are then swiftly put in place to 'realign' individuals with the neoliberal 'project' through the Wellbeing Agenda; as in Procter's 'angry boys'.

This chapter will attempt to offer an alternative explanation for the perceived increase in mental health problems reported in CYP and explored in Chapter 1. It will address Research Question 4 in determining if the anxiety and distress being experienced is as a consequence of the interventions within the Wellbeing Agenda, which creates intolerable tension between the CYP lived reality and the expectations of education policy. It will aim to make a persuasive argument, drawing on a range of research in an effort to achieve a sustainable position that posits, what we are actually registering is not a rise in mental health issues, reported or otherwise, but a novel form of 'resistance' to the alienating experience of schooling and the interventions that are being instigated. This is important because the type of resistance being exhibited is being enacted in very private and personal ways. If this type of resistance can be

recognised as such, it has the potential, if appropriately interpreted, to raise awareness of oppressive practice.

A sociological perspective will offer an explanation of resistance using a range of narratives that will lay out the argument upon which the form and structure of this new resistance might be mandated. The later psychological perspective will consider resistance from a position relating to the use and application of therapeutic intervention strategies that are now part of mandatory practice within educational institutions. From September 2020, these have been incorporated into the national curriculum as health education from primary school to post 16 setting. In the final conclusion of the thesis, I will also consider how the two informing narratives can both account for the rise in reported mental health issues and the reasons why current 'treatments and therapies' are having limited impact on addressing the problem. A further crucial aim of this chapter is to provide a nexus, a point at which both sociology and psychology can agree on the resistant form of behaviour that is being examined and recognise how the interpersonal nature of this resistance, enacted through the physical body, can explain the increase in amount of psychological distress that is being reported.

4.1. Defining Resistance

A succinct lexical definition of the term resistance is given by Osborn (2010:8) who traces its Latin and Anglo-French origins as literally '*taking a stand*'. However, he further expands these definitions as meaning both to exert oppositional force and to mobilise the self to withstand the force of effect. This gives a useful starting point to consider the nominal and semantic meaning of resistance. In its application to research it inhabits a variety of contexts and as a construct, indicates evolutionary and transitional changes that have taken place in the application of resistance to theory and practice over time. It also allows researchers to determine what is being resisted; how resistance is being affected, why resistance is being mobilised and to consider the ultimate aim of the resistant activity. The latter definition uses the term '*defeat the force of effect*' (*ibid:8*) which is of crucial importance in the context of counterbalancing the oppressive and dehumanising forces found within educational practice and policy.

4.1.2 Resistance in a Disciplinary Context

Historically, many researchers have engaged with concepts of resistance across a range of disciplines from sociology and education to anthropology and political science. Resistance is also used within the framework of specific psychological theories relating most closely to the psychodynamic approach. It is within this context that I wish to explore the relationship between the *extro*spective application of resistance concomitant with sociology, examining a range of interpretations to consider resistant 'action' and what it can reasonably constitute; with the *intro*spective approach taken through psychology in examining conscious (or unconscious) motivation to action (or inaction) and how it is personally affected. This is to ascertain if there can be a duality of position on resistance in determining a valid currency of comparison, similar to that positioned by Lapping (2007). She suggests that with a dual reading of resistance between the two disciplines, significantly richer layers of data become available for analysis as *'...psychoanalytic insights can enhance descriptions of social phenomena'* (*ibid*:4).

Central to the theories of resistance that inhabit these varying fields is the established notion that acts of resistance are attempts at 'undermining' rather than 'opposing' power. What is less clearly defined is how different disciplines apply constructs to address the positioning of resistance within their collective theoretical discourses. What this means is that traditionally, when sociology and psychology speak of resistance, they are talking about different constructs.

To set resistance into some manageable contexts it is circumspect to briefly consider the early theories of resistance and identify some of the problems of applying resistance theory to contemporary study. What is not possible, by limitations of space, is to provide a detailed history of resistance theory from its early conceptual emergence in work by; Bowls and Gintis (1977), Hobsbawm (1965), Thompson (1967) and Willis (1977) to the present day. This early work, whilst contributing to a wider understanding of what it means to resist and the early description of the forms that resistance might take within their historical context, allows familiarisation with underpinning concepts of meaning in the sociology framework of resisting. It does not, however, engage with alternative forms of resistance, such as the 'everyday' resistance suggested by Scott (1989) which is the direction this research focus will take.

A key feature in much of the early sociological work around resistance has been in recognising the use of a conscious and intentional *modus operandi* of behaviour like protest, disobedience and subversion, through action, vocalisations or silence to challenge the force of oppression by a subordinate minority or marginalised groups. For example, in the refusal to engage, counterculture, physical acts of sabotage, verbal and physical opposition and defiance, typically seen in Willis's explanation of the 'lads' behaviour through smoking, disruptions of lessons, playing practical jokes on teachers and verbal abuse of pupils that followed the rules.

In order to reconstitute an understanding of what resistance means in terms of accepted modes and interpretations, there needs to be recognition of the evolving (and devolving) social, political and economic topography of resistance. It is reasonable to assume that, as resistance is very much a reaction to social, economic, cultural and political power as Chin and Mittelman (1997) identify, then the more complex societies become, the more complex the modes of transmission and targets of resistance, for example in the resistance potential of 'new technologies' suggested by Maeckelbergh (2016). Lilja and Vinthagen (2009) refer to power and resistance not as a symmetrical binary but rather an asymmetrical hybrid. In that the individual can be both an agent for change as subject and subjugated by the strategies for change as object. In this way Vinthagen and Johansson (2013) agree that *'...resistance is always situated in a context, a historic tradition, a certain place or social space forged by those who rebel'* (*ibid*:15).

Therefore, a notion of resistance and its modes or representation during the 1960's, 70's and 80's, for example incorporated into works by Aggleton and Whitty (1985); Bowles and Gintis (1977) and Willis (1977) would be inappropriately placed to serve as a model in representing contemporary debate and reflecting current assumptions around resistance as a process enacted today. A social, political and cultural confluence of factors and forces serve to elaborate upon how the resistances identified in Willis' (1977) work, differs significantly in process and function from the resistance commentated upon and explored in later and contemporary research. This is important because it is apparent that historically, the forms, types and processes of resistance that were engineered and experienced have changed over time.

Iñiguez de Heredia (2017:51) has suggested that an 'all-encompassing' theory of resistance that could be universally agreed and applied across all disciplines or time frames is an

unrealistic prospect. This is because the nuanced insight that is achieved from theoretical frameworks, positions and perspectives of a subject specific 'gaze' would be lost. Indeed, Moss and Osborn (2010) have referred to the tensions that arise in trying to singularly conceptualise resistance as being akin to *'...an Escher staircase'* (*ibid*:3). What is clear is that any discourse on resistance must have its roots securely fixed within the 'inter' and 'intra' personal dynamics of power, because resistance is always the domain of the subordinate. Fundamental to Iñiguez de Heredia's argument is that the intention of any act of resistance must have at its centre the motivation to *'...avoid, tame or challenge domination'* (2017:52). What has been drawn from this work is the importance of establishing a conceptual framework to contextualise any debate around potential, implied or actual acts of resistance. However, it is useful to consider briefly more recent work on resistance within a schooling and educational context.

4.1.3 Considering Resistance in an Educational Context

Giroux (1981) suggests that resistance theories offered a continuation and 'apex' to examine the relationship between capitalism and the nature of schooling. He indicated these arose from the dearth of consideration around consciousness and conflict, emanating from early theories of Social Reproduction. Intimating that through the lens of a neo-Marxist perspective, tensions could be explored that would expose the *'...pockets of opposition*' inherent in any oppressive system (*ibid*:12). Importantly he expressed a key element that indicates not only that resistance provides a means by which oppressed individuals could withstand the domination of capitalism, but that the ability to produce resistance in turn made 'space', a gap wherein the reconstitution and reformulation of an individual's social and political identity could be shaped; bent by external oppressive forces.

This served two purposes. It made clear, through the raising of political awareness within the working class, that resistance was possible. Meaning that there existed the potential for change, but also it highlighted where gaps emerged in what were previously deemed to be a seamless 'fit' between the prescribed and hidden curriculums of schooling and the demands of the shop floor. What Giroux referred to as *'...undermining oversocialised and overdetermined models of imposition theory*' (*ibid*:12). In this way, Giroux argued against the deterministic and reductionist notions that social reproduction took of culture, a singularity that is subject to what he termed a 'static analysis', focusing comparatively on cultural

components such as language. He replaced this with an image of a complex dialectic, of interplays between different features within culture such as structure and ideology, what Hall and Jefferson (1976:10) refers to as *'...maps of meaning'.* This is a complex mechanism by which individuals both navigate through and introspectively organise their cultural and social world. This seems to imply that individuals construe their social affinities in relation to the topography of their personal map, which in turn assimilates new information to revise the social connections and affiliations it contains. Within this map, room for resistance was created, inside its pockets, troughs and 'bolt holes'.

This work is revisited by Massa (2016) who indirectly addresses the concept of 'intangible' spaces to resist, in research on the sites of resistance as existing in a virtual environment, which 'de-territorialises' physical spaces and re-envisions them as electronic spaces, existing in technological forms through the use of new social media. This not only links to the work of Zuboff (2019) considered earlier, in construing the nature of places that capitalism annexes to intrude, where the opportunity for oppression expands itself into the on-line world that many CYP now inhabit. It also reinforces how the earlier theories of resistance, identified at the beginning of the chapter, would be significantly limited in their ability to engage with types of resistance within domains that were not in existence at the time. For example, within school, resistance looks very different for the electronically savvy 21st century child.

However, Massa's work draws comparisons between the maps of meaning suggested by Hall and Jefferson, which assembled interpersonal socio-cultural relationships and examined spaces these make for collective action within and between affiliated individuals and groups. Versus those that can be highlighted and traced in Massa's comments. Stating that cultures of resistance must be self-sustaining over time and that this is achieved through enduring forms of social attachment, which create 'moral communities'. These nurture resisting identities and provide support for shared ideals and actions in 'communities' of social mapping (2016:10).

4.1.4 Examining Concepts of Resistance from a Sociological Perspective

In the use of 'resistance' in application across and between disciplines, there exists neither a single unifying definition of resistance, nor a consensus to the nature, type and variance

within which the boundaries of what constitutes resistance can be framed (Hollander and Einwohner, 2004:534). Frustrations are elucidated upon further by Weitz (2001:669) who suggests that definitions, where they are indicated, remain so *'...loosely constructed'* that they become either, reductive and impotent (in that researchers effectively see resistance '*everywhere*') or marginalised and diluted (to the extent that resistance it is seen '*nowhere*').

This issue is examined in greater detail in an analysis of the current, complex position of resistance research by Courpasson and Vallas (2016) in their *Handbook of Resistance*, which has offered up what they term a *'conceptual toolkit'* (*ibid*:1) for researchers of resistance. This has generated insight into the field and range of application of resistance in contemporary work. Their research raises important questions around the nature of resistance, identifying the abstracted nature of existing theoretical construct around it. Moreover, they declare that the terrain around resistance has largely remained *'unchartered'.* Indeed, they stipulate that unifying resistance to a single, unassailable construct is not possible given its multiple roles across a range of competing disciplines and inherent complexities in its latent and manifest function of expression. They further attest to the unstable and fluid nature of resistance across multiple academic paradigms and the hope of creating a single unilateral definition as being impossible because resistance *'...precludes any possibility of being exhaustive'* (*ibid:*7).

As part of the reinvigoration of work in the field of resistance, a range of authors have contributed to the meaning and measure of resistance and these are augmented in the *Handbook of Resistance* to encompass a variety of places and spaces for resistance to occur. Particularly identified by Courpasson and Vallas are four specific areas that relate to *Sites*, *Languages*, *Technologies* and *Geographies* where resistance is enacted. It is my hope that any future 'handbook' considers the domain of 'intrapersonal resistance' which I believe is an important emergent field within the research discourse. Whilst it is not especially categorised or identified directly within the current work, there are key areas that illustrate many of the instances where such deeply personal resistance, in terms of the defence of the constructed self, can be identified and interpreted. For example, in the work by Ong (2001) examining strategies used by Malay women to resist oppression within a factory workplace by 'spirit possession', cites directly the *'...violation, chaos and draining of one's essence'* which Courpasson and Vallas interpret as *'...decentring the individual actor'* (2016:6).

What Courpasson and Vallas (2016) do advocate is that resistant forms that are not identifiable by their intended target should not be diminished or dismissed. Perhaps more importantly, they assert that they have *'...adopted a wary view regarding the question of motivation and intent'* (*ibid*:6), as in this regard they view conscious awareness of specific action as *'...fleeting and elusive'* (*ibid:*6). Here they suggest that ultimately, consciousness of action is manifest subsequent to its execution and not as a pre-emptive intention. What this suggests is that resistance can indeed be undertaken without conscious awareness at the time it is enacted and that the construct of action as a form or measure of resistance is an emergent property of the phenomena itself, deriving meaning largely in relation to the context in which it has occurred.

Further, they draw on a Foucauldian assessment of resistance here, which is an important consideration of the idea that intrapersonal resistance can be established as an authentic contribution, not least because it expressly cites that domination through subjugation is *'...a continuous and uninterrupted process which subject our bodies, govern our gestures, dictate our behaviours'* (Foucault, 1976:97). Further, they go on to summarise that in their view, *'...resistance may or may not reflect unconscious intent*' (2016:7). This is important because it suggests that the concept of resistance, to date, has been the domain of sociologists who have interpreted its manifestations within a socio-political and socio-economic context.

What has been lacking is a consideration of the *psycho-social* aspects of resistance, where there exists a rich field of information, accessible through a psychological 'gaze' linked to the internalisation of domination and subjugation, as seen in the examples given above. The internal process of thought and unconscious, preconscious and conscious acts created by the individual's attempt to resist are bereft of psychological conceptual scrutiny, in much the same way that the performance of a car is discussed, with no real acknowledgement of the working of the engine in its manufacture. This nascent knowledge, in my view, deserves consideration by psychologists, who have little to say in relation to resistance outside of its meaning within a psychoanalytic setting. We are behind, as a discipline, in taking the work forward and considering the transition from an external, socio-political artefact of defiance, to an internal, psycho-social assessment of the mechanisms as an act of self-preservation, manufactured to consolidate 'self' unity. A term I describe as 'psychic salvage'. An emotional self-rescue mobilised against attacks on the core identity. Ybema, Thomas and Hardy

(2016:21) have further indicated that individuals *'...continually construct and reconstruct resistant identities'* as a consequence of the mechanisms that they deploy, they suggest that resistance itself is a process that constitutes and reproduces identity. Courpasson and Vallas suggests that resistance *'...leaves a mark'* (2016:8) on individuals who utilise these strategies of defence, which speaks to a need for psychologists to mobilise and address the dynamics implicit in the creation of this *'...identity in flight'* in respect of self-construct and self-identity (*ibid*:23).

This analogy of an indelible mark is furthered in the consideration of Wearing (1990) which adds a critical dimension of two-fold importance, by exploring resistant acts in motherhood from a feminist perspective. She expands the sphere for acts of resistance whilst also considering an analysis of losses and gains this action achieves. Wearing reimagines the nature of acts that can be deemed as resistant, which have traditionally related to labour and employment. She makes the distinction between resisting in public and private, by utilising accessible means that allow for resistance, in what is a very confined socio and micro-politically subjective space. She argues for labour resistance within the personal domain of motherhood. By arguing thus, she widens the parameters for assessing further what acts, situations or events can be legitimately regarded as resistance and lends credence to the argument that small acts of simple resistance, with no deliberate or overt political agenda, can register important emancipatory and contra-repressive change. Reinforcing the point that any act of resistance, no matter how measured or how small, by having been enacted, *'...leaves its mark, like ink on blotting paper'* (*ibid*:38).

This suggests that acts of resistance can have an indelible quality that leaves an impact or impression, but more importantly has the potential to change lived experience at a personal, local and global scale. To follow the metaphor of 'leaving marks' further; repeated small stains can either establish a prominent overall pattern or change the underlying colour of the fabric entirely. A further expansion of the metaphor can be seen in Mills (2014b) work as she continues the analogy of resistance as 'mark making' in utilising Lacan's concept of *'becoming mottled'* as a means of resistance using mechanisms like mimicry or camouflage. For the women in Wearing's research, their resistance comprises of 'refusals and gains'. The refusals (and thus rejections) are of their domestic routine and chores, the surrender of their free time to child-centrism and of their reluctance to allow the change in their perceived status to

dictate their subsequent behaviours. The gains she discusses refer to the control they acquire and exert over their own time, the subtle shift in the use of power to co-opt and direct familial support in childcare and the formulation of an awakening consciousness of their own socio-political agency through action. She thus brings resistance into the sphere of the personal and affective.

4.1.5 Resistance as an Intrapersonal Action

As a segue to the work that follows in establishing a justification for the argument that resistance can be unconsciously motivated and enacted, Blume and Kimelberg (2016:192) have identified that resistance is not restricted to external acts but *'...passes through internal emotional lives'*, and encompasses not just behavioural aspects, but carries also *'...deeply emotional conflicts'* (*ibid*) that are inextricably entwined with feelings. It is therefore important to expand understanding of resistance to consider the nature of subjectivity and the internal psychology of resisting, which is a necessary prerequisite to furthering knowledge of the micro-political aspects of internally constructed schemas of defiance and opposition.

To a certain degree, there has to be a change of emphasis for resistance theory to be utilised in the capacity that I intend. That is to say, evidence is required to facilitate the departure from accepted notions of resistance. So, aside from being a conscious, politically driven, externally enacted force of defiance at a specific target of oppression, using practical strategies of opposition. Work has to be sought out that reimagines an alternative reading of resistance. One that focuses on establishing if acts of resistance can be manifest differently, in a subjective, intrapersonal domain that qualifies the act as having been construed from emotional and psychological responses. This is examined to some extent by De Casanove and Jafar (2016) in their consideration of the human body as a site of resistance. Whilst I recognise that this is not directly linked to internal psychopathology, it at least starts to move the focus of resistance to the internal processes of individual subjective experience. As McLaren (2002:116) has identified *'...in the micropolitics of individual resistance, it is bodies that resist'*. This identification of bodies as sites of resistance, (that bodies are both the originator of and agents for the opposition being presented) is novel and diverges significantly from earlier established theories. In their summary they outline embodied resistance from a largely feminist perspective within four sections, namely, body modification, the construct of beauty, aspects of dress and the body as the vehicle of protest and activism. Again, in respect of the

concept of intrapersonal resistance, this could include bodies as sites of self-harm in signalling emotional trauma and distress.

To take this work further, there could also be an argument to focus 'corporeal' resistance more widely to encompass the brain and mind, which form part of the 'resisting' physical body. However, there are some sections within the work that are significant in this regard. For example, Sutton (2010) identifies ways that physical bodies can be used in protest and activism, where she outlines the embodiment of emotions in protest. She criticises that sociologist often fail to consider the role of 'affect', '*Bodies are relevant to protest because they are the vehicles through which emotion is displayed or dissimulated'* (*ibid*:151). Notwithstanding, this work is important because it is one of the very few that considers an affective dimension present in resistance at all. Sutton also makes the point that protests do not just ignite emotion in the people who are supporting the action, but they also engender sympathies or condemnation from onlookers, whether the protest is vocal, or silent.

De Casanove and Jafar make a further important contribution here in that they critique the work on the body as a site of resistance for failing to consider the level of harm protest can cause to the body. For example, in the actions of dominant and oppressive groups, consider the treatment of young people demonstrating collective resistance in Hong Kong during the anti-China protests in 2019, where police were reported to have used 'excessive' force with rubber bullets and tear gas (Griffiths *et al*, 2019) and the more intimate and personal harm from resistance enacted in the cases like hunger strike and the resistance to medical intervention and treatment. It is legitimate to therefore consider, that the acts of self-harm seen in increasing prevalence in CYP could be taken as a form of resistance.

Moving forward with the concept of the body as a site of resistance, Haynes (2013) has examined the 'affective turn' as it relates to theories of resistance. Importantly Haynes makes the case that, actions that can legitimately be regarded as resistance should be viewed through an affective filter *'...an affective approach to resistance would pay attention to those barely perceptible transitions in power and mobilisations of bodily potential that operate below conscious perceptions and subjective emotions of social actors'* (*ibid*:560). She concludes with the key point that resistance can operate at a different level of dynamic power relations, within the emergent affective domain.

4.1.6 Assessing Resistance as an Unconsciously Motivated Force

Haynes has identified that in any attempt at resisting, a dual binary of opposition and action are always present. It has been suggested that not all acts of resistance are consciously motivated; however, this is a contentious point. Not least that there is an emergent potential for change to arise from opposition that is not resultant upon action, but that has accumulated sufficient kinetic or inertial energy, (created by its own force of movement) to create substantial shift and change results as a residual force, rather than as a direct action. For example, an analogy would be, the draft made by an individual passing a candle having sufficient force to extinguish the flame, it is not an intentional act, but the result of the movement past the candle causes the flame to be extinguished in the same way as deliberately blowing it out. However, Haynes identifies that the perennial problems that exist around resistance, namely intent and recognition, is not easily reconciled.

Integrally, Haynes also questions whether there needs to be an 'intention' to resist before an action can be deemed to be resistant, a point regarded as being essential in most current existing literature and research around resistance theory. She seeks to address this directly by creating a re-conceptualisation of the necessity for intention of action to be regarded as resistance, using a Deleuzian interpretation of the concept of affect. This constitutes a reading that draws a distinction between the sociological precepts for affect as simply an emotional response; to a more considered psychological construction of affect as a catalyst that increases the intensity of freedom. This is not just the preserve of the subject in a reactive capacity but distinguishes itself as containing within it the potential to mobilise an action response.

Citing Deleuze and Guattari's (1987:16) definition of affect, the critical differential variable being the intrinsic capacity to affect, which she argues is autonomous from the experience of the individual subject's personal power. This seems to formalise the notion that affect involves the individual's capability to mobilise forces in opposition, through emotionally processed material that exists separately from the 'felt' emotion itself. Thus, it locates itself into the more familiar sociological frameworks of forces that are known and recognised by their effect, rather than by their contingent definition. What this should further illustrate is the dearth of psychological research that could be assessing this relationship between agency and affect, intention and sublimation.

This makes a compelling case to consider the impact of affect in expanding the parameters of resistance. In detailing that *'...the ontology of affect is inseparable from transition and movement,'* Haynes (2013:562) expounds that this establishes the evolution of resistance from everyday macro-political acts, (typified by collective forms of protest, recognisable from historical traditions of resistance). She further cites *'...affect's ontology as being that of the middle or the in-between'* (*ibid*). In Haynes analysis, she effectively elaborates on two fields of resistance. The macro-political, which focuses on what she terms visible struggles of collective power, here mobilised against traditional targets and agents like class, oppression and the structures and strictures of domination (*ibid*). This is compared with the micro-political struggles that she perceives exist within the intra-personal fields of identity politics and other forms of social and humanistic movements. This emphasises the key determining features of the duality for resistance as being one relating to quantity and scale (*ibid*:563). To naturally follow this analysis, one may conclude that local, personal and individual struggle is categorised as micro-resistance, which is regarded as small scale, deemed to have less impact than the collective acts of resistance she identifies as being large scale and more effective in challenging structural oppression and inequalities. This seems to preclude individual acts of resistance from being as effective as the large scale co-ordinated or organised acts of resistance.

I disagree with this point. My argument alludes to the fact that the personal and individual can have a significant impact that is both affective and effective. Not as a directly organised or mobilised force – i.e., personal acts of resistance in mental wellbeing are individual and small scale, but accrue and accumulate momentum that acts as the kinetic force previously discussed. Even though it is not actually adhering to any model of collective action, it operates collectively by the weight of numbers and by an aggregation of effect. The Wellbeing Agenda was not required to be implemented because of large scale protests, public action, political rallies or collective acts of group defiance. It was deemed necessary due to an effect of attrition, because of the small, personal, individual and private struggles with individual mental distress. The Wellbeing Agenda constitutes one of the largest scale measures of direct intervention seen within contemporary education.

A further interesting aspect to consider in establishing the position that the 'affective turn' currently being witnessed in education relates not to individual psychopathy, but to 'social

myopia' in relation to oppressive educational policy initiatives and directives. One such example is drawn from the work of Cloward and Fox-Piven (1979). Some four decades ago they were writing around the issues of female deviance and resistance, mostly as a critique of the narrow focus on female resistance as being somewhat homogenously identified and attributed to stress, created by the impact of family and gender inequality. At this time, they make crucial distinctions between the types of gender differences in the playing out of both resistance and deviance, detailing that female deviance was seen significantly in actions that were *'...typically individualistic, privatised and self-destructive'* (*ibid*:651). They elaborate further by identifying that, within the literature of that time scant regard was paid to the nature and content of the resistance behaviour, due to the nuances of some types of female resistance being simply to 'endure'. They explain in more detail that much resistance at that time for women was *'...privatised and disabling'* (*ibid*:652) existing largely around women's ability to make concessionary gains by resorting to physical and mental illness and addiction (for example to prescription medication).

A distinction was drawn regarding female deviance and resistance as being wholly bio-psychological, existing exclusively within the female psyche. This was attributed to stresses from a range of factors, including changes within the female body's biochemistry, and the tension between limited role availability, fulfilment in occupational fields and the rise in educational opportunities for woman. However, this caused conflict due to the limited availability of the roles women could generally fulfil and the 'weakened' and overmedicated stages of childbirth and menopause. Ehrenreich and English (1978) refer to this as the cultural ideology of 'feminine fragility'. The paper largely critiques the dominant paradigm that views female deviance as dependent almost entirely on a gender determined argument around stress, mostly due to its inability to account for different aspects of deviant or resistant behaviour in violation of social norms, for example prostitution, drug addiction or mental illness. As well as the inadequacies of measuring the level and extent of stress, and the failure to satisfactorily explain the impact of stress that is considered outside of the social context within which it is generated. For example, in an abusive or co-dependent relationship and the social isolation often experienced by women in family structures.

Following on from this research, Cloward and Fox-Piven (1979) make visible the paradigm shift in women's consciousness at this time, in reconstructing subjective and intrapersonal

resistance as *'...being led to embrace a social ideology emphasising health and a pre-occupation with illness'* (*ibid*:660). This is stark because much of the commentary that follows presages the very situation being played out in many educational institutions, some forty years after this was predicted. They state that the extensive rise in health systems and structures that invade and intervene in daily life, will cause a '*restructuring of deviant behaviours'* (*ibid*:664) with increased medicalization of stressful situations, that will push more and more women into resistance through therapeuticised experiences, most notably mental health issues and self-destructive action (like self-harm or dysmorphia). Cloward and Fox-Piven argue that this is an irresistible force, brought about by the dynamic changes in oppositional social forces that have a transformative effect on the systems themselves. They argue that this is due to women being forced to think that social tensions they experience in their external world, stem from an internal, compromised mental health.

Highlighting sharply what they term as the symbiotic relationship between *'...entrepreneurial medical profession'* and *'...physical and psychological woes of middle-class women'* (*ibid*:668), Cloward and Fox-Piven demonstrate that women internalise external issues. Persuaded to look for an explanation not within the discordant, oppressive gender bound experiences that they faced within patriarchal hegemonic systems of domination and control, but instead directed to look within their own 'enfeeble' minds and 'weak' bodies. '*Women were encouraged to deviate in sickly ways, and the healthcare system provided elaborate paraphernalia such as clinics, hospitals, labs and drugs which reinforced the ideology of stress as a sickness, that existed within their private selves'* (*ibid*). This mechanism of ascribing sickness as 'private', failed to consider the numbers for whom such personal distress may be manifest.

One further important point to reinforce is Cloward and Fox-Piven's conclusion that the more exposure women had to doctors, clinicians and other medical 'professionals,' the more likely they were to be diagnosed with mental illness and prescribed medications that treated both psychotic and neurotic, rather than physical conditions. For example, in the prescription of sedatives, anti-depressants and stimulants. Cohen (2004) makes the connection that the repetition of deviant practices as what he terms 'lived opposition' can become 'conscious acts of resistance' in transforming social change, mobilising personal resources from a subversive dynamic to an emancipatory one. Where Cloward and Fox-Piven's work becomes predictive

is that they hypothesised that there would be an upsurge in the number of women who would present as suffering from mental illness. In particular self-destructive forms like self-harm, which were attributed to stress and anxiety-based diagnoses, due in part to the resistance 'gains' that the acquisition of a mental health problem served. Also, to the ideological shift that has led matters relating to women's situation in a social context, being attributed to internal bio-psychological weaknesses, rather than external oppressive forces.

This point relates directly to the outline given in Chapter 1 of the rates of behavioural distress in CYP. The NHS Digital (2018) report outlining that emotional disturbances were more common in females than males and especially in females aged 17-19 years of age (at around 22.4%). This notion of physical resistance within the body can perhaps be best synthesised by considering the issue of self-harm in CYP. ONS (2020b) identified the main cause of death in adolescents' aged 10-24 in England and Wales during 2019 as being by intentional self-harm, suicide and poisoning (601 individuals). However, in this respect McManus *et al* (2016) specify self-harm is not in itself a mental disorder but is indicative of extreme mental distress. Brooks *et al* (2015) have shown in their study that 22% of 15 years old have reported self-harm, from a sample size of 140,830.

This is corroborated by PHE (2021) who identified statistics for admission to hospital for self-harm in 10-24 year olds as being 43,037 (per 100,000) of which 7,371 (per 100,000) was for 10-14 year olds (for the period 2019/2020). Nuffield Trust (2020) have also identified that admission rates for hospital where CYP have self-harmed has increased by 36% (up 182 per 100,000 population to 690) for females, but remained constant for males at around 200 per 100,000 population). It states explicitly that self-harm is a way of expressing *'...overwhelming emotional distress' (ibid)*. This would seem to support Cloward and Fox-Piven's assertion that increases in emotional distress would be interpreted as intrinsic biochemical deficiencies, ignoring the social conditions leading to the increase in distress. It can further support the assertion that such harm could be reinterpreted as personal resistance.

This work demonstrates that there has been a move towards a consideration not just of the body as an agent of resistance in organised protest, but that the body (and more importantly the emotions themselves), occupy a site for resistance to happen that has been previously overlooked. It also identifies that the affective and subjective experience of the body can, in itself, become protest. It is important now to consider if these can further migrate to

encompass the 'processes of mind' as registering resistance. Interestingly, Kurik (2016) suggests that in light of the 'affective' turn in education, the time has come to consider an 'anthropology of resistance', where the study of resistant 'affect' should be established within an ontological framework, to provide greater understanding of the nature and practice of conceptualised resistance (*ibid*:58).

4.1.7 Assessing Resistance as Silence

An example of the expansion around what can be understood as resistance and the use of the body in protest is examined by Wagner's (2012) research into silence. This 'silence' is a key thread in much sociological research, for example Acheson (2008); Ferguson (2003); Glenn (2004); Jaworksi (1993) and Ophir *et al* (2009) and appears to suggest that there are alternative means and measures to resist oppression. In considering silence as a resistive mode, Wagner comments on silence not in the absence or lack of language, but in the performance of what he describes as *'...an embodied action in the world'* (Wagner, 2012:100). Thus, silence is not located in negative opposition to sound, but in positive production of space. This allows Wagner to consider what silence actually does rather than focus on what it is. In this respect he regards silence as a political act. It is framed in this context because it relates directly not just to the absence of language as sound, but to the *'silencing'* that establishes itself by the refusal to hear and to deny opportunities for oppressed voices when they do speak (*ibid*:101). This becomes important because it illustrates that when subalterns offer silence, it reclaims the silencing and transposes its potential by manufacturing *'...an unarticulated position of resistance'* (*ibid*:105).

The theme of silence is explored because he articulates that when dominant groups experience silence from an oppressed or marginalized group, it necessitates that the discursive relations are rearranged and repositioned. The dominant agent's role is reversed into trying to *'...undo the silence'* (*ibid*:102). In the solicitation of language, in the lack of verbal responses or cues, in the rejection of a common linguistic frame of reference, language cannot dominate in elaborative or restrictive code, in the use of negative binaries or in the distilling of the subaltern's situation by layers of saturated subject and object status, from what Spivak (1988:307) calls *'...the place of disappearance'* which she refers to as a *'...violent aporia'* (*ibid*:306). What Wagner suggests is that whether silence is elective, enforced or coerced or whether the individual is perceived as an object and faces oppression and

domination, it does not remove the potential for them to exercise power from this place of disappearance.

Finally, in this brief assessment of sociological resistance, I wish to consider forms of resistance that currently defy conventional understanding in terms of measures of gain. I intend to reinforce why new measures of considering resistance, from an intrapersonal position, are urgently needed. Perry and Selden (2000) have examined a critical issue that further develops the understanding of resistant acts and their impact by assessing an area thus far not critically considered in mainstream theory. This is unusual because the act of resistance undertaken carries zero gain for the individuals who enact it and it is only in the kinetic impact of its consequences that any gain is visible. This further implies that resistance as a conscious act may also be unintentionally altruistic. Further, that affective resistance can be as potent as organised resistance – as questioned by Haynes (2013).

Perry and Selden advocate that resistance itself does not, by necessity, have to be based within either recriminatory action or from a psycho-emotional position of resentment or despair. In fact, it may be deployed as a specific mechanism to enable personal resources to be effectively mobilised in staging protest at what they refer to as *'...intersubjective struggles of everyday social experiences'* (2000:302). In this way they have highlighted work around the increasing rates of suicide in China in young rural women. This has led to the raising of national interest and, according to Phillips *et al* (2002), resulted in a series of major conferences on suicides and specific intervention strategies which have indicated the depth of concern felt, not just in the Chinese media, but by government and wider international agencies. In this way it is clear that the personal act of suicide has, at a uniquely intrapersonal and micro-social level, had a macro-social effect.

They have further proposed that the recent increase in suicides is as a result of the national and local policy initiatives within China (in particular on the androcentric positioning of the single child policy), but also correlates with China's increasingly capitalistic economy. Ren (2016) has highlighted that in China, there are approximately 500 suicides a day by women. This is thought to be higher in rural areas, representing over 1.2 million women counted from 2009. They position this increase in suicide as an indicator of resistance, largely due to the 'interfusion' of the psychological processes of thought and feeling, in that emotional and moral values become difficult to separate, so a compromised social system can be manifest

in dysfunctional moral action, *'...collective delegitimation experiences are associated with subjective states of demoralisation'* (Perry and Selden, 2000:307). In this way the suicide is a singular act, based on subjective feelings of despair that are created by political and economic agendas, brought about by threatening an individual's personal identity and social integrity within their local world. This private act within a personal space has had resonant consequences across China and thus has been more effective in generating an appetite for transformation and change, than demonstrations or other forms of direct political protest, disobedience or subversion. This can be seen as evidence to suggest that the intrapersonal, subjective, affective enactment of resistance is legitimate and potent, contrary to Haynes (2013).

