

Chapter Eleven



What young people think about mental health problems



Young people's perspectives:

In this chapter I consider how young people's perceptions of mental health issues are complex and context-based. Also, having unfolded layers of diverse and complex understandings of difference, I reveal how young people's individual sets of experiences, personal constructs, beliefs and values can create an understanding of individuality within group attitudes.

Voice of the developing researcher:

I consider the intellectual position I am now able to take, as I present the multifaceted contributions I believe that I have made in the field of understanding the perspectives of mental health problems held by mainstream pupils. Throughout the research process I have simultaneously grown as a researcher as well as developing as a practitioner. I have found the professional voice of the teacher, and as such the potential for hearing the voice of education alongside that of the medical practitioners within a multidisciplinary team. At the end of this part of my journey I show how I am no longer restricted within the tightness of definitions but am able to hold the idea of difference within sameness and a confidence in not having a definitive knowing.



In this final chapter I provide an account of the arguments that have emerged from my study and that I am now able to bring together. I put forward what I have come to understand of young people's perceptions of, and attitudes towards, those experiencing a mental health problem and how these may in turn influence the re-introduction of their peers back into a mainstream school setting. I consider the language used to describe mental health, the power and influence of that language, the nature of individual experiences and the impact of education on the reduction of stigmatising attitudes. Having framed my own thoughts and arguments I then demonstrate how the knowledge and understanding I now have relates to my own earlier beliefs, which I show as having been comparatively simplistic. Recognising the complexity of the nature of my research I acknowledge that many issues remain inconclusive, as new questions have emerged and my personal constructs have continued to change.

I conclude my submission by considering my role as a researcher and the influences my findings have had, and will continue to have, on my own and others' practice and my own personal development within a multidisciplinary team (4.3.4).

11.1 Young people's perceptions

11.1.1 Language of mainstream pupils

First I consider the language used by the young people in mainstream schools. Their responses to my questions were extremely diverse and, whilst holding the individual in mind, in this section I represent the main shared issues with quotations, in italics, raised during the interviews.

The majority of the participants had said, in the questionnaire, that they understood what experiencing a mental health problem meant but when asked, in the follow up interviews, to explain their understanding many appeared to find it difficult to put their thoughts into words with some having to rely on actions:

'Something a bit wrong up here' [taps his head] ...'

'Is it when you go a bit [touches her head]?''

Perhaps I had put my participants in a position of feeling that their own language would be considered unacceptable and as such it had been taken away from them in a prohibitive manner. I suggest that without the use of words that they thought I might believe derogatory they did not have a language with which to articulate their own sense of mental health problems. Therefore, it seemed that by either being keenly aware of the need to be politically correct, or having a very limited vocabulary at their disposal, many of the young people were hesitant and unsure of their understandings of experiencing mental health problems. It may also be the case that respondents did 'understand' at a level but were not able to articulate that understanding. That is, it remains something the individual 'just knows' but cannot explain.

Others however, did attempt to explain their sense of mental health problems by using language that could perhaps be considered inappropriate and derogatory:

'She sometimes acts mad or mental, like she just goes crazy ...'

Not only do I believe that the young people demonstrated a limited vocabulary for talking about the sensitive issues surrounding mental health and struggled to put their 'knowing' into words, but that they also showed a lack of understanding of some of the words that they did use or heard others say. On reflection this was perhaps to be expected, as young people often have to work out for themselves what words mean, and in so doing they may make mistakes (Crystal 2006) in terms of common usage at least. As such this may result in young people either using words that do not have the meaning they actually intend or that the meaning they believe they have has changed in the way that they are used:

'I don't like to say it cos it's not just people with mental health problems it's people with spinal bifida and my aunt's got that ... spaz doesn't mean that though does it?'

I take, for example, the word 'spaz', a word that many of the young people said that their peers would use to describe someone experiencing mental health problems. But the word itself is short for the term 'spastic', and relates to or denotes a form of muscular weakness, typical of cerebral palsy and has been used in the medical field since the 18th century. However, in the 1970s and 1980s the term spastic became considered abusive and today is usually used as a slang word to describe someone regarded as experiencing a physical or learning disability and who is perhaps viewed as incompetent. It can also be used to describe a person who acts in an irrational or spontaneous fashion or who is considered clumsy or inept. But throughout my research it became evident that many of the young people appeared to show little or no comprehension of such historical origins of the words they used and as such a sense of the meaning the language they use might have for others that do. This is perhaps due to the fact that as society develops the meanings of words either change or are no longer used in everyday conversation. For example words such as 'asylum', 'imbecile' and 'uneducable' are now deemed as 'old fashioned', while the word 'special', which is in everyday use, has evolved to have specific meanings, for different people. For some it may carry derogatory connotations and as such be regarded as potentially stigmatising.

I now examine the word 'special', a word that appeared in my data and which has very specific meanings for those young people who have a history of being pupils classed as having special educational needs (SEN). Special education, in the UK at least, is a term used as part of a formalised process designed to ensure that young people experiencing learning difficulties, mental health problems, specific disabilities (physical or developmental) or even those considered gifted and talented, receive either modified instructions or an individualised curriculum. However, the term appears to have become mostly associated with those pupils with learning disabilities and has undertones relating to words such as 'idiot' and 'retard'; words that were also part of my data. So although used in the practice of teaching as a diagnostic label to ensure that a young person has access to appropriate support, teachers in the field of special education, including those working with pupils experiencing mental health problems, have told me of being asked 'how are your specials?' in what seems a disdainful and disparaging manner. So although the word 'special' has dictionary definitions of such senses as: of surpassing what is common or usual, exceptional, peculiar to a specific person or thing, there is evidence that in the world of mainstream pupils it can have discriminatory connotations which can be hurtful and potentially stigmatising.

