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**“|We could end up in a lot of trouble”
Teachers’ communications with young
children about mental health**

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Abstract

Purpose – Stigma towards people with mental health problems is a significant problem and appears trenchant despite recent anti-stigma campaigns. Attitudes develop in young children, and may be stronger and less malleable in adolescence. Early intervention may be important for mental health education and stigma prevention. Theory, evidence and practical considerations suggest that teachers' involvement is key. By exploring communication about mental health between teachers and young children, it will be possible to elaborate how stigma develops and may be ameliorated. This study explored teachers' accounts of this communication and the factors that influence it.

Methodology – Semi-structured interviews with fifteen primary school teachers were transcribed and analysed using a grounded theory approach.

Findings – Discussions about mental health were largely absent from the classroom, due to teachers' anxiety. Teachers felt the need to protect children from exposure to people with mental health problems and even from information about the topic, believed they lacked the necessary expertise, worried that such discussions were outside their remit, and were anxious about parents' reactions.

Originality/Value – This was the first study to interview teachers on this topic and suggests that a significant opportunity to address stigma is being missed. Teachers' silence may reinforce that mental health problems are taboo, and prevent children from developing knowledge and a language to talk about mental health. The inclusion of teachers in early mental health education is more sustainable and could promote more inclusive attitudes, especially if supported by educational policy and curriculum.

Keywords - school, young children, teachers, mental health education, stigma prevention, policy, grounded theory

Article Classification – Research Paper

Introduction

Prejudice, stigma and discrimination are significant problems for those experiencing mental health problems. The impact on those affected can be severe, including significant disadvantage with respect to income, employment and housing (Cooke, 2008; Thornicroft, 2006), as well as social exclusion and negative psychological effects (Baumann, 2007). For many people these problems cause more distress than the original difficulty (Cooke, 2008). Stigma also often leads to delays in help-seeking, with negative consequences for treatment outcomes (Pinto-Foltz & Logsdon, 2009). In recent years there has been significant government investment in anti-stigma campaigns aimed at the general public. Gains have been relatively modest and attitudes appear entrenched (Evans-Lacko et al., 2014).

Stigmatising attitudes are commonly thought to develop in childhood through social influences including parents, siblings and children's media (Mueller et al., 2014; 2015).

Prejudice towards those with mental health problems (MHPs) is reported to develop from the ages of seven or eight (Hinshaw, 2005). This would suggest that primary school age may be the optimal point to intervene as derogatory attitudes are undeveloped and not yet entrenched.

Whilst there have been a number of projects delivering mental health education in schools and aimed at reducing stigma (see Schachter et al., 2008; Yamaguchi, Mino, & Uddin, 2011; Mueller et al., 2015 for recent reviews and meta-analyses) only five were delivered in primary schools, and only one uncontrolled study was in the UK (Shah, 2004). Within the UK primary school curriculum, the Social and Emotional Aspects of Learning (SEAL) programme aims to foster children's social, emotional and behavioural development. It has been viewed positively by staff (Hallam, 2009) but does not address mental health problems directly. There have been recent calls for this to be changed (Siddique, 2015).

A second relevant factor is who delivers the teaching. Anti-stigma interventions in schools have most often been delivered by outside agents (e.g. Sholl et al., 2010; Yamaguchi et al., 2011). However, there are reasons to suggest that a more effective approach might be for interventions to be delivered by teachers, perhaps supported by others. Firstly, teachers appear to have a significant influence on children's knowledge, attitudes and behaviours (Hess & Torney, 2009, Mueller et al., 2015). Secondly, the fact that mental health is not currently part of the mainstream curriculum may itself send a message that it is a taboo subject. A recent petition to Government to include mental health in the school curriculum achieved over 50,000 signatures (Syed, 2015). Thirdly, some have argued (e.g. Pinfold et al., 2003) that delivery by teachers would be a more normalising and inclusive approach than reliance on external agents, which may contribute to an impression that mental health problems are unusual and only the domain of 'experts'. Fourthly, incorporation in the curriculum and delivery by teachers promises to be a more robust and sustainable model than delivery by outside agencies whose funding arrangements are often insecure (see e.g. Dearden, 2014).

However, some studies have found that teachers tend to be reticent regarding involvement in such interventions. Ventieri et al. (2011) found that some primary schools declined an invitation to participate in a teacher-led anti-stigma programme. Reasons cited included concerns about parents' reactions and about the appropriateness of teaching children about MHPs, together with a lack of confidence in knowing how best to respond to issues that might be raised. Askill-Williams et al., (2007) found that teachers felt that they lacked the necessary knowledge and confidence to implement a MHP module in secondary schools. Graham et al., (2011) used a survey to elicit the views of Australian primary and secondary teachers regarding mental health education. Most respondents felt they lacked the requisite

knowledge, skills and confidence to deliver teaching on mental health. They requested more training, resources and parental involvement.

In order to plan effective mental health education initiatives, it is therefore necessary to understand the processes that might be influencing teachers' attitudes and beliefs about mental health, the extent and nature of their current communication with pupils on this topic, and the processes that might be influencing this. To date, no studies appear to have examined this in detail.

The current study used a qualitative methodology, interviewing primary school teachers to elicit their views and to try to construct a preliminary theory of the processes that might be at play. It is hoped that the findings will inform both further studies and also effective school-based interventions to address mental health related prejudice and stigma development, and in turn influence curriculum and policy.