4.2 Summary

This section has sought to summarise a range of points relevant to resistance that have set, in context, the potential for reframing resistance from the orthodoxy of established sociological position of the 1960's, in respect of social reproduction, to expand thinking around what can constitute resistance. It has highlighted why traditional concepts relating to physical acts of opposition and subversion, in the work of earlier theorists, is insufficient in understanding the types of contemporary resistance that are being witnessed in a world that has moved on by over five decades, for example in the resistance of 'virtual' communities. It has sought to give examples of how resistance has conceptually evolved to incorporate a range of views such that resistance may not be intentional, but can be generated from a subjective and affective dimension. The body itself can be viewed as a site of resistance and acts of resistance produces indelible change in the individual psyche of resistors. Also, that resistant acts can be inaction (silence), resistance can occur in a private and personal sphere and personal micro-political resistance can have an impact macro-socially. It has identified where sites of resistance can be located in a mental health context (self-harm), it has illustrated that changes in consideration of resistance have been impacted by the 'affective turn', that acts of personal resistance can take place that have no gain for the individuals enacting them and finally, there is precedence that resistance can be 'unwitting' or unconsciously motivated within an existing sociological framework.

It is important to establish what type of acts can be persuasively deemed to constitute 'resistance' within an intrapersonal space. Further, it needs to be established if such acts can

be manifest in a form that is reactive but not subject to conscious will. If, as Hollander and Einwohner (2004) assert, resistance can be '*unwitting*', what might this look like? I have therefore elected to use Hollander and Einwohner's framework of resistance to explore this position further. This will seek to critically assess the model they have produced and focus on their concept of '*Unwitting Resistance,'* which they determine as an act not being intentionally motivated by the individual, but perceived as such by the observers of the act. From the perspective of psychology, this could equally translate to being resistance from a place of the 'unconscious'. In the next section, I will outline the rationale for this choice and expand on the components and elements of resistance that lead me to engage with these specific conceptual ideas.

4.3 A Sociological Perspective - Holland and Einwohner (2004)

In the previous section, I examined aspects of resistance theory and the broader definitions and applications of its concepts. This was in an attempt to establish that forms of resistance are not exclusively motivated by conscious and deliberate action, but can be explored using the affective domain of the intrapersonal, subjective and emotive. This section will examine one specific model that I will use to demonstrate how this form of resistance could be generated, by foregrounding the 'spaces' that are invisible within the framework. This work was selected as it is the only example that identifies a distinct categorisation of terms in a structured model that relates to resistance.

There are disagreements about the nature and meaning of resistance that exist with good reason. What is apparent is that embodied within the use of resistance are complex notions of socio-political, socio-historical, psycho-social (and psycho-pathological) action, situation, position, agency and engagement across the diverse application of its use in mainstream academic disciplines, which have developed both across time and within historical contexts. Coupled with this are its variations in focus; from individual actions (or reactions), collective actions in respect of means of utility and in institutional action with regard to agenda and policy. There are further aspects to consider in defining resistance that relate to the setting or context within which resistance is experienced. For example, when seeing resistance within organisational and institutional provinces like education and employment, but also in wider areas like literature, media, fashion and entertainment (Hollander and Einwohner, 2004:534). Perhaps the area that is most keenly divisive is in establishing the 'modes' of transmission for

resistance. This relates to the mechanisms through which resistance is enacted and it is in this area where most disagreement arises.

In their offering of a 'typology of resistance' Hollander and Einwohner explore the different aspects of resistance in order to configure a framework (s*ee Fig. 1*) to codify current ideological thinking. They indicate that this focuses on common elements found across and within different disciplines and application of concepts, which they define as discordant. From this synthesis they identified two recurring themes, most notably the aspects of *'recognition and intent'*. Importantly, it must be noted that this framework is written from a sociological perspective, so it is feasible that the typology they describe would be inappropriate for use within other disciplines where competing or alternative meanings of resistance are recognised and adapted. A further caveat is stated that rather than seeking to provide a 'unifying' definition to the complexities of resistance, they seek to provide a lens through which the 'dissent' surrounding it can be better understood. It is not made clear as to which, if either, concept of recognition or intention carries most gravitas in determining an action to be resistant. In summary the typology seeks to *'...clarify concepts upon which work rests'* and *'...to better understand the circumstances under which resistance occurs*' (*ibid*:535). In this regard it is a useful basis upon which to construct a position on resistance theory.

Fig.1 Table showing Types of Resistance: Hollander and Einwohner (2004:544)

		Is act **recognised** as resistance by	
	Is act **intended** as resistance by actor?	Target?	Observer?
Overt Resistance	Yes	Yes	Yes
Covert Resistance	Yes	No	Yes
Unwitting Resistance	No	Yes	Yes
Target-Defined Resistance	No	Yes	No
Externally-Defined Resistance	No	No	Yes
Missed Resistance	Yes	Yes	No
Attempted Resistance	Yes	No	No
Not Resistance	No	No	No

The framework they have proposed recommends that there is consensus of opinion that resistance must involve some degree of opposition. They advocate that this is by an 'act' (a commission of behaviour) and seem to specify that the act must be witnessed or observed by others to validate or authenticate its significance, as it explicitly states that *'...actors, their targets and interested observers may judge an act to be resistance'* (*ibid*:544). However, they indicate that this does not have to be unanimously agreed by all agents in order to constitute resistance, as their table shows. Indeed, in only one configuration (*Overt Resistance*) is there unanimity of recognition by all three agents. It is therefore not clear whether Holland and Einwohner intend for *only* this concept to be adjudged as *actual* resistance. This is a somewhat contentious point at it seems to conclude that resistance mostly becomes defined by the external perception of the resistant action, from attenuation by the oppressors and is located in the *post hoc* social construction of meaning through the action of observation, rather than *ad hoc* in terms of the implied meaning imbued by the perpetrator of the act with the generated intention to subvert.

Hollander and Einwohner identify that some researchers are complicit in adding to, not detracting from the confusion around the meaning and interpretation of resistance by failing to declare, define or extrapolate the form of resistance they are intent upon using, or the purpose for which the mechanisms of resisting are being used. This work provides a helpful conceptual model that offers navigation around some previously ill-defined constructs of resistance theory. However, it remains unclear how the strength and register of resistance can be best understood from considering the trifold position that seems to necessitate an acquiescence between the competing agents, for example does *Unwitting Resistance* provide a stronger claim to be regarded as resistance because it is *perceived* to be such by two agents, but with no intention from the actor. Or is A*ttempted Resistance* stronger because there was actual intention to resist, but this was not deemed as such by all agents. There seems to be no qualitative account of which Yes/No combination has more validity. It would be unsatisfactory to claim that the different types of resistance have parity, as this is clearly not the case in considering the combinations of possible labels. This also leads to consideration that in order to fully appreciate the mode of resistance, the agents should all have a synchronous and mutually shared context of meaning implicit within the resistance being enacted, which can by definition, only inhabit the actor's gaze.

Notwithstanding, I have elected to utilise Holland and Einwohner's model of resistance for several reasons. Firstly, it produces a field topography that allows some navigation around the concepts of resistance with discretely designated attributes and features that are not difficult to understand and can fit comfortably within the sociological and psychological discourses utilised. It is also a point of reference for the type of resistance that this research will focus on. Secondly, the model is the only one that allowed for the possibility of 'unwitting' resistance. This opened up the potential of an intersection between the sociological and psychological aspects of resistance which will explore a 'recontextualisation' of concepts into analysis, as envisioned by Lapping (2007). Further, the model creates 'space' where other aspects of resistant forms may become emergent. It does not claim to be complete. It positions itself as a starting point for research concepts to derive meaning when investigating the phenomena of resistance, providing a conceptual framework of understanding against which context can be 'translated'.

This model does serve to summarise the key areas of resistance and provides useful designators for novel terms that previously have all been labelled 'resistance', with no discerning features or characteristics. However, problematically, there is significant disparity in the application of some of the categories and labels utilised and in some examples the agency of the individual is significantly undermined. For example, if *Externally-Defined Resistance* is neither intended by the actor nor perceived by the target, the resistance appears to exist solely in the interpretation of the act by the observer, in which case is it actually resistance or something else, for example paranoia. Likewise, the *Unwitting Resistance* mentioned appears to suggest no intention on the part of the actor but is interpreted as such by the observer and target. Moreover, if there is no intention to resist, there can be no clearly defined target, because something has to focus cognition to modify behaviour. So, it is unclear how a target can construe behaviour as resisting when the actor has no recipient in mind. This would seem to say more about the psychopathology of the target, than the actor's intent.

The typology, as Hollander and Einwohner point out, has key limitations, not least that there is considerable disagreement between individuals about what acts can be deemed as resistant. They cite the example of certain types of hairstyles or clothes (e.g., *Punks* [my example]) and contrast this with political marches, pickets and protests. What the typology does contribute is the precursor to some common parlance when engaging with research

around resistance. So, this becomes a useful construction in providing a vocabulary, to establish dialogue around what is meant when researchers talk about 'resistance', since it provides concrete and discrete labels with which to usefully apprehend what is being described, when resistance is spoken about.

4.3.1 A Search for 'Spaces' within the Framework

The blurring of definitions for resistance becomes more problematic as constructs within the framework are more closely examined. The model seems naïve and insufficient to explain the complexity of resistance for several reasons. It diminishes the power of the individual to assert autonomy if their actions are only acknowledged as authentic if validated by others. There may be a genuine effort made to resist, using strategies discussed in the earlier chapter, where a careful balance of losses and gains, as well as harm and marginalisation have to be considered. The model also fails to account for a range of subtle, micro-political forms of resistance (see the later discussion on Scott (2018)). Further, to specify that resistance has to have 'intent' or it cannot be classified as resisting is to ignore discourses which indicate something different entirely. Not least in claiming that a 'knowledgeable intent' always precedes a specific act. In respect of criminal justice, a process exists to determine if there was aforethought and premeditation in acts deemed unlawful, which seems to suggest there is a significant gulf in the discriminating position between the intentional and unintentional.

Invariably not all mediating acts in general are riven from conscious thought. Similarly, not all thoughts result in acts and not all acts appertaining to intention of thought are subsequently viewed as they were intended. So, there are critical issues with the formulation of the model, but many constructs it contains are useful in expanding the framing of resistance, for example the inclusion of resistance that is enacted but not necessarily in the way it was intended (*Unwitting Resistance*).

Suggested here is that the fundamental issues that arise for the model are that it restricts modes of resistance to 'action' and to the propagation of resistance through 'intention', thus dismissing research that has emerged to create space for 'non-action' to be filled with intentions to resist. Their inclusion of *Unwitting Resistance* hints at challenging the implication that resistance is exclusively a conscious and premeditated process, resulting in an 'act', but this is not sufficiently elaborated.

It may therefore be useful to revise the categories to include 'Reactive Resistance'. For example, resistance that is unconscious, oppositional and nuanced in reconstructing ways to transform power relations, could also be an act of resistance, not intentionally construed by the actor, not recognised by the target nor noticed by the observer but which could, nonetheless, be a form of resistance recognisable as such only *after* there are emergent changes in the situation of the oppressed. This 'Reactive Resistance' could be an act, action (or non-action) that has conscious (or unconscious) intent, which is recognised as resistant retrospectively, only after the consequences of such actions are felt. This is similar to the actions of the Chinese women discussed by Perry and Selden and to some degree the reactive self-harming due to emotional distress. The potential to 'unconsciously motivate' will be further expanded in the following section relating to psychological resistance.

Moreover, in considering the model, it would be unnecessary to include '*Not Resistance'* as a category within the model if this just represented the existing *status quo*. The reason this could be justifiably included is that *Not Resistance* is designated to indicate no change to the power relationship between the subjugated and the oppressors. This invites the suggestion that, conversely, there could be a form of *Not Resistance* that does allow for a systemic change in dynamic power relations.

This view is problematic, not only in the sociological sense of hegemonic power, political agendas and constructionist discourse (we all invariably construct our own world view) but, also from a psychological perspective. It creates difficulty as it presupposes the actor has direct access to his/her intrinsic motivations, which many perspectives, in particular the psychodynamic approach, would argue are not possible due to the nature of the unconscious mind. Gaining access to authentic internal states is, accordingly, not possible because the states that create intention are driven by the unconscious mind, which is by definition inaccessible. Marxist theorists may also suggest that, an actor who exists within a false consciousness may reject action as resistance or opposition to oppression, in which case the psychodynamic explanation of resistance as a mechanism of defence would demonstrate a duality. Perhaps therefore, resistance would be better considered if the prime directive was to identify the impact, change, modification or difference the resistant behaviour had the propensity to create. This would mean that questions of deliberation, intention, conscious

action or unconscious regulation would be of secondary concern, and potentially unify the focus away from the *process* of resistance, to the *product* of resistance.

As illustrated, their work suggests key components that are critical in the consideration of a psychological discourse for resistance, aside from that located within the psychodynamic traditions as it identifies issues appertaining to resistance as both agency and self-identity. It is upon this point that psychological theory can effectively join the discursive argument. Abowitz (2000) offers a different interpretation of resistance that adds veracity to the new 'wave' of resistance as being removed from the strictly socio-political formulations based within a neo-Marxist perspective.

This linked closely to theories of social reproduction and therefore somewhat limits its register to what Fernandes (1988) describes as a structurally determined and functionalist binary of oppression as dominance /subordination, therefore limiting its transformative and emancipatory potential. Whilst Fernandes advocates that *'...resistance is usually mistaken for attitudes, behaviours and actions in opposition to ideological inculcation'* (*ibid*:172), Abowitz takes what she terms a 'pragmatic approach', allowing for resistance to be interpreted using transactional analysis of 'resistance as communication' and the means through which individuals can give voice to dialogue around oppressive systems, power imbalances and inequalities, in an attempt to transform experiences. However, common to most sociological thinking on resistance, is the framing as a *conscious* intentions to act which is central to most sociological narratives. Abowitz suggests that not all acts of resistance have to be either conscious or intentional. She suggests that resistance is not always directly produced by the conscious self in undermining cultural or social norms.

This moves the discourse around resistance further on from being a consciously motivated action driven by intention, by permitting an emergent window through which resistance could be viewed as a necessarily protective 'reaction' that is be self-preserving. Not only does it embrace conscious 'silence' (an intention to non-action), as a passive agentic means by which to resist, as in Wagner's (2012) case study of an immigrant man avoiding deportation by refusal to speak, which he describes as *'...micro-political resistance'* (*ibid*:100). It also considers how many micro-political resistances are accomplished, within a contemporary hegemonic context, where individual autonomy has been assailed across a range of intrapersonal, personal, social, political, economic, organisational, institutional and systemic

spaces, which may have been diminished to such an extent that they function only on an unconscious level. For example, in Rogers-Vaughn's (2013) argument around the construct of depression as resistance. Couldry (2010) makes an important connection here in that the neoliberal *tour de force* is to 'systematically deny' voice, in particular reducing what he calls marginalised voices, 'other' voice and voices of opposition, whilst at the same time promoting the belief that everyone and everything is equally heard within a climate of 'freedom of speech'.

This would imply that the typology model suggested by Hollander and Einwohner (2004) would be neither necessary nor sufficient to explore this type of resistance due to the lack of conscious intention they proscribe *'...the actor's conscious intent is key to classifying a behaviour as resistance'* (*ibid*:542). Whilst Scott (1985) specifies that intention has to be conscious and that this must link to the action (or inaction). In later research (Scott, 1990) acknowledges that for some suffering oppression, whilst resistance is conscious, it may be enacted in a private rather than public forum because to do so publicly would be a high-risk strategy, especially where such resistance is individual.

This would link to the typology as being *Attempted Resistance* because neither the target, nor the observer is aware that resistance has happened. In this regard, resistance is measured more by intention than by recognition or by impact. However, Leblanc (1999:15) suggests that *'...resistance can occur at a level beneath consciousness'*, this would leave the only option to recognise resistance as a burden of recognition. Hollander and Einwohner themselves indicate that cultural variance may negate an accurate recognition of resistant behaviour, so this leaves a paradox that resistance may be *neither* intentional (due to a lack of conscious awareness or an unconscious motivating force) nor recognised (due to conflicting cultural knowledge or ethnocentric bias) but still be classified as resistance. This suggests that resistance may then be unconscious, unrecognised and initiated only within a private sphere. This indicates a need to redress current understanding of what modes of operation can be identified as resistance, along with the need to expand the lens through which acts can be viewed as 'oppositional'. If action were to happen that changed or modified suffering, where no origination can be reliably observed, it may well be the consequence of some form of resistant non-action, unwittingly or unconsciously motivated. In psychological terms, this would mean motivated by unconscious thought that is not available for conscious

consideration, but in a Freudian analysis, would still be considered as intentional, similar to that of 'motivated forgetting' (Freud, 1909).

4.3.2 An Alternative reading of the Framework for Resistance

It would be reasonable to suggest that sufficient examples have been generated to plausibly modify the resistance framework as seen below (*See Fig. 2*). This incorporates an additional dimension of resistance by considering the action potential contained within it, allowing '*No Resistance*' to continue as an example of 'inaction' having no change potential. This categorises 'Reactive Resistance' - defined as resistance that is unconsciously motivated or 'affective resistance' - as inaction that *has* change potential.

Having created an additional dimension to the original model, it is now necessary to find evidence to support this as a plausible alternative framework of explanation. Whilst considering the suggested changes to Holland and Einwohner's original model, in order to constitute and differentiate between action that is unconsciously derived and consciously unintended, further consideration needs to be given to more fully explore these themes. This involves a careful unpacking of the value base and assumptions leveraged in the anatomy of resistance presented in the framework by assessing the potential implications for change inherent in the categories used.

(*Fig.2 Table showing a suggested revision of Hollander and Einwohner's Types of Resistance (2004:544) by incorporating a dimension of Change Potential which leads to another category of Reactive Resistance)*

		Is act recognised as resistance by		**Does the act have change potential**
	Is act intended as resistance by actor?	Target	Observer	**Potential**
Overt Resistance	Yes	Yes	Yes	**Yes**
Covert Resistance	Yes	No	Yes	**Yes**
Unwitting Resistance	No	Yes	Yes	**Yes**
Target-Defined Resistance	No	Yes	No	**Yes**

Externally-Defined Resistance	No	No	Yes	**Yes**
Missed Resistance	Yes	Yes	No	**Yes**
Attempted Resistance	Yes	No	No	**Yes**
Reactive Resistance	**No**	**No**	**No**	**Yes**
Not Resistance	No	No	No	**No**

Holland and Einwohner suggest that *Unwitting Resistance* is behaviour generated by the actor, so there is a product of 'commissioning', of 'doing' something, but the behaviour being enacted is not intended as a deliberate act in the pursuit of resistance. *Not Resistance* according to the framework is where no resistant behaviour is generated by the actor, so there is an act of 'omission', no action is observed and it is not viewed as resistant behaviour. In the amended categorisation, it has been suggested that the restriction of the definition of resistance resting solely upon recognition across three dimensions of Actor, Target and Observer was limiting and failed to consider the potential impact of resistance in affecting change in social and personal domains. The modified model suggests a dimension that assessed resistance in terms of its impact. This allows for a different reading of resistance in terms of human agency and is informed by the work of Scott (2018). This changes the outcomes for these actions or inaction, therefore *Unwitting Resistance* does carry the potential for change, whereas *Not Resistance* does not. The dimension of 'Reactive Resistance' mimics the appearance of *Not Resistance* (in respect of the degree of recognition) but differs in its potential to create change. It mirrored the features of *Not Resistance* but adopted the potential of *Unwitting Resistance* because it is an act of 'commissioning' albeit unconsciously motivated (rather than an act of omission).

The implied values given in Holland and Einwohner model are somewhat problematic, according to Scott (2018) who has closely examined the interpretation and meaning of inaction in her work '*The Sociology of Nothing'*. This has opened up 'space' within the model to allow for the possibility that 'not resisting' might still facilitate change. Crucially Scott identifies that *'...nothing must still be accomplished or 'done', whether or not we are aware of doing it'* (*ibid*:4). Scott goes on to suggest (using the work of Brekhus (1998)) that enaction of 'nothing' can be categorised as non-presence, non-identity and non-participation, typified

by intentional commissioning and omissions, or more interestingly, unintentional commissioning or omission. This identifies that non-behaviours of the marginalised, oppressed and subjugated should be considered as constructed operations of agency, she asserts that *'...nothing is not just a passively endured condition, but a reflexively managed modal experience'* (Scott, 2018:4).

She further offers that electing to do 'nothing', taking the position of 'not' is still a micro-social process which creates a pocket, to consider why actors elect not to do things, a space to open the possibility of resistance, for example in her consideration of *'...working to accomplish nothing'* (*ibid*:6). This raises interesting possibilities for the categorisation of *Not Resistance* in the framework given. This is important because 'non-doing' or 'non-being' can be a conscious act of omission, which is an action in itself. Brekhus (1998) has stated that there is a dissymmetry in sociological observations of phenomena, skewed to the 'marked'. He addresses these as features of social exploration with a focus on the unusual and the uncommon, whereas the 'unmarked' are regarded as mundane and ordinary. What he crucially identifies is that the 'unmarked' are generally perceived as passive and neutral, for example in deviance and political activism and therefore are disregarded as being unworthy of study.

Brekhus makes a suggestion that sociological study should 'reverse mark' or focus on the 'background noise' of 'the rest'. Scott (2018) asserts that this background should be inverted, which would involve *'...studying the negative space around marked social obj*ects' (*ibid*:7) which she accomplishes by considering a range of 'none' behaviours such as inactivity, inertia, absence, invisibility, emptiness, silence and quietness. Interestingly, these examples bear important similarities with behaviours identifiable within the Wellbeing Agenda as features and characteristics that would necessitate intervention. She concludes by suggesting that 'nothing' and 'not' has '*implications for 'self''* (*ibid*:15) and are productive and creative phenomena. So, the *Not Resistance* identified by Holland and Einwohner can be differently interpreted, necessarily as an act of omission, but with foregrounding it has the potential to 'unpack' meaning and make space to consider that *Reactive Resisting* may be an act of omission, which is in itself resistance, suggesting we can *'act by not acting'* (Loy, 1985). Consider the resistance identified earlier by Cloward and Fox-Piven as resistance by '*enduring*' and that offered by Cohen (2004) in lived opposition, who cite the adoption of preoccupation

with illness (and mental illness) as a site of resistance. This would also not be visible on Holland and Einwohner's original framework.

4.3.3 Collective Personal Resistance

The section examines the concept of personal resistance through mental ill health, but enacted collectively, not as a group action like protest or demonstration. This would relate to an example of 'Unwitting Resistance' in Holland and Einwohner's framework, where an action can be deemed as resistant but not detected as such by the observer. However, it describes a process through which resistance can serve to create agency. This research is also interesting as it relates to the construction of 'media' created mental health issues that were outlined in Chapter 1.

Behrouzan (2015) has researched meaning making narratives in 1980s Iranian youth around mental health issues that she terms *dépréshen*. She relates this research to the changing political and social landscape after the Iran-Iraq war during 1980-1988. She has argued that these events created a perceptual shift in sensibilities around dialogue on mental health, which included a 'normalisation' of concepts, terminology and constructs of what it meant to be mentally unwell (p.400). Behrouzan's initial focus was to research the increasing rates of depression, anxiety and suicide in the country, along with a rise in the public availability of information around pathology and treatment. In particular, she states that this enabled Iranians to express their feelings about the changes they had experienced and its impact upon them. This moved from the sphere of the subversive (as discussion of war was discouraged) to shared experiences using a medicalised lexicon that enabled communication around 'social ailments' and distressed states that were experienced by many (p.401).

Behrouzan's depicts a country that has moved rapidly towards psychiatrization in order to understand the aftermath of the war and speaks of an 'emerging discourse' of mental health, adopted by many and promoted within the media and on social media. In particular, she points to the adoption by young people of the terms of reference to pathology, collective called *Prozak* to refer to any anti-depressants. Her research suggests that the feelings of emotional distress present in trauma, PTSD, depression and anxiety had become 'normalised' in discourse and was regarded almost as a national malaise that was described a *dépréshen* (rather than a singular meaning equivalent to western understanding of depression). Her

research is an ethnography based on observations that young people were regularly using medicalised and pathologized language to describe themselves (for example in blogs) and the official statistics indicating an '*explosion*' in the use of anti-depressants (p.401). Behrouzan's aim was to consider medicalisation as a form of self-expression and agency for young people in Iran.

In Behrouzan's interviews with her participants, she identifies themes that emerge in explanations of their mental states. All described a sense of feeling depressed, all disclosed that they were taking medication and, in the discussion, all raised the issue of their feelings about the war, their experiences and how it affected their lives (for example one individual describes the children's television programmes they watched, others described the warning sirens that signalled bombings and fleeing to safety). What is interesting is that the three Iranians interviewed (Samāneh, Ramina and Dina) reported still feeling depressed, despite being very young children when the conflict happened and for one, no longer living in the country (two participants lived in Iran and were interviewed in Tehran, one lived in Los Angeles). A feature that Behrouzan's describes of her participants is how their affective dialogue is linked inextricably with the historical context of their experiences of growing up in a conflict zone. All of the subjects of Behrouzan's study locate their sense of helplessness, sadness, loss and melancholy to external factors, for example in the loss of 'coffee shop culture' and freedom to talk with other like-minded people, failures of visa applications and broken relationships (p.409); disagreements with parents and in a loss of friends who have migrated; feelings of loneliness (p.413) and uprooting due to political dissidence (p.417). Of interest is that all of the individuals within the study used terminology that related to 'suffocation' and feeling unable to 'breath', which was expressed in terms of stifling, potentially alluding to freedom and choice.

The individuals in Behrouzan's study were interviewed separately and in different places and at different times, but she references their switching between 'I' and 'we' in their accounts as a feature of their framing of meaning making (p.412) which she explains as collective social narratives and shared memories of difficult times (p.413). What is important here is the impact that the external environment they were exposed to as young children (many with vivid memories of changes in schooling during the conflict) had in shaping their memories, which subsequently informed their affective responses. They spoke sometimes in the 'I' of

their personal experience, but phrasing impacts of the conflict in the 'we', as what happened to 'us'.

She comments that *'Ramin and his peers locate hope, as if 'recovering' from this depression would equal overcoming a historical condition'* (*ibid*:414). Behrouzan suggests however, that to affect a recovery would require more than treatment of the current sense of emotional distress or melancholy, but would necessitate a reframing of history (p.414). In this respect, she questions the way that young people in Iran are constructing their identity around psychopathology as a cultural and collective response to conflict, rather than a personal mental illness. She concludes that the level of mental health issues and degree of consumption of anti-depressants (which Behrouzan suggests is in some cases self-medication, with no pre-determined or diagnosed mental health issue) is analogous to a 'broken process' rather than a broken person (p.421). She comments *'...their pasts and presents are in a dialectic of transmission: they infect, invade, haunt, interrupt, interrogate and re-write one another'* (*ibid:*421). Behrouzan asserts that she is not trying to '*pathologize a generation'* (*ibid*:421), but the findings from her research illustrates how the clinical narrative has become internalised and 'normative' as a means by which young people who have experienced conflict have created meaning and sense from their shared experiences.

The application of Behrouzan's work to the situation of CYP within the U.K can be seen in her critique of how the narrative of psychopathology and the 'self-diagnosed' disorders of the young Iranians operated to create 'collective meaning' around the experiences of their 'interrupted childhoods' (p.422). Considering also how the 'transmission' of *dépréshen* (almost as a contagion), surfaces in every layer of memory around their social, cultural and political lived experiences. In the 'rewriting' (through blogging) of the 'collective' narrative, the embodied experience of *dépréshen* becomes inexorably linked to the recounting of their history as an embodied person. The term itself has come to stand for more than a type of mental illness (within its clinical context) but has come to represent for people a range of thoughts and emotions, to represent their feelings about living in Iran during both the time of conflict and as consequence of the post-conflict social, cultural, economic and political landscape left in its wake. What can be taken from this work is that psychopathology becomes a 'currency' of communication of affect that exists outside of its clinical application, which can serve as a co-construction of the young person's history within their lived context. It is

interesting to note that the 'blogging' activity that the participants engaged within in Behrouzan's work is indicative of the style of expression preferred by the 'Porcelain Angels' in Beeker *et al*'s (2020) study, who used the same style of social media 'catharsis' to promote the benefits of treatment and medication. It would have been interesting to see whether the same perspectives on *dépréshen* existed in different generations within Iran, for example the young people born post 1990 or older people who were aged in their 50-60s during the conflict, to see whether the effect that Behrouzan describes is an exclusively a generational one.

Bajoghli (2018) has critiqued Behrouzan's work, outlining her mapping of the development and acceptance of psychiatric diagnosis and therapies in Iran, which have contributed to the collective consciousness outlining her emphasis on the importance of 'language, literature and self-expression' (p.434). Of interest here is Bajoghli's comment that a key driver of the wider acceptance, adoption and application of the clinical discourse was state media, which extensively promoted issues around mental health. This is reflective of the current situation in the U.K (as highlighted in Chapter 1) across social media, print media and wider multi-media which is promoting the 'crisis' in mental health issues around CYP. Bajoghli has referred to these as the 'clinical vernacular' (p.435) which provided a vehicle for people to communicate about their experiences following the conflict. She also critiques the study by commenting on the omission of work by religious bloggers and by identifying the omission of reference to diaspora material.

Navarro (2016) also supports Behrouzan's research and emphasises the importance of the central theme as being *'...psychiatric subjectivities arising from the medicalisation of human experiences and emotions...not necessarily the effect of top-down process of psychiatric colonization'* (*ibid*:8). Navarro comments that the infusion of the clinical narrative within Iran has been created by wider aspects within the collective social memory of recent historical events which are especially shared by the generation that were children during the 1980-1988 conflict. He suggests that the past is constantly 'kept alive' or resurrected through an 'online rendering' (p.8). Navarro makes the point that the medication is taken not for the treatment of clinically diagnosed mental illness, but as a habituated means of managing social and cultural malaise through a common lexicon which provided a 'tool' that made the meaning in their life 'intelligible' (p.8). He further outlines that Behrouzan's explanations of the

participant's emotional experiences in a medicalised framework increases their 'capacity' for personal agency (p.9) rather than detracts from it. This is due to the clinical dialogue and means of expression (if not the actual medication being taken) which has a 'transformative and transitional' effect (p.9). What he argues is that rather than identifying the participants as 'victims' of a colonizing psychiatric discourse (top-down), they have utilised the shared narrative and reinterpreted the language to take ownership of, represent and shape their experiences, for example in allowing a 're-engagement' with their external social environment and personal and community relations (p.9).

4.3.4 Connecting Resistance with the Wellbeing Agenda

This chapter has set out to establish that sociologically, concepts of resistance have expanded and evolved to encompass acceptance of resistance within new contexts. It has attempted to show that resistance does not have to be an external act (Blume and Kimelberg, 2016); the body is recognised as a site of resistance (McClaren, 2002); that affect can be viewed as resistance (Kurick, 2016), that both silence and non-action (like 'enduring') or non-intention can be resistant (Cloward and Fox-Piven (1979); Scott (2018) and Wagner (2012)). This section has also attempted to establish that resistance can be unwitting (Holland and Einwohner, 2004) and also not necessarily consciously constructed (Abowitz (2000) and LeBlanc (1999)). What has been demonstrated is that sociologically, constructs of resistance have moved from the external, public, conscious, intentional and commissioned to the internal, private, unwitting, unconscious and omitted. I have also suggested how inclusions within one theoretical model can make 'spaces and pockets' for resistance to happen and be recognised and acknowledged. In the same way that 'enduring' can be a form of resistance. It could be suggested that emotional 'suffering' is also a form of resistance because an individual only suffers through a non-acceptance of their situations or circumstances. If these were passively accepted, then anguish or distress would cease. However, in refusing to accept, suffering could be seen as a register of resistance and in continuing with that refusal, suffering is maintained.

In considering the Wellbeing Agenda, an advocacy for witnessing mental distress in CYP allows an emergent twofold path of resistance. The adoption of mental health labels, emanating from the imposition of the Wellbeing Agenda, can be considered as '*Not Resistance'* by the individuals for whom the interventions have been put in place. This is with the proviso that

Reactive Resistance is now reinterpreted considering the suggestions made by Scott (2018). It does not register as conscious resistance intentionally commissioned by the actors, it is not identified as resistance from the targeted (indeed it would be viewed as compliance), nor is it seen as resistance by the observers, who perceive only the meeting of a 'need'. Consider also that Blume and Kimelberg (2016) suggested resistance emanated from affective states that were 'marked' by significant emotional conflict and that the 'marks' left indelibly in the process of resisting were also identified by Courpasson and Vallas (2016) and Wearing (1990). It could be argued that the 'adoption' of the mental health categorisation and labelling by numbers of young people is a 'non-act' of resistance. The 'marks on the fabric' left by this form of resistance are seen in the emotional and psychological distress suffered and endured by these individuals. This now requires that the oppressor works to 'undo' the psychological distress that is a consequence of the neoliberal educational agenda which has put in place a surveillance system to identify individuals who exhibit signs of non-conformity to 'mental health ideals'. This restructuring of behaviour as pathology to encompass mental wellbeing has created pockets and troughs where resistance has the potential to be commissioned or enacted through omission.

A significant point is that the new 'therapeutic' interventions within the Wellbeing Agenda seek to 'undo' the silence, by enforcing 'talk' based therapies onto CYP which, as Wagner identifies, is an act of oppression. The therapeutic basis of interventions using techniques and practices within psychological perspectives, like the psychodynamic approach, carry with it a recognised resistance to the process of therapy that is articulated through psychological defences erected to protect the core self. This identifies then, that CYP could be interpreted as attempting to resist on a range of intrapersonal fronts. The next section will discuss how the second path of resistance emanates from the enforced intervention measures perpetrated upon CYP, in an attempt to create 'resilience' and manage the mental health label. This will link to the additional category of Reactive Resistance created within the model, which has the power to create personal and social change.

4.4 A Psychological Perspective – Resistance in Therapy

Introduction

The previous section drew on a range of sociological perspectives to argue that resistant forms of behaviour could be reframed from actions seen as macro-political, external phenomena manifest in protest, dissent and subversion; towards examining micro-political, intrapersonal types of resistant behaviour. This culminated in the identification of a subjective and affective 'corporeal' base for resistance that organised itself in uniquely personalised acts of silence, non-action, endurance, self-harm, suicide and mental suffering. These are distinct from the types of 'industrialised' resistance seen in earlier theories. It concluded with a discussion on how these resistant acts reframed the narrative around resistance and initiated a line of thought that considered how resistance around current wellbeing practices in education could be construed. In the final chapter, there will be an attempt to illustrate the convergence of these key themes; in order to support the position that education policy, in the form of the Wellbeing Agenda interventions (which dictates the necessity for resilience) is what is being resisted. This is due in part to the medicalization of education driving much of the current agenda; it is not unreasonable to suggest therefore, that aside from being 'in school' children are now, by deliberate design, also 'in therapy'.