This clearly shows the difficulties faced when categorising language as being discriminatory or otherwise and how language is always in a state of change with new words entering the

language and with the meanings of others changing to take account of new ideas both within and between social sub-groups.

11.1.2 A new language?

Not only did my analysis of the data reveal that young people either misuse or have different meanings for the words in their own language from that of a different generation but that their vocabulary is becoming very much influenced by the sounds, grammar and vocabulary of other cultures and foreign languages. In recent years people have travelled more and there has been a marked increase in the number of people who have come to live in this country from a wide range of ethnic backgrounds and cultures. This has led to the convergence of languages and to the development and general use of ‘street language’. It has been estimated that by the year 2010 over thirty percent of all school-age children in this country will come from homes in which the primary language is not English, which could be an indication that street language will become the most common form of verbal communication between all young people not only in the street but also in schools. In my own research for two of the young people interviewed English was their second language.

Although very few young people responded to my research questions with street language it does concern me that the examples given (Appendix 6a), according to the urban dictionary (17), are extremely insulting within their Jamaican culture of origin, and where the user of them could be putting themselves at great risk of being harmed. Again, this provides strong evidence of young people using words that they may be aware of as not being acceptable but may not have a full understanding of their potential impact. But looking at it from a different perspective, perhaps the young people who used these terms were aware of their potential impact and were out to shock although this in itself could be considered a particularly dangerous ‘game’ to play.

Not only did my main research study demonstrate issues with the convergence of cultures and languages, and perhaps a limited vocabulary for talking about mental health issues, but my small-scale project also revealed that certain languages now spoken within the family units of some pupils in multicultural schools do not have words for ‘mental health’ or ‘psychosis’. This again is a worrying situation with the number of young people experiencing mental health problems reported as increasing and in my own experiences many of which are from ethnic minority backgrounds:

‘Parents for whom English is not the first language had little understanding of mental health difficulties. In trying to work with them around the issues for their child, there were difficulties as there is no word for psychosis in their language so something like ‘brain thinking problem’ is used. They found it really difficult to distinguish between organic neurological problems and mental health problems.’

(Response from teacher of pupils experiencing mental health problems)

11.1.3 Misunderstandings

‘I know you believe you understand what you think I said, but I am not sure you realize [sic] that what you heard is not what I meant.’ (Bruggen and O’Brien 1987: 4)

Communication is multi-layered and I have looked at how words can have different meanings for people according to their experiences and the discourses they construct. It is also evident from the interview transcripts that the young people confirmed Crystal's (2006: 76) views that 'it is possible to change the meaning of a word or a phrase simply by changing the pitch level [or tone] in which it is spoken'. I refer in the interviews to the 'weight' of a word, by which I mean a combination of the tone, the intonation and gestures such as facial expressions used by the speaker to determine the impact their words will have on others. It was this weight or power that the young people believed could turn a word often associated with being derogatory into a cursory, playful comment to their friends. They also believed in their own ability to recognise the different meanings put on to words in this way:

'Like in our friendship group we call each other [names] all the time as a joke, not hurtful or anything. In that situation it isn't hurtful.'

But, they also thought that:

'... sometimes it is said and not meant to be powerful, but the person who it is said to takes it in a way that makes the word really powerful and in a way it wasn't meant to be that powerful and then it can just cause all sorts of other problems.'

This suggests that perhaps it is the reaction from those receiving certain words that gives them their weight of meaning rather than the way they are transmitted.

The interviews held with the mainstream pupils certainly revealed a strong feeling that a young person who has experienced mental health problems is inclined to be extremely sensitive to language and in some cases claim to have heard unintended offensive undertones and then possibly overact to the situation:

'... you'd be careful what you say and do around them. You don't know if they'll take offence type of thing like that, so you just have to sort of like be careful.'

'[I'd be] more careful about just the way I am around people and I know that things can potentially start off a series of events by saying something or doing something ...'

This would agree with the literature that speaks about self-stigma by which young people internalise the stigma of their group and live with such a dislike of themselves that they may misinterpret many of the behaviours displayed and or the language used by others as stigmatising. So this then raises the question as to whether it is in fact self-stigma or perceived stigma, relating to feelings of shame and an oppressive fear of being stigmatised, that causes the young people living with mental health problems to describe experiencing stigmatisation, rather than incidents of overt public-stigma. I believe that the responses given by the mainstream pupils provide evidence to suggest that elements of stigma do lie in the reactions of those experiencing or who have experienced mental health problems as:

'... they think that they are different from everyone else.'

Accepting this view I acknowledge that self-stigma and perceived stigma do have a part to play in the stereotyping of those experiencing mental health problems as 'crazy', 'messed up', 'special needs', 'mental', 'depressed', 'stupid', and 'self-conscious' or even

‘perfectionist’ and that what people are called has major consequences for social interaction, (Figure 11.1).

I do believe however, that although not overtly revealed in my study, a degree of public-stigma is present but hidden under layers of a socially acceptable language and perhaps a sense of denial of stigmatising those exhibiting differences. This would suggest that all three forms of stigma are present to some degree in mainstream schools creating a complex, multi-layered integral system of stigmatisation. In view of this it is clearly difficult to unpick what is a (i) ‘misunderstanding’ (the focus of this section) from (ii) a ‘mis-use’ of a term from (iii) deliberately obscuring stigmatising attitudes by the use of an ambiguous term from (iv) a use of language designed to shock.