Method

Participants

Interviews were conducted with fifteen practising primary school teachers from three schools in London and Brighton. All had experience of teaching primary school children (i.e. ages 7-11). There were 5 teachers from each school, aged between 26 and 59 (mean age = 36.1) and with between 3 and 35 years teaching experience (mean teaching experience = 9.5 years). Twenty percent were male, and 73% were white British (one teacher identified as other white origin, one as black African, one as black caribbean and one as mixed ethnicity).

Design

A qualitative design was employed using semi-structured interviews. These allowed the open-ended questions necessary to collect rich data. Topics covered included the extent and

nature of teachers' current communication with pupils about mental health, the factors that affected this, and ideas regarding how this topic might best be taught.

Procedure

Ethical approval for the study was obtained from Canterbury Christ Church University (Salomons) Research Ethics Committee. Headteachers at three primary schools in London and Brighton were contacted and agreed to distribute information about the study to their staff. Interviews were conducted at the schools by the second author, herself a former primary school teacher. They lasted 40-65 minutes and were audio-recorded.

Analysis

Data were analysed using the Grounded Theory approach outlined by Charmaz (2006). This approach is widely used to examine subjective accounts regarding attitudes, beliefs and behaviours. Themes emerging from the data informed the development of a preliminary theoretical model, which was then reviewed against the transcripts in an iterative process. Guidelines for ensuring quality in qualitative research were followed (Williams & Morrow, 2009): initial and selected subsequent transcripts were independently coded by two researchers, regular audit meetings were held to discuss coding and the emerging theory, and respondent validation was obtained by sending participants a summary of the findings and eliciting comments. A reflective research diary was kept and bracketing interviews (Fischer, 2009) examined the possible role of the researchers' prior experience and beliefs on the analysis.

Results

The most striking finding was that discussions about mental health problems appeared to be almost completely absent from the classroom. Table 1 outlines a preliminary theory of some of the processes that appeared to underlie this absence.

Figure 1: Theoretical model accounting for why discussions of mental health problems are absent from primary school classrooms

[Insert figure 1 about here]

This framework provides a possible way of understanding the absence of conversations about mental health in the classroom. Its three elements – teachers' emotions, teachers' beliefs and teachers' behaviours – will be described in turn.

1. *Teachers' Emotions*

The overriding emotion described by teachers was fear: fear of what might happen if they talked to children about mental health problems, and fear of those who experience such problems.

1.1 Fear of complaints from parents. Teachers were concerned about how parents would react when they heard that MHPs had been discussed in the classroom, anticipating complaints:

'... if a child goes home and says, 'oh we heard about people today that get really depressed and sit in their room and shout and stuff', the parents get scared so they complain.. You've got to worry about that now...about how parents react to stuff like that.' (Teacher H4)

1.2 Fear of triggering undesired behaviours and emotions in children. Teachers feared that discussing MHPs would result in children worrying that they had a particular problem or trying out undesirable behaviours:

'If you start to talk to some children about stuff like that...it can almost encourage them to want to try it or to see how it feels.' (Teacher H4)

They were also concerned about upsetting children:

'...bringing it up...they could feel upset, they don't know how to handle it...I don't want to be the one to trigger anything in a child's life like that...' (Teacher X3)

1.3 Fear of giving children the wrong information. Teachers felt that they did not have the requisite knowledge and skills to talk to children about MHPs. They worried that discussions about MHPs might generate questions from children which they could not adequately answer:

'...if I don't feel secure talking about something and I don't have a solid knowledge of it because if they ask me a question I wouldn't want to give them an answer that wasn't accurate or I wouldn't want to try to elaborate on something that I didn't know a lot about...' (Teacher X1)

Teachers often believed that expert knowledge was necessary for such discussions:

'...they need to bring in an expert who will come and work with the children and myself...I think that's safer for the children – I don't want to feel that I'm giving them the wrong impression...some things I just think, I can't go any deeper because I just feel out of my depth and I'm worried that twenty years on children will turn round and say, 'Mrs X told me that'...' (Teacher X4)

1.4 Fear of people with MHPs: Teachers were fearful of people with serious MHPs:

‘...you just see people that make you feel a little bit intimidated by their behaviour...’

(Teacher L4)

They were also aware that wider society is also fearful, and cited media coverage associating such problems with violence as a factor in their avoidance the topic:

‘...the parents hear these terrible things on the news, ‘these psychotic killers have been released and gone and stabbed somebody’, and they might think, ‘oh, you’re going to tell my child that there’s lots of psychotic people around’...’ (Teacher H5)

2. Teachers’ Beliefs

In addition to fear, specific teacher beliefs also appeared to be playing a role: beliefs about mental health in schools, beliefs about mental health in general and beliefs about their professional role.

2.1: Beliefs about mental health in the classroom

Teachers held five main beliefs related to mental health in schools:

2.1.1: Mental health does not come up. Teachers frequently reported that mental health did not come up as a topic of discussion:

‘...it doesn’t really come up as something they talk or enquire about so I suppose it doesn’t open up the thoughts about having conversations about it.’

(Teacher X5)

It is interesting to speculate what teachers meant in this regard: it seems likely that children had mentioned distressing thoughts or emotions, but teachers may have distinguished these from ‘mental illnesses’ or ‘mental health problems’ which they saw as something different.

2.1.2: MHPs primarily affect adults. Some teachers saw MHPs as more commonly affecting adults and so less relevant to children:

‘...with adults I associate it more with schizophrenia and