It is important to consider what contribution can be gleaned from a psychological perspective, to assess whether the argument being asserted, that what is being witnessed is resistance rather than a mental health 'crisis', can be justifiably reasoned. This will allow consideration of how to reframe the narrative away from that of a medically driven model of mental illness, towards a more emancipatory objective of foreshadowing the reactions that are being witnessed as 'defensive mitigation', against a therapeuticised curriculum and aggressive surveillance in the creation of what Durfour (2008) regards as *'...precarious, acritical, psychotisizing subjects'* (*ibid*:42). This can be positioned to suggest that CYP are resisting the conditioning of thought, embedded within the Wellbeing Agenda as the demand for 'resilience', which is a necessary and rational response in the defence of self. A useful analogy to consider here is that the instinctive protection of the physical body by reflexive actions can be extended to include a 'reflexive' defence of the mind.

The only perspective that allows an engagement with this concept across the psychological paradigms is the psychodynamic approach. Literally meaning 'active mind', this approach is unique in that it examines the concept of the unconscious mind (Freud, 1900) and its impact on motivation and behaviour. Founded upon the work of Freud (between 1891-1939) it

suggests that, aside from the functionality of the brain studied within neuropsychological domains and the processes of mind studied within the cognitive domain, there exists a third, 'hidden' way to understand the human construct of the subjective 'self' entity. Freud (1923) argues that there is a tripartite 'topography' of mind and it is necessary to briefly outline the components of his multiple models, as an overview, before it can be used to examine what contribution psychological resistance can make to understanding adolescent behaviour, deemed to be psychopathological.

4.4.1 The Fundamentals of Freud

Freud's constructs of the human dynamic self are complex and involve an array of biological drives, unconscious mechanisms and specialist language to locate resistance into a psychodynamic framework. Freud asserts that there exists internally a series of complicated drive relationships that work dynamically to construct and protect the self-identity or 'psyche'. This is the subjective and constructed 'core' self. Freud identifies a 'landscape' to the human mind, a topography often referred to as the 'Iceberg Model' with specific components, the Conscious, where thoughts, feelings and motivations are 'known' and within mental reach, so can be considered and most usually recalled at will. Freire (1973) has labelled consciousness as '*delirious flux'* because it represents a state of constant tumult, transition and change which creates an '*inconclusive experience'* because information, knowledge and understanding constantly flow through it and are not fixed. The Pre-conscious, thoughts that are 'just below the surface' but could, under certain circumstances, becomes emergent or 'known' to self. Importantly, they cannot be willed to mind but are 'triggered'. This would effectively 'sit' at just on the water line. Finally, there is the Unconscious mind, which is the largest part. It is completely 'submerged' and not directly accessible to conscious thought.

Within the Unconscious, there exist motivational forces that influence behaviour and desire which Freud referred to as instinctual drives, namely, Eros (the Libido) and Thanatos (aggression) designated as the instinct to survive and the instinct to destroy. Repressed memories and experiences deemed too painful to hold within the conscious mind are also contained within the unconscious. A further aspect of Freud's (1923) theory relates to components of the self which includes the Id, which is present from birth, the Ego (or identity of selfhood) and the Superego, which is the development of morality, social responsibility and conformity. Perpetual conflict occurs once the Ego and Superego fully develop, as the Id and

Superego fight to dominate the Ego, which is regarded as frail, malleable and easily damaged. Ferrell (1996) has suggested that *'...unconscious is that with which consciousness struggles'* (*ibid*:1) to emphasise the symbiotic nature of the two. Therefore, in simple terms, the Unconscious is seen as a 'vessel' that contain thoughts, feelings and memories that are troubling, two conflicted strong drives or 'life and death' and the natural impulses of the Id, which is in constant tension with the Superego. These are all potentially, highly destructive forces. It also illustrates that there already exists significant conflict and struggle in the human mind, albeit unconscious. However, the products of this struggle, neurosis, are present in behaviour.

4.4.2 Defence Mechanisms and the basis of Psychological Resistance

A major component of Freud's work and the aspect that is essential to focus on in terms of resistance is the dynamic motion of the instinctual drives. Due to the disruptive force that the Id exerts, the Ego (or sense of self) is assailed and seeks to minimise the impact, using a range of defence mechanisms, such as repressions, regression, displacement, sublimation, and reaction formation. The Ego operates through the Reality Principle, which tries to manage the demands of the Id by satisfying its needs in a 'socially appropriate' way. Most importantly, according to Freud, mental illness like neurosis is created through repressed, traumas and the constant deployment of defence mechanisms in the early development of the self. As suggested by Berthold-Bond (1991) neurosis for Freud is created from the *'...path of regression, taken by the libido which creates a 'sinking back' of the developed mind*' (*ibid*:196).

Regression in this sense means a 'retreat' back, psychologically and emotionally, to an earlier stage of development where the individual felt safer, (in the earlier, psychosexual stages) in responses to threats and anxieties. This means that there is a desire to return to a less 'emotionally complex' state. Further, he identifies that '... *mental illness is a response to the developed mind's encounter with an experience of pain it cannot cope with* (*ibid:*197). What this identifies is that the Ego uses defence mechanisms, like a shield, to protect itself from the competing demands of the Id and Superego which jostle to dominate behaviour and action. The Superego is divided into the Conscience, which serves to 'punish' the Ego for transgression, by creating guilt or shame and the Ideal Self (Ego-ideal) which is the 'internal' model of the 'best' self. Therefore, the Superego operates as the Morality Principle. The Superego expands, develops and evolves over time to incorporate new values and standards

as an individual matures. However, there can be negative aspects here, as if the Ideal Self standards are too high, this can lead to constantly experiencing negative feelings of failure of humiliation.

When the Ego is exposed to the internal conflicts that external experiences can create, it 'retreats' (regresses) away from the real, or outside world into self-constructed, palliative internal mental states that are designed to reduce anxiety. Somewhat paradoxically, Freud identified that it is not possible for individuals to find constant or permanent states of happiness if an individual has a *healthy* psyche. Indeed, the anxiety provoking responses of the Ego are synonymous with a healthy and competently functioning consciousness. Berthold-Bond has suggested that when the Ego feels threatened it withdraws to the internal world to re-stabilise and seek reunification *'...all minds engage in a recurring cycle of withdrawal from the world of suffering, followed by the attempt to project a unity from out of self'* (*ibid*:197). What this suggests is that it is expected (and normal) to feel anxiety because this is a symptom of a fully functioning psyche. It also identifies that self-unity is essential to optimal function. Where there becomes an issue for Freud is when the Ego becomes besieged with demands and overuses defence mechanisms to enable it to cope. It uses mechanisms of defence to the extent that psychotic states can be induced, where individuals no longer have a grasp on the 'reality' of the outside world. Or, where Ego defences are so extensively used as to subvert and compromise the substance of the 'core self' identity. Indeed, Steinkraus (1971) cites Hyppolite in stating *'... the essence of man is to be mad'*.

So, periods of intense anxiety, categorised as 'mental illness' within the current 'wellbeing' climate, for Freud, are actually normal states of being, propagated by the defensive psychic function. It could therefore be suggested that preventing or attempting to *remove* these features of Ego defence could be potentially damaging, as it renders the Ego impotent in maintaining its instinctual equilibrium. This could therefore cause an escalation to more pathological behaviours, simply because the 'valve' in effect has been blocked or removed. An ambition of the Wellbeing Agenda is to promulgate 'perpetual happiness', to remove any feelings of negativity, anxiety or stress. However, this, according to Freud, is not a 'natural' state and would compromise effective functionality of the delicate balances within the psyche. Not least because a loss of external threat to person *diminishes* the internal

reinforcement of the 'core self' identity, which is shaped by the management of conflicts that arise.

4.4.3 Repression as a mean to Resist

It would be useful to understand the process by which repression can happen in order to understand how the need for resistance arises. Anxiety is created due to the constant and dynamic withdrawal and deflection of mechanisms used by the Ego to protect itself, in response to difficult and painful external world experiences that could undermine the Ego's ability to remain stable. Much of the stability the Ego seeks is generated through the shielding offered by defence mechanisms, one of the most frequently used is repression, which functions to keep distressing or threatening material out of consciousness. It is literally 'pushed' into the Unconscious and 'forgotten' as a type of amnesia. Crucially, according to Freud, the presence of resistance indicates that there is repressed material within the Unconscious, for which the resistance acts as a 'gatekeeper'.

Ferrell (1996) has suggested that Freud viewed the instincts that conflict within the unconscious as 'bodily energy' that demands satisfaction. To achieve satiation requires physical action where something external is brought into the body, for example food or drink. The mind is able to facilitate the body's satisfaction of the instinctual desire and it is these desires, according to Freud, that are central to the development of personal identity. Effectively as Ferrell reports *'...the mind is a product of the body's demand for some response to its need*' (*ibid*:9). This means that for the mind, the *body* is perceived as equally as threatening as the outside world because of its constant needs. In this way the mind does not *distinguish* between internal and external demands. So, conflict can not only arise from the generated internal struggle of the competing drives, but from the engagement with the outside world in satisfying them.

This would suggest that the mind is 'subservient' to the instinctual drives and is pressed into service in order to constantly meet changing needs. Therefore the mind has, by necessity, to produce a sophisticated and complex mental structure that is capable of managing the constant and competing demands of the instincts, in this capacity it forms representation, which are words derived from abstract energy forms within the unconscious, these are used as 'ciphers' to stand for, or represent something, for Freud, Ferrell suggests *'...to name an*

image, is what it means to make something conscious' (1996:62). Due to the level of complexity and polarised motivations of the instinctual energies, conflict is created from competing demands and the mind must find some mechanism of protection, by limiting the internal pressures that this situation creates, or it would risk potential dissociation or disintegration. What this suggests is that the mind also has to manage and negate the demands made upon it by the internal drive forces; it does this by creating complex representations of need. However, this process is also extremely taxing as the drives are demanding and often competing for resources to be satisfied.

Where the cost of meeting a need is too great and could result in a loss of self, the mind uses repression as a defence against the demands it is trying to satisfy, in the bombardment of representations it experiences. As Ferrell has stated *'...the mind negotiates between the need for survival and an indifferent world*' (*ibid*:10). One of the key instincts in the Ego is the instinct to survive, to self-preserve, which is a reason that protective defences are erected. So effectively, the mind is defending itself against its own conflicted processes. This would suggest that repression can logically be seen as the refusal to make a demand conscious, or give it representation, so that it can be acted upon. Freud has argued that this repressive defence is costly in terms of the psychological and somatic impact, as he believed that somatic symptoms were *'...physical expression of the psychical conflict giving the idea a reality in the body'* (*ibid*:16) such conflicted states could be seen to manifest as self-harm and anxiety. The aim of psychoanalysis has been to detect where repressions have failed, by identifying what has 'leaked' and been made conscious, which can only be observed indirectly during the therapeutic process. These constant conflicts and attempts by the Ego to defend give rise to the concept of a 'wounded self' (Wolfe, 2005).

4.4.4 Criticisms of Constructs of Repression

It is important to establish that there is disagreement between psychologists and indeed psychotherapists as to the veracity and validity of repression as a construct that generates resistance and there are multiple criticisms of Freud's metapsychology focus; for example, see Eagle (2000); Fongay (1999); Kihlstrom (1999); Klein (1969); Maze and Henry (1996); McIlwain (2007); Nesse (1990) and Rofé (2008). Freud did not 'create' the concept of the unconscious, he did however attempt to supply a clinical narrative to give an explanatory framework to enable understanding of unconscious mental dynamics and is supported in this;

see for example Bornstein and Masling (1998); Holmes (1990); Rapaport (1960) and Weinberger and Westen (2001). There is also support for Freud's application of repression as a defence, i.e., Anderson (2006); Billig (1999) and Kreitler and Kreitler (1990). Boag (2012) writes extensively on repression and discusses the 'paradox' apparent in ego defending by highlighting that this entails the ego 'knowing' or being aware of that which it is supposed to not know, in order that it can know to protect itself. This would constitute both knowing and unknowing simultaneously. However, Fayek (2005) illustrates that this is possible in explaining that the issues relate to what is attended to, so in effect there exists an 'unconscious consciousness'. This suggests knowledge can be selectively ignored or unattended to, in some cases, in order not to provoke arousal. This concept is mirrored in Bollas' (2017) work on the 'unthought known', which represents experience that the individual has awareness of but which they are unable to contemplate (for example within the Pre-conscious).

However, modern theorist within the approach would argue that the psychodynamic work is a multifaceted and versatile systemic network that encompasses a range of modalities, including therapeutic attempts to manage resistance. It broadens and deepens understanding of human mentality and the origination of problems. It can effectively explain and offer treatment for mental health concerns like irrationality, dissociation and anxiety. In what Tummala-Nara (2015) suggest are diverse cross-cultural applications. According to Fulmer (2018), the psychodynamic approach offers both etic and emic perspectives and has an exclusive focus on the experiential contribution from the individual with client perception being of paramount importance. Work in the field of repression also refers to the phenomena as Dissociative Amnesia, see Weinberger (1990).

Further, Fulmer (2018) identifies within his four key themes as contributions within contemporary psychodynamic theory that there are unseen forces motivating behaviour. Aspects of personality shape behaviour and experiences, which in turn shape what individuals become. The past, early life history and childhood experiences, powerfully construct (and diminish) self-concept. Proponents of modern psychodynamic theory are active within the mainstream of psychology, for example in the companion publication of a DSM V alternative for psychodynamic therapists PDM 2 (*Psychodynamic Diagnostic Manual*) (Lingiardi and McWilliam, 2017). Fulmer (2018) identifies other important contributions to modern

psychotherapy made in the work of McWilliams (2011) and Shedler (2010), see also Summers and Barber (2012).

4.5 Understanding how Defence Mechanisms operate to create Resistance

The previous sections established a basic underpinning framework of psychodynamic theory, which included a simplified outline of the main components of the model of mind, according to Freud. This identified the components of mind, the dynamic aspects relating to drives, a brief outline of conflicts and an explanation of repression as an operational defence it is important now to explore some of these concepts in further detail. Understanding how defence mechanisms operate gives insight into how resistance works within a psychodynamic approach. This allows consideration of how this knowledge, coupled with the earlier work on the sociological aspects of resistance, can be utilised to broaden understanding of how behaviour that represents as anxiety; for example, in feelings of unhappiness, depression, self-harm and alienation, which can be designated as mental health issues, could actually have a different origination altogether.

To analyse the aspects of resistance necessary to extend the argument, it is useful to closely consider how resistance operates psychologically, from where it is derived and how it is created. Earlier, examples of the 'retreat' of the Ego were given as a general principle of how defence mechanisms are used to deflect drive forces. A further engagement is required to ascertain how this translates to the kind of resistance that will be used to later argue against the Wellbeing Agenda. Further, it links the aspects discussed in the previous section which arrived at the conclusion that sociological research has now embraced the principle of the body as a site for resistance. Of importance here, is that the action of any therapeutic intervention *itself,* is sufficient to trigger resistance.

Critically, resistance within a psychological framework serves two specific purposes. In the first instance, it is encountered, effectively because the Ego is in a 'place of safety' and does not want to re-emerge. So, resistance can be regarded broadly as a type of defence mechanism. Secondly, resistance is created to 'repel' the intrusion into the carefully constructed defence network behind which the Ego resides, seen in the complex representations of interpretation identified earlier. This is seen in the techniques originally developed by Freud in psychoanalysis, which is an attempt to uncover unconscious conflict

and generate catharsis (unblocking through energetic release). Most often this is attempted by using therapeutic techniques like free association within 'talk' therapy. This is important because consideration should be given as to how much of the Wellbeing Agenda is predicated upon therapeutic interventions using counselling 'discussion' in therapy, based largely upon many of these underpinning principles. For example, IPT (Interpersonal Psychotherapy) is available through the NHS IAPT portal (NHS, 2018).

Initially, it is useful to consider how resistance is used as a defence mechanism. In Wolfe's (2005) concept of the 'wounded self' this internal state is created as a response to painful self-views generated by negative memories or experience, which are often then generalised and internalised. For example, in CYP this could be argued to include negative experiences like bullying, abuse or early trauma, but this could reasonably be expanded to include 'intervention' from schools, academically, which identify 'failures', or the identification and labelling of 'abnormal' behaviour such as demotivation, apathy, sadness and withdrawal that then attracts intervention. This would create negative self-views of failure or difference which would lead to anxiety. This aligns closely with the earlier description given of the Superego's Ego-ideal. Alladin and Amundson (2016) have referred to this 'wounded self' as *'...the person's chronic struggles with their subjective distress'* (*ibid*:5).

These types of experiences are often generated at times of high anxiety or stress. They further suggest that in Freud's original theory, he divided anxiety into two specific categories, Signal anxiety and Traumatic anxiety. Traumatic anxiety is displayed when the Ego becomes overwhelmed and mobilises somatic responses to manage the threat, for example panic attacks and hyperventilation. Signal anxiety is designed to alert the Ego to potential threat, in order that it can mobilise an appropriate mechanism of defence. This is to try to prevent the onset of Traumatic anxiety which the Ego would be unable to defend against. This identifies that there is a warning mechanism that the psyche deploys to avert the onset of extreme levels of anxiety. This warning mechanism can often be triggered when individuals feel overwhelmed or when they detect (consciously or unconsciously) potential threats from the environment. These warnings take the form of much of the emotional distress seen in CYP, such as shaking, blanching, nausea, hyperventilating and crying.

These dual processes operate unconsciously, so it is feasible the individual would be unaware of the mobilisation of the defences within the conscious mind but may subsequently

experience the *effects* of their inability to defend for example as a panic attack. However, as they are occurring, the individual may be unaware of the intrinsic cause of the anxiety i.e., the failure of the Signal anxiety to appropriately pre-empt the Traumatic anxiety. In this way resistance functions as a defence mechanism as it produces an early warning of imminent threat, to allow for appropriate defensive measures to be taken, 'resisting' any potential existential threat. This explanation is useful in considering how often CYP can be in an anxiety induced state, but they are not always able to explain why they feel anxious, as the signal threat was detected at an unconscious level and mobilised automatically.

Barabasz *et al* (2016) has advocated that to better understand the components of resistance to healing of the wounded self, it is necessary to first understand how the Ego or 'self' is constructed in terms of its energies. Barabasz *et al* explains this as determining if they are infused with Subject or Object *energy*. This necessitates a clearer understanding of what constitutes being 'within' the self. They argue that representations of artefacts and energies that are perceived as being outside of the 'self' are regarded as Object energy, even if that artefact constituted something within the body. Aspects that are experienced as being within the 'self' are viewed as Subject energy. How these types of designations are made is determined by the level of feeling. Accordingly, Object energy can 'activate' internal processes, but will not be regarded as *belonging* to the self. However, if a thought is imbued with Subject energy, it is designated as belonging to self. So is perceived of as being within the self. Example given in their illustration is when hypnosis causes someone to be unable to sense a limb. A similar example would be the Rubber Hand Illusion (Botvinick and Cohen, 1998). These are both representations of the transfer of subject and object energy within the mind. In the first example, the limb is clearly still connected to the body, just not under conscious control as it could be argued the 'Subject' energy is removed and so it no longer acknowledged as 'within' the body, being of 'me', 'mine' or 'myself'. The reverse being true for the Rubber Hand Illusion, where something not 'of me' is infused with subject energy and becomes 'part' of the body. This metaphor of dynamic energies is useful for two reasons, it serves to help understand how resistance can be created, but it also provides an explanation as to the basis for somatic responses.

They further explain how these energetic states are fluid in an example of imagining an internal picture of a highly critical parent. Visualising the image of the parent can cause their

criticism to be (unconsciously) felt which would then provoke anxiety. Thus, Object energy is significantly impacting the Subject self, or in their words *'...a 'not-me' is powerfully affecting the 'me'* (2016:90). They use this example to identify that these introjections, which they explain as representative interpretations based on perspective, can create disturbing and disquieting intrusions into the mind's function, creating a hostile psychological response. Most importantly, what they establish as the basis to their premise is that introjections such as this become internalised and so transform from Object energy into Subject energy. This gives such artefacts the power and traction to continually provoke anxiety that is not recognised as being 'externally' generated, but still elicits Ego defensive reactions. This subtle shift in energy is sufficient to trigger resistant defences. What this means is that resistance can be initiated by *internal* as well as external phenomena, so the resistance can be generated against internal as well as external sources. It emphasises the complexity of psychological resistance and the interconnectivity of subjective internal functions and states in its creation and maintenance.

A further illustration of the complexity in understanding resistance can be seen in Emmerson (2013) who expanded upon this by explaining that when the introjections with Subject energy become conscious, they create what he termed 'vaded ego-states', which create anxiety provoking responses based on a range of negative emotions like fear and rejection. Therefore, the individual will exhibit incongruent emotions responses relative to their current circumstances or environment. They display inappropriate reactions and feelings of disempowerment in respect of the stimulus that has triggered them. So, an example would be a CYP asked about their concentration may react very defensively and become disproportionately angry. At this time, an energetic exchange happens and the Object energy becomes the Subject energy and therefore assumes the status of 'me' and so is perceived to be 'inside' the self, triggering a defensive response.

A further component emerges in this regard. According to Barabasz *et al*, simply attenuating or paying attention to an Object will cause energy to move into it. This means that any externally derived object or process can effectively become internalised and transformed to a status of '*within the self*'. With the implication being that any negative thoughts or emotions associated with an unpleasant earlier memory or experience has the potential to be classified within the mind as being subjectively originated i.e., belonging to the 'self' and therefore

continually provide a trigger. This makes treatment with any types of therapy hugely problematic. Mostly because individuals become resistant to any type of 'top down' therapy, as the process that is provoking the anxiety may not even be accessible to the conscious mind and is believed to be generated endogenously, not exogenously. So, if an individual is asked why they are experiencing anxiety, it cannot necessarily be located as a consequence of any outside source, action, stimulus or input. It also means that constant energetic flux moves the 'causes' of such anxiety between internal and external states. Therefore, attempts to 'treat' anxiety with medication or other therapies like CBT, approaching it as a fixed and localised entity with a 'known origin' would be ineffective. For example, an 'irrational thought or belief' could potentially not even be identifiable.

One final component contributes to the potential for resistance as a defensive act. This is through integration and differentiation (Werner, 1957). This happens in early development and creates schematic memory into which all future knowledge is assimilated. Integration involves amassing concepts to expand meaning, building on knowledge that is already known. Differentiation means establishing an understanding of discrete concepts so as to make comparisons, this aspect of development is normal and adaptive. However, if differentiation is used excessively, it can become a maladaptive dissociation as to accommodate effectively, both functions have to work collectively to consciously hold a representation or image. For example, a young person builds knowledge of different types of vehicles, like cars, buses and trains and this overall establishes schematics for transport. In differentiation, difference between the components offer a chance to compare and extract more information, i.e., trains can take more passengers than a car, but a car journey is generally quicker. Losing the ability to differentiate means dissociation occurs. This could be seen as having all the pieces of a jigsaw but having no sense of what the picture is supposed to show.

This suggests that an individual will see more complex patterns of difference, but struggle to make sense of the whole. Therefore, the propensity for disproportionate responses to anxiety provoking situations is high. Barabasz *et al* suggest that this dissociation is pathologically created from early childhood and this method of representing the world creates deeper self-wounds and leads to further, entrenched defensive resistance subjectively generated to protect against the core self-integrity from perceived threat. Further, as explained, excessive rumination has the potential to transmute Object into Subject energy, which would then

trigger Signal anxiety which then provokes a defensive reaction. This is important as many therapies focus on reflection, which requires a revisiting of often trauma provoking memories. Adding to this, the denial of representation of an object seeking to 'become known' can illustrate the complex psychological schematics against which therapy is foregrounded, if it is to be effective.

Accordingly, wounded ego states are highly resistant as they have been created to separate the pain of negative emotions from the conscious state in all of the ways outlined above. The individual is motivated to maintain them as they form a shield to prevent psychological pain. Therefore, the process of therapy itself can mobilise a protective or hostile Ego state that then creates an 'internal enemy' which resists any interventions where discovery may occur. The fact that it has been successful in defending the Ego for so long means it is likely to remain. Why this is important is that Ego states can be infused with Object energy and so are not recognised as part of 'self' or as emanating from within the individual. This lack of recognition means they are not under conscious control and can further act as Signal anxieties to foreshadow emergent Traumatic anxieties, prompting cyclical anxiety patterns that are self-reinforcing and that can be triggered by the onset of therapy intervention.

4.5.1 Models of Therapy Resistance

Having considered resistance as a form of Ego defence, it is now useful to examine the alternative process of resistance from within the psychodynamic approach as an opposition to any type of therapeutic intervention. Freud (1901:312) was the first to identify what this could be in explaining that *'…resistance is the avoidance of painful affect'*. Bauer, Harré and Jensen (2013) have further suggested that the attitude of many modern psychotherapists is founded on an incorrect belief that *'…resistance is something to overcome to get to the real issues of therapy'* (*ibid*:67). In fact, they argue that resistance is the task of therapy itself, to understand what resistance is and more importantly how it is being used and why.

Earlier models have identified a range of factors that demonstrate resistance in action during therapy, for example established frameworks such as Greenson (1967) are mainstays of working with client resistance. In this model he devised two mechanisms of resistance as being Ego-syntonic and Ego-alien. If the client is demonstrating Ego-alien resistance, they are willing, able and prepared to work on its discovery. If it is Ego-syntonic, then the client is

unwilling, unaware or unprepared to accept its presence or may trivialise or minimise its potency, affect or importance.

For Greenson, the task of therapy is transformative, but in relation to changing the *type* of resistance from one to the other to effect treatment, in effectively 'removing the gatekeeper'. This involves working with the client in transition to allow the Ego-syntonic to become Ego-alien and therefore open to resolution. Once identified, the therapist's task is to understand what the resistance is trying to achieve, how it is sustained, what purpose it solves and what specific form it is taking. This is to induce a '*therapeutic alliance'* which according to Bauer *et al,* is not with the client, but with the client's Ego. This will lead to an eventual *'...working through, in which the resistances are played out, exhausted and eventually abandoned'* (2013:67). This is in keeping with Freud's original theoretical premise that resistance is, essentially, a defence against *recovery*. In this regard the geography of the two components of resistance are in different psycho-emotional locations, the defensive resistance can be identified as contained within the Ego, whereas the opposition to recovery is contained within the Id. Freud (1937b) therefore identifies a more accurate representation of this phenomena as being *'...resistance against the uncovering of resistances'* (1937:239). This relocates and migrates the focus from simply discovering Ego defensive protective 'shields', to a deeper unravelling of the repressed Unconscious conflict.

Later models to explain types of resistance have been created, which enable a clearer understanding of the mechanisms and process that the unconscious deploys to disrupt the therapeutic process. For example, Mahalik (1994) developed the *Client Resistance Scale* (CRS) which categorised resistant behaviours, taking the starting point of resistance as being an 'opposition to', and thus directed that there were five oppositional behaviours that could be encountered during therapy. These included (1) opposing expression of painful affect; this was identified as failing to successfully articulate painful memories or experiences that could enhance awareness of them in order to minimise psychological discomfort. (2) Opposing recollection of material, i.e., in giving vague detail about the self or the issue, this creates tension for the client who has a vested interest in allowing the problem to remain un-named but feels pressured into self-disclosure. This often manifest as silence or superficial chat, recollection of meaningless events or information as a 'smoke screen'. (3) Opposing the therapist; this is seen in a lack of engagement, hostility or interpersonal negativity, not

accepting views or insights and adopting a 'siege mentality' of defensiveness and non-cooperation. Importantly, Auld and Hyman (1991) suggest that the therapist can be perceived as an 'attacker' which, according to Mahalik (1994), creates the problem that *'...therapists can generate resistance, by using poorly timed and inappropriate interventions'* (*ibid*:59). (4) Opposing change; this focus on how desirable the *status quo* is in terms of secondary gain, versus the level of desire to change and lose the protection afforded by it. This is because the '*status quo'* is maladaptive and painful. This fear of changes maintains dysfunctional and detrimental patterns of behaviour. (5) Finally, opposing insight; the client rejects the insights given, which are often seen as disturbing or painful, so resistance here acts to displace self-knowledge as it causes anxiety. Importantly, Mahalik expresses that *'...resistance is not a unidimensional phenomenon'* (*ibid*:59) but is reactive, responsive, evolving and shifting in how it operates to defend.

Other assessment scales of resistance have been devised for example Chamberlain *et al* (1984) and Schuller *et al* (1991). There have been criticisms of the CRS most notably in its failure to recognise that resistance is not a discrete phenomenon and that it morphs through the interaction between client and therapist. It lacks any robust underpinning theoretical framework and it seems to suggest that resistance is either present, or not, which fails to account for nuanced resistance being present when any Ego defences are used and the utilisation of such defences, as has already been examined, constitute a healthy operational psyche. However, it has been beneficial in explaining client's behaviour in allowing the therapist to recognise signs that resistance is happening. Moreover, what is important to elucidate here is that Freudian therapists locate resistance as being within the client and present as a defensive mechanism, against intrusion into the complex, elaborate and systematic creation of the 'core' self.

This approach has been applied in explanations of the nature of resistance during therapy, for example, Messer (2002) reinforces the adaptive nature of resistance as a function to defend the Ego. The focus of therapy is to gain insight. Insight relates to understanding internal conflict, hidden motives and interpersonal patterns of behaviour that are disruptive or dysfunctional and which prevent individuals gaining satisfaction from life. The question Messer asks concerns what they are defending against, in order to maintain personal stability. There is a threat to a positive equilibrium that is being effectively compensated for. He

describes resistance as the habitual and automatic ways that clients both reveal themselves and keep aspects hidden from themselves and others (*ibid*:158). He further suggests that resistance is important because it is the way that clients can preserve a sense of autonomy and defend or protect their sense of 'self'.

Interestingly, Messer makes a comparison between resistance in the mind's psychopathology to the physiological function of the body's immune system, designed to identify, repel and destroy invading pathogens. This is a useful narrative to think more about how therapy might by regarded as an invasion, infiltration or intrusion on the defended 'self', which, one could argue, is being shored-up for a reason. Schlesinger (1982) gives a similar medical analogy in suggesting that, rather than seeing resistance as opposition, to regard it as similar to a GP taking reports of pain symptoms from a patient to determine their illness. Resistance is a communication of distress and the manner in which resistance is exhibited is the individual's method of coping with the crisis. Messer also identifies that *'...a therapist can respond to a client on the basis of their own issues, which can lead to interventions based more on their own needs than those of the client'* (2002:162). This is useful when considering the 'requirement;' to pursue action within the Wellbeing Agenda which prioritises the policy or wellbeing over the practice of wellbeing, as seen in Chapter 3.

This aspect of failure with the therapist's competency should be investigated further as it has significant implication for people undergoing therapy. Not least because there is an implicit suggestion that therapy could, in effect, potentially make matters worse. For example, Plakun (2006) has suggested that one aspect of treatment resistance in psychotherapy can be created by the therapist not engaging in the appropriate roles with clients in analysis, for example failing to manage transference and counter transference effectively can create resistance. This resistance can be present within the vocabulary, for example, the therapists may unconsciously mobilise ego defences of their own in a counter measure against the individual's hostility. What this effectively means is that in both instances, therapist and client are engaged in communication from behind a resistant wall of entrenched Ego defending. It also suggests that inexperienced therapists can significantly worsen the individual's psychological state.

4.5.2 Considering the Implications of Therapy

This section has attempted to explain some of the causes of resistance within a therapy context that are explained and illustrated with specific models of resistance i.e., Mahalik (1994). This has given defined examples of types of behaviour that are recognised as resistant within a therapy context and it has also identified how poor practice from the therapist can create further resistance. This is important for the Wellbeing Agenda because primarily, a significant number of interventional measures involve CYP being placed into 'counselling' situations and encouraged to 'talk' about the issues they are perceived as having. For example, Parker (2011:4) has stated that in 'talking' therapy *'...absences, in that which is unsaid, omitted, missing or contradicted*' are often of greater value in understanding than what is said. The issues raised above have implication for the further rolling out of the Wellbeing Agenda in educational settings; as such interventions are being carried out in schools by unqualified individuals, using psychological measures like talk based counselling and cognitive therapy. What this section has attempted to illustrate is that multiple defence strategies can be mobilised by individuals within a therapy context that put barriers in place to prevent access to the client's mental processes through psychological resistance. This is in order to protect an individual from therapeutic intrusion. It has also identified that some interventions could be creating further psychological damage and resistance due to inexperienced or unqualified practitioners. It is also important because for the majority of CYP who are 'syphoned' off into therapy, every psychological perspective is positioned within an approach that requires intrinsic challenges to the functioning of self.

4.6 Establishing Agency

A major criticism of the therapeutic work around all areas of psychotherapeutic intervention has been the issue relating to agency. This is true especially of the client-therapist dynamic, where the therapist works to support the client to develop 'insight' and experience 'catharsis' to support their recovery. Whilst the approach is significantly more equitable than the orthodox psychopharmacological and psychiatric regimens of treatment, despite the client being 'in therapy' there is still a perceived lack of agency on the part of the service user.

Within the context of research, diagnosis, management, treatment and recovery from mental ill health, medical and psychological professionals are regarded as being 'clinical experts' that

work with individuals who are labelled as experiencing mental health issues, conditions and disorders. This creates an imbalance in the health relationship with practitioner voices being regarded as authoritative because of their professional training, education, expertise and social conventions of deferral, created by perceived inequalities in knowledge and position (this is explored by LeFrançois, 2008). Further, priority (and supremacy) is given to biomedical explanations of mental illness, with a reliance of genetic or biochemical models, driven largely by pharmaceutical companies and professional reliance of diagnostic manuals like the DSM V and ICD 11.

More recently there has been an effort to engage with 'survivors' (individuals who have utilised mental health services) to access and obtain their unique perspectives on provision and delivery of mental health and care services which has been called 'Mad Studies'. An example of this can be seen in Faulkner's (2017) work that focuses on experiential knowledge from previously marginalised service users, which gives additional dimensions to research in a range of personal narratives, expanding the richness of available evidence and contesting assumptions from more traditional research methods such as clinical, random controlled and blind trial. Faulkner makes the point that when considering treatment for mental illness, it is established that benefits are derived from a range of provision which encompasses psycho-social support (like housing, benefits and emotional scaffolding through peer groups) (p.4), she argues that in austerity, these types of support are least likely to be provided, in favour of clinical interventions like medication (due largely to cost). The benefit of this type of support are, she suggests, overlooked because research that identifies that these provisions are important is deemed as *'...qualitative, anecdotal and unrepresentative'* (*ibid:*5).