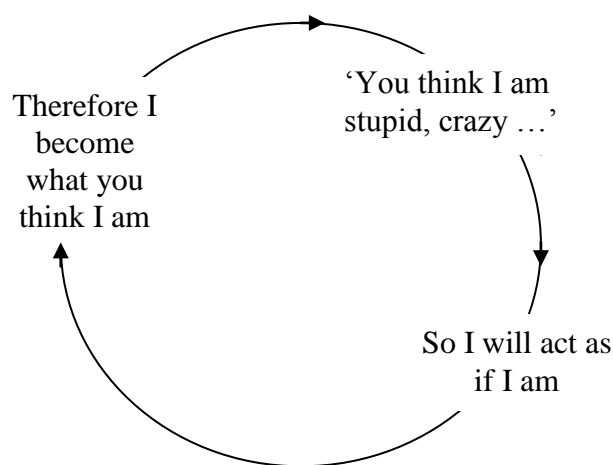


Figure 11.1 What people are called may have major consequences for social interaction

I now look at further evidence within my research data to support the views that I came to and which I explained earlier in this section.

11.1.4 We don’t but others do

So far in this section I have highlighted the difficulties with choosing appropriate language in an increasingly multicultural and diverse culture. I have also argued that perhaps young people are not always aware of the meanings of the words they use, but that they may have the potential to be considered as derogatory. However, it could be counter argued that the young participants are well aware of what language is suitable to use when referring to such sensitive issues as mental health problems. The evidence for putting forward this point is the discrepancy between the type of vocabulary that the young people said in the questionnaire that they would use and what they said their peers would use to describe a person experiencing a mental health problem. The majority of young people responded with language of their own that I considered as compassionate, considerate and empathetic, but put forward words that their peers might use which I believed to be insulting, offensive or belittling.

From their responses I came to believe that pupils in mainstream schools have an understanding of what it means to be seen to be ‘politically correct’, (that is to avoid the use of derogatory language) and as such make the effort to use a language that neither causes upset nor hurt. But, this does not mean to say that they will always have an empathetic language readily at their disposal or, if they do, that they will chose to use it in connection with those experiencing mental health problems. Some participants in the questionnaire said that they would use words I had considered as compassionate yet resorted to a less sensitive language during the course of the interviews:

‘... he went a bit crazy ...’

‘... they might not be a freak ...’

‘If they are slightly different then they are seen as weird.’

The sentiment of suggesting ‘others’ as using language that could be considered derogatory was also echoed in the responses of the adult professionals in the small-scale project. This might, of course, be a wholly genuine indication of their own use of specific language versus those terms used by others. Or on the other hand, this could be seen as a general lack of ownership and perhaps self-denial. In either case it demonstrates the difficulties for me, as the researcher, in making visible and tangible something so ephemeral but yet considered to be so powerful. I believe that my research has shown that although some young people may not be fully aware of the historical use or implications of the words they might use they are able to recognise the difference between an appropriate and derogatory language. Others however, on learning the potential implications of a word or phrase explained how they would chose to make the informed decision to use an alternative:

‘Freak, I don’t like that word, I hate that word ... We were reading this book in English a while ago. I can’t really remember what it is about, about a boy who is really tall or something and so everyone calls him a freak, because they thought he was different ... we didn’t really know what it meant we got told because our English teacher told us how nasty the word was ... Since we read that book in English nobody uses ‘freak’ anymore.’

It therefore seems fundamental that young people be given the chance to make such informed choices by being educated in the meaning of words as well as the likely impact of these words on others, particularly on those more sensitive and vulnerable young people.

11.1.5 Understanding differences

I now return to the different perspectives expressed by the young people in the questionnaire and the follow-up interviews. To be more specific, in the questionnaire survey the majority of young participants said that they understood the meaning of experiencing a mental health problem, and the difference between a mental health problem and a learning difficulty. But during the interviews many appeared uncertain or confused. Others however, came over as confident that their particular understanding was correct, although very different to my own. I remind the reader that in Chapter One I had defined a mental health problem as involving a breakdown in the cognitive, perceptual or emotional functioning that prevents a person from being able to adequately manage his or her everyday life. I also distinguished a mental

health problem from a learning disability in that the latter is usually congenital, often involving deviant or delayed developmental pathways and is effectively irreversible, unlike the former for which treatment may alleviate symptoms or contribute to a cure (Campbell and Heginbotham 1991). It is clear that my own definition is rooted in a 'knowing' that is part of my professional training and has been further shaped by my own professional and personal experiences. In this sense, it is therefore not surprising that the pupils interviewed held differing definitions from myself.

Many of the young participants appeared not only to struggle with construing their own personal discourse around what it means to experience a mental health problem but also, as I have already suggested in this chapter, they did not appear to have a language with which they could articulate their thoughts or, at least do so with some confidence. Some of those who did communicate an understanding offered an explanation with reference to experiences in their own worlds:

'My mum works in a mental health place so I've learnt a lot about it. It's sometimes [when] people think that they are three ...'

'Not as high achieving maybe, they need help and my family has got er Down's syndrome and so needs a lot of help ...'

'My uncle's dad has a mental health problem and he had to go into a home because they couldn't control him.'

Others referenced media representations such as popular television soap operas:

'I recognise a character in EastEnders that might be described as experiencing a mental health problem, I can't think whose kid it is but it was born with Down's syndrome or something ... it struggles, it can't cry and it ... needs special help.'

'... that lady who was going out with Phil ... I just think she has gone mad because she like keeps hurting the little boy and stuff for no reason.'

These findings are in agreement with those of Secker et al (1999) who had also carried out research into young people's understanding of mental illness.

From these responses I maintain that these young people do have an understanding of a problem that is different to a physical illness or injury and that can make life at school and in the community temporarily difficult. However, they showed a great diversity in their levels of perception from:

'... like mental health, they [other pupils] can understand it in a basic term like someone is not well but I don't think that they quite understand what it's like for the individual ...'

to a comprehensive or extensive understanding of how a mental health problem can become of such severity as to render 'normal' life in the community impossible and the necessity to receive specialist in-patient treatment within an adolescent psychiatric unit:

'To me it would mean that they found it very difficult to cope maybe with if they had family problems or certain things in their life ... and they had too much of it and they basically gave up on themselves ... breakdown couldn't cope with work, couldn't cope with life anymore they just stopped.'

I believe that the young people had clearly reflected how mental health problems are frequently difficult to diagnose and label with any degree of accuracy, even by the medical world, and are often perceived by the general public to be associated with learning difficulties.

The young participants had demonstrated their engagement with the questionnaire through their choice of captions for the cartoons. It is clear that many had interpreted the images with reference to the vignettes, associating a pupil who had been absent from school for a long period of time with being lonely and needing to catch up with their work. The questionnaire had provided partial evidence for suggesting that young people do recognise and relate to differences, which was then echoed during the interviews:

'They would act differently.'

'... because they have had different things.'

'... thinking differently, but then everyone thinks differently. Can't say thinking wrongly because it's everyone's point of view.'

However, although the young people had demonstrated an ability to focus on difference(s), some of which they acknowledged as finding 'disturbing or threatening' (Marshall 2004: 185), they also either showed a lack of a full understanding of the significances of the difference or the ambiguity of a language by which to articulate the differentness.

With respect to coming to an understanding of the significance of being considered as different and/or living with a mental health problem I looked at the distinction between sadness and depression. Many of the girls, who I interviewed, spoke of their peers experiencing depression and that by listening to them they were able to support them through this difficult time:

'I had to watch them feel depressed ... but then I just think that's helped me ... quite a few people might have to go through that ... I just stood by them and ... they could talk about it whatever it was. [I] just made them feel comfortable around it ... knowing that I wouldn't question them about anything unless they wanted to talk about it.'

I believe however, that they may have perhaps been talking about sadness rather than clinical depression. Being sad will still carry negative feelings that can be extremely painful but by labelling sadness as depression these young people are perhaps suggesting that there is something wrong with the other person and that they are experiencing a psychological disorder (18). This demonstrates the complex relationship between how little the young people understand with respect to mental health problems and how words change in meaning; and perhaps take on a different meaning for each individual. While discussing this difference between sadness and depression I would also like to draw attention to the research of Rose et al (2007). They showed that young girls who do 'co-ruminate' over their personal

problems may in fact develop increased levels in positive friendship quality but also in anxiety and depression, and are at risk of their more serious underlying internal problems being unnoticed because of these outwardly caring friendships. It may well be that my professional training and experiences have led to my being highly sensitive to the nuances of meaning between these terms and clearly the girls to whom I refer cannot be expected to share my own kind of understanding. Nevertheless, there was an indication of a lack of awareness on the part of some of the pupils of the gradations of [normal] sadness to [not normal] depression.

Some of the participating pupils also noted that it is not exclusively those with mental health issues who are picked out in mainstream schools and made the target of prejudice and discrimination, anymore than any young person who presents a differentness of any kind. Every school pupil will have a difference of one sort or another, tall, fat, clever, the list is endless but their differentness will be commented upon and often in what could be felt as a derogatory and stigmatising way, placing them in a stigmatised group. Although, of course, many young people at school will attempt to hide any difference by seeking anonymity in sameness (2.1.1):

'At school everyone gets called stuff all the time.'

'I get called stuff all the time by other people. I just know that they're just saying it and I don't care ...'

The young people's responses substantiated my beliefs that language can be used to have the effect of categorising people into groups, according to what are seen to be their differences and which may be 'assigned worth and importance to varying degrees depending on a variety of factors, not least of which is the judgement of what is 'normal', 'acceptable' or 'natural' ...' (Marshall 2004: 187). It could be considered that it is this judgement of what is normal or acceptable that influences the interaction some young people are prepared to have with others:

'I don't know how to be around them ... I don't know what to say.'

'[If I know someone does have a mental health problem] then so it's made me be more careful about just the way I am around [them] ...'

I do not believe that such attitudes are necessarily stigmatising or even discriminatory but a genuine uncertainty as to how to be and what to say. Such actions however can leave the person who is experiencing problems feeling isolated which can then lead to negative thoughts about his or herself and ultimately intensification of feelings of self-stigma (2.2). Although others who have experienced being with those who have a difference say:

'I sometimes go in and see them. There's a guy there called John, he's all right. I talk to him when I go down and stuff, he's just got some problems.'

I return to the issues of how I consider young people's perceptions of mental health problems as being specifically context-based in section (11.2.2) where I consider whether within a mainstream school these misconceptions are such a problem as I had first believed.

11.1.6 Who does have the power?

The emphasis at the start of my research project had been around the inequality of power between the healthy mainstream pupils and those experiencing mental health problems. In Chapter Four I had made assumptions by speaking of the powerful, healthy, mainstream group and the oppressed, group experiencing mental health problems. Yet, having heard the stories of the mainstream pupils it could perhaps be argued that they are the ones who are maligned, by their peers, those experiencing mental health problems and specialist teachers (small-scale project), as being considered to be prejudiced and discriminatory against those that they see to be weaker than themselves. Society (and I include myself in this category) has stereotyped and labelled them as being intolerant and holding stigmatising attitudes towards those with mental health problems. Society has made assumptions as to what they will think, how they will react and what language they will use and, what they mean by the language they do use. However, my own research provides evidence to suggest that such attitudes, where they do exist, are possibly the results of a lack of understanding and knowing how to be, which as I have explained can lead to fear and avoidance. I believe that such behaviours may be caused by lack of education with regards to mental health issues experienced by adolescents and access to an appropriate language.