Faulkner further suggests that as a consequence of this approach, in limiting the discourse around mental health to a narrow focus on clinical interventions, identities that are created through a process of navigating mental illness (which for some can be life-long) are minimised, marginalised and devalued. This means that perspectives from service users are not taken into consideration. Faulkner contrasts this with Disability Studies where subjective and experiential first-person narratives are engaged in multi-disciplinary approaches to treatment and service provision, what Jones and Brown (2013) have identified as expertise derived from lived experience. This is important because a focus on the prevailing clinical narrative excludes wider discussions that could give insight into better and more appropriate support for

individuals who experience mental health and whose perspective could be invaluable in managing treatment and intervention. This also means that discourses that are critical of, or challenge the privileged clinical and biomedical models of diagnosis and intervention are 'silenced'. Crucially, inviting service users to be equal and active contributors to research around mental ill health, what Faulkner refers to as *'...closing the distance between researcher and researched'* (2017:6) enables not only a more authentic profile of service efficacy to be established, but leads to the possibility of creating novel and alternative knowledge. Faulkner introduces this concept by discussing Standpoint Theory, which could work by mapping service users existing knowledge and theory onto clinical and decision-making frameworks for mental health treatment and support. An example cited includes Glasby and Beresford (2006), whose study involving service users as participant uncovered discrimination and abuse of service users in a review of hospital provision. Research using more traditional methods (focusing on standards, targets and the experience of staff within the service) would not have yielded this information. Whilst it could be suggested that complaints processes, satisfaction surveys or service user feedback could potentially have uncovered similar findings, it potentially would not have been contextualised in a format useful for identifying where systemic and procedural issues could be creating tensions.

Giving service users an opportunity to engage in the research process (other than as participants *within* research) is empowering and adds to the agency of service users in having control, direction and decision making in the process of their own treatment and recovery, importantly, something that can be missing for service users with mental health issues who may be subject to limitations of rights and freedoms under mental health legislation. This is especially true if utilising Survivor-Controlled Research (Russo, 2012), which is critical both of orthodox research on mental illness and the biomedical narrative of its causes, diagnosis and treatment. This emancipatory approach allows service users to maintain autonomous control over their own stories and again, is fundamental in generating agency and a sense of 'experiential authority' (p.10). For example, Faulkner indicates service users highlight a social model of mental distress as identifying factors that can explain actions like self-harm and voice hearing, more reliably than clinical research and biomedical explanations of behaviour, advocating for peer group and self-help services in support of distress, rather than medication and psychotherapy.

Moreover, the impact of groups to share experiences also, according to Sweeney (2016), allows for a politicisation of knowledge sharing and collective action. This is relevant as it is suggested by Faulkner that *'...there is a vital connection between individual experience and collective, socially situated knowledge(s) about oppression and discrimination'* (2017:15). This form of approach to research around mental health issues is also crucial as it leads to challenges of the underpinning and 'accepted orthodoxies' of diagnosis, treatment and management of mental illness that is embodied within the psychiatric and psychological discourses around '*mad people'* (p.15).

The themes discussed by Faulkner are continued in research that illustrates many of the points raised in relation to Mad Studies, linked to participatory research with service users. Faulkner *et al* (2021) investigate survivor-led research around the use of psychotherapy as a support for service users with a specific focus on the assessment process and the 'gatekeeping' function it performs in treatment access. The research examines themes of disclosure and withholding around shared information in IAPT psychotherapeutic assessment interviews and provides information around a range of considerations when such assessments are enacted, for example the sub themes identified as the focus of the research included trauma and desperation, fear of judgement, trust and safety, deconstruction of self, hope and balancing sharing and withholding of information (*ibid*:1). Faulkner *et al* suggests that a problem with assessments is the *'...reinterpretation of experiences through the prism of illness and diagnosis which can render it almost impossible for individual storytelling and meaning making'* (*ibid*:2).

This 'reinterpretation' through a biomedical/therapeutic lens is the 'deconstruction' of personal narratives that are discussed in Mad Studies. Utilising survivor-led research enabled services providers to conceptualise issues raised by service users such as re-traumatisation, the attitude and conduct of therapists conducting the research and importantly, the 'respect for the journey' that service users had travailed in the process of their illness and recovery. These 'outsights' (Smail, 2006) are invaluable contributions that can *only* be given by someone who has experienced the process of therapy from a user's perspective. The conclusions relating to the 'dilemma' faced by service users in balancing what to share and withhold, offers a range of rich information for future planning of IAPT provision. This point also links to the work carried out by Risq (2014) who identified major concerns around the provision of

the IAPT programme, especially in relation to the bureaucratisation of target driven policies within the service, for example citing appointment timings and 'housekeeping' issues above the delivery of quality health care.

The concept of Survivor-Studies is further supported by Butler (2001) who has suggested in her research of 'giving an account of oneself' that taking a subjective frame of reference for the self and discussing the 'I' in a range of context, which includes personal narratives, stories and histories, may be problematic, citing that *'...the only way to know myself is precisely through a mediation that takes place outside of me'* (*ibid*:23). This is because the 'I' has to be constructed in the co-creation of 'self' with the 'Other'. In this respect, it lends support to the concept of survivor and self-help groups as an affirming and functional process to generate semblance. Butler's work forces a consideration of the extent to which an account of oneself can be given, arguing that personal narratives can be disorientating and only construed through an ethical reciprocation from the present 'Other', which necessitates a degree of vulnerability. She suggests that this is because we cannot speak with 'authority' about our own life as *'...the 'I' cannot tell the story of its own emergence, and the conditions of its own possibility, without in some sense bearing witness to a state of affairs to which one could not have been present, prior to one's own becoming, and so narrating that which one cannot know'* (*ibid*:26). This is not to say that the 'self' cannot be 'know'; but rather, as Butler suggests, that there is an 'opacity' to self that is construed in the recounting of one's thoughts and actions that are reliant upon the 'Other' to intersect. Butler refers to this as *'...my story always arrives late'* (*ibid*:27). She argues that in constructing this 'account' it has to be given to the 'Other', we cannot give an account without the presence of the 'Other', indicating that expression is performativity and that without 'Other', we are effectively 'wordless' (Butler and Berbec, 2017). Moreover, Butler suggests that in sharing these exposures, or narratives, there is provided a basis for resistance. Reflecting on concepts of resistance using the physical body seen in both De Casanove and Jafar (2016) and McLaren (2002), Butler identifies that both protest and vulnerability (to precarity and austerity) are also manifest in bodily enactment.

In further work on vulnerability and resistance, Butler (2014) identifies that 'spaces' of appearance occur during the process of embodied political action to foreground 'the disappeared'. Referencing those marginalised and alienated groups that include gender and

cultural differences, race and religion, 'undocumented' peoples and others deemed by specific societies as 'disposable persons' (p. 4). Butler expresses the need to enable alliances between marginalised groups within society to act as a political lever against precarity, which she determines as a condition created politically through the pursuit of neoliberal policies, which cause a disintegration in the social and economic support networks of marginalised groups, leaving them differentially exposed to poverty, violence and injury (p.5). In simple terms, Butler suggests such groups can be identified by asking of policy changes '*Whose safety and well-being are now at risk of being compromised?*' (2014:5).

Butler (2014) also considers aspect of vulnerability that link to the creation of 'discursive categories' (p.1) which she includes as labelling and name calling. Identifying that labels which are bestowed upon individuals have in themselves a power to shape discourse, she argues that there is a 'performative' effect in the action of such naming, because of what the naming represents and the expectations it creates in the presence of the 'Other'. This could be seen in the example of labelling with disorders previously discussed of ADHD, depression and anorexia, where Butler states that the level of regard that is given is correlated with the name/label to which the individual has been ascribed. This theme is reflected in the 'respect for the journey' and attitude of the therapist components of the Mad Studies examined by Faulkner *et al* (2020) as a condition of disclosure during psychotherapy assessments for IAPT. In Butler's (2014) work, she speaks expressly around gender discourse, but the points she makes can be appropriated to reflect discourse around the 'naming' of mental health issues. For example, in reference to gender conformity, she states *'...we can describe the powerful citational force of gender norms as they are instituted and applied by medical, legal and psychiatric institutions, and object to the effect they have on the formation and understanding of gender in pathological or criminal terms'* (*ibid*:7).

4.7 Summary

This section has examined the creation and function of resistance from within a psychodynamic perspective, in order to balance the argument against the sociological narrative as complementing, rather than competing explanation for the high levels of distress reported by CYP. This approach was used to illustrate that by selecting different perspectives from within psychology (rather than the dominant biological and positive psychological approaches) the argument is give a different complexion. A focus on aspects of theory such

as the use of defence mechanisms, types of anxiety, energetic drive patterns and internal defensive states were examined to illustrate how resistance is internally constructed as a protective shield, designed to maintain Ego integrity.

The chapter set out to address Research Question 4, to determine whether the intervention measures of therapy, in response to wellbeing policy, has created a type of interpersonal resistance. The perspectives were able to illustrate why interventions from within the wellbeing programmes would fail to impact levels of anxiety and in some cases may actually exacerbate them. It also illustrated that the drive to create perpetually 'happy children' is, according to Freud, fundamentally in opposition to the natural functioning of the psyche. It was also able to demonstrate the potential harm that could be created by 'counselling' intervention in the wellbeing remit as 'talk' therapy, especially when conducted by untrained individuals with no understanding of the complex intrapsychic devices that exist to manage internal and external conflict states.

The sophisticated interconnectivity of these mechanisms of defence has also illustrated how incongruent and hostile emotional reactions and responses can be triggered when attempting to alter core-self operations. This 'undoing' of the self in the Wellbeing Agenda can be seen in simplified terms as the Ego's realisation that its experience of distress is being undermined by interventions that attempt to unravel its defensive actions. A physical example would be that a child is told not only that the fire is not burning its hand; but that it should not be complaining about the heat. When represented in this way, it illustrates the threat endemic in the agenda of 'wellbeing'. It can therefore be suggested that evidence from within the psychodynamic approach supports the assertion in Research Question 4 that wellbeing interventions can be a trigger for resistance in an educational context

CHAPTER 5 – DISCUSSION

Introduction

This thesis began by outlining that research within education should work to promote social justice, raise awareness of oppression and criticise current policy and practice where it can be perceived as failing to confront inequality. It cited the outlines incorporated into Denzin's (2017) framework which specified that ethical research should create intention to operate outside of 'spaces' that seek only to maintain the hegemonic social order.

The premise of this research was to provide an alternative position from which wellbeing interventions could be considered. The research was structured around four questions based on threads of representation, alienation, resilience and resistance. This was in order to establish why the statutory interventions created through a raft of guidance, policy and legislation had thus far, seemingly failed to reduce the number of CYP being reported as having a mental health issue. Research Question 1 concluded by stating that there was no recorded increase in clinical mental health disorders and used the NHS Digital (2017) survey, underpinning much of the increase in intervention, to illustrate that there was not an actual 'crisis' in mental health as statistically, the rise in numbers of CYP experiencing mental distress was not significantly higher than earlier surveys. Moreover, much of the reported 'crisis' was extrapolated from estimates and assumptions from within the survey data. This related also to the language that was used in reporting, which perpetuated the impression of an expansion in mental health issues, for example using terms like 'may have' an illness, reported to *have* a condition and by association, a disorder. However, it did find that there were higher recorded incidences of emotional distress in CYP, seen from the significant increase in referrals made from within educational institutions to secondary care routes.

Research Question 2 identified that there was sufficient evidence to assert that changes in the context and economic basis of many educational settings due to marketisation could be shown to have increase the experience of alienation in CYP. The effects of alienation can present in ways that manifest as anxiety, strain, tension and stress leading to an increased reporting of 'mental health' concerns, which reflected the increased levels of referral seen in Chapter 1, especially through primary care routes and education providers to CAMHS.

Research Question 3 assessed where the 'wellbeing' narrative had originated and examined changes in government priorities, most notably tied to PISA survey outcomes (especially of 2015) to illustrate that interventions in social and emotional behaviour management were reactive in shaping policy to redress perceived economic incapacities in U.K CYP. It cited that the Wellbeing Agenda had been 'fetishized' and was positioned not from a place of compassion and care for mental and emotional distress but for measures of affective control. It also suggested that the wellbeing interventions themselves could be responsible for generating the reported increase in issues of mental distress. It further examined how the wellbeing narrative has created strategies to promote 'resilience' as a core principle which have had a detrimental effect on CYP's self-concept.

Finally, Research Question 4 assessed whether the reported 'mental health crisis' could be repositioned as resistance to both the alienating experiences of marketized schooling and to interventions through the Wellbeing Agenda which aim to 'normalise' affective function. Consideration was given to psychological approaches to resistance from within psychodynamic theory, which has a tradition of understanding resistance against therapeutic intervention. This was also examined from a sociological position to consider locating the body as a site of resistance, which was achieved using research, for example by Courpasson and Vallas (2016). This comparison was only possible due to changes in perceptions of resistance in the discipline of sociological in recent years with a refocusing on personal and micro-social types of resistant behaviours.

5.1 Alienation and Resistance

The research has also illustrated that socio-economic factors are diminished or ignored within educational context when determining 'wellbeing', in spite of manifesting issues potentially having a political and economic cause as Moncrieff (2018) and Gill (2015) have suggested. Martinez (2005) has stated that all assessments and interventions constitute a political act. In this regard it is relevant to reconsider Reveley's (2013) point that school strategies in the form of wellbeing intervention programmes are the product of 'cognitive capitalism'. Which use the psychology disciplines to exploit Isin's (2014) 'neuroliberally' driven technologies of affect to measure 'capacities' and 'dispositions' in self-audit, which are assessed against artificially conflated and politically engineered metrics of 'desirable' behaviours. Reinforcing that such devices are focused less on authentically redressing the inequalities inherent within the

system that creates alienation and more on 'mindfulness' and 'self-awareness' to distract individuals away from comprehending their own oppression. As Knight (2014) would argue, 'keeping the secret public'. This state of keeping individuals vulnerable creates, as Reveley (2013) has stated, a reduction in resistance possibilities. This re-visits Ferguson's (2017) argument that the objective of treatment is to alter the individual's world view, to accept their oppression and alienation by becoming resilient to it; it does not seek to remove inequalities in the processes and systems within which they are forced to exist.

The 'crisis' identified in the first chapter, if viewed as the psychological harm of alienation, can be recognised in Van Haute's (2013) suggestion of a patho-analytic principle, where individual state of distress are reflected in the psychological state of the wider (CYP) population. The 'collective mental distress' could be construed as establishing a socially patterned defect (Fromm, 2002) created through the structural pathogenesis discussed by Sell and Williams (2020). The capitalist realism described by Fisher (2009), the lack of reimagining a world existing outside of capitalism creates '*reflexive impotence'* in the attempts of 'non-protest'. This is supported by Hardt and Negri's (2012) view that there are no 'spaces' left outside of capitalism, it necessarily identifies that 'pockets' where resistance can be enacted must now become more 'personal'. The spaces in which to resist constrict further in legislation such as the recent *Police, Crime, Sentencing and Courts Bill* (GB. Ministry of Justice, 2021), meaning new methods of 'protest' are required to be found as 'traditional' forms of sociological resistance diminish. Rosales and Langhout (2019) have identified that oppressed individuals who exist within '*tight spaces'* must resist covertly and in ways not detectable by individuals who live within privilege or who '*exercise state power'*.

It therefore follows that if resistance is being created through the processes and operations of capitalism, via the impact of alienation. Then none of the diagnostic criteria or wellbeing intervention strategies that are implemented will be adequate or sufficient, because they do not recognise the underlying cause of mental suffering as being external to the self. It would necessarily follow that if the reasons for mental illness have been erroneously fabricated as being biochemically created, then 'treatments' would be ineffective in resolving the problem. Such interventions do not focus on supporting alienated individuals with the distress caused through their suffering, but instead subjugates their authentic feelings of despair into strategies of emotional suppression and 'self-regulation' through the creation of 'resilience'

training. In this respect, resilience can be positioned as a measure of 'counter-resistance', as it seeks to 'fold back' resistance onto itself to supress and subsume its effect, in ways similarly described by Allen (2014). The further point here is that a perpetual expansion in resilience is required because of an ever-increasing range of social injustices, with ever-decreasing alternative strategies.

A potential explanation of this concept can be found in Elliott (2000) who makes a useful distinction between the internal mental states typified by descriptors used in the psychopathology of mental illness, such as anxiety, sadness, isolation and misery and alienation which he regards as *'...an incongruity between the self and external structures of meaning*' (*ibid*:2). He identifies further that where alienation exists, it must be from 'something'. Thus, the incongruity occurs, not through a 'schism' in the internal comprehension of self (or one's own mental processes, obsessions or neurosis), but by the separation from an external point of reference. His examples include family, community, faith and friends. Therefore, both the cause of alienation and the subsequent affective response to it are created from an external locus of control and are not generated from the cognitive constructs of mind. Alienation thus moves from the outside in, not the inside out and therefore cannot be 'repaired' internally.

Elliot makes reference to three constructed categories of alienation; *personal*, which he summarises as feeling alienated from the affiliated groups the individual inhabits; *cultural*, which he explains as a type of displacement, (for example in migration), and finally *existential* alienation, a more complex construct which in part refers to feeling distanced from internal beliefs, values and ideologies, *'...this is not just realising that your own particular castle is built on thin air, it is realising that you are built out of air yourself'* (2012:6). In all of these examples can be seen traces of Marx, Marcuse and Fromm's view of alienation. Elliott regards this as being a wholly disorienting experience, causing significant psychological challenges to the individual to reconcile and moreover being no easy matter to restore, as such separation destabilises the edifice upon which constructions of self are founded. He regards then, not that there is a splitting of the self, but that there is rupture in the relationships between self and others and in the concordance of intrinsic beliefs and world view. Therefore, in the separation 'from something,' it is both a removal of the ability to function socially and the distancing of the mind from its own constructed core beliefs. Mills (2014b) has further

positioned concepts of displacement of self in alienation by considering psychological responses to extreme distress *'...the idea of taking yourself from your own presence seems to resonate with stories of how some people use dissociation to escape the trauma of their immediate surroundings'* (*ibid*:216). This (literal) fracture from self as 'splitting' is a consequence of profound emotional affect.

In this regard, Elliott posits a dichotomy; if the 'measure of success' for psychiatry, psychology and mental health professionals is internal mental wellbeing, then it follows that a sense of alienation, which is not an internal emotional state, is unable to be 'cured' by medication or counselling. The issue is that psychiatry and psychology cannot address the complex dissonance caused by alienation, as the alienating process is embedded in society, as suggested by Gereluk (1974), but reflected within the individual and further; because it is not possible to address the affective response to alienation, only the description of how alienation feels for the individual. In this regard Boler (1997) has already identified that linguistic descriptions given of feelings and emotions are problematic. Especially in considering that much of the psychology-based treatments are constituted around 'talking therapy' which holds as a fundamental central tenet the ability to accurately identify, explain and express feelings. Therefore, this provides no substance or solution to the eradication of feelings of alienation, not least because a sense of alienation is induced by external, social and economic factors, which are mirrored in the internalised emotional state. What this does suggest is that treatments can be used to mitigate the level of felt alienation (expressed through affective dissonance), but the reality of enduring the suffering caused by alienation in the external, lived world remains. Already addressed is the position of suffering or enduring as a mode of resistance.

In this regard, individuals are forced to create a deliberate 'incongruity' between their felt emotion and the external reality. This is because the interventions are aimed at altering perception, not at changing conditions. This feeling is hinted at in the description given of existential alienation described above, where the individual becomes separated from their own internal ideology. Elliot reinforces the point by identifying that *'...one cannot simply fix everything just by changing one's own individual outlook'* (2012:7). Which can be seen in comparison, as previously mentioned, with Ferguson (2017) stating that the *aim* of therapy is *'...about changing the way you see the world, rather than changing the world'* (*ibi*d:5).

However, Elliott's work is not unproblematic. Whilst it serves as a very useful example of the importance of considering that medication, especially with antidepressant drugs, cannot redress the dis-ease created through alienation, for example those caused by feelings of being alienated *from* something. This is due to the emotions being induced not by an internally directed state, but through an externally reactive one. It highlights that the only intervention offered is to minimise the intensity of the discomfort experienced by people as a result of their alienation. The difficulty is that the felt experience of alienation is often obscured by explanations of internal feelings *expressed* as psychopathology, as Boler (1997) has suggested. A further point to raise here comes from Bollas (1987) who states that some individuals adopt what he refers to as a 'normotic' personality which is typified by a rejection of the subjective felt experiences. He defines this as individuals having an exceptional 'drive' to be normal, which he characterises as emotional numbing. He asserts this consists of *'...a self that is conceived as a material object among other man-made products in the object world'* (Bollas, 2018:87). Further he identifies that psychoanalysts are becoming aware of mental health issues caused by *'...partial deletions of the subjective factor'* in response to managing distressing emotional states such as dissonance and dissociation (*ibid*:87). This could be reinterpreted as the '*automata*' that Marcuse (1964) describes as the denuded self-state that is experienced through the process of alienation. When an individual loses all subjective feelings and becomes just 'object'.

Considering his explanation further, it is difficult to rationalise Elliott's position that, if alienation is, as he suggests, a separation from something external to oneself, it is unclear how his explanation for existential alienation, *'...questioning the very terms on which a life is built'* (2012:5) is in any way 'external' to the self, as his earlier account of alienation implied. This somewhat undermines his argument, unless it can be repositioned to consider that alienation does not come from the perceived self-construct, ideologies and internal values, but from the *realisation* that the constructs individuals are being pressured to hold are ambiguous, illusory and at odds with their lived experience and their own construct of 'self'. This would be illustrated by the 'resilience' programmes present within the interventions of wellbeing. The substance upon which these beliefs are founded would therefore be a fabrication. They are designed, through treatment, medication and therapy to shape a world view that creates a paradox between the affective constitution of the internal self-state and the expectations required of the 'normalising' hegemon. This would indeed represent

alienation from an 'assumed know', which could be destabilising to the self, it further contextualises the purpose of resistance against such intrapersonal intrusion, but also creates 'space' as a means of divesting false consciousness.

5.2 Alienation from Self as a Colonial Legacy

Hook (2005) and other researchers (e.g., Bhabha, 1983) critique explicitly the impact of psychology in creating alienation, in what he terms the 'identity trauma' (p.475) of black experiences. He suggests this type of alienation is unique to black and ethnic minority groups, arguing that this failure to recognise how psychology is implicit (and instrumental) in maintaining these disparities identifies 'gaps' in the approach taken within critical psychology, effectively rendering it colour-blind. Hook suggests that this act of omission prevents contributions from psychology being used as a mechanism to confront racism, which is a fundamental aspect, along with politics, in understanding the components that constitute 'othering' and 'alterity'. He extends this point further by identifying that critical psychology can be understood as *'...the systematic examination of how dominant accounts of psychology operate ideologically, and in the services of power'* (2005:477) which he implies 'limit' the types of criticality that psychology can actually level against itself. Hook goes on to suggest that critical psychology could provide a dual focus, for examining the relationship between psychology and power (in terms of its use as an oppressive force) and also to destabilise unequal power relationships for the social good (p.477). He further maintains it is important to examine the *ways* in which critical psychology is and can be critical, rather than dismiss the disciplines attempts at critical reflexivity, identifying contributions from Hayes (2001) in highlighting the necessity for psychology to address 'injustices and inequalities' (p.47).

An example of the contribution that critical psychology could make in Postcolonial Theory can be seen in Fanon's (1986) writings in his work *Black Skin, White Mask*, where he explicitly calls for a psychoanalytic approach to consider the layers of violence and oppression that exist within colonialism and racism. Hook uses Lebeau's (1998) term of 'psychopolitics' to describe this dimension of criticality, which Hook expresses as *'...the critical movement between the socio-political and the psychological, each of which becomes a means of critiquing the other'* (2005:479). Fanon writes with the intention of not only exposing the power relations endemic within colonialism but attempts to use psychoanalytic theory as a political instrument in order to generate resistance to these powers. Fanon conceptualises the tensions, conflicts, violence

and dysfunction that is the experience of being a black subject living in a socio-political environment of white domination, in particular he references 'white masking' and 'lactification' (p.479) as a method of coping within the dissonance (and dysphoria) this forced environment creates. Fanon articulates terms like 'inferiority' as a socially constructed response to the neuroticization of 'whiteness' created through the 'cultural subordination' (p.479) that is felt by the identity violence of colonial force, in its displacement of the self from its own cultural norms and values.

This is relevant because not only are the cultural values and norms of the coloniser's 'alien' to the colonised, but a primary driver of such values is the degradation and hostility that accompanies the view of the colonised as 'othered'. Fanon illustrates this point by relating the emotional and psychological burden of 'acting white' that cultural imperialism demands, but further where 'whiteness' becomes 'interpellated' into the black psyche, creating what Fanon describes as a problematized identify in '*pathologies of liberty'* (1986:81). The intrapsychic dynamic of identity conflict is coupled with the extrinsic impact of overt racism to create racial objectification (p.480) that is brutalising. In rearticulating Hook's initial criticism of critical psychology, he suggests that ascribing to 'purist' forms of psychology (in focusing on biology, cognition and emotion) ignores the physical behaviours that emerge from it, especially when they are physical enactments of racist expression, which Hook concludes *'...abstract pressing political contexts out of consideration or analysis'* (2005:480). This abstraction, according to Hook, is problematic as it ignores the impact of systemic, material and institutional relations to the physical and verbal enactments of racism which he suggests 'underwrite' experience of psychological existence for those individuals living within an internally and externally colonised environment (p.480).

Fanon has articulated the extent of damage inflicted upon individuals living in this duality as being not just as colonialisation of culture, land, values and history, but of 'the mind' (1986:14). In considering Fanon's work, it is essential to be mindful of the historical issues within domains of psychology like the clinical diagnosis and treatment of mental illness, the recognition by many researchers of the disparity in detention, access to services, provision of services and engagement with treatment of black and ethnically diverse people (highlighted in Chapter 1) and in recent research, most notably by Kapadia *et al* (2022), in reporting

disparities in provision of mental health services and support and Ayodeji *et al* (2021), in calling for exposure to racism to be classified as an ACE.

Bhabha (1984), writing around colonial discourse reflects similar themes to Fanon in his work around 'mimicry', relating to the 'white mask', referencing the use of mechanisms to create 'camouflage'. This does not suggest being hidden, but rather the 'I' being obscured from view as an authentic self. He relates this as having a twofold meaning, the mimicry present in the colonised in 'imitation' of the coloniser and the representation of the colonised in the eyes of the coloniser, towards increasing homogeneity *'...colonial mimicry is the desire for a reformed, recognizable Other, as subject of a difference that is almost the same, but not quite'* (*ibid*:126). He further identifies that mimicry, which is imitation not identification, is constructed around ambivalence. Bhabha suggests that such imitation is ironic, as mimicry *'...emerges as the representation of a difference that is itself a process of disavowal'* (*ibid*:126). He identifies this state of being as 'white, but not quite' (p.130). Bhabha remarks that whilst this process is psychological and emotionally debilitating for the colonised, reflecting the mental strain outlined in much of Fanon's writing, he takes an additional position that such mimicry is undermining to colonial power, this is in respect of the 'distance' that it effects. The 'impersonation' is not authentic, as Fanon has stated, it is a mask, both Fanon and Bhabha state that this results in 'slippage' (p.127), but for Bhabha the 'gap' creates a place for resistance as there is no identity behind it, which can be critically read as disrupting the authority of colonial discourse (p.129). It is this 'partial presence' behind the 'mask' that is a threat to the colonial authority as it has not been able to successfully induce *internalisation* of colonial or imperial values, traditions and beliefs, what Bhabha refers to as 'colonial narcissism' (p.130). He suggests that mimicry as camouflage is imperative as it does not 'harmonise' repression, difference (or resistance) by absorption, but rather creates 'resemblance' that *'...defends presence by displaying it in part'* (1984:131).

5.3 Existential Alienation

A psychological theory that enables better understanding of increased levels of psychological and emotional distress created through alienation can be found in concepts of Existential Isolation (EI) for example Bolmsjö *et al* (2018); Breitbart (2017); Helm *et al* (2019); Larsson *et*

al (2020) and Van Tilburg (2020). Social Isolation could be felt by the absence of others for example through alienation, which may be derived from the sense of feeling alone, even if not *literally* isolated from others. Helm differentiates this type of isolation as being unique because it does not simply refer to experiencing loneliness or not being within a social group, it relates specifically to *'...the sense that others do not validate one's subjective experiences of reality'* (2018:4), which also links to Butler's concepts of being 'wordless'. This can be linked directly to explain how the Wellbeing Agenda can itself create alienating and isolating experiences for students, which then leads to existential crisis. This can in part be created by practitioners failing to recognise or validate the lived experiences of many CYP within education practice. Rather than inequalities and injustices being prevented or eradicated, CYP are instead faced with programmes to instil 'resilience', which is to deny the essential truth of their oppressed state. This is because as Matthews (2019) identifies, capitalism has no ability to prevent deterioration in mental health. This 'forcing' of a 'normalised' world views onto the individual means that their external reality is denied. Intervention programmes ignore socio-economic and socio-cultural experiences and focus instead on convincing CYP that they are in some way 'defective' in functioning and must subject themselves to regulation or medication. This issue is important as it has impacts on the rights of the individual agency of CYP and relates to their sense of existential isolation.

LeFrançois (2008) has researched CYP's experiences of inpatient mental health care at an adolescent unit, from the position of children's rights whilst accessing services. This emphasises what she terms a 'coercive' agenda in relation to the CYP participation within their provision, where locating the individual CYP as 'vulnerable' through their perceived mental health issues also deems them to be 'without capacity' in making decisions relating to their own treatment and care. This is despite legislation making statutory provision for consultation and collaboration with children in the care that they want to receive. Her criticism is structured around the adult professional's ability to deem or determine what level of 'capacity' a CYP possess and, by association, what contribution they can make to 'rational' decision making around their own care. The thrust of Le François' argument is the vague terms that constitute legislative responsibility, cited from the *Mental Health Act* [GB. Department for Education, 1983], as considering emotional maturity, along with psychological state and intellectual capacity. This is because all of these terms have no concrete measures, so are based on the individual or collective view of the adults in charge of their care. She further

argues that, rather than emancipating children as equal participants in the decision-making process, this type of terminology *'...reinforces the accepted cognitive inequality of children in relation to adults, which helps them to maintain the status-quo'* (*ibid*:212). The impact of this position is to locate children as passive receivers of care, highlighting also that the 'best interest' argument used by adults is coercive in co-opting children's power, effectively vetoing their choices and interests by using claims of 'protection' as a means to disempower children, effectively 'silencing' them.

The importance of these strategies is explained as a means to maintain both social control and sustain adult interests, which relate to working practice, operational efficiency and programme effectiveness, rather than collaborative care. A key finding of the research suggested that not only did children feel their voices were not heard, but also that where attention was paid to their requests, expressed preferences or choices, this was only at points that concurred with existing adult clinicians' views or beliefs. Concern was also expressed by the children that failure to comply with treatment programmes, interventions, medication regimens or cooperation with professionals incurred consequences that ranged from refusal of home leave, suspension or discharge. An important aspect of Le François' research is in concluding that involvement and participation in the group and other therapeutic activities was not only demanded, but the nature of the participation and interaction was prescribed and enforced by the adult clinicians involved in the CYPs care. Why this is important is that it removes agency from the CYP receiving treatment, based upon the view of the adult practitioner. Interestingly, she also advocates that *'...the protectionist arguments relating to their [the children's] need for safety was often explained as a barrier to participation and was used as justification for not allowing the young people a voice'* (*ibid*:223). Le François' concludes by stating that the treatment of the young people within the unit researched constituted an assault on the rights of the child and an abuse of power. She further emphasises the use of 'participation' as an oppressive mechanism of practice to denude individual agency. This creates disempowerment and 'enfeeblement' of children, who become viewed as lacking capacity to make rational choices, based on their inability to comply with treatment programmes. This research is an ominous foreshadowing of the rising intentions within the Wellbeing Agenda. This includes the 'forced' inclusion in mental health and wellbeing activities within schools for children deemed as having 'problematic' attendance or behavioural issues; the sanctions in place for 'failing to comply' with agreed

actions and interventions; the positioning of teachers as 'mental health' police in identifying CYP for intervention and also the consideration that, the units described by Le François' are the very institutions that many CYP will find themselves in as a result of the School – CAMHS relationship. This links also to the enforcement of participation in wellbeing 'initiatives' under the auspice of 'safeguarding' and 'protecting' the CYP.

These actions can create within CYP a sense of Existential Isolation (EI) which is supported by theorists like Yalom (1980) who suggests that EI is created through the different ways individuals experience external input from their social environment. Pinel *et al* (2017) was able to correlate EI with alienation in the *Existential Isolation Scale* using Spearman's Rho to achieve (r=.32) showing a moderate positive correlation. This metric does not claim to measure mental health or wellbeing; it attempts to assess the extent to which individuals feel isolated from those around them.

In furtherance of this work, Helm *et al* (2019) introduces a *State Trait EI Model* which suggests that individuals mediate their experiences of their world through their sensory experiences of it. In this regard they are isolated on account of the uniqueness of their experience, but most usually shared constructs of experience can be established with like-minded individuals or groups of people. This sense of isolation may intrude into consciousness under the influence of situations or events which create a sense of aloneness of being. Helm divides this into State (situation) and Trait (disposition) EI which has the potential to create emotional distress. State EI can be elicited by inter-group comparisons or an activating event (like being alone in holding a strong opinion). These are usually singular experiences that can be overcome by moderating exposure to lessen the impact of the negative experience and re-establishing mutually shared experiences with others. However, if the individual experiences perpetual State EI events, or is unable to satisfactorily reduce heightened states of EI by mediation, then this can become a *'...stable internal trait of individual difference'* (*ibid*:10). Helm differentiates this by identifying that State EI prompts positive action to ameliorate its effect, for example in considering views of alienation from the 'universal self' (Fromm (1963) critiqued in Smith (2020) in the recovery of lost self-harmony); whilst Trait EI creates negative reaction of withdrawal, distress and a sense of hopelessness. Established Trait EI can in the long-term increase individual's vulnerability to a range of negative mental health aspects like anxiety and suicidal ideation (Hayes *et al* (2008)). However, these are created as a response

to the alienation felt through Existential Isolation, not because of pre-existing internal disorders of mind; in this regard it can be argued that the alienation experienced is the *cause* of mental distress.

5.4 A Singularity?

Throughout this research, there has been an intention to create a 'singularity' which could harmonise the narrative on resistance between the disciplines of psychology and sociology. Not a 'place' of agreement, but a 'space' of concordance around which the tensions inherent with their respected observances of resistance could align. This is a challenge as it requires satisfaction from a range of fields within psychology, for example the cognitive, biological and psychodynamic.