From the mainstream pupils' accounts I also gained a strong inference of it being those who Goffman referred to as the 'discredited', those who possess '...a stigma, an undesired differentness from what we anticipated' (1963: 15) as being the powerful group. They may present behaviours that are difficult for the mainstream pupils to manage such as:

'... they may not be as friendly, they may be more angry so they will not be as friendly towards you ...'

to more extreme cases like:

'... they're odd ... [He] seems obsessed on killing and war ... he's always talking about weapons and doesn't like a lot of people ...'

And, as I have already emphasised young people do not always know what they are dealing with. The boy who made this last statement went on to say:

'I think in fact he might have a learning disability. I'm not sure.'

So perhaps we need to move away from thinking that there exists an inherent dualism, which I referred to earlier as a false dichotomy, of pupils being stigmatised and the 'stigmatiser', the victim of stigma and the threat of holding stigmatising attitudes. As I shall demonstrate in the next section the reality appears far more complex.

11.2. My contribution to the knowledge of practice

11.2.1 'Imagine. A theory that explains it all.' (Faulks 2005: 140)

I had expected my data to confirm ex-psychiatric inpatients' descriptions of their experiences of returning to mainstream education and the views of the professionals (small-scale project)

in that mainstream pupils show stigmatising attitudes towards pupils having experienced mental health problems. However, I found little evidence to support this expectation. As I delved into the issues around mental health and stigma the situation was not as I had first thought. It became clear that it was far more complex. However, this study does draw out three key findings. First the complexities that have become evident are around context-based perceptions, second that self and perceived stigma influence the interpretation of language and third public-stigma is not clearly visible in the three mainstream schools that took part in this study. I shall now take these three key points in turn and discuss them in greater depth.

11.2.2 Context-based perceptions

This first point acknowledges that my research has shown a context-based complexity with respect to young people's conceptions around the issues of mental health with particular reference to language. As a result I have shown a wide variation in conceptions about the nature of mental health problems held both between individuals and indeed by the individuals themselves. In short, some young people did not subscribe to any unified understanding of mental health, presenting what appeared as disconnected and confused thoughts. They did not demonstrate a cohesive understanding but, of course, this is not surprising as we the professionals, also find it difficult to define some of the key points around the aetiology and symptoms associated with mental health problems. As such those working in the field of adolescent mental health often find it difficult to come to an agreement as to where 'normal' adolescent behaviours become sufficiently different in nature to be labelled as the signal of a mental health problem (2.2.1). We should not expect more of our pupils than we can reasonably expect of ourselves.

I have also shown how language, behaviours and responses are all context-based and in Chapter Ten (10.1.2) had considered how the young people's responses are governed by time, place and context. I now reflect on how a young person may modify their understanding in accordance with the peculiarities of a specific context. As such language used and behaviours displayed may be thought of as derogatory and stigmatising in one context yet acceptable in another. Recognising a peer as asking for help or needing extra support in class may not be considered derogatory, but when the level of support entails attending a 'special' unit or school then it may. Or, having seen a peer, who has experienced mental health problems and considered depressed, sitting alone and then giving them space may not be considered as ignoring and isolating them. However, crossing the street to avoid an ugly, strong and aggressive looking young male who is sitting on his own could be seen as prejudiced and discriminatory (2.2.5). But perhaps others might view this action as legitimate self-preservation.

I had been led to believe, by the young people I teach and the results of my small-scale project, that a label of mental health could have a negative influence on the attitudes of mainstream pupils towards those young people returning to school after receiving psychiatric treatment. Then, during my research I became concerned that such influences might be increased by the mainstream pupils' misconceptions of mental health. However, I now reason that within a mainstream school these misconceptions are perhaps not such a problem, as I had first believed. They are only part of a multifaceted system and, as I explained earlier, such misconceptions should be of no surprise considering professionals find it difficult to define some of the key points around mental health problems.

The experiences of those returning to the mainstream education system after having received in-patient psychiatric treatment cannot be accounted for easily. The attitudes of the mainstream pupils need to be considered as being influenced by a combination of perceptions, language, labelling and their responses to behaviours, all of which my research has shown need to be appreciated as being context-based. These attitudes are formed by adolescents who are coming to terms with their own place in the world and who may feel fear of the unknown and the pressure of a need to conform for their own, perceived preservation (2.1.1):

‘I think that it is the situation that they had been in, that it influenced me. It makes you think about the situation that they are in and ... what they are doing means something different.’

‘You don’t really know if they are putting their hand up to ask a question or whether ... you just know what you see in the picture.’

But, my research has shown that, within this complex construct, labelling can have varying influences. Sometimes it appears to rationalise behaviours that may otherwise lead to a stigmatising response from others such as name-calling or avoidance:

‘... I’d probably feel sorry for her ... if it were a person in that situation I would want to kind of look after them a bit more ...’

Yet, it may also highlight stereotypical beliefs of those experiencing mental health problems:

‘... I thought that if he has had mental health problems then it might lead to threatening behaviour cos sometimes ... people that have problems like that are quite aggressive ...’

But then for others knowing something about a person does not appear to make any difference to the way they interpret behaviours or in the way they would treat them:

‘It’s just that she has been off school for a long time, not the problem she has been off for.’

There can also be a difference in the levels of influence that behaviours have on attitudes; higher levels of objectionable behaviour seem to open up fewer opportunities for discrimination and stigmatisation (Chapter Six). Although this demonstrates the complex relationship between behaviours, labels and stigma there is an added complication in that I have also shown that many young people do not have a coherent view with respect to mental health problems and their individual views will change depending on context. Their views will also be influenced by who is asking the question and why they are asking and how they ask. In fact Brockman et al (1979) had suggested that a researcher with a medical background would find more positive views towards those experiencing mental health problems. They also suggested that closed questions would also produce more positive responses.

Therefore, in a sense, what appears to be a pupil’s understanding of mental health shifts according to the context in which questions are asked about it and according to who asks the questions. But, even in the context of ‘relating to peers at school’, my research showed that

some pupils were uncertain in their responses. The pupils I questioned were, as a direct result of my questioning, having to face issues which they may well have avoided addressing (Chris's interview Chapter 8) in any real way up until that point.

I conclude that most young people, understandably, have little understanding of the specific issues around mental health problems but they do show understanding and tolerance of differences. This then leads me to consider a second complex relationship between self, perceived and public-stigma.

11.2.3 Developing a resistance

The second key finding in my work, although its precise nature is still unclear, is that adolescents recognise perceived stigma, and to some degree self-stigma, to be present amongst young people experiencing differences. The young people who I interviewed in the mainstream schools indicated that both perceived and self-stigma develop a barrier to them developing relationships with returning peers. They recognised those with 'problems' as thinking of themselves as different and as such mis-construing the language and actions of their mainstream peers as stigmatising:

'I think other people would take the words and think they mean something that the other people hadn't meant by it ... To the person saying it, it is just a word, that's it and they'll forget about it in five minutes, but the person who they say it to it's a much bigger deal ...'

'Do they mean this or do they mean that? And there are so many different ways you can interpret just one word that ...'

Although I had had expectations that the outcomes of my research were ultimately going to be around educating mainstream pupils and staff in how to 'be' around those having experienced mental health problems I now believe that it is more about working with my pupils on how to 'behave' and as such develop a resilience (18) with respect to the language and actions of others. Those experiencing mental health problems need to consider the impact of their own behaviours on their mainstream peers (2.3.3).

Although in her article, 'The curious case of the tail wagging the dog: well-being in schools,' Craig (18) discusses how over protection of all our young people in schools today may encourage learned helplessness and lead to a breakdown in resilience towards the knocks of everyday life, I believe that my pupils do need specific support in managing to live and cope in a busy, bustling school community. In short they will need support to '*...start developing a thicker skin...*' rather than feeling that the world is against them. However, I do understand that for some their problems will preclude them from being able to re-construe their thoughts around their mainstream peers and as such being able to make a successful re-integration back into school (Chapter One).

I return to the idea of supporting young people to consider their impact on the mainstream pupils and how they may re-construe their personal constructs, with respect to others perceptions of mental health and stigmatisation, in section (11.3.3).

11.2.4 Making the tacit visible

Third, I found minimal evidence that deliberate or premeditated stigmatisation of those experiencing mental health problems exists within the three participating mainstream schools. This claim however, is complicated in that the majority of respondents, and this did include the adults (Chapter Three), believed that others would use language that was categorised in my study as derogatory to and about those with mental health issues. I believe that this suggests that although stigmatising attitudes are believed to be present in the adolescent world that ownership is placed on the ‘other’. I have shown that if such stigma does exist in mainstream schools then it is difficult to draw to the surface and make visible as most young people, in my research, demonstrated empathy and tolerance towards differences and specifically those involved with experiencing mental health problems. Also, my evidence indicates that those young people who are inclined to demonstrate stigmatising attitudes towards those with mental health problems are also very likely to stigmatise those exhibiting any kind of difference (mental or otherwise).

I suggest that naming and disclosing a mental health problem may not need to be considered any more of a problem than recognising any other difference. As such, I consider that mental health issues need not be singled out in schools as a ‘problem not to stigmatise’. This could, as I have already discussed in Chapter Four (4.5.2), have an adverse effect by inadvertently promoting stigmatising attitudes. Although I acknowledge that mainstream pupils do need to be educated in the causes, prevention and severity of mental health problems I also recognise that how such information is delivered needs to be carefully considered. I believe that in order to provide all our young people with an adequate education with respect to the causes and prevention of unnecessary breakdowns in mental health then the appropriate health professionals are invited into schools to work in the classroom alongside teachers in a joint multidisciplinary approach. However, I recommend such interventions with reservations. I consider that in talking about mental health problems, and in particular depression (11.1.5), we could inadvertently encourage and heighten feelings we may wish to eliminate. Such feelings include a learned helplessness and a desire to be given a label, in an attempt to explain away differences within an accepted range of normality. In fact this latter concern may even be partially responsible for the reported increase in incidents of mental health problems in schools.

The three key points that I have discussed explain how the issues surrounding stigmatisation of those young people who return to mainstream education after a period of in-patient psychiatric treatment are far more complex and multi-faceted than I had first considered. Perhaps I had been naïve to expect to find straightforward answers to my questions.

11.3 Voice of the developing researcher

11.3.1 Differences within practice

‘I have not reached my [final] destination ...’ (Faulks 2005: 269)

Throughout this submission I have demonstrated a reflexive engagement with my practice in relation to the theme of professional learning and development and, within the story of my

research have shown how ‘... different kinds of linguistic, social, political and theoretical elements are woven together’ (Alvesson and Skoldberg 2000: 5).

Although my research has focused on the views of mainstream pupils I acknowledge that it is not just the young people who will have had different experiences of those with differences. The experiences of teachers in mainstream schools, teachers who work with adolescents in psychiatric units and psychiatrically trained medical staff are also not comparable. Even in my own practice conflicts of interest often arise between the professionals with respect to the treatment of young people experiencing mental health problems. The medical staff do not always appear to understand the interactions within a mainstream school culture and as discussed earlier mainstream teachers may not always have a full understanding of the complexities of a young person experiencing mental health problems. This situation can then create a tension between the medical and educational models of practice and as a result between medical treatment and educational achievement.