This research has stated tentatively that the increase in mental distress seen in CYP (as damage to the core self-concept), was manifest from a position of intrapersonal resistance, a defence of the 'self' mobilised to preserve psychic integrity. Thus far, changes have been traced in the meaning and construct of resistance over time from a sociological perspective and resistance within the psychodynamic approach has been assessed from a psychological perspective. The evolution of sociological theory in this case has allowed for an acknowledgement that resistance is not just enacted within the external social environment. It has also been recognised as taking place within a personal internalised domain through the work of researchers like Courpasson and Vallas (2016); DeCasanove and Jafar (2016); McLaren (2002); Sutton (2010) and Wagner (2012). Locating sites of resistance into the human body and mind has allowed for an expanded understanding of what it means to offer resistance, whether this is intentional or non-intentional, enactment or non-action, silence or endurance. This indicates that sociology has therefore 'moved inwards', in contemplation of resistance as being generated from and enacted *within* the self as a means or indicating protest, defiance and subversion.

In this regard, psychology also needs to make a similar theoretical shift, harnessing a converse expansion outward, to allow contemplation of defences of the self to be linked not only to external environmental triggers that solicit internal defensive responses to perceived psychological threats; but to social aspects arousing responses because they are integral to self. This is in order to move towards a theoretical position of considering the self as not solely

internally constructed or defended, but subject to overlapping social influences in its basic orientation. This is considered in much social psychology for example in Festinger (1957); Leary and Cox (2008) and Lieberman (2010); but these positions do not relate to the internal mechanisms of defence found within the psychodynamic approach. More essentially for the purposes of this research, a map needed to be found that allows the creation of a 'confluence'; a point at which resistance as the defensive response to the protection of the self can sufficiently be explained by a single theory or concept, which can incorporate resistance and alienation in a way the has the potential to satisfy both sociological and psychological perspectives.

One such example can be found in Social Baseline Theory (SBT) (Coan and Sbarra, 2015). SBT provides a point at which the social can become intrapersonal. The theory dictates that the human brain is biologically hardwired for social interaction and functions most effectively in pro-social environments. According to Coan and Sbarra, this is because the human brain assumes there is proximity to socially accessible resources through the presence of others, as this mitigates risk and minimises the amount of effort needed to accomplish objectives and goals. This is mediated though attachments made in closely woven, interconnecting chains of social relationships, such as family, extended kinship groups and community. For example, they cite that accessibility to interpersonal contact induces interdependence, superordination of shared goals and the mutual attention required for load sharing. This is believed to be an adaptive anthropological response to high levels of primed attachment and social ecology. If this 'proximity' becomes registered as being absent, it causes physiological distress signalled by the brain as limitations in perceived resources. This subsequently increases the individual's cognitive load, requiring the brain to draw on more personal bioenergetic resources which force itself into conservation. Crucially, they identify that *'...social resources and metabolic resources (like oxygen and glucose) are not differentiated by the brain. They are treated interchangeably'* (2015:2). This resonates with the point already made in Chapter 4 by Ferrell (1996) that for the mind, the *body* is perceived as equally as threatening as the outside world.

Essentially, the absence of others causes the brain to react as if sensory stimulation had been *added*, not subtracted, which would seem counter intuitive. In other words, the brain has to work harder when it is alone than when it is part of an affiliated social group. The inclusion of the term baseline relates to the resting basal function within the brain, measurable using fMRI

techniques. What this shows is that brain baseline function *assumes* social proximity to maintain stasis. When the person is alone, this increases the brains effort as it perceives the resources for adequate function to be absent. The brains baseline state or 'resting state' is therefore measured as stable *only* in proximity, not in isolation, when it must alter energetic output to start to compensate for the perceived loss.

Coan and Sbarra also comment that at the neural level, *'...the brain encodes what we experience as the self...and this self is expanded* [neurologically] *by relationships with others'* (2015:3) in other words schematically, the brain does not differentiate incoming encoded stimulus as being derived from the self or from the affiliate, it treats it as the same. Relating again to Ferrell 's (1996) work which identified that the mind does not distinguish between the energetic demands made on it from inside or outside of the body and indeed perceives the body as producing the same level of threat as external sensory stimuli.

They use the term *grafted* to identify the importance of relational others in our construct of self and further that the brain is more effective in budgeting bioenergetics resource availability when relational proximity is established. Relationship absence or loss causes '...*diminishment*' of the self, along with a loss of both *'...objective and subjective efficacy'* (2015:4). Coan and Sbarra have argued that this experience of loss is literal in terms of physical proximity. What could also be proposed is that the loss of proximity could be figurative in terms of considering the change in perceptions of proximity and closeness caused by alienation. This would place the brain into a defensive mode on a physiological as well as psychological level. This could also relate to the energetic switch described by Barabasz *et al* (2016) between the object and subject self. In Coan and Sbarra's conclusion, they focus on the importance of social relations in managing a range of psychological difficulties, it is therefore not unrealistic to presume that the absence of a social sense of belonging and affiliation (alienation) can lead to *ungrafting,* displacement and estrangement of the self – so in a removal from the social density of proximal relationships to the social sparsity of isolation, it is possible to extrapolate to the impact that alienation might have in damaging psychological and emotional equilibrium and triggering defences.

Of further importance here is that the brain's action is produced at an *unconscious* level, the changes in brain basal states it not derived from conscious thought, it is automatically adjusted through attenuation. In short, this system is aroused due to the perceived increase

in cognitive load caused by a removal of affiliates from the individual's proximity. In Coan and Sbarra's original study, they used physical pain to determine the extent to which proximity mitigated the biological responses, in the rating of the sensation of pain in severity. This was transposed in their research to consider the emotional suffering that arose from the disintegration of intense emotional relationships, for example through bereavement or divorce. This could reasonably be further extrapolated to consider that 'suffering' rather than just pain could potentially mimic this response. This is not such a leap of faith as current research exists that identifies emotional pain can be responded to by the body in precisely the same way as physical pain, for example see Eisenberg *et al* (2003); Kross *et al* (2011); Panksepp (2003); Sel *et al* (2020); Sturgeon and Zautra (2016) and Zhang *et al* (2020).

The basis of this claim rests upon neurobiological research which has understood that located within the brain is an area called the Somatosensory Cortex, (which processes incoming sensory information) and 'maps' out areas of the body that correspond with sensory input. Several such sensory maps exist with in the brain. This is established upon the basis of somatotopy, where discrete brain areas correspond to specific parts of the human body, for example in Penfield and Boldrey (1937) diagram of the Somatosensory Homunculus (see *Appendix 10*), an image examining the relationship between complex fields in the cortical regions and the mechanisms of motion and sensation. What this implies is that there is a 'sensory map' of how the processing of external environmental stimuli is managed within brain resources as that inflowing stimulus relates to specific parts of the body and the amount of processing dedicated to it. This is supported in research that examines somatosensory cortical 'remapping' after amputation, which can explain phenomena like Phantom Limb Pain (see Collins *et al*, 2018). It is therefore not unreasonable to suggest that social isolation may well impact the responses created through this sensory map, as Coan and Sbarra explicitly state that the loss of proximity causes the brain to respond as if sensory input had been added.

However, what is currently absent from research is how the brain provides regulatory mapping for sensory inputs that prompt emotional arousal that are produced internally. It can be surmised that the brain is likely to have constructed a blueprint or map for control and regulation of its own executive processes in the management of the body's complex and multiple systems that link to emotional arousal. I argue it is the presence of such a 'map' that

can be detected in the baseline responses from the fMRI that was used in testing for SBT, because relying on just pain reflexes should have seen the Somatosensory Cortex responses *increase*, not decrease, as it did in the presence of significant others, because the pain stimulus reflected less autonomic stress for the brain, when it should have registered as more.

Therefore, this implies that an external stimulus *input* is not required when alienation occurs to prompt a response, which will harmfully impact brain ecology and cause an alteration in the baseline metabolic state. This is because alienation causes feelings of social isolation to occur, which according to SBT creates stress within the brain and both a physiological and psychological response. As previously outlined, this is due to the loss of social affiliation causing the brain to react as if sensory information had been *added,* which is a consequence of the brain registering that essential resources are now absent. This aspect of the SBT also links closely to the EI and State Trait Theory related by both Yalom (1980) and Helm *et al* (2019), who suggested individuals experience isolation as their stimuli and sensory processing is unique.

5.5 Conclusion

This research has generated 'spaces' that should be further considered by educational practitioners who are committed to social justice. It has challenged the view of the Wellbeing Agenda as a 'roadmap' of care for the physical, mental, psychological and social health of CYP. It has, along with the research that has been cited herein, illustrated the polemic nature of the wellbeing debate and highlighted the lack of critical evaluation that should have followed its inception. I have argued that the Wellbeing Agenda has become 'fetishized' and represents care and compassion in theory but not in practice.

I have outlined a range of research that has brought into question the objectives of the Wellbeing Agenda against the 'therapeutic turn' in education. This has illuminated wider governmentalist ambition to annex emotion through technologies of affect. This offers an opportunity to become conscious of the oppressive practices that are inherent within the process of identification, designation, management and intervention within the wellbeing remit, which now operates as a marketized entity. It has also highlighted how the emergence of the 'pathology of adolescence' can be seen as a threat to CYPs agency.

Further research needs to be conducted in relation to transitioning from the current practices of 'wellbeing' to a radically different method of support for young people that examines their situational environment and context, rather than assesses their dispositional pathology and traits. This is in order to support intervention practice through a care remit that enables socio-economic factors to be addressed first and CYP not to be drawn into pathways of psychiatrization. For example, Parker (2007) has identified that psychologists must move away from the dominant paradigms that continue to reproduce existing oppressive power structures and relations towards critical psychology, he calls for psychologists to work *'prefiguratively'*, to form *'...practical political alliances'* (*ibid*:12) with individuals who have been constructed in the image of 'psychopathizing subjects'. Fisher (2009) has stated that '*...the current ruling ontology denies any possibility of a social causation of mental illness'*, stressing that *'...the task of repoliticising mental illness is an urgent one'* (*ibid*:37). This advocacy is further supported by Mills (2012) who has identified that *'...the medicalisation and pathologization of children's lives prevents children's resistance and survival from being read politically'* (*ibid*:453). One way this could be achieved is to consider a moving away from the trajectory of clinical diagnosis and towards a model that considers the types of issues that CYP in educational context and settings might face. For example, the adoption of a support strategy that considers the importance of a range of wider factors in dealing with emotional distress.

An example of this type of mechanism can be seen in the Power Threat Meaning Framework (PTM) (Johnstone and Boyle, 2018). It looks to examine ways of recognising and working with emotional distress, troubling behaviour and unusual experience that does not recourse to diagnostic categories or axes within psychiatric publications like the DSM V and ICD 11 and a subsequent labelling of a named mental health disorder. A key feature of the framework is that it does not assume behaviour or experiences are derived from biological or psychopathological causes and embraces wider treatment responses outside of pharmacology. Further, it can be argued to take a cross-disciplinary approach to understanding psychological behaviour in recognising how cultural, economic, social and relational factors can influence the manifestation, presentation, intensity and persistence of emotional distress and behaviour. A key priority of the framework has been in acknowledging the role of the service user in managing their distress and in recognising their 'expert' status within their own management and recovery (p.8).

The framework operates by examining four indicators that link to the three titular constructs of; *Power*, in its widest sense, which includes legal, personal, interpersonal and economic (p.8); *Threat,* which relates to the operation of power on the individual and considers extrinsic and intrinsic forces (p.9) and lastly, *Meaning*, which examines sense making relating to the personal and individual constructs of the service user, but which are mediated through expression of the power and threat (p.9). The final component is the *Threat Response*, which is the presentation and deployment of the resources and coping mechanisms required to manage the potential threat, which link to both socio-cultural aspect and inter/intrapersonal reactions and responses (but recognises biological components like the fight or flight response) (p.9). Of interest is that the model is viewed as symbiotic, with no one component being privileged above the other and no single construct being engaged without the other.

This model is important because it enables wider aspects of distress to be considered in responding to individuals in personal or emotional crisis. For example, the model advocates removing the bias from within the biomedical approach to assuming something is (biologically) 'wrong' with the individual, to instead proceeding from the PTM position of questioning '*What has happened to you'* (Power), '*How did it affect you'* (Threats), '*What sense did you make of it*' (Meaning) and '*What did you have to do to survive'* (Threat Response) (p.9). This model looks to be a very useful addition to supporting a range of service users and in particular, would be beneficial to use within an educational context where much of the 'anxieties' that exist can be better remediated through a process like PTM; rather than the current mechanism of 'referral to CAMHS'. This model has the potential to support CYP in managing a range of issues linked to the school context (like exams, bullying and workload). This has been evaluated by O'Toole (2019) who advocates for the use of the PTM framework in schools. Of particular value is the model's explanatory potential for a range of wider issues as the framework has the scope for extended application beyond the individual, for example Morgan *et al* (2022) has applied the PTM framework to consider the threat of climate crisis on behaviour. Moreover, the model itself has capacity to consider Adverse Childhood Experiences (ACE) in early development which would deliver a programme more aligned with social justice ideals, especially in relation to CYP from marginalised groups, diverse ethnic backgrounds and those experiencing poverty. However, there are concerns and criticisms around the framework that focus on a range of issues, for example the lack of specificity or 'treatment' and 'solutions' (Milligan, 2022), the confusion over the internal structure of the

model and its ‘similarities’ to existing measures and definitions (Morgan, 2023) and issues with its overall aims and proposed outcomes (Harper and Cromby, 2020).

5.5.1 Psychologization

The thesis has attempted, from the outset, to illustrate the importance of considering the impact of psychological constructs, theories and practices when they are utilised with political intention. I have illustrated how using a ‘different type’ of psychology, in examining an issue like the framing of the mental health debate, can give a different perspective and different outcomes when situated outside of a neoliberally driven context. Of importance in this work, I believe, is that it demonstrates how the implementation of the Wellbeing Agenda itself has a negative impact on CYP and by positioning this response as resistance, it generates a political dimension to the effect of often passive, unconscious and none commissioned acts that are not present in the other models the work has considered. The importance of this work is not just that resistance impacts the school situation, but that it has longer term consequences into employable adulthood. This reading of mental illness can identify the true extent of damage being created in this type of programme, along with the Trauma-Informed Practice briefly discussed.

Whilst it is unfair to punitively admonish the discipline of psychology as a whole for the misuse of some of its parts. I would draw the analogy that it is a body of knowledge that can be utilised in different ways, for example I have illustrated how shifting approach from a biological to a psychodynamic perspective can reframe the debate and uncover motivating forces which act deep within the individual’s personal self-concept, which have a strong influence on emotion, thought and behaviour. I have indicated in the thesis the issues that relate to the diagnosis and classification of mental health and the documented problems of relying on a purely biological paradigm. I have identified concerns around the political ambition of the BPS to ‘get its feet under the table’ and the use of psychology as a political framework, but I have also highlighted its work in attempting to address the issues with the NICE guidelines in the diagnosis of depression and in the commissioning and funding of the research into the PTM Framework, which is itself trying to move away from a medicalised diagnosis for emotional distress.

The critique that I have given, throughout the research, has been a criticism of the application of psychological theory to meet the needs of neoliberalism in particular (and capitalism in general). This has considered issues with the diagnosis of mental illness within and through state educational settings, the medication of children, especially very young children with pharmacology interventions, the implementation of MHFA in schools and the move to 'lay' diagnostic practices, the overly familiar relationship that schools have to CAMHS as a type of 'feeder institution' to frontline services, the adoption of clinical language into educational practice that creates 'fuzzy boundaries' between emotion and genuine pathology, the implementation of non-specialist services through IAPT programmes, the creation of the wellbeing framework using positive psychology theories and the implementation of resilience strategies, psychotherapeutic techniques and proxy referrals that are constituted by and within settings.

The issue of agency has also been addressed within the research, aside from the inclusion of related studies, the thrust of the argument that has been proposed is that CYP are demonstrating agency through resisting, but we are failing to recognise and acknowledge this. The critical evaluation and analysis that has been conducted herein is not to undermine the discipline of psychology, but to question, as a body, where our ethical priorities genuinely lie.

5.6 Possibilities for Future Research

In completing this thesis, I have attempted to ensure that is has supported the values of social justice. Denzin has stated that research should use 'discovery' to improve oppressed people's situation or circumstances. I believe the work within this thesis has made visible a situation, in the application of wellbeing interventions, where social injustices happen. This is important in highlighting and illustrating where oppressive forces may be operating on individuals to limit equity. My methodology was inspired by both Matias, in seeking to undo the '*silence*' that theoretical researchers face by deliberately choosing theory as method and by Patel and Patel, who called for an instinct of inquisitiveness to gain fresh 'insight' into old problems and in the 'overpowering' of unknown facts that were 'hidden'. In applying Evaluative Inquiry, I have sought to embody DeRijcke *et al's* concept of using evaluation to locate the research into both a political and practice context and especially in articulating a subordinate value of concerns around the Wellbeing Agenda as a dominant academic practice. Given further

Bendix-Petersons' view that teachers are often limited in ways that they can reject policy, my own resistance has been in critiquing the premise of the agenda and its myriad interventions.

The thesis has contributed to research such as Harwood and Allan, Malacrida and Ecclestone and Hayes who have expressed concern about the increasing pathologization of education. The work has also systematically deconstructed the NHD Digital Survey to identify significant flaws in both its methodology and application as a foundation document for much of the intervention that followed. There has also been a systematic deconstruction of one of the main measures to test for mental illness in CYP (Boxall Profile) which casts doubt on its veracity to adequately measure children's mental health at all. This research has also taken an interdisciplinary approach to theories of resistance to identify a connection between alienation and ungrafting as a consequence of wellbeing interventions, highlighting that the application of measures within the Wellbeing Agenda, in its current form, can constitute emotional harm to CYP. The thesis has also found gaps in the framework of resistance where the paradigm can be expanded to include acts of 'uncommissioned' resistance, which have the potential to create change and give recognition to individual actions, which can be identified, acknowledged and politicised.

Moving forward, the next steps on from this research would be additional study and raising awareness of the negative impact that wellbeing interventions can have in creating existential alienation. It is also a potential source of studies into the values and beliefs of teachers in Post-16 education, as to their views on the medicalisation discourse within education, as well as counselling training which is almost exclusively psychologically based. Whilst being aware that the PTM Framework has limitations in respect of potential solutions or treatments, it would also be worthwhile to investigate how successful its implementation could be in a Post-16 environment and identify ways that this could be used to work with CYPs resistant states

Consider this.

In 1948, Aldous Huxley wrote to George Orwell after the publication of his novel *1984* to express that, rather than enforced fear and obedience, a more effective way for the ruling elite to maintain power was to create a context where obedience was 'willing'. In this regard he suggests that people can be influenced to "*love their servitude*" and that individuals could be conditioned into a "*like of their inescapable destiny*" Dacre (2015). This is the premise for

his book; *Brave New World* written in 1932, that created a dystopian world where people *'...think they are always happy' (ibid).* Accordingly, Huxley created a society that portrayed humans living a 'sterile' existence of ersatz happiness, lacking in love, compassion and empathy in favour of the pursuit of hedonism, narcissism, consumption and egocentrism.

If any negative or uncomfortable thoughts arose, citizens were encouraged to take *'Soma'* a psychotropic drug that altered the mental state, inducing feelings of happiness through supressing unpleasant, worrying or unhappy thoughts. Thus, the psychological oppression of citizens through a range of technologies was covert, subtle and systematic. Pradas (1999) summarises that the citizens in Brave New World have become 'automatons', devoid of any capability to feel qualitative emotional experiences. Thus, they are both diminished and dehumanised. Schermer (2007:7) proposes that *'...in Brave New World, soma stands for alienation, de-humanization and superficial mind-numbing pleasure'*.

Huxley's intention was to illustrate the problems contained within the fragile construct of false happiness. The citizens in *Brave New World* were not intrinsically happy, if they were, there would be no need for Soma, instead they medicate away their anxieties and concerns, so they were not felt or experienced. Implicit within the narrative was that they were still present. The issue that Huxley is eschewing is that happiness is maximised at the expense of every other emotion and rather than leading to fulfilment and contentment, it created constant need for immediate gratification, through '*all manner of consumption'* (Lombardo, 2018).

Many parallels can be drawn here not only with the implementation of the 'well-being' policies and practice, for example the emphasis on 'mindfulness;' focusing only on the present, but also the prescription of drugs like Fluoxetine (Prozac) and other antidepressants to negate the ability to 'feel' or experience any negative emotional states. The current Wellbeing Agenda has as its core principle the requirement that individuals should only experience positive felt emotions, with any negative feelings being labelled as detrimental, damaging and harmful. There is a risk that, in promoting policies of 'well-being' to protect individuals from harsh emotional experiences, caused by external social factors like alienation, individuals become 'dehumanised'.

Brave New World has illustrated that, through manufacturing a population that is regulated with medication, individuals can indeed, come to love their servitude. The population exist in states of artificially manufactured happiness that creates the existential alienation described by Elliott. They feel emotion but take Soma to mask their negative experiences of affect, thereby suffering alienation from their own emotional reality. The fact that they take Soma identifies that their fundamental human nature has not altered; it has just been overwritten with conditioning and medication, but not to the extent where they do not feel negative emotions at all. This locates the citizens of Brave New World as dehumanised agents, the automaton of Marcuse's one-dimension, the 'normotic' personalities described by Bollas as citizens live just as 'objects' to be consumed. Individuals exist in a constant state of oppression that they remain unaware of because they have been tranquilised. Their happiness reinforces their oppression, by creating stability to allow control, the World State's use of Soma, therapy and hedonism does not function to fulfil their intrinsic human needs, but it does manufacture their 'wellbeing'.

APPENDIX 1

Statistical Analysis of Counselling Referrals

In order to consider the college's position in respect of trends in the uptake of mental health support services, I was able to access the early statistics on counselling support. This was for the academic years (2013/2014 the first year within college counselling services were made available), (2014/2015) and (2015/2016). Data is not available within college after this time as the college withdrew counselling services from onsite delivery and contracted external counselling support provision once funding became available, so the college now 'commissions' services. Therefore, from the academic year (2016/2017), all students were referred to outside services, but the three-year averages give and interesting context against which the work in Chapter 1 on the media promotion of the 'crisis' in mental health can be considered. It appears that initially, college-based statistics seem to be contraindicating nationally reported trends.

Fig. 7 Data Table showing college based statistics for Counselling Support Referral

Academic Year	2013/2014	2014/2015	2015/2016
Number on Roll	1,779	1,921	1,792
Total No Accessing	172	165	116
Ratio	1:10	1:12	1:15
Of which Female	113	115	92
Of which Male	59	50	24
Total Hours	662	695	465
Average Per Person	3.84 Hours	4.2 Hours	4 Hours
% Self-Referral	35%	38%	42%
% Staff Referral	31%	30%	32%
% Other Referral	34%	32%	26%
1 Most Referred	Stress 37%	Stress 39%	Stress 38%
2 Most Referred	Family/Rel 20%	Depression 22%	Depression 28%
3 Most Referred	Depression 16%	Family/Rel 13%	Family/Rel 16%

These figures were provided directly by counselling support services based on records of contact and show details of student numbers, referrals and reasons for referral. The total hours were given as allocated staff time, but the average number of sessions has been

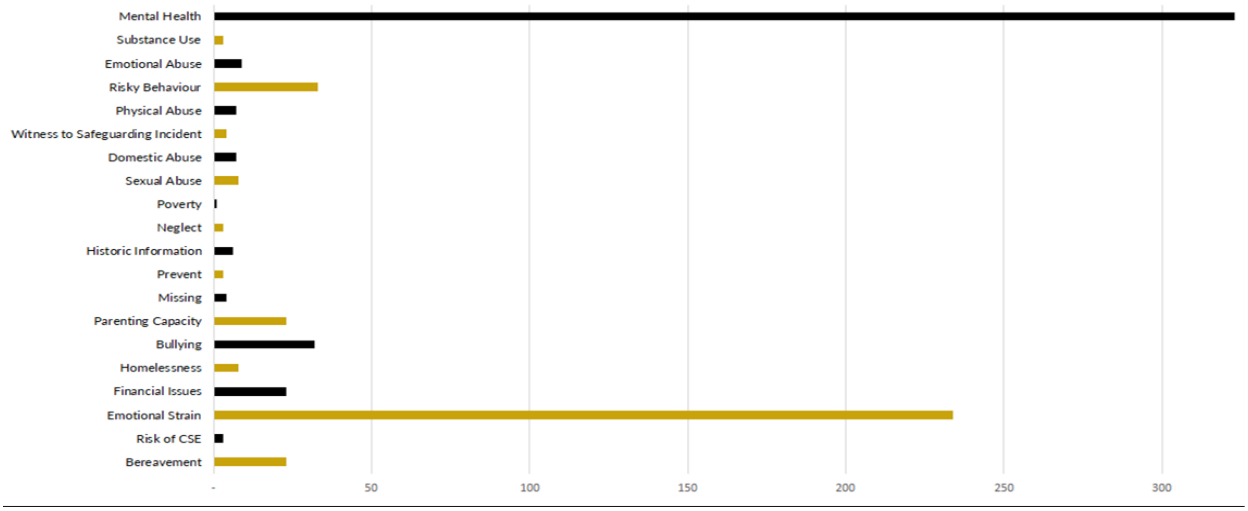
produced here for the purposes of comparison. The table outlines the numbers accessing support in relation to the whole college cohort, it identifies which mode of referral was made, for example 'self' or 'staff' and also gives the three most common reasons for referral to counselling services.

Trends that can be seen in the data recorded suggest that in the three years shown, (which incorporated the key period of media representation of mental health issues as being in 'crisis') there was a steady *reduction* in the number of students that accessed college-based counselling services. The average amount of time spent in sessions by student also decreased in total number of hours. The figures that are most noticeable are the increases in the number of *Self Referrals* to the services, (7% in three years) and the increase in the number of referrals for *Depression* of 12%. However, consistently, *Stress* remained the main reason for referral to the services offered. Importantly, the 'depression' referral does not represent only those students diagnosed by clinical specialists as having a depressive disorder, but those self identifying, or being identified by college-based staff as having 'depressive symptoms'. The ratios, which are problematic because they cannot detect multiple referrals, and are used as an approximation all show ratios less than the 1:8 (and 1:6 in some publication) of CYP with a 'recorded mental health issue'. If these figures represented only clinically diagnosed disorders, the ratios would be significantly lower.

Whilst caution must be used in interpreting this data, for example as most students stay at college for two years, it is possible that a significant number of students are duplicated within the three years overlap as they may continue to need support in their second year and continue contact with the support services. These would be recorded within any two of the three separate years illustrated, so these are not necessarily 'new referrals', in which case actual numbers of students accessing services would effectively be even lower. However, in terms of initial impressions, it is interesting that depression has increased exponentially across each of the three years as a percentage (16%, 22% and 28%) representing a 12% increase in a relatively short period of time within a reduced cohort. Further, the percentage of overall cohort accessing services has remained fairly constant, in 2013/2014 of 1,779 there were 172 (9%) accessing support, in 2014/2015 of 1,921, 165 (8%) and in 2015/2016 of 1,792, 116 (6%) of the cohort accessing services. In fair comparison the numbers of students on roll were more similar for 2013/2014 (1,779) and 2015/2016 (1,792) a difference of just 13

students, which further emphasises the impact of the increase in both data for the levels of depression (16% to 28% +12%) and the number of self referrals (35% to 42% +7%).

What this data seems to suggest is that, within this three-year period, the number of self referrals has increased at a similar rate to the number of referrals for depression, whereas the staff referral rate over the three-year period has remained relatively static. Interestingly, the 42% recorded for depression is in the year with the lowest cohort number on roll, suggesting that potentially, a higher proportion of students self-referred as having depression. This is an important point as it emphasises the number of students in college with a *declared*, not *diagnosed* mental health disorder. Lines (2002:6) has suggested that *'...some pupils will not be 'clinically depressed' so much as severely down and in a state that they label as 'depression'*. There is a distinct difference to be drawn here between clinically recognised disorders that have been diagnosed by a medically qualified professional using a range of assessed measures and a 'self-declared' label of 'depression' to represent, as Lines (2002) has indicated, feelings of unhappiness, being overwhelmed, failing to cope or generically 'upset'. In other words, as the opposite feeling to 'happy'.



Academic Year 2018 – 2019 Reasons for Referral to Outside Services

It must also be considered that the numbers relate to 'new' referrals and not 'new' students, so multiple referrals could have happened for the same student but for different reasons, also there may be significant under-reporting for students that felt themselves to have issues but did not come forward, or students could be already accessing clinical support by medical practitioners and so elected not to utilise college-based services.

This snapshot is useful for two reasons. It initially illustrates that the 'epidemic' of mental health issues being written about in the national news media between (2013-2016) was not reflected in the experiences of staff and students within college at that same time. However, this relates only to levels of reported mental health and wellbeing issues, it could reasonably be argued that many students did not self-refer or were not detected by staff or others as having any issues. Whilst it shows students were accessing services, it is not in the numbers identified by NHS Digital (2018). Compare this with the graph given below:

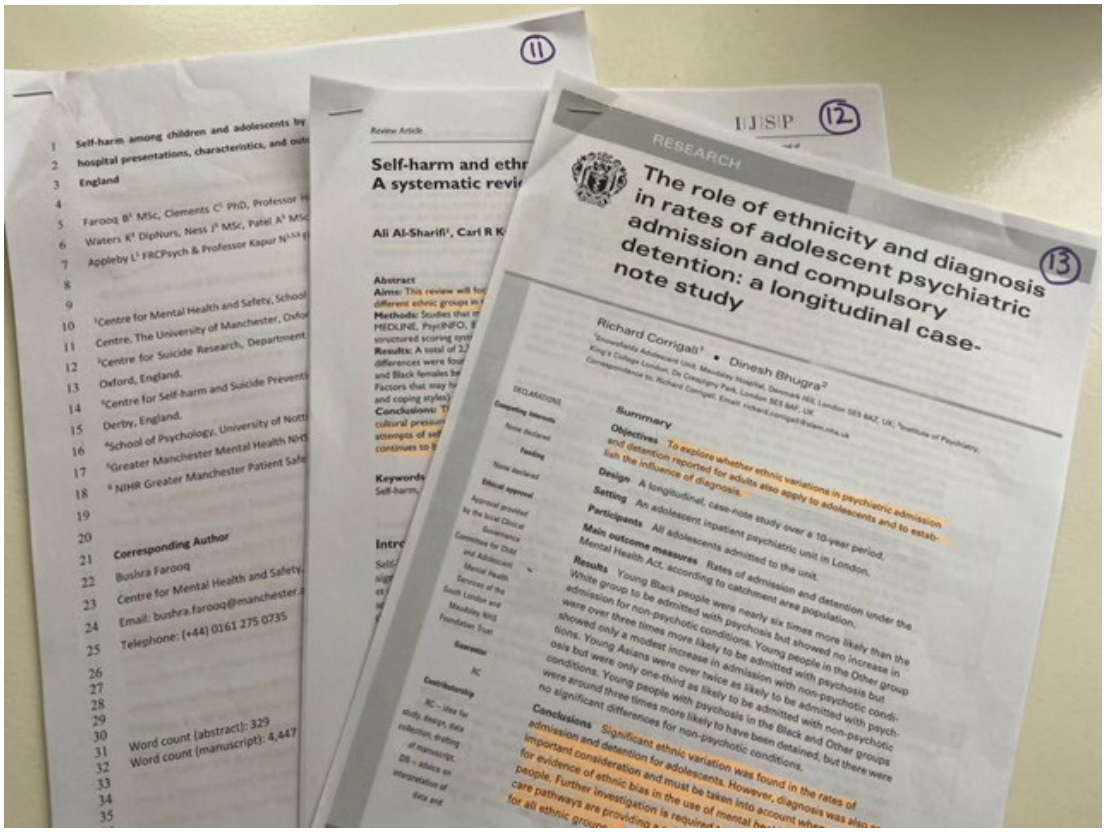
This represents referrals out of the college to commissioned counselling support services for the last academic year where statistics are available (2018/2019), which were generated by staff, self or others using specific indicators for referral (one type only – meaning no 'multiple' referrals were made) which show that over 569 students had accessed services for mental health issues (339) and emotional strain (230). What these statistics show is that for the cohort in this academic year against the numbers on roll (1,708) this represents 30% of students being affected by these two issues, significantly higher than those being referred in the earlier three academic years. What this may reflect is that some students preferred not to use within college services but were comfortable with being referred to outside specialists. However, it is more likely, given the extensive amount of promotion for these services around college, more students are being persuaded to think about themselves as mentally compromised or are encouraged to 'declare' mental health issues they feel, or are advised, they may have. It is also worth noting that the consistently highest recorded reason for referral previously (Stress) is no longer an option for referral, so it is likely that this has been subsumed into either of the other two categories. Why this is problematic is that stress is not a mental illness, so this may be artificially inflating the numbers.