My overarching research aims have been based on facilitating the improvement of the transition process for pupils from education within the mental health sector back into mainstream education. Although I have not yet developed a definitive understanding of the reactions of mainstream pupils to those returning to school after a period of psychiatric in-patient treatment, through my enquiry I have provided additional evidence for understanding the nature of the stigma of mental health problems within mainstream schools. I have also developed a methodology for exploring sensitive issues with young people, which facilitates articulation of their perceptions of a topic that can often be considered difficult to talk about.

In this last section of my dissertation I explain my personal development in having experienced the reflexive processes involved in carrying out a practice-based research enquiry at doctoral level. I consider the impact this personal development is making on my own practice and its potential impact on professionals within the Unit School, Adolescent Unit and other institutions. I also consider the need, within my practice, to manage the ‘interplay of contradictions’ (Dyson 2001) and reflect on the dilemma of recognising differences and the ideal of a totally inclusive society.

‘[The] ways in which we treat difference are problematic. For example, we deal with difference by treating certain groups of students differently ... or the same ... Interestingly, both approaches to dealing with difference achieve exactly the same thing: they affirm difference.’ (Artiles 1998: 32)

Although I attempt to separate personal development and contribution to practice they are very much entwined and one cannot be satisfactorily explained without mention of the other.

11.3.2 Personal development

This dissertation is not only about a research process but also an unfolding story of my own personal journey from classroom assistant to an academic working at doctoral level, and from scientist-mathematician dealing with definitive solutions to studying within a social constructionist framework and the uncertainties and complexities of human nature. The journey has been difficult and there have been times when, ‘... [my] mistake, [I] now believe ... has been trying to make sense of life ...’ (Ahlberg and Ahlberg 1993: 61), but yet it has also given me a sense of belonging within being, in some ways, different and seeing things

differently. Taking a reflexive approach I have explored how my autobiography has influenced the way I have constructed my views and beliefs, which in turn have informed and influenced the ways I have approached my practice and research. Both professional and personal experiences have influenced the way in which I have shaped an understanding and made meaning of my research findings. I have considered my place in relation to education, the young people and my colleagues in terms of the 'insider-outsider' phenomena (Hellowell 2006, Hammersley 1993, Merton 1972) and teaching and researching within established organisational structures and ideologies.

I have contextualised my research by including my own perspectives and those of other professionals and young people with diverse experiences. This has allowed me to become aware of the culturally situated meanings that I have brought to my own research and to appreciate the complexity of the lives of those people who have participated in my investigation (Artiles 1998).

Having made the decision to study for a Doctorate in Education, rather than apply for a headship, I believed that I would be able to shape the environment in which I worked without being at the top of an organisation. In order to do this I have developed a sense of not only being a teacher of children but, through coming to an understanding of how people create their world around them, a facilitator of learning for both young people and colleagues. I have developed a confidence in my own ability to research into, develop and articulate my understanding of my practice of working with young people who are often perceived, by themselves and others, as being different.

During the course of my research journey I have moved away from an approach of trying to critique and change society as a whole, to coming to terms with the reality that I would not be able to change the world for those living with mental health problems but that I might be able to be more effective in enabling them to cope with the world, however imperfect it may be. I have also recognised that, as a professional working with young people experiencing mental health problems, I had often placed much of the blame for my pupils feelings of belonging to a stigmatised group on the attitudes of mainstream pupils. Taking up a personal construct psychology approach to my research has helped me to understand that rather than needing to attempt to change the attitudes of all mainstream pupils it is more important to provide a supportive and permissive practice in order to help those experiencing problems change the ways in which they perceive the world. In many cases these young people have developed a feeling that they are not normal, they are different. They cannot cope with difficult comments made by their school peers, something which another young person might well be able to shrug off, and they develop feelings of being stigmatised and or bullied. But rather than living with feelings of being a failure and of not fitting in with their mainstream group, I recognise that with support and time they may develop more positive personal constructs of their particular differences, which they may in turn come to see as less distinguishing than they might first appear. I realise that in order to make a successful re-integration many young people need to challenge and change their constructs with respect to the attitudes of the mainstream peers towards mental health, although I do recognise that some constructs are difficult to change. As a teacher I can only change the world as it is available to me, but yet I can support individuals in my care to develop strategies and understandings within themselves that will enable them to change their own world and the way in which they continue to journey through their own lives. I have come to see my own role as enabling rather than one that primarily confronts prejudice and seeks to undermine it.

The mental disciplines of studying a practice-based doctorate have certainly influenced the way in which I approach my day-to-day work, particularly with respect to not thinking of mainstream pupils and teachers as the 'other'. This confidence has also allowed me to take on a new role of working with a small group of day pupils at the Unit School (1.2) who do not have the input of the medical disciplines on a daily basis and as such I am responsible for helping them manage their transition back into mainstream school.

11.3.3 Contribution to my professional practice

I am now more able to talk about the experiences of mental health problems as potentially resulting in behaviours that mainstream pupils may perceive as different to such an extent that they are unsure how to deal with the differences and as such find themselves putting a distance between themselves and the 'ex-mental health' patient. Although I believe that some young people having experienced mental health problems are able to behave in ways that do not cause their peers concern, for others I do have a justified confidence in suggesting that this may, due to their diagnosis, be too difficult for them to contemplate or achieve. For these young people, I would recommend that a return to mainstream school as being inappropriate, although a more suitable provision is often not available (1.7). I believe that the education system needs to acknowledge that all young people are different and have individual needs, which should be catered for within the mainstream system without reference to special educational needs versus mainstream education. As such I will continue my drive for an alternative education provision to be offered these young people within smaller and supportive schools after in-patient psychiatric treatment.