To elaborate this further I assessed the results against information from the examinations office in respect of 'special arrangements' for people during external and internal examination and assessment procedures. This could cover a variety of measures from students with physical disabilities who need an amanuensis or a student who may need to be in isolation (for example with epilepsy) as well as other measures like requiring a computer to type out answers to examination papers. More recently this has covered the number of individuals with 'anxiety related issues' or additional learning needs who request a room on their own. In 2013/2014 there were 210 students requiring special arrangements (11% of the

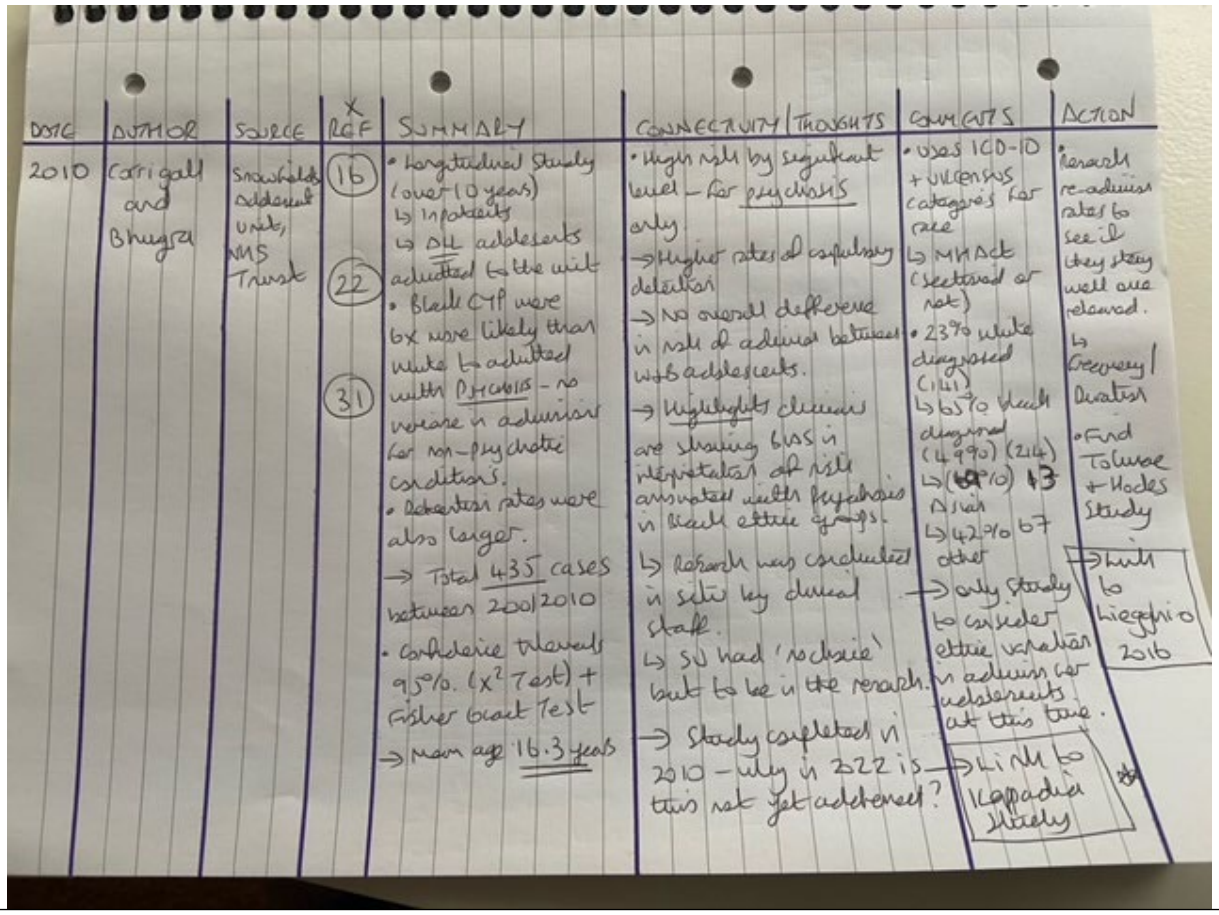
overall cohort) however 58 of these students required a room on their own (27% of the total requiring special support) citing ‘panic attacks’, ‘stress’ and ‘anxiety’ as the most common reason for requesting isolation. In 2014/2015 the number requiring special arrangements was also 210, which was 10% of the overall cohort. However, 55 required a room on their own which was 26% of that figure. In 2015/2016, 145 students required special support, 8% of the total cohort and 45 students requested isolation during their assessments, a figure representing 25% of the overall number requiring additional support. So, it would seem that as a percentage of the overall cohort of students requiring special assistance, the 2013/2014 saw the biggest overall percentage of students with requests for isolation 0.32% of the entire cohort. Interestingly the later years have more erroneous results, as in 2014/2015 despite the cohort overall being substantially smaller than the preceding academic year (by 129 students), the overall percentage difference of the entire cohort requiring isolation during assessment was negligible 0.28% (13/14) to 0.25% (14/15) a difference of just 0.03%, suggesting that a larger proportion of students requested isolation due to stress and anxiety in the year with the smallest measured overall cohort.

If you assume that the individuals being given counselling for stress and anxiety recorded in the counselling statistics were also the ones who requested an individual room for assessment purposes, you would have expected to see only a marginal increase in the statistical difference, given that respectively, the percentage deviated by an average of less than 3% in each of the three years. This was found to be the case. Thus, meaning that the reduction in the need for individual rooms due to stress or anxiety has fallen in line with the reduced number of stress and anxiety related appointments in the counselling services.

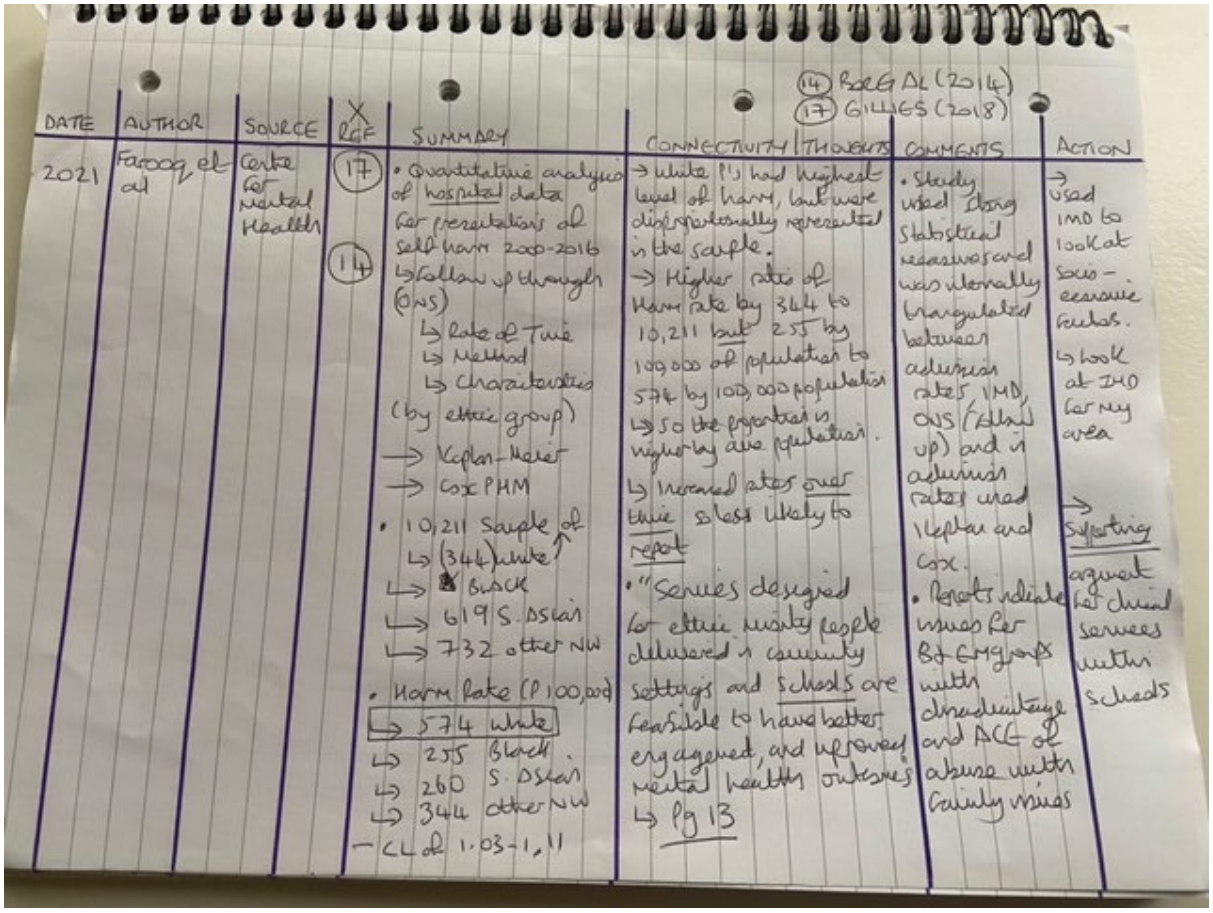
APPENDIX 2



All studies are **Numbered** so this makes cross referencing easier.



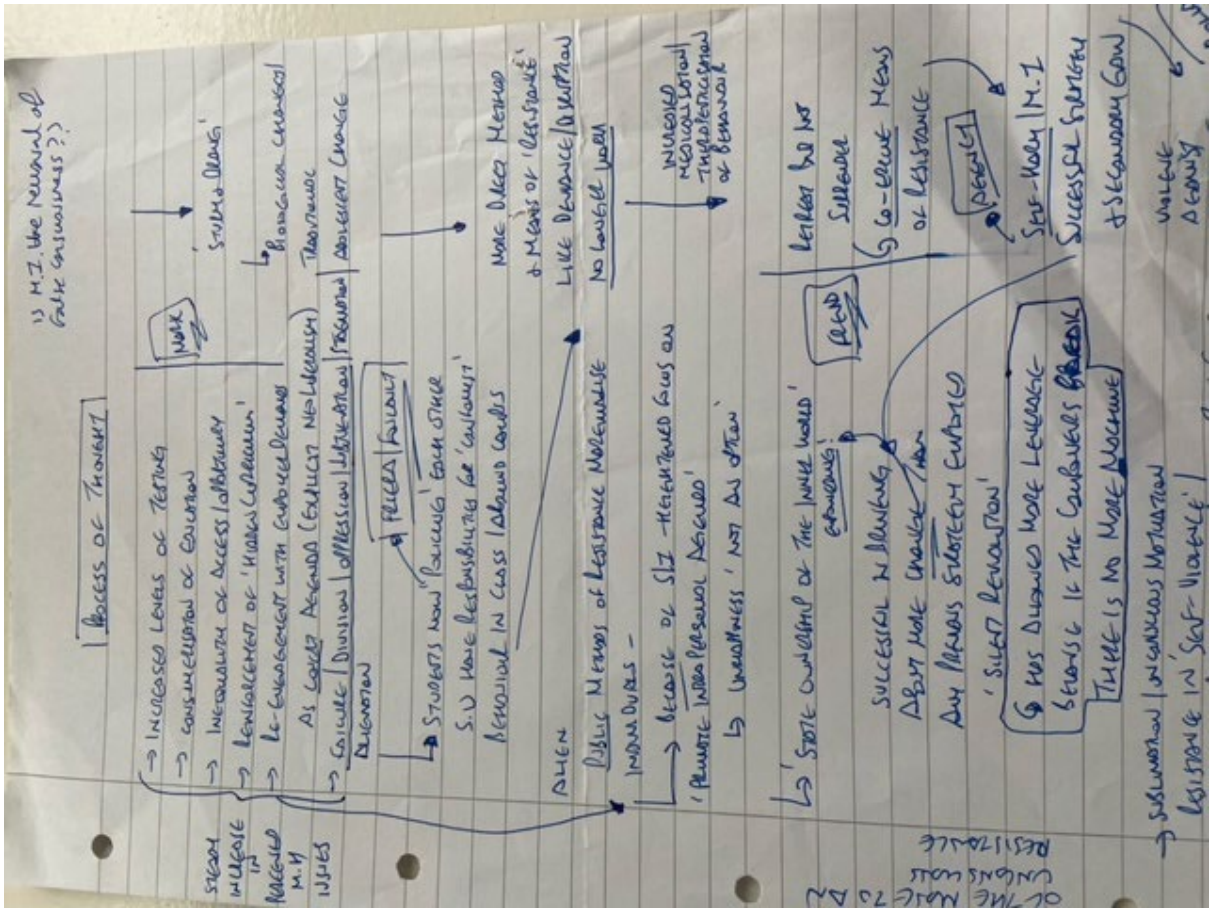
Studies are then summarised for key points, details about how they were conducted are extracted along with relevant data i.e. findings, method used.

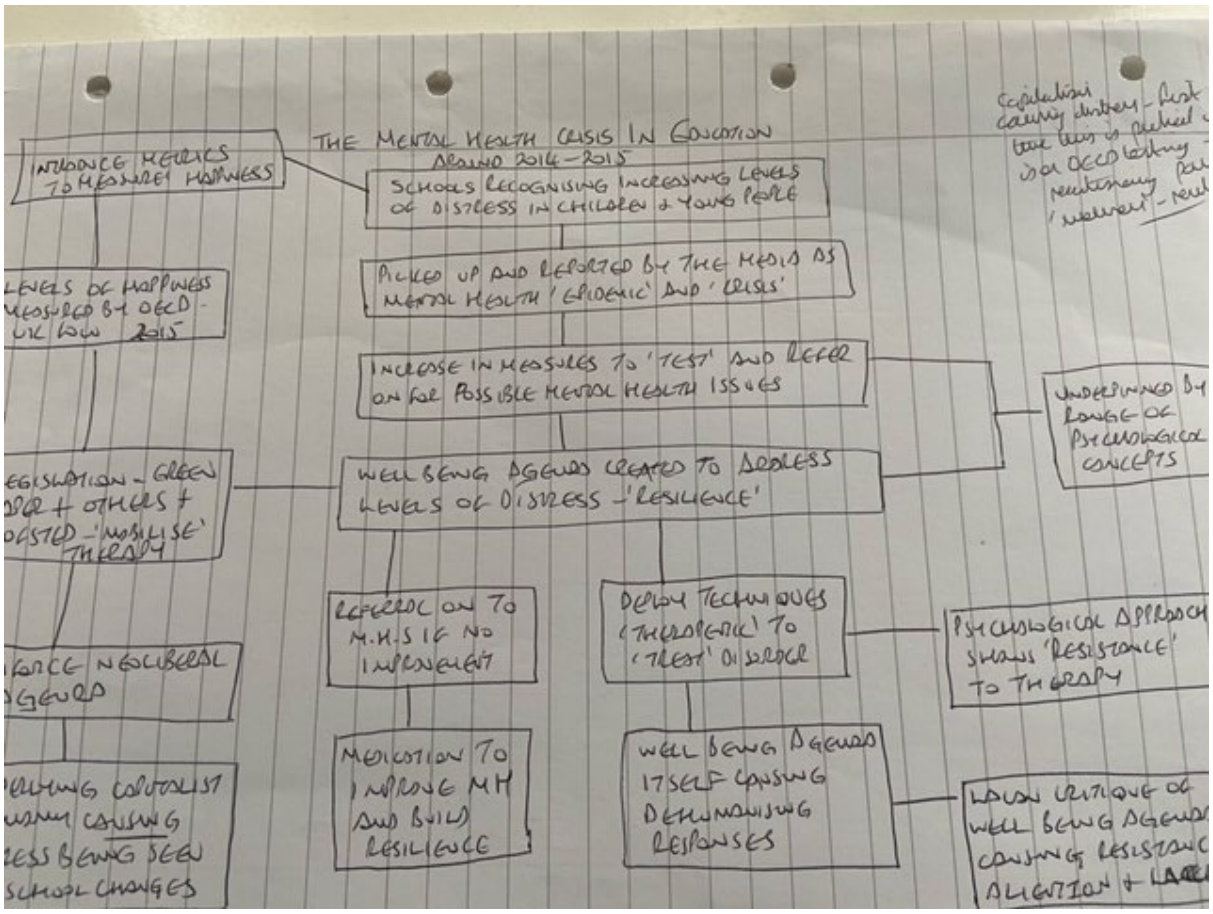


Once key points have been extracted, I look for connections with research that I have already covered (in the examples here I have illustrated how they have links to studies that I have already completed (Bor, 2014 and Gillies, 2018). There are also action points to address, for example Farooq's study used the IMD, it was the only study I looked at that used this, which prompted me to look at the IMD for my own area and also mention the use of the IMD in the thesis. This study also SUPPORTS the use of clinical services within schools. In the Corrigall study, there are clear links to both Kapadia's report and Liegghio's research, prompted by the compulsory utilisation of service users. The information that emerges when reading and summating in this way – and the triangulation with other studies (or theories) enabled an argument to be formulated. For example, Farooq's study is contrary to my personal view on the increased use of clinical services within schools, but was still used as it gave valuable insight into actual admission rates for self-harm which was a point mentioned within the thesis.

Corrigall's study raised a question for me on readmission rates and duration, so I looked at further research to understand how these impacted CYP in U.K. The study also mentioned disadvantage, so I looked for other issues around ACE and included these within the thesis. This process is extremely time consuming but it allows for themes to emerge from the evaluation of the secondary data and captures the process of creative thought around the work represented.

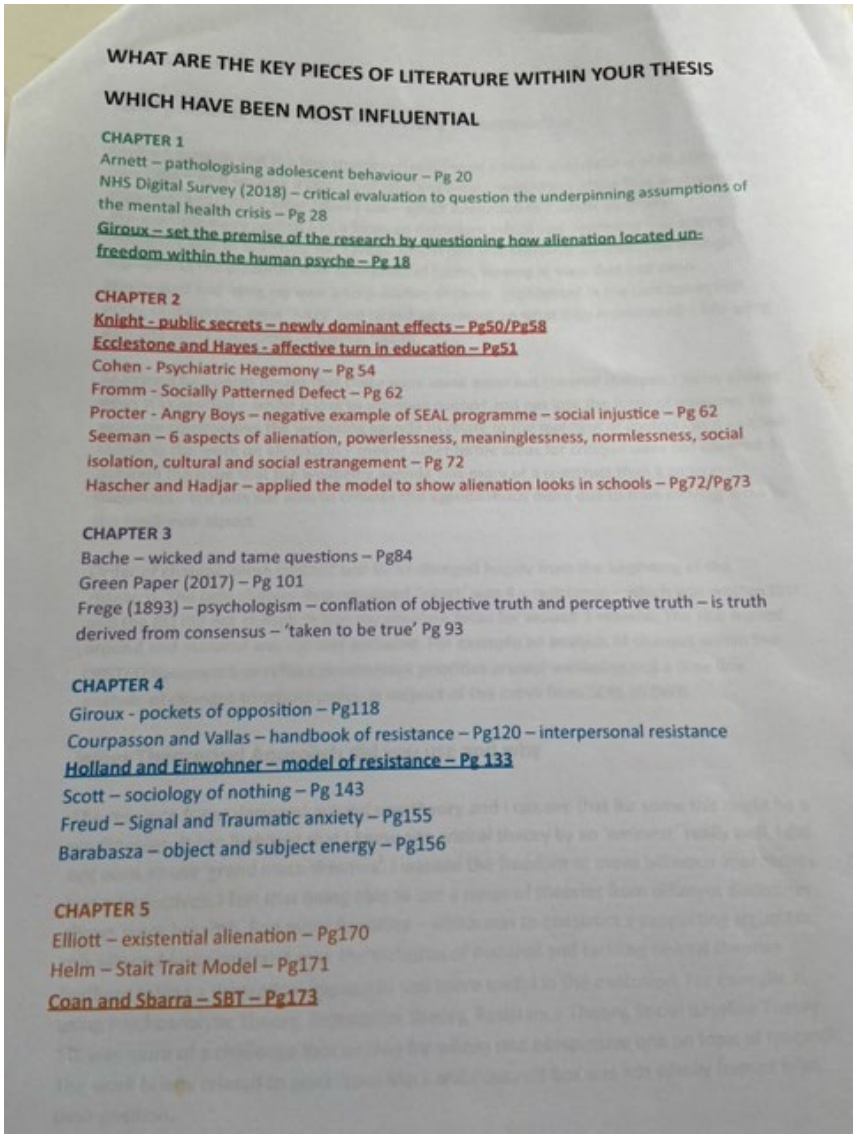
Due to visual problems with using a screen for too long, I almost exclusively hand write and produce contemporaneous notes as I read.





Examples of mapping schematics for ideas and concepts.

I then produce typed notes to consolidate my research and consider how they might be used within the arguement (and the Viva).



WHAT ARE THE KEY PIECES OF LITERATURE WITHIN YOUR THESIS

WHICH HAVE BEEN MOST INFLUENTIAL

CHAPTER 1

Arnett – pathologising adolescent behaviour – Pg 20

NHS Digital Survey (2018) – critical evaluation to question the underpinning assumptions of the mental health crisis – Pg 28

Giroux – set the premise of the research by questioning how alienation located un-freedom within the human psyche – Pg 18

CHAPTER 2

Knight - public secrets – newly dominant effects – Pg50/Pg58

Ecclestone and Hayes - affective turn in education – Pg51

Cohen - Psychiatric Hegemony – Pg 54

Fromm - Socially Patterned Defect – Pg 62

Procter - Angry Boys – negative example of SEAL programme – social injustice – Pg 62

Seeman – 6 aspects of alienation, powerlessness, meaninglessness, normlessness, social isolation, cultural and social estrangement – Pg 72

Hascher and Hadjar – applied the model to show alienation looks in schools – Pg72/Pg73

CHAPTER 3

Bache – wicked and tame questions – Pg84

Green Paper (2017) – Pg 101

Frege (1893) – psychologism – conflation of objective truth and perceptive truth – is truth derived from consensus – 'taken to be true' Pg 93

CHAPTER 4

Giroux - pockets of opposition – Pg118

Courpasson and Vallas – handbook of resistance – Pg120 – interpersonal resistance

Holland and Einwohner – model of resistance – Pg 133

Scott – sociology of nothing – Pg 143

Freud – Signal and Traumatic anxiety – Pg155

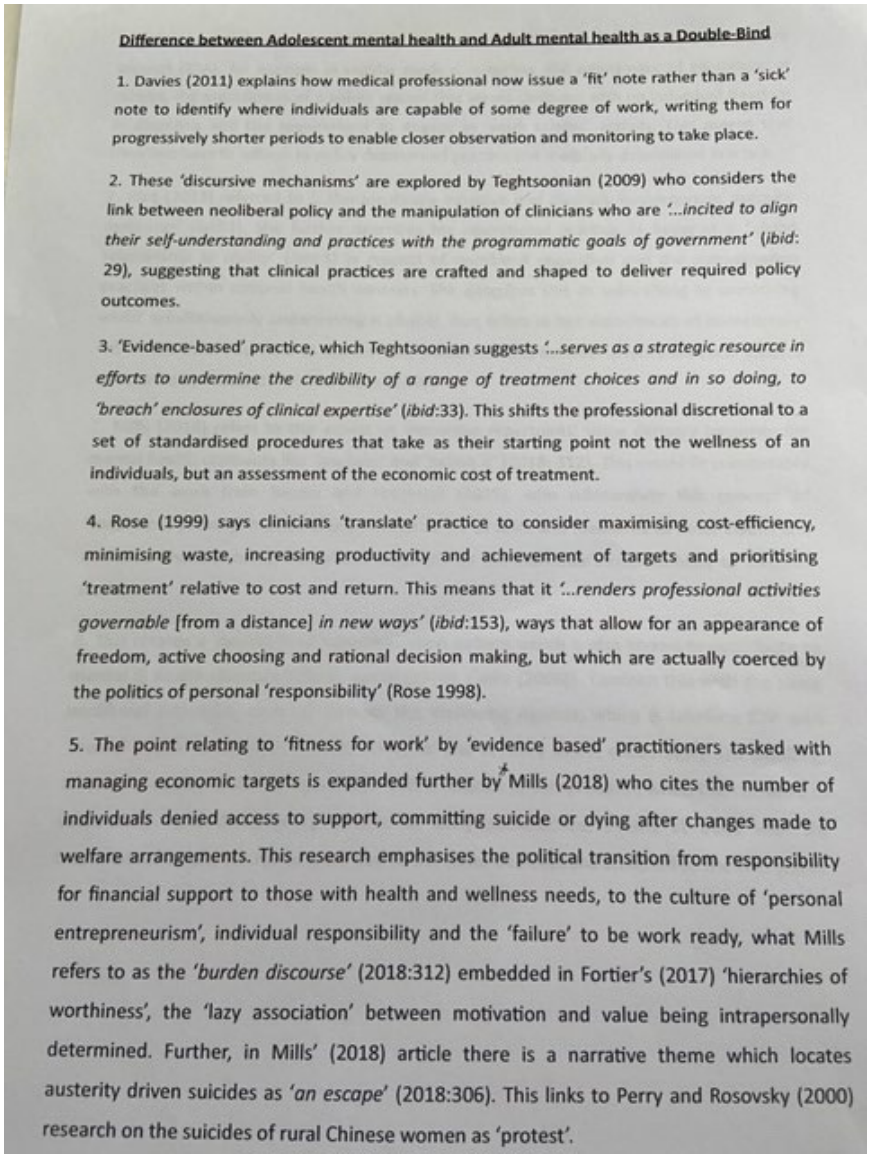
Barabasza – object and subject energy – Pg156

CHAPTER 5

Elliott – existential alienation – Pg170

Helm – Stait Trait Model – Pg171

Coan and Sbarra – SBT – Pg173



Difference between Adolescent mental health and Adult mental health as a Double-Bind

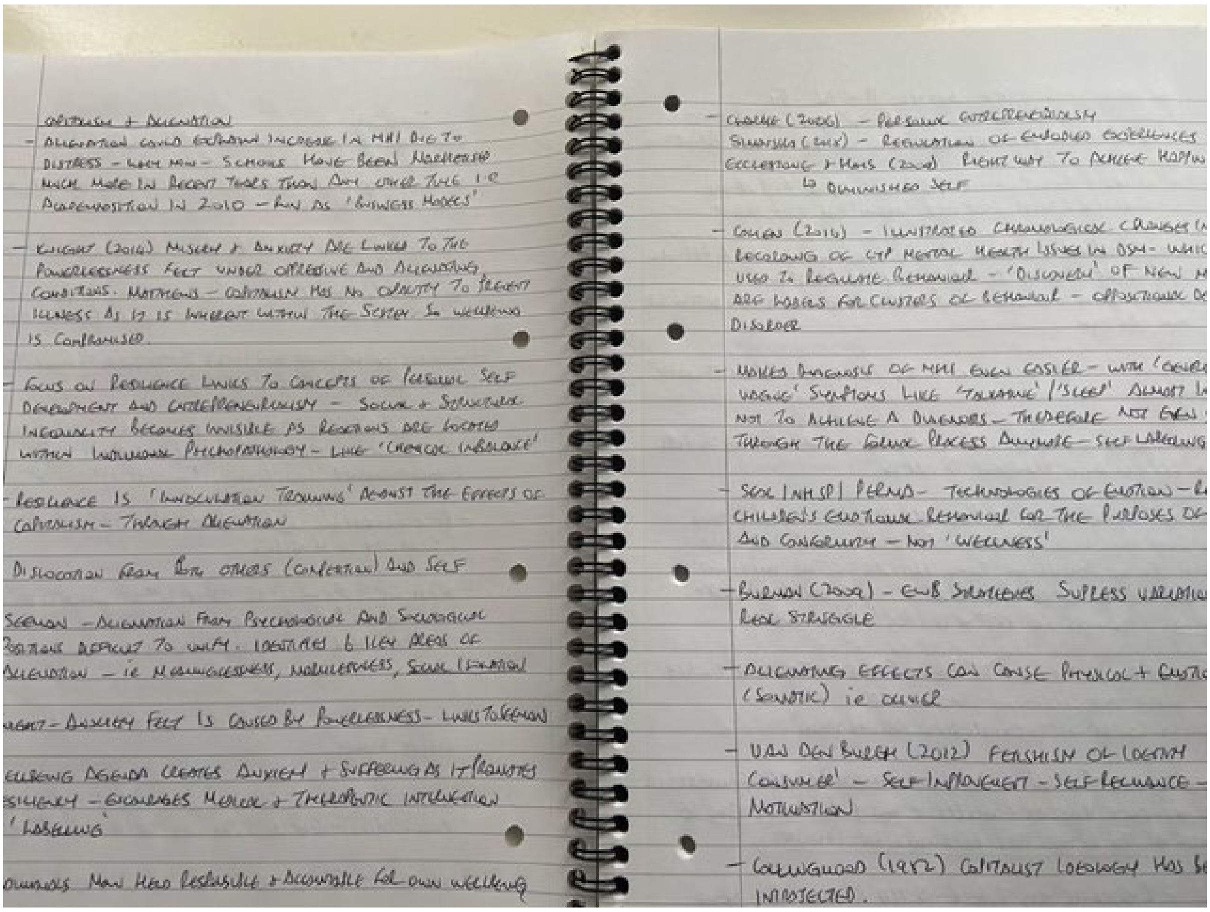
1. Davies (2011) explains how medical professional now issue a 'fit' note rather than a 'sick' note to identify where individuals are capable of some degree of work, writing them for progressively shorter periods to enable closer observation and monitoring to take place.

2. These 'discursive mechanisms' are explored by Teghtsoonian (2009) who considers the link between neoliberal policy and the manipulation of clinicians who are *'...incited to align their self-understanding and practices with the programmatic goals of government'* (*ibid*: 29), suggesting that clinical practices are crafted and shaped to deliver required policy outcomes.

3. 'Evidence-based' practice, which Teghtsoonian suggests *'...serves as a strategic resource in efforts to undermine the credibility of a range of treatment choices and in so doing, to 'breach' enclosures of clinical expertise'* (*ibid*:33). This shifts the professional discretional to a set of standardised procedures that take as their starting point not the wellness of an individuals, but an assessment of the economic cost of treatment.

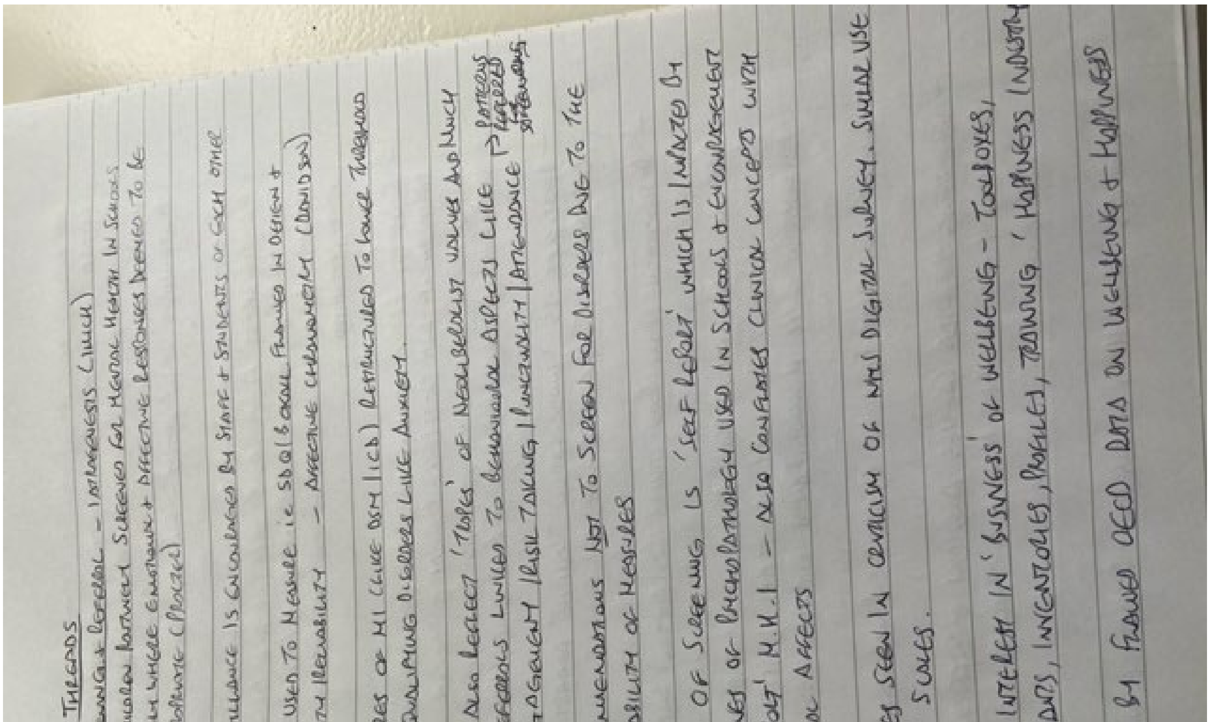
4. Rose (1999) says clinicians 'translate' practice to consider maximising cost-efficiency, minimising waste, increasing productivity and achievement of targets and prioritising 'treatment' relative to cost and return. This means that it *'...renders professional activities governable* [from a distance] *in new ways'* (*ibid*:153), ways that allow for an appearance of freedom, active choosing and rational decision making, but which are actually coerced by the politics of personal 'responsibility' (Rose 1998).

5. The point relating to 'fitness for work' by 'evidence based' practitioners tasked with managing economic targets is expanded further by Mills (2018) who cites the number of individuals denied access to support, committing suicide or dying after changes made to welfare arrangements. This research emphasises the political transition from responsibility for financial support to those with health and wellness needs, to the culture of 'personal entrepreneurism', individual responsibility and the 'failure' to be work ready, what Mills refers to as the *'burden discourse'* (2018:312) embedded in Fortier's (2017) 'hierarchies of worthiness', the 'lazy association' between motivation and value being intrapersonally determined. Further, in Mills' (2018) article there is a narrative theme which locates austerity driven suicides as *'an escape'* (2018:306). This links to Perry and Rosovsky (2000) research on the suicides of rural Chinese women as 'protest'.