However, for those pupils who are able to return to mainstream schools I believe that they are able to help their mainstream peers reconstrue their perceptions of mental health problems. Young people make meaning through their own interpretations of the interactions they have with others. This allows for each individual, who has experienced a breakdown of mental health and a period of in-patient psychiatric treatment, to influence the meanings given to such a situation by so called 'normal mainstream pupils' through the interaction that they have with them. That is, the ex-mental health patient has the capacity to help mainstream peers develop and change their constructs with respect to mental health problems. It seems to me that the pupil experiencing mental health problems has within him or herself the potential to break the cycle of perceived/received stigma (Figures 7.1, 11.1 and 11.2) and that they may benefit from my support in developing this opportunity. This approach could prove more beneficial for a young person returning to mainstream education than relying on a third party to smooth the way for them, or 'passing' and accusing their peers of having stigmatising attitudes towards them which they (and the literature) claim can lead to prejudice and discrimination.

Having considered the importance of young people's constructs, I have developed a greater understanding of the approach that underpins the way in which I conduct my daily practice but which I had previously found difficult to articulate. I have developed an understanding of how I support the young people in my charge to challenge their often-distorted constructs around school and education by creating 'environments which enable individuals to actualise themselves on their own terms - emotionally, intellectually, and socially' (Joyce 1972: 169). I encourage and support them to 'reconstrue their past, so that they [are] no longer the victims of it' (Butt and Burr 2004: 9). I consider that this understanding can reduce the gap between the medical and education models and will allow me to have agency as a teacher

within a multi-disciplinary team and as such share good practice with colleagues in my own work place and other institutions. However, for me, this agency appears to have come at a cost. People need to have something that they can bring to a team in order to develop their own identity within that team. But this can bring a threat to the hierarchy, which I am at present experiencing within my own practice as the gap between the educational and medical disciplines appears to be widening.

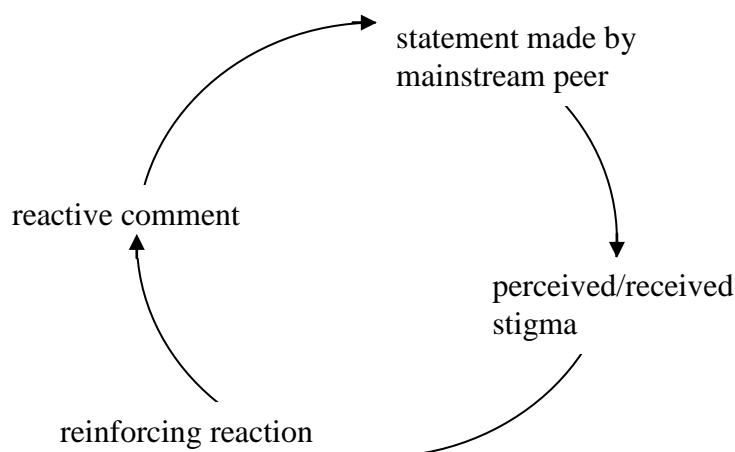


Figure 11.2 The stigmatising cycle that I may give young people the opportunity to break

I conclude that professionals working with young people need to consider a ‘living dilemma’. We need to keep at the forefront of our work the dilemmas of whether we treat all young people the same or acknowledge their differences and treat them differently, whether we believe language used is discriminatory or acceptable adolescent language; and whether to encourage young people to disclose their ex-psychiatric patient status or to ‘pass’. It does however seem that these dilemmas will continually shift as I work with a transient client group to which every young person will bring their own constructs. Each new encounter with a young person will impact upon my own experiences and as such influence the way I persistently develop my own constructs and working practices. However, working through my research has led me to acknowledge and accept that these ongoing dilemmas that constantly change, hence ‘living dilemmas’, are more than acceptable. They are essential if I am to give young people the opportunities to make informed decisions with respect to the ways in which they approach their re-integration back into a mainstream educational setting.

I am now able to offer a reasoned argument for encouraging young people and colleagues to consider different perspectives. Through my research I have become confident in not having a ‘definitive knowing’ and in developing a greater understanding and acceptance of the diversity and complexity surrounding difference. It is this deep awareness of a transitory knowing that is the message I wish to communicate to both colleagues and pupils within my own practice.

Having presented my submission I now propose to disseminate my key findings in professional journals and at conferences (Appendix 11a and Appendix 11b). By drawing on my contributions to practice in the wider sense I now consider my own recommendations for the practice of others. I propose to share my findings, specifically those around supporting

young people experiencing mental health issues to develop resilience to the everyday knocks of being a mainstream school pupil in the 21st century, within similar contexts to my own nationwide. I will have the opportunity to do this at the Units United Annual Conference at which I propose to lead a workshop in 2010. I also propose to support ESTMA tutors, by running a series of workshops, in how to work with young people experiencing mental health problems. Working with pupils in isolation, in venues such as libraries and at the kitchen table, these tutors often report feeling unsure as to how they are able to support such pupils in returning to their mainstream schools. They appear to share the experiences of mainstream pupils in that both say: ‘What can I say? How should I be?’

There also exists within my thesis a publication related to my contribution to understanding expectations and potential prejudices, how these might be manifested in the education of young people who have had mental health problems and their peers, and how they might be managed by teachers. I believe that such a publication could be of significant relevance to any professional supporting a young person experiencing any difference that could lead to stigmatisation as they will face the daily dilemmas of whether to treat them differently or not, as both approaches seem to affirm difference.

In addition, I consider that there exist two further potential publications; the first could support and influence the research approaches of others conducting studies into sensitive topics with young people and the second, provide any new researcher with an insight into the use of visual metaphor to present and clarify their own research story.

However, this is not the end of my own research story, as I shall continue to look into the issues around young people’s resilience with respect to the rigours of being an adolescent experiencing a mental health problem in the 21st century.