CAPITALISM + ALIENATION
- ALIENATION COULD EXPLAIN INCREASE IN MHI DUE TO DISTRESS – [illegible] – SCHOOLS HAVE BEEN MARKETISED MUCH MORE IN RECENT YEARS THAN ANY OTHER TIME i.e ACADEMISATION IN 2010 – RUN AS 'BUSINESS MODELS'
- KNIGHT (2014) MISERY + ANXIETY ARE LINKED TO THE POWERLESSNESS FELT UNDER OPPRESSIVE AND ALIENATING CONDITIONS. MATTHEWS – CAPITALISM HAS NO CAPACITY TO PREVENT ILLNESS AS IT IS INHERENT WITHIN THE SYSTEM SO WELLBEING IS COMPROMISED.
- FOCUS ON RESILIENCE LINKS TO CONCEPTS OF PERSONAL SELF DEVELOPMENT AND ENTREPRENEURIALISM – SOCIAL + STRUCTURAL INEQUALITY BECOMES INVISIBLE AS REASONS ARE LOCATED WITHIN INDIVIDUAL PSYCHOPATHOLOGY – LIKE 'CHEMICAL IMBALANCE'
- RESILIENCE IS 'INOCULATION TRAINING' AGAINST THE EFFECTS OF CAPITALISM – THROUGH ALIENATION
DISLOCATION FROM ~~[illegible]~~ OTHERS (CONFORMITY) AND SELF
SEEMAN – ALIENATION FROM PSYCHOLOGICAL AND SOCIOLOGICAL POSITIONS DIFFICULT TO UNIFY. IDENTIFIES 6 KEY AREAS OF ALIENATION – ie MEANINGLESSNESS, NORMLESSNESS, SOCIAL ISOLATION
[K]NIGHT – ANXIETY FELT IS CAUSED BY POWERLESSNESS – LINKS TO SEEMAN
[W]ELLBEING AGENDA CREATES ANXIETY + SUFFERING AS IT PROMOTES [R]ESILIENCY – ENCOURAGES MEDICAL + THERAPEUTIC INTERVENTION 'LABELLING'
[IND]IVIDUALS NOW HELD RESPONSIBLE + ACCOUNTABLE FOR OWN WELLBEING

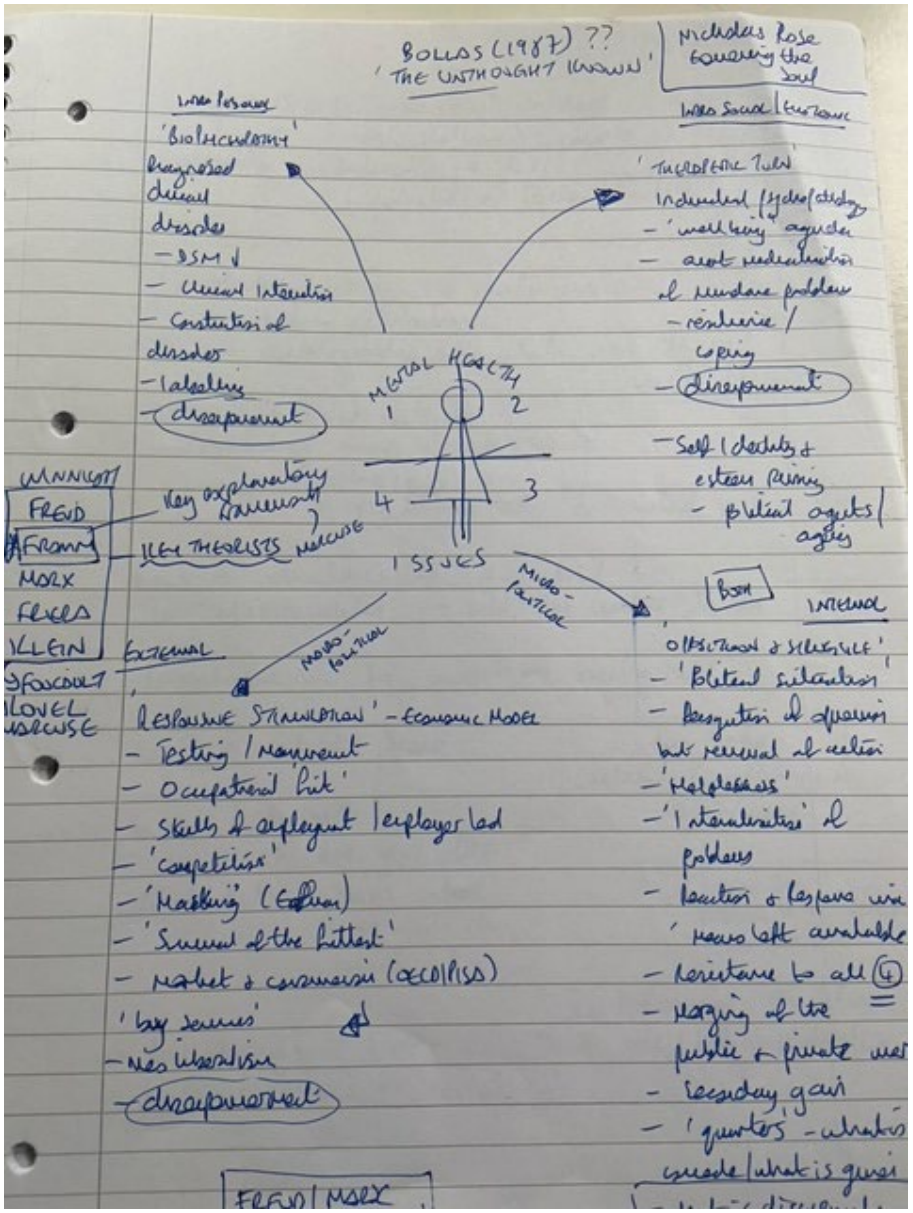
- CLARKE (2006) – PERSONAL ENTREPRENEURIALISM
SWANSEA (20XX) – REGULATION OF EMBODIED EXPERIENCES
ECCLESTONE + HAYES (2009) RIGHT WAY TO ACHIEVE HAPPIN…
↳ DIMINISHED SELF
- COHEN (2016) – ILLUSTRATED CHRONOLOGICAL CHANGES IN RECORDING OF CYP MENTAL HEALTH ISSUES IN DSM – WHIC… USED TO REGULATE BEHAVIOUR – 'DISCOVERY' OF NEW M… ARE LABELS FOR CLUSTERS OF BEHAVIOUR – OPPOSITIONAL DE… DISORDER
- MAKES DIAGNOSIS OF MHI EVEN EASIER – WITH 'GENER… VAGUE' SYMPTOMS LIKE 'TALKATIVE' / 'SLEEP' ALMOST I… NOT TO ACHIEVE A DIAGNOSIS – THEREFORE NOT EVEN … THROUGH THE FORMAL PROCESS ANYMORE – SELF LABELLING
- SEAL | NHSP | PERMA – TECHNOLOGIES OF EMOTION – R… CHILDREN'S EMOTIONAL BEHAVIOUR FOR THE PURPOSES OF … AND CONGRUENCY – NOT 'WELLNESS'
- BURMAN (2009) – EWB STRATEGIES SUPPRESS VARIATIO… REAL STRUGGLE
- ALIENATING EFFECTS CAN CAUSE PHYSICAL + EMOTIO… (SOMATIC) ie ANGER
- VAN DEN BERGH (2012) FETISHISM OF LOGOTH… CONSUMER' – SELF IMPROVEMENT – SELF RELIANCE – MOTIVATION
- COLLINGWOOD (1982) CAPITALIST IDEOLOGY HAS BE… INTROJECTED.

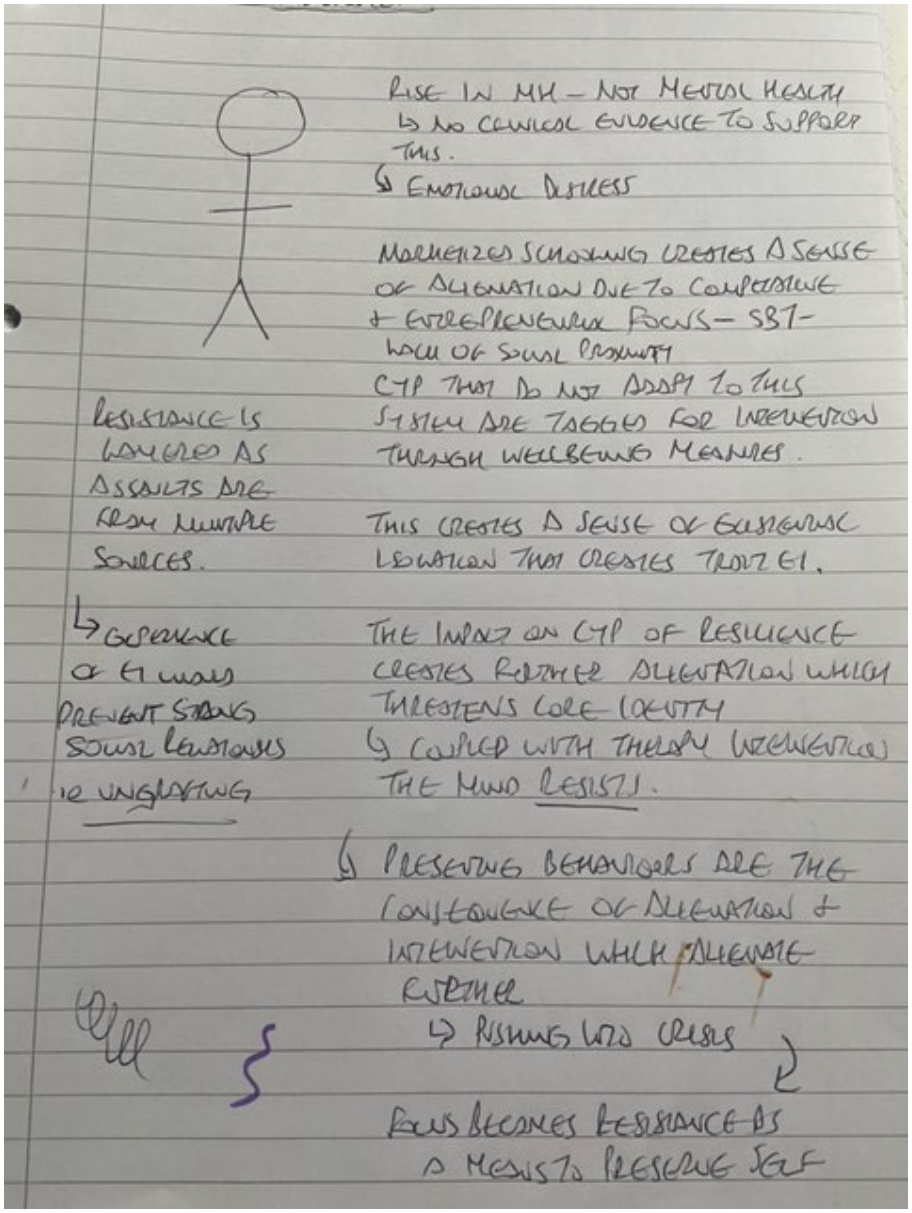


THREADS
SCREENING + REFERRAL – INTRUSIVENESS (LILLICH)
↳ CHILDREN ROUTINELY SCREENED FOR MENTAL HEALTH IN SCHOOLS USUALLY WHERE EMOTIONAL + AFFECTIVE RESPONSES DEEMED TO BE INAPPROPRIATE (PROCTOR)
- SURVEILLANCE IS ENCOURAGED BY STAFF + STUDENTS OF EACH OTHER
- TOOLS USED TO MEASURE ie SDQ (BOXALL PROFILE) FLAWED IN DESIGN + VALIDITY | RELIABILITY – AFFECTIVE CHEMISTRY (DAVIDSON)
- MEASURES OF MI (LIKE DSM | ICD) RESTRUCTURED TO LOWER THRESHOLD FOR QUALIFYING DISORDERS LIKE ANXIETY.
- TOOLS ALSO REFLECT 'TROPES' OF NEOLIBERALIST VALUES AND MUCH OF REFERRALS LINKED TO BEHAVIOURAL ASPECTS LIKE → PATTERNS LINKED TO BEHAVIOURS
DISENGAGEMENT | RISK TAKING | PUNCTUALITY | ATTENDANCE
- RECOMMENDATIONS NOT TO SCREEN FOR DISORDERS DUE TO THE UNRELIABILITY OF MEASURES
- MUCH OF SCREENING IS 'SELF REPORT' WHICH IS INFLATED BY NARRATIVES OF PSYCHOPATHOLOGY USED IN SCHOOLS + ENCOURAGEMENT TO 'REPORT' M.H.I – ALSO CONFLATES CLINICAL CONCEPTS WITH EMOTIONAL AFFECTS
- EXAMPLES SEEN IN CRITICISM OF NHS DIGITAL SURVEY. SIMILAR USE LIKERT SCALES.
- VESTED INTEREST IN 'BUSINESS' OF WELLBEING – TOOLBOXES, CONSULTANTS, INVENTORIES, PROFILES, TRAINING 'HAPPINESS INDUSTRY'
- DRIVEN BY FLAWED OECD DATA ON WELLBEING + HAPPINESS

Periodic reviews of information from emerging themes allow for – 'where am I in constructing the argument' by summating both comments, thoughts and action points to see the direction the work is taking.

Examples of diagrams to consider ideas and concepts. These also helped to track assumptions and questions areas that I had neglected, or challenge findings to ensure they were triangulated.





APPENDIX 3

HANSARD DEBATES AND PARLIAMENTARY QUESTIONS

Amanda Salloway MP (5 January 2016)

What steps have been taken to involve young people in plans for improving children and young people's mental health?

Liz McInnes MP (25 January 2016)

What estimates have been made of the number of children in schools with mental health problems; and what assessment has been made of the capacity of schools and sixth form colleges to appropriately support those children?

Ben Howlett MP (25 January 2016)

What steps are the government taking in schools to support young people with their mental health?

Luciana Berger MP (25 January 2016)

Concern has been raise by four Government Select Committees on the dire record of PSHE (for delivering Mental Health Training in schools). When will the government give the proper action to support child and adolescent mental health services?

Nick Morgan (Secretary of State for Education) – responded by outlining £1.25billion for the training pilots roll out program, the PSHE Association, further training for schools and the provision of counselling.

David Rutley MP (22 March 2016)

What steps are the government taking to improve support for the children and young people with mental health problems?

Dr Lisa Cameron MP (22 March 2016)

Eating Disorders among children and teenagers causes life threatening health problems and even death. What steps is the minister taking to enable early detection and intervention, which result in better prognosis and support closer to home?

Luciana Berger MP (22 March 2016)

Outlined reported incidences of schools and colleges being unable to secure services for large rise in reported number of students reporting anxiety, (two third were unable to access services and of those reported to CAMHS the outcomes were poor). Will the minister confirm that the money promised to children's mental health will reach those services and not be used to plug gaps in hospital budgets?

Alistair Burt MP (Minister for Community and Social Care) responded with budget breakdown, including £28m for expanding IAPT (Improving Access to Psychological Therapies).

Helen Hayes MP (27 October 2016)

Cites extracts from the Fourth Report from the Education Committee: Mental Health and Wellbeing of Looked After Children, Sessions 2015-2016, HC 481 and Responses Document CM 9284)

What further progress has been made since the [Government's] response and what are its plans to further improve mental health services for young people?

She further cites Association of Colleges report that 127 colleges who responded reported referral problems to health services. 61% stated their working relationship with local mental health service providers was only 'fair'. Threshold for services in adolescent mental health are increasing, making referral more difficult (for example BMI too high to be assessed for Eating Disorders). Survey by National Association of Head Teachers stated one third of primary schools have access to school based counsellors, with 59% having counsellors on site for around one day per week.

John Glen MP (27 October 2016)

Is it important to recognise that we heed an integrated solution, which requires educational and NHS responses. So that schools can get in very early and start tackling some of the behaviours that lead to poor mental health outcomes?

Mike Wood MP (27 October 2016)

According to one statistic, only between 25-35% of young people with diagnosable mental health conditions access support. Does this not underlie the need for much better training and much more awareness among both teachers and GPs in respect of early identification as well as early intervention?

Tim Loughton MP (27 October 2016)

Lists issues that contribute to potential mental health issues in children and cites *'...the pressure to succeed in school and the hothouse of exams and testing are not conducive to the best mental health'.*

Kevan Jones MP (27 October 2016)

In the same debate comments *'...we have national standards and curricula for physical education, so we should have them for mental health as well*'.

Dr Lisa Cameron MP (27 October 2016)

In the same debate comments *'...given that the weight of evidence for child and adolescent mental health services is in favour of psychological rather than pharmacological interventions..., clear structures must be in place to support the delivery of effective evidence-based psychological therapies..'*

Wes Streeting MP (27 October 2016)

In the same debate *'...it is no good asking Ofsted to inspect schools on mental health provision if school's referral to CAMHS are going unheard.'*

Christina Rees MP (27 October 2016)

In the same debate *'...although the department for Education has introduced character-building and resilience programmes, the report notes that this is not the best method of improving wellbeing in young people and instead proposes further training for teachers and academic staff.'*

Outlines the Youth Select Committees recommendations that mandatory mental health training should be in initial teacher training programmes, the inclusion of trained counsellors in all schools and services available in every secondary school.

Norman Lamb MP (10 January 2017)

Initiates a debate pertaining to supporting children's wellbeing and mental health in a school environment.

'*I do not want to over-medicalize this problem; we do not want to drive everybody into treatment. What we do want to do is prevent the need for that, so we must shift the system so that it focuses much more on preventing ill health and deterioration in health and schools are necessarily central to that*'

Identifies that the BACP have assessed the cost of delivering in school counselling intervention across all state funded schools in England as being £90m per year.

Luciana Berger MP (10 January 2017)

In the same debate identifies school counselling services are being cut due to budget limitations.

Madeleine Moon MP (10 January 2017)

In the same debate states increases in the number of self-harm incidences. '*Self harming in 16-24 year olds has doubled since 2000. One in four women and girls aged 16-24 have self harmed, raising to one in three among over 18s. In 2000 one in 15 young women between the ages of 16-24 reported having self harmed. By 1025 that figure was one in five.'*

Jo Churchill MP (10 January 2017)

In the same debate cites *'...at the schools and colleges I go to, particularly my sixth form college, the pastoral care teams reckon they spend up to 70% of their time on mental health issues.'*

Liz Saville-Roberts MP (10 January 2017)

In the same debate cites '(*Of a young constituent) ...her issues of anxiety appear to be reduced when she does not attend formal education, but she now needs to achieve formal qualifications. Surely our education system should match the needs of the child and not expect our children to be moulded to the needs of the education system.'*

Barbara Keeley MP (10 January 2017)

In the same debate states *'...if schoolteachers take on the role in mental health, they need to be able to make a referral to mental health services quickly. On average nearly one in four young people are turned away due to high thresholds for accessing services.'*

Simon Hoare (7 February 2017)

What steps is the government taking to prevent mental illness and provide mental health support for children?

Dame Rosier Winterton MP (7 February 2017)

Will the Green Paper look at the role that Educational Psychologists could play not only in providing support and assistance to young people with mental health problems but in preventative work?

Mark Pawsey MP (7 February 2017)

Will the Secretary of State say more about how children's mental health services can work more closely with schools and the education system more broadly?

Gregory Campbell MP (7 February 2017)

What pressure and persuasion is the Minister bringing to bear in the education system, particularly in primary schools, where young people have, on occasion, had this kind of a diagnosis and problems have been created within school?

Luke Pollard MP (4 July 2017)

What plans do the government have to improve the integration of mental health services for young people and adults?

Mary Glindon MP (10 October 2017)

What discussions has the Minister had with the Secretary of State for Education on promoting improved education in schools and youth settings to tackle the stigma associated with mental health?

Sir Desmond Swayne MP (10 October 2017)

Family doctors undertake such work (mental health support) but why have only a quarter of them had any formal training in mental health?

Sir Vince Cable MP (10 October 2017)

Since the demand for children's and youth health services far outstrips supply, will the Secretary of State consider diverting resources to voluntary bodies, which have much lower threshold for referral?

Jim Shannon MP (10 October 2017)

Do the government not recognise the importance of treating mental health with equal status to physical health?

Catherine McKinnell MP (6 November 2017)

Read out a statement from the Petition by Adam Shaw: '*Currently mental health is only taught as an optional component of PHSE – but this is not good enough. Understanding mental health is an*

absolute life skill and should be as fundamental to the school curriculum as reading and writing. There needs to be compulsory collaboration and integration between mental health education and physical education, so that children and young people can understand that maintaining good mental health is equally vital to their wellbeing.'

'*Currently mental health education is taught inconsistently in the UK and only in secondary schools – despite 1 in 5 children experiencing a mental health difficulty before the age of 11.'*

Sir Nicholas Soames MP (6 November 2017)

Because of the lack of training for teachers in this particularly important subject, what is being applied now is really just emotional first aid? If people are to do more, they have to have the ability to teach more. How does she see that working out?

Catherine McKinnell MP (6 November 2017)

In the same debate states *'... teachers are not mental health professionals, they are teachers by profession. It is therefore vital that we improve not only our educational input but the training and support for teachers so they can deliver this support at an appropriate level and are able to signpost and refer if professional input is required.'*

Rachael Maskell MP (6 November 2017)

In light of the fact that mental health challenges start when people are young, it is crucial that schools have mental health practitioners who can support young people. Teachers are not health professionals and therefore do not have the necessary skills. They have numerous other pressures to focus on, so is it not crucial that we have mental health practitioners in schools?

Chris Ruane MP (6 November 2017)

In the same debate cites *'32.3% of 15-25 year olds have one or more psychiatric condition. The wider point about all of these terrible statistics is that even people who are not adversely affected by mental ill health can be taught in school through modern positive psychology and mindfulness to lead flourishing lives. The whole wellbeing curve of mental health could be shifted if we took that root and branch approach to putting mental education I our schools'.*

Rachael Maskell MP (6 November 2017)

In the same debate states *'...is it not crucial that we also understand the triggers, the causation of mental health conditions in young people and where the stress factors fall, for example in the pressures of the exam system? Those issues should be addressed*'.

Catherine McKinnell MP (6 November 2017)

In the same debate responded to the above comment and states *'... one of the issues that young people raise with me time and time again: the amount of stress and pressure that they feel under from a worryingly young age'*

'*The level of academic pressure that young people are under from a very young age is a big concern and one that I would like the government to listen to seriously and address.'*

On a further point, she cites *' I know just how much pressure young people feel under as a result of ever-increasing demands for schools to deliver right academic results.'*

'There are increasing concerns about the introduction of the English Baccalaureate and its significant narrowing of the curriculum at many secondary schools, which reduces the opportunity for many pupils to excel, such is the pressure on schools to deliver results in a small number of Government – defined core subjects.'

'*There is a really disturbing pressure on primary age pupils as a result of significant recent changes to the curriculum, school performance measures and SATs. A recent Guardian Survey found that 82% of primary school leaders had seen an increase in mental health issues among primary age pupils around the time of the exams, with effects including loss of eyelashes through stress, sobbing during tests, sleeplessness, anxiety, fear of academic failure, low self- esteem, panic attacks and depression.'*

'It seems to me that there is little point in the Government mandating compulsory mental health education in our schools while they actively undermine pupils' mental health.'

'Achieving a balance between promoting academic attainment and well-being should not be regarded as a zero-sum activity. Greater well-being can equip pupils to achieve academically. If the pressure to promote academic excellence is detrimentally affecting pupils', it becomes self-defeating. Government and schools must be conscious of the stress and anxiety that they are placing on pupils and ensure that sufficient time is allowed for activities which develop life- long skills for well -being. '

'*More must be done to ensure that health and well- being are given appropriate prominence in inspections and in contributing to the overall grade given to the school or college. The recently appointed Chief Inspector should, as a matter of priority, consider ways in which the inspection regime gives sufficient prominence to well-being.'*

Robert Halfon MP (6 November 2017)

In the same debate cites *'...the first rung of the educational ladder of opportunity is addressing social injustice, and there is a real problem of social injustice here.' '...problems for children and mental health seem to be endemic in our schools system for a variety of reasons...'*

Sir Nicholas Soames MP (6 November 2017)

In the same debate cites *'I think this is a National crisis'. 'This is a real National crisis and the scale of it is only just beginning to be realised'.*

Sir Oliver Heald MP (6 November 2017)

In the same debate cites '*This has got to the point where it is of great national importance'.*

James Morris MP (6 November 2017)

In the same debate cites '*People use the word 'crisis' which I am always wary of using. It is not as if this crisis started today.'*

Chris Ruane MP (6 November 2017)

In the same debate cites 'The WHO say that by 2030 the biggest health burden on the whole of the planet will not be heart disease or cancer; it will be depression. ''*This tsunami of mental ill health is coming our way and I believe we are ill prepared for it..."*

'If we can build strong children and give them that resilience, it benefits the individual child and their family, and the knock on effects of building in that resilience from an early age will benefit our economy and health services down the decades.'

'Being tested at school at the ages of five, seven, 11, 14, 15 ,16, 17, 18 and 21 produce massive stress on young people.'

Dr Lisa Cameron MP (6 November 2017)

In the same debate states '*Addressing this issue is not only economically vital, but about skilling up our future generation to cope with mental wellbeing and to cope holistically with life.'*

Mike Kane MP (6 November 2017)

In the same debate states *'[Intervention in schools] ...will not deal properly with the burning injustices faced by children and young people with mental ill health'.*

Alex Chalk MP (12 December 2017)

Does the Government agree that as well as looking at cure, we need to look at prevention and to understand why this explosion is taking place?

Sandy Martin MP (12 December 2017)

Does the Government believe, as I do, that while four weeks would be an improvement on most of the waiting times that our children and young people have had to face up until now, that maximum wait needs to be upped to until actual treatment and not just until the assessment for treatment?

Jim Shannon MP (12 December 2017)

Does the government agree that it is time not for words but for action that would see the Health Department and the Department for Education working cohesively to address the issues discussed (access to child mental health assessment)?

Rachael Maskell MP (12 December 2017)

Does the government agree that the Green Paper places more and more focus on teachers, as opposed to health professionals, providing mental health support? Teachers are already stressed by the volume of work that they have to do and they are not trained as medical professionals, so should that emphasis change?

Luciana Berger MP (12 December 2017)

In the same debate states '*At the same the department of Education is piling extra pressure on students with more testing.'*

Rachael Maskell MP (12 December 2017)

What are the government going to do to address the causes of poor mental health in young people?

Steve Reed MP (19 December 2017)

What assessment has been made of the adequacy of access to mental health services for children and young people?

Trudy Harrison MP (19 December 2017)

What steps are the government taking to improve the provision of mental health services for children and young people?

Christopher Pincher MP (19 December 2017)

What steps are being taken to improve health provision for children and young people?

Michelle Donelan MP (6 February 2018)

What steps are being taken to improve mental health provision for children and young people?

Edward Argar MP (6 February 2018)

What steps are being taken to improve mental health provision for children and young people?

Kirstene Hair MP (6 February 2018)

What steps are being taken to improve mental health provision for children and young people?

Michelle Donelan MP (6 February 2018)

What more can be done to ensure that adolescence who are in desperate need of help get that help before it is too late?

Edward Argar MP (6 February 2018)

How will steps taken in the [Green Paper] help to reduce waits [for between referral and assessment services] in Leicestershire and across the country?

Alex Chalk MP (6 February 2018)

Does the government agree that as well as improving the treatment of adolescent ill health, everything possible needs to be done to prevent crisis from occurring in the first place? Do they agree that we need more research into why we are seeing as surge in Cheltenham and elsewhere in the world, so that clinicians can best tailor their responses?

Ellie Reeves MP (6 February 2018)

The Government has said that these waiting times are a tragedy, but how bad do things have to get before the government takes action?

Paula Sherriff MP (6 February 2018)

Research by the children's Commissioner revealed that the spend on children and young people's mental health services varied by CCG from between 0.2% to 9%, resulting in services in some areas being described as 'shockingly poor'. Can the Secretary of State therefore explain the reason for the variation, and will he commit to matching Labour's pledge to increase the proportion of the mental health budget spend on CAMHS services?

Barbara Keeley MP (8 March 2018)

Urgent Question: To ask the Secretary of State for Health and Social Care to make a statement on the CQC review of children and young people's mental health services.

Does the Minister recognise that imposing high eligibility thresholds means that children and young people are only treated when their condition becomes more serious? These high thresholds are prompting some GPs to tell children to pretend their mental health is worse than it is.

Fiona Bruce MP (8 March 2018)

Does the Minister agree that helping children with their mental health challenges needs to involve, wherever practical, their families, family relationships and inter-parental relationships, as recommended by the Early Intervention Foundation?

Jeremy Quinn MP (8 March 2018)

The CQC has recommended that Ofsted should be charged with looking at what schools are doing to support mental health. Will the Minister take that up with his ministerial colleagues in the Department for Education?

Liz McInnes MP (8 March 2018)

With increasing numbers of university students having mental health problems, what action will the Minister take to ensure better joined up care, with better communication between them and university GPs and student's welfare services?

Steve Double MP (8 March 2018)

We continue to have a problem with clinical commissioning groups in delivering front line services, even though the Government are providing more money, so what steps will the Minister take to ensure that CCGs allocate the money provided to those services?

Ellie Reeves MP (8 March 2018)

The CGC review found that children were waiting up to 18 months to receive treatment for their mental health conditions. In Lewisham, the Government are cutting the budget for child and adolescent mental health services by 5%. The Green Paper will not help children currently waiting. What will the government do to address this?

Connor McGinn MP (8 March 2018)

The Minister's description of mental health services will not be recognised by anyone providing or using services. Does he think that cutting funding for the north-west borough's partnership year since on year since 2011 has led to an improvement in services?

Tony Lloyd MP (8 March 2018)

How will he guarantee that every GP surgery will have the necessary capacity to deliver excellence in mental health services for our young people?

Rachael Maskell MP (8 March 2018)

It takes time to train mental health staff, so what are the Government going to do in the interim to ensure that we have staff in the service?

Nick Smith MP (8 March 2018)

Phase 1 on the CQC review noted that there were unacceptable variations in quality. How can quality be provided more consistently throughout the country?

Anna Turley MP (20 March 2018)

What estimate has been made of the number of young people who have not had access to child and adolescent mental health services after a referral in the last 12 months?

Vicky Foxcroft MP (20 March 2018)

What estimate has been made of the number of young people who have not had access to child and adolescent mental health services after a referral in the last 12 months?

Does the Minister accept that cuts to mental health services mean that too many young people who have suffered trauma are not getting the support that they desperately need?

Andrew Bridgen MP (20 March 2018)

Mental health problems clearly have a wider societal cost. Does the Minister agree that treating mental health issues in children benefits not only the child, but the future of our society as a whole?

Paula Sherriff MP (20 March 2018)

Will the Minister tell us exactly what she is doing to fix what many health professionals say is a broken child and adolescent mental health service system?

Layla Moran MP (4 December 2018)

The NSPCC says that the number of schools seeking help from mental health services is up by more than a third in the last three years. The number of referrals to NHS child and adolescent mental health services by schools seeking professional help for a student was 34,757 in 2017-18. Ta is the equivalent of 183 every school day. To say that this is anything other than as crisis would be wrong. We are facing a mental health crisis in our schools.

The National Education Union found that 49% of education staff said that secondary school pupils had been suicidal as a result of the stress they were under, and more than half of professionals surveyed said that funding for support for pupils' mental health in schools was inadequate.

Layla Moran MP (4 December 2018)

In the same debate cites '*The government are fostering a culture of senseless competition amongst schools, in which results from a single set of narrowly focused high stakes exams are the be all and end all. That is not good enough.*

'We have a curriculum that encourages multiple levels of failure'.

Andrea Jenkyns MP (4 December 2018)

Does the Minister agree that the government are making a step in the right direction by ensuring that young people will be prioritised with school based mental health support available in every part of the UK?

Citing a constituent's letter *"putting children in boxes which suit a government body is, in my opinion, creating mental health issues at a very early age"*

'I would like the debate to focus on that toxic culture'

'The Education Policy Institute reports that the number of referrals to specialist children's mental health service has increased by 26% over the past five years, although the school population has increased by only 3%. Something is clearly going on, whether it is lack of early intervention or increased pressure'.

'We are not looking at the core issues that are driving the problem. Unless they do that, we are always going to be playing catch up.'

Stephanie Peacock MP (4 December 2018)

Does the Minister agree that it is quite concerning that people need to be in absolute crisis even to get a referral?

Dr Dan Poulter MP (4 December 2018)

(A declared interest of being a practising doctor in mental health services and a member of the Royal College of Psychiatrists.)

In the same debate states *'...in addressing young people's mental health, it is important that we do not over-medicalized issues such as teenage angst or normal patterns of growing up. It is important that we do not follow the American system where a lot of young people are on medication, without there necessarily being a good evidence base for that. We have to be very careful about over-medicalising problems, or medicalising problems too quickly, which is perhaps how we should look at it'.*

Rachael Maskell MP (4 December 2018)

One issue that has been raised is the narrowing of the curriculum. The perfectionism that is expected of our young people – and the exam methodology itself – is putting incredible strain on them. This has been seen in schools – but in particular at York College, where there has been a 23% increase in the number of young people with mental health challenges in the past year.

Emma Lewell-Buck MP (4 December 2018)

In the same debate cited ..Barnardos accused the government of *"...sleepwalking into the deepening crisis in children's mental health"*

'The government are acting in a manner that exacerbates poor mental health in children and young people, the Minister [For School Standards] said on the record *"we do not want children to be under pressure with exams" and stated that nothing that his department has done make things worse. Yet children are being placed under unbearable pressure because of high stakes exam culture fostered by the Government, resulting in feelings of chronic low self-esteem and stress. In a study commissioned by YoungMinds earlier this year, 82% of teachers said that the focus on exams had become disproportionate to the overall wellbeing of their students. Similar concerns have been raised by the Education Committee, while some head teachers said that their students had attempted suicide over exam pressure".*

Layla Moran MP (4 December 2018)

In the same debate stated *'...I am sure that many people out there will be heartened to hear that students should not be feeling the stress of exams, but the fact is that they do. It is a shame that the Government will not take responsibility for the part they have played in creating this culture'*

Tim Farron MP (18 December 2018)

Presenting a Petition from Constituents. 'The petitioner requests that the house of commons urges Government to end the 75p per head allocation and give Cumbria the money it needs to keep our young people mentally healthy and support those in the early stages of experiencing mental health problems specifically by funding a mental health worker for every school and college in Cumbria.

Bim Afolami MP (15 January 2019)

What the aims are of the new mental health support teams to be placed in schools and colleges, and hat steps those teams will take to improve mental health for young people?

Paul Blomfield MP (11 March 2019)

What recent assessment his Department has made of the adequacy of support in schools for children and young people?

All data listed here is directly taken and reproduced exactly from Hansard Online – by search term Child Mental Health and specific dates between (2016-2019). Available at https://hansard.parliament.uk/search/Debates?startDate=2016-01-01&endDate=2019-04-28&searchTerm=mental%20health&house=Commons&partial=False

[Accessed on 11/04/19]

APPENDIX 4

Introduction of an APPG for Psychology

On 28 September 2017, an All-Party Parliamentary Group (APPG) was established for Psychology with a remit to:

'*Raise awareness amongst parliamentarians and policymakers of the importance and relevance of psychology, combining research and best practice briefings to ensure that MPs have access to a psychological evidence-based approach to policy development.'*
(BPS, 2017)

The APPG has the British Psychological Society (BPS) as its Secretariat. There are significant numbers of All-Party groups on a vast range of eclectic fields, including specific areas, like health, infrastructure and environment, and more specialised topics for example Children in Care, Animal Welfare, Cancer, Design and Innovation and Sports. Although the APPGs are informal groups, and have no designated power or status within parliament, they are able to exert some influence on government and policy. They usually act as information points, which may involve consultation with external organisations or individuals in a fact-finding capacity, the majority of groups on the register of interests states their purpose is to 'promote awareness' in some way. For example, the APPG on Health states its purpose is to *'...generate debate and facilitate engagement'*, other APPGs identify their role is to *'...provide a forum for...'*, *'...promote the interest of'* and *'...make recommendations to policy makers*' (Parliament.co.uk, 2020)*. The APPG on Antibiotics: a truly pressing issue of global concern, whose Secretariat is the British Society for Antimicrobial Chemotherapy, indicates it exists to *'...raise the profile of...'*, further, the actual Mental Health APPG identifies its objective is to '*Inform parliamentarians about all aspects of mental health*' (Parliament.co.uk, 2020)*. The point being made here is that very few of the 355 APPGs (correct as at 24/02/20 – the list is updated every 6 weeks) makes reference to using mechanisms of practice to *develop policy*. The fundamental assumption implicit within the claims of purpose for the Psychology APPG, is of an 'evidence base' which is a problematic term when applied to this field. There are direct challenges currently facing the discipline, for example the Replication Crisis which has seriously undermined much of the research

* To find Aims and Objectives for the APPGs – use the link below to the register and then select the APPG, this will take you to their website where aims and objectives are stated.
https://publications.parliament.uk/pa/cm/cmallparty/201216/contents.htm

findings from many areas of the discipline, calling into question what psychology thinks it knows, leading to a question on the veracity of a claim to 'evidence'. Moreover, typically, the field of psychology is populated by competing (and irreconcilable) perspectives to explain behaviour. So, a further question would be positioned as an enquiry into whose 'evidence' is being presented here? As a brief example consider that the causes of abnormal behaviour can be assessed using multiple frameworks, (Deviation from the Statistical Norm, Deviation from the Social Norm, Failure to Function Adequately , Deviation from Ideal Mental Health, using different reference manuals (DSM-V or ICD-11) from wholly different perspectives. Behaviourism would suggest mental health stems from maladaptive learning and reinforcement; Cognitive proponents would argue it emanates from maladaptive perception and thinking, whereas Biological advocates would suggest it is physiological deficiencies, in biochemical imbalances or CNS misregulation. If the discipline has fundamental differences in its actual approach to what constitutes a problem, (let alone what a possible solution could be), with each of the perspectives taking a different starting position, all with contradictory underpinning assumptions concerning an array of issues, (from causes and manifestations of behaviour to motivations) along with significantly different working methodologies - to explain the same behavioural phenomena - then it is fallacious to talk about 'evidence' in this way. The BPS advertised on its website a BPS conference during which Sir Mark Walport (Chief of UKRI) will discuss ways that '*Psychology research has an impact on public policy*' (BPS, 2019a). Perhaps more alarmingly, the BPS website explaining the constitution of its new Policy Team, with the express intention of ensuring that the influence of psychology is *'...heard in the corridors of power and [has] a seat at the table that matters'* (BPS: 2019b).

APPENDIX 5

CONCERNS EXPRESSED BY BPS IN RELATION TO CHANGES TO NICE GUIDELINE FOR DEPRESSION

The NICE website (updated in April 2018) references the NICE Guidelines (NICE, 2009) as the foundation document for treatment pathways and protocols for recognition and management of depression in adults. It still references depression as being differentiated using ICD 10 and *DSM IV*, which is out of date, (the current version is DSM-V) and it states the reason for this is that these guidelines cover 'sub-threshold depressive symptoms' which fall below the diagnostic threshold for Major depressive disorders, but allows a diagnosis of Minor depressive disorders with the presentation of just one symptom, consistently over 2 weeks, from three key criteria including loss of energy, low mood and Anhedonia (an inability to feel pleasure). It also states the DSM-IV criteria for diagnosis is more rigorous than the ICD-10 criteria, (which is used predominantly in the UK) and further that the majority of research evidence it draws on to give public guidance is generated using the DSM. It specifies that the guidelines were reviewed in 2013, but there is little change between the previous and current recommendations.

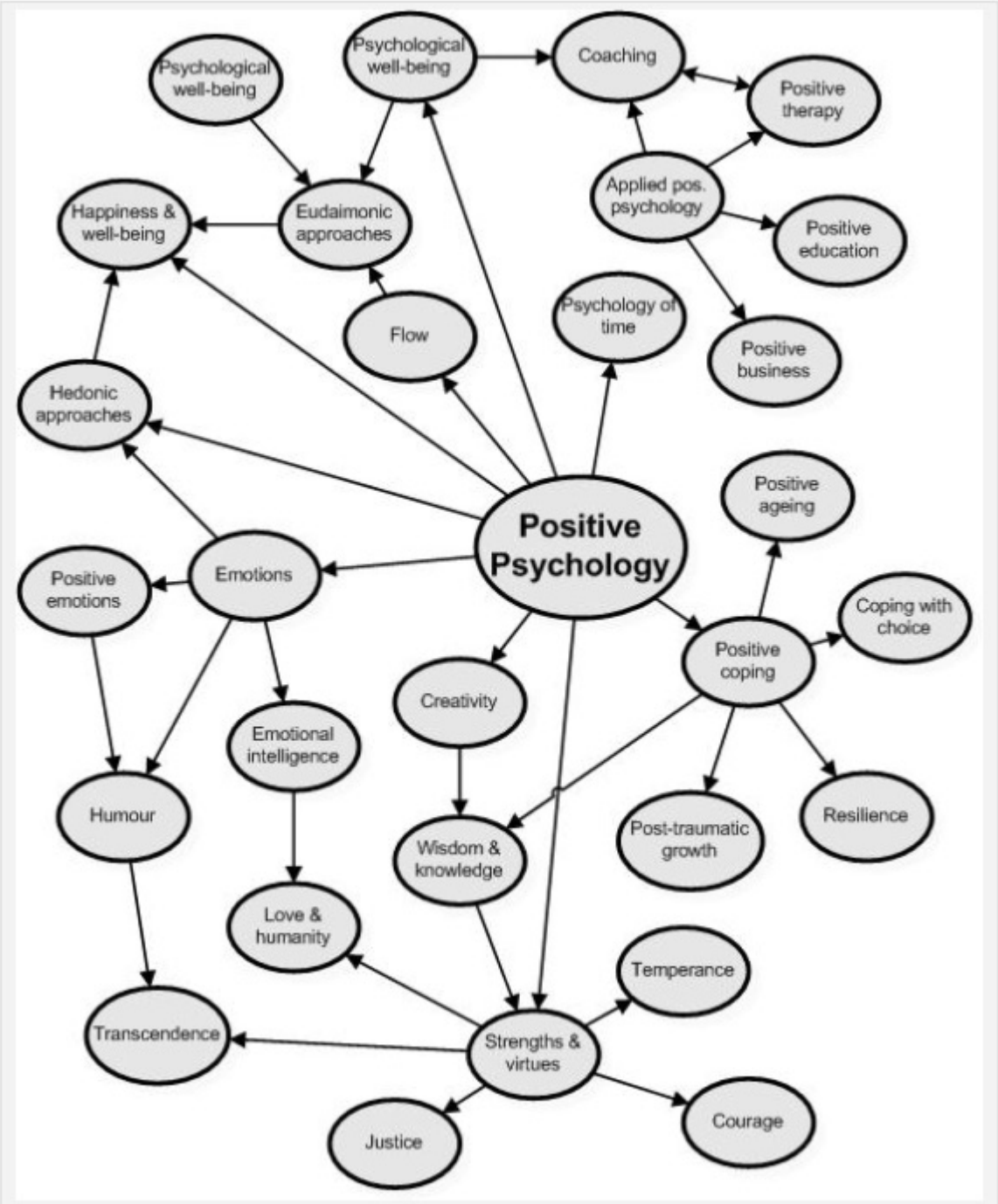
The current NICE guidelines for depression have been subject to much criticism relating to a range of issues including methodological concerns around inclusion of patient experiences of interventions, the misrepresentation of severity of symptoms, the over-dependency of prescribed drugs in first line treatment and categorisation of symptoms into unified groupings. This has been underpinned by over thirty-five health-based organisations as well as individual clinicians and practitioners.

In September 2017, the British Psychological Society (BPS) published a response to the National Institute for Health and Care Excellence (NICE) proposed changes in the diagnosis of depression in adults and expressed concern on every section of the amendment, i.e. '*The society is concerned regarding: the suggestion that antidepressant medication is not addictive*' (Section 1.4.)... *'diagnoses of 'personality disorders' reflects social conventions and these change over time*' (Section 1.1) ... *'the diagnosis of depression when diagnosis itself has questionable reliability and validity*' (Section 1.1), it concludes by stating *'The society calls for an approach that fully acknowledges the growing amount of evidence for psychosocial causal*

factors and the limited amount of support for the 'Disease Model' of depression' (Section 1.13.). These concerns were neither addressed, nor recommendations adopted (NICE, 2017). In (February 2018) a further group of stakeholders, including the Royal College of Psychiatrists, petitioned for significant changes in the proposed new guidelines, by lobbying to table an Early Day Motion which was supported by cross-party MP's. This resulted in an extension to the consultation process, by 4 weeks– but at its conclusion in June 2018, the original draft document stood, and the recommendations have been deferred until the next revision window (NSUN, 2018). NICE continue to promote medication routes as the preferred pathway from treating depression.

APPENDIX 6

POSITIVE PSYCHOLOGY MODEL



PositivePsychology.org.uk Available from: http://positivepsychology.org.uk/what-is-positive-psychology/?option=com_content&view=article&id=104:pp-mind-maps&catid=61&itemid=100023 [Viewed 23 December 20]

Image from the above website showing the strengths and virtues promoted within Positive Psychology. Of interest are the virtues like positive emotions, emotional intelligence, resilience, happiness and wellbeing, positive therapy and post-traumatic growth which are key features of social and emotional learning programmes and the Wellbeing Agenda.

APPENDIX 7

These tables identify key theorists within Resilience Theory and illustrate the similarities and differences between concepts and applications. Shean (2015:24-26).

Taken from: Shean, M., (2015). *Current theories relating to resilience and young people: A literature review*. (Victorian Health Promotion Foundation). [Online]. [Viewed 17 April 2021]. Available from: https://evidenceforlearning.org.au/assets/Grant-Round-II-Resilience/Current-theories-relating-to-resilience-and-young-people.pdf

	serious risk experiences and a relatively positive psychological outcome despite those experiences (Rutter, 2006)	• Mental features (e.g. sense of agency) influence resilience • Turning point effects can influence resilience when older • Attend to biology of resilience and gene-environment interactions • Social relationships are protective	• Comparison of children in two different settings • Strong focus on competence	psychopathology • Identify aspects of risk that contribute to causation • Teach mental features • Maintain challenge to developing coping skills • Introduce turning points into adulthood • Pay attention to biological pathways
Garmezy	Resilience is not impervious to stress. Rather, it is designed to reflect the capacity for recovery and maintained adaptive behaviour that may follow initial retreat or incapacity upon initiating a stressful event (Garmezy, 1991a)	• Focus on development • Focus on positive • Addressed community, family, individual level factors (e.g. temperament, the presence of some caring adult, sources of external support)	Project Competence (Garmezy et al., 1961) • Minnesota • Positive focus • Children born to parents with schizophrenia and children with referrals for behaviour problems	• Look at all levels in interventions (community, family, individual factors)

	Definitions	Theory	Empirical support	Implications for therapy/population health
Werner	The capacity to cope effectively with the internal stresses of their vulnerabilities (labile patterns of autonomic reactivity, developmental imbalances, unusual sensitivities) and external stresses (illness, major losses, and dissolution of the family) (Werner, 1982)	• Identified differences between factors that affected resilient at individual, family, and community level • Noted differences between boys and girls • Resilience changes over time (resilience is not fixed) • Resilience is dependent on balance between protective factors and risk factors	Kauai longitudinal study (698 infants born on island of Kauai) (Werner, 1982) • Noted individual, family and community differences between risk and resilience Follow-up of Kauai study in 1985–86. Found protective factors: • Dispositional attributes of the individual • Affectional ties within the family • External support systems (church, work)	• Many children "self-righted" in all but the most persistently adverse situations" • Increase understanding of generalised resources and their effect • Investigate the effect of social policy • Review role of siblings and grandparents • Implement support from outside family • Develop a child's sense of coherence • Change is possible with the right resources
Luthar	A dynamic process encompassing positive adaptation within the context of significant adversity (Luthar et al., 2000)	• Resilience is multidimensional (competence in some domains not others) • Factors are not polar opposites • Too much diversity in measurement of domains	• 144 adolescents inner city public school (mean age 15.3) (Luthar, 1991) • 227 mothers who had substance abuse and their children (Luthar et al., 2003) • Affluent youth (Luthar and Latendresse, 2005).	• Attend to "factors that are salient in that particular life context, those that affect a relatively large number of people in that group" (Luthar et al., 2006) • Focus on biological influences

	Definitions	Theory	Empirical support	Implications for therapy/population health
Masten	Children who have good outcomes in spite of serious threats to adaptation of development (Masten, 2001) The capacity of a dynamic system to adapt successfully to disturbances that threaten system function, viability, or development (Masten, 2014)	• Variable focused – statistical relationship and patterns between variables • Person focused – identify resilient people and find how they are different from those who are not resilient • Factors exist at child, family and community level • Phenomena is ordinary process of development through basic human adaptation systems • Developmental cascades • Late bloomers • Discussed context and culture in 2014	• Project Competence (see Garmezy) • Tested influence of parent quality and intellectual functioning from childhood to late adolescence (205 children aged 8–12 years, then 189 adolescents 14–19 years old seven to 10 years later)	• Some children lack "basic resources nor the opportunities and experience that nurture the development of adaptive systems" (Masten, 2001) • Identify hotspots of change (see Masten, 2007) • Have positive objectives • Promote competence (competence begets competence) • Track progress in terms of developmental competence
Ungar	The outcome from negotiations between individuals and their environments for the resources to define themselves as healthy amidst conditions collectively viewed as adverse (Ungar, 2004)	Seven tensions of resilience: 1. Access to material resources 2. Relationships 3. Identity 4. Power and control 5. Social justice 6. Cultural adherence 7. Cohesion • Emphasis on environment's capacity to facilitate growth • Individual qualities are triggered or suppressed by environment	• 89 youth (12–23) in transition from childhood to adulthood (Ungar et al., 2007) • 11 country qualitative study – 19 Aboriginal and non-Aboriginal Canadian adolescents interviewed (from sample of 89 Canadian youth, aged 15–18) (Ungar et al., 2008) • 14 site mixed methods study over 1500 youth, 14 communities, five continents (Ungar, 2008)	• Privilege local knowledge • Interventions need to be sensitive to most influential resources • Intervene at multiple levels o Culture o Community o Relationships o Individual • Intervene to help children navigate the tensions • Better documentation of local youth's construction of resilience, the better the intervention will be

APPENDIX 8

SNAPSHOT OF THE IMPACT OF CHANGES MADE FROM THE GREEN PAPER (2017)

Focusing exclusively on affective experiences fundamentally changes the nature of teaching, which leads to feelings and emotions being regulated and regimented by schools. Through this constant demand for access to their 'inner' feelings, children are effectively placed into 'forced confessionals' where they have to expose every negative or unpleasant thought, leading to what Horwitz and Wakefield (2007) describe as a '*profound intrusion'* into their lives. Craig (2009:17) further warns that allowing unlimited psychological interference in both the sharing of private, inner feelings and the intervention of psychological based therapies and techniques carries risk, not least because inexperienced and unqualified staff intervening in complex emotional problems may exacerbate the problems or create new ones.

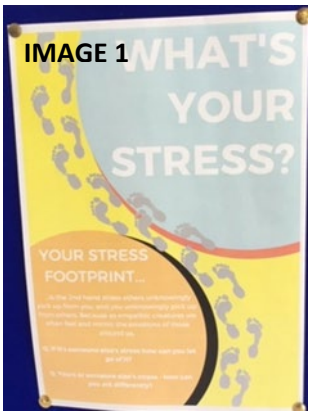
This illustrates the increasing role that education is being forced to play in the 'policing' of mental health, with institutions needing to produce new policies to incorporate the monitoring and assessment of mental health in students. Along with the demands placed on education staff in recognising mental health concerns in CYP. What follows is a brief summary of changes within my own institution as a consequence of The Green Paper (2017).

1. Services and Promotion

The college is now required to offer and promote a range of mental health services to students as part of their statutory responsibilities. This has necessitated a substantive restructuring and expansion of pastoral support services organised as a core team of wellbeing staff, including the Mental Health Lead and Mental Health Support Staff. These inhabit the newly created 'Wellbeing Area' which has a range of facilities and services for students. This area's function is to package the wellbeing support offered which includes physical aspects like displays, information sites and rest areas, quiet rooms, free snacks and drinks and meeting rooms for appointments and discussions. Services include referral on to counselling services outside of college, access to wellbeing support staff for discussions, pre-booked 1-2-1 support sessions and crisis support. The area has high visibility in a newly developed area of the college which offers facilities 'clustered' around wellbeing and care. The wellbeing 'hub' is located at the confluence to all main college services, for example the study centre, computer suites, library, food facilities and the interchange between the

different sections of the campus. It therefore gets the most foot fall in the college day. It also has a generous allocation of funding, equipment, accommodation, resources, wall space and display areas and is given a high profile in every external promotional event for the college.

Part of the Wellbeing Agenda 'promotion' requires that all students are exposed to direct wellbeing support. This includes the active marketing around college of the available wellbeing services and the promotion of mental health issues, including strategies to manage mental health. Seen here are a range of images taken from around the college that show extensive permanent displays of promotional support for mental health services. This is a small selection of the vast amount present, in every physical area of the college including social space where students may queue, the Wellbeing Services Area, the library, on walls along the corridor and within every faculty and individual department. Much of the material is asking students to consider aspects of their lives that could be regarded as having the potential for creating mental ill health. A specific example is given in the poster '*What's your Stress*?' (see Image 1). This 'normalises' stress but also 'pathologizes' it at the same time. It makes the automatic assumption of stress existing, (it does not ask if stress is being experienced). This is enough to book an appointment with the wellbeing team for 'intervention'. Other examples I witnessed were students being stopped and asked to 'rate' themselves on a 'Wellness Wedge' (see Image 2) and if placing themselves in the yellow, orange or red section, then they were booked in for an appointment as an immediate referral for support from the wellbeing staff. Further information includes posters suggesting the prevalence of mental health issues, for example, the poster that states '*1 in 4 people suffer from a mental illness. Why are we still scared to talk about it*' (see Image 3). This number is not supported by the NHS Digital (2018) report which (erroneously) specifies that for college student's age range it is 1:8, so this is misleading in suggesting more people are affected than potentially are.



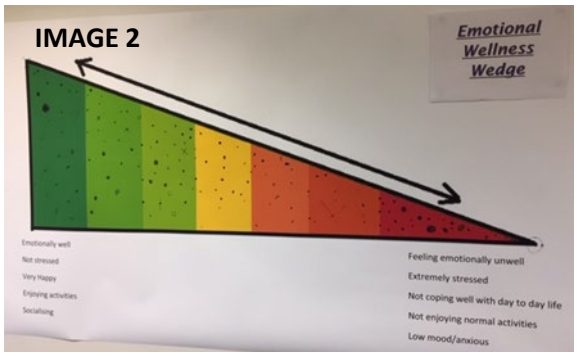


IMAGE 3

What this type of promotion does is effectively produce a constant reinforcement that the student must be experiencing 'some form' of disorder, that they just have not reported yet or been made aware of. It is present in every aspect of their college life, including on the displays and promotions mentioned here, but also on the VLE platforms, on their individual electronic accounts, the college's social media presence, the website, even in the college toilets – by accessible phone numbers, encouraging disclosures. It is present also within the cafeteria and food outlets, within most classrooms and through the induction, enrichment and tutorial programmes, where students' complete surveys to assess 'wellbeing', take part in 'wellbeing awards' and run 'wellbeing societies'. This rationalises that all students have wellbeing issues that they have not yet been made aware of.

Changes have also been made in the dynamic between academic and student support staff. Previously academic staff had overall responsibility for managing a student's timetable, course, academic progress and performance, along with management of behaviour and potentially contact with parents in respect of any of these standards not being met. This was in conjunction with pastoral support, who would work with academic staff to improve outcomes for students. However, if a student declares or is identified as having a mental health issue, the support team member now takes the lead in the student's college journey. Measures can then be put in place to 'support' the students which include a suspension of all academic sanctions that may have been put in place, extension or removal of deadlines for work, except for those externally set (like examination dates), withdrawal from lessons to be 'mentored', the option of learning from home for extended (but managed) periods, the operation of a 'card' system where students can show a card and be allowed to leave the lesson, unchallenged, because they are feeling stressed or unable to cope, which usually results in students working in the Wellbeing Area. Students can also request Individual Learning Plans from academic staff where special measures have to be incorporated, for example not being 'pressured' in class to answer questions out loud, not being asked for late homework, not being required to sit in or with certain people or places, not being required to take part in group work or practical tasks, basically this necessitates an attempt by staff to remove any potential 'adverse' triggers for individuals who may have declared they have mental wellbeing issues.

This is a problematic situation for many reasons. Firstly, this creates competing priorities for the college. The removal of academic staff as the individual responsible for the student's progress does not include the removal of their accountability for the student's success. Performance management processes for academic staff are not weighted for students who have these measures in place. The student's study programme is now regulated by support staff, who have the authority to instigate moving students across and between courses, designating what work deadlines need to be completed and what work the student should be given to do, altering deadlines and setting priorities across the subjects that students undertake. However, support staff are not responsible or accountable for the impact any interventions they make may have, for example in the retention issues that this creates within faculties, the potential poor performance of students and the support staff's lack of understanding in ascertaining the amount of work that may be required, or what potential impacts this might have on student's subsequent career aspirations or overall progress. Often conflicting tensions arise in what the student needs to achieve, for example in their university offers, with arrangements that have been put in place allow them to achieve. Often a refusal to engage is sanctioned by support staff members.

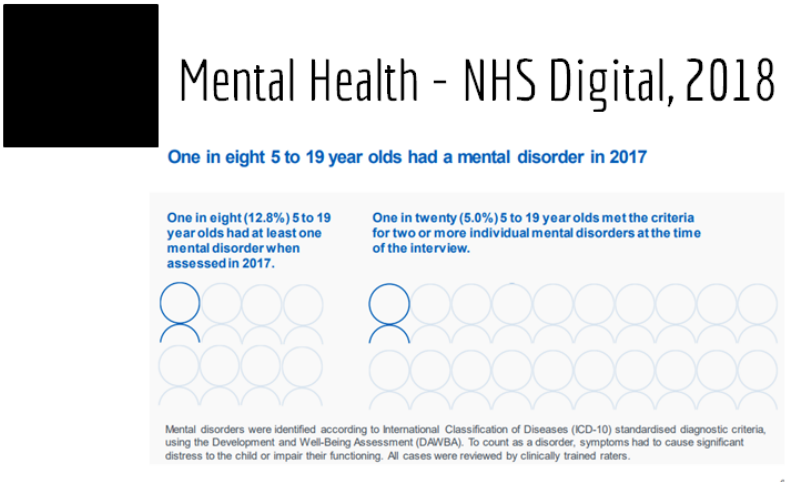
2. Changes to Policy

Subsequent to the Green Paper (2107) there have also been new academic policies introduced within college to manage student wellbeing issues. These include the Mental Health Needs Policy (2018) and the Health, Wellbeing and Fitness to Study Policy (2018). I will briefly address points within the policy here. The policies state that he college has instigated the following in response to the Green Paper (1.3:p3) (1) introduced a mental health lead (Champion) and that the college will (2) actively promote emotional and wellbeing in college, (3) oversee mental health training for staff and (4) put in place a curriculum that *'...supports student's acquisition of emotional literacy and the skills and dispositions of personal resilience'.* The policy outlines the action that staff need to take to recognise and intervene where mental health issues are suspected (1.7:p4) stating that staff will receive training in detecting mental health issues and identify *'...the support they can offer to students with mental health needs'*. In Section 2 the policy states that students can choose not to disclose they have mental health problems, which it acknowledges makes intervention difficult. What

it does not acknowledge is that this creates tension with expectations within the teaching staff's role or providing appropriate support and intervention. This is especially problematic given the list of 'Early Warning Signs for Mental Health' given in the policy's Appendix A (p9) which include 'working slowly', 'making mistakes more often', 'inability to concentrate', 'disorganised and forgetful', 'poor timekeeping', 'restlessness and agitation', 'tiredness, lethargy and lack of motivation'. This list is reminiscent of the points made by Cohen (2016) and in some of the diagnostic criteria seen within both the DSM and ICD as 'potential symptoms' for both anxiety and depression.

3. Training

Mental Health First Aid training has already been delivered within the college and wider mental health awareness training is now a mandatory requirement for all staff. It is delivered several times a year, along with Safeguarding and Prevent which now forms part of staff's contractual obligations to attend. Recent training (in 2020) saw dissemination of information relating to the number of services used within college and the statutory responsibility of staff to monitor student's wellbeing, by recording and reporting observations, as well managing student's own disclosures. This included details of what to look for in 'monitoring' and where to 'report' on the college's electronic student record system. From the full training presentation I have selected the following slides:

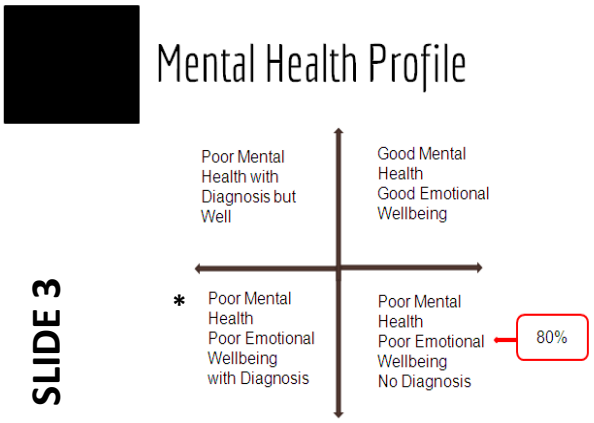


This slide (1) represents the 'justification' for the tracking, monitoring and reporting of mental health issues. It is clear it draws on 'evidence' from the NHS Digital (2018) report discussed at length in Chapter 1, which concluded by outlining that there was no exponential increase in recorded mental health issues. This point is further reinforced by Craig (2009) who identified that the 'perceived' increase in mental health issues in young people was somewhat

driven by data from the World Health Organisation estimations on global mental health numbers, but these are compromised as they are based on flawed data that created overinflated prevalence estimates because of changes made in the DSM III and later iterations. This was discussed in Chapter 1 as being the result of removing context from the diagnostic process of disorders like Depression.

This slide (2) shows a video clip relating to the work of the Anna Freud Centre, directing staff to the Toolkit and Directory resources for use with students. This is with an expectation that staff became familiar with the different methods and, for key staff, in conjunction the Mental Health First Aid training, ensuring they were competent at identifying and recognising mental health 'disorders'. This linked to the information given relating to the work of the Anna Freud Centre which illustrated the specific preventative approach to mental health that is being taken.

This final slide (3) was explained as the cohort group within college as a 'breakdown' of mental wellbeing, with the intention that *all* students would fall somewhere within this diagram. This is important because the figure given in red is indicative of the main group of students who made up the majority of people who were likely to come forward for mental health support. This is relevant because the 80% refers to the percentage of students who require support, NOT individuals diagnosed with a mental health disorder. So, what this is saying is that the majority of users of the service are students who self-refer and who do not have a diagnosed mental health issue. In fact the figure of less than 5% was given for the group identified by the (*), in other words students with actual mental health disorders who were



accessing specialist clinical services. When considering the numbers from the NHS Digital (2108) survey in the training above, the numbers here do not correlate with referrals made. For example, the NHS Digital survey states 1:8 children have a mental health disorder, then this would equate to around 214 students from the cohort of 1,708 for the year 2019/2020. However 339 students have been referred with a 'mental disorder' which represents nearer 1:5 and with 'emotional strain' being included (230) could potentially represent 1:3. This seems an unlikely statistic to suggest that every third student has a 'diagnosable' mental health disorder.

APPENDIX 9

THE STEPPED CARE MODEL

Figure 1 The stepped-care model

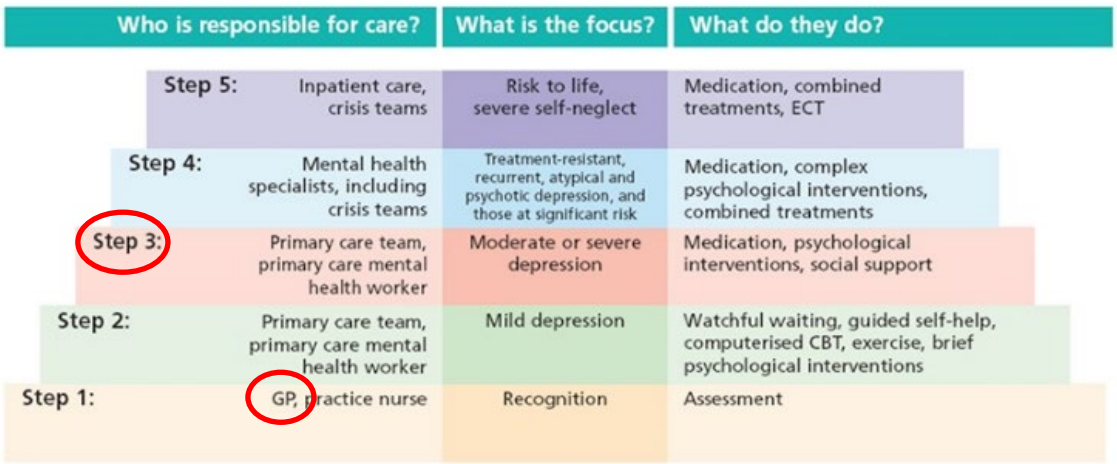
Focus of the intervention	Nature of the intervention
STEP 4: Severe and complex[a] depression; risk to life; severe self-neglect	Medication, high-intensity psychological interventions, electroconvulsive therapy, crisis service, combined treatments, multiprofessional and inpatient care
STEP 3: Persistent subthreshold depressive symptoms or mild to moderate depression with inadequate response to initial interventions; moderate and severe depression	Medication, high-intensity psychological interventions, combined treatments, collaborative care[b] and referral for further assessment and interventions
STEP 2: Persistent subthreshold depressive symptoms; mild to moderate depression	Low-intensity psychosocial interventions, psychological interventions, medication and referral for further assessment and interventions
STEP 1: All known and suspected presentations of depression	Assessment, support, psychoeducation, active monitoring and referral for further assessment and interventions

[a] Complex depression includes depression that shows an inadequate response to multiple treatments, is complicated by psychotic symptoms, and/or is associated with significant psychiatric comorbidity or psychosocial factors.

[b] Only for depression where the person also has a chronic physical health problem and associated functional impairment (see depression in adults with a chronic physical health problem: recognition and management [NICE clinical guideline 91]).

Stepped Care Model

Fig. 2: The Stepped-Care Model (Wellbeinginfo.org, 2019)



This model shows how referrals can be made through the IAPT programme. This operates using a website accessible to young people over the age of 16 years. What follows is an example of how emotional distress, as mental wellbeing concerns, can be 'transformed' into a diagnosed mental illness. This is because access to psychological treatment can, initially, by-pass the individual's GP. The IAPT website *explicitly states* that the interventions given in therapy relate to the NICE Stepped Care Model where PWPs work in services without the need of an initial GP consultation or referral. However, at the second stage on the website it is necessary to enter the GP name and address, so they would be notified that the service had been accessed (Stage 3 of the model) (see *Fig. 2* above), and that referrals can be made direct to the PWP. The first diagram (*Fig. 1 above*) shows the actual NICE clinical care pathway for Depression.

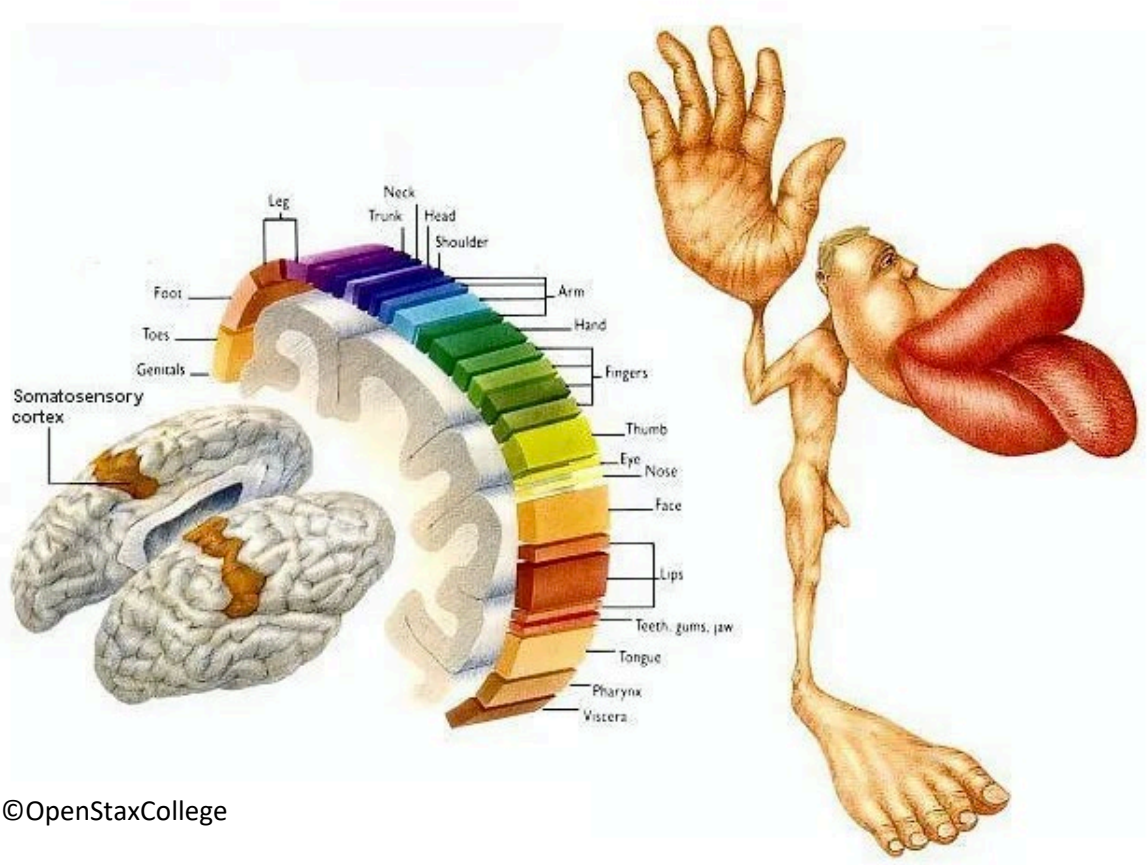
Fig. 2 (above second) shows the same model but as it has been modified for use in wellbeing services through IAPT. What is important to note is the position and function of the GP and the PWPs. It could reasonably be assumed that, within the process of this model, non-medically qualified, i.e. not clinically competent wellbeing staff are at best, making decisions on diagnostic criteria and labelling the individual, or at worst, accepting the self-styled label an individual has already designated for themselves as a starting point for psychological therapy, (in that the individual can attend stating they have Depression) and relegates the GP to the status of assessor, prior to intervention being carried out *further up the model*.

Why this is important is that it demonstrates that an individual can use IAPT web-based services to see a PWP (at Stage 3) directly, without going through Step 1 services with a GP. In other words they bypass the recognition of the problem and assessment stage. So potentially, a 17 year old student could self-refer through the online IAPT portal and be treated by a PWP based on being given a diagnosis at school of 'being depressed'. Then make an appointment with a GP, presenting as an individual with depression and potentially being prescribed medication. Importantly, the first diagram shows Stage 3 as working with individuals who are *sub-threshold* – in other words not acute enough to trigger floor thresholds for referral to clinical services.

APPENDIX 10

The Somatosensory Homunculus

Image showing the 'sensory map' for touch within the brain, the human figure is scaled to create proportions for allocation of touch receptors within the cortex.



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Available from: [https://www.vox.com/2015/1/28/7925737/touch-facts]

[Viewed 16 March 2021]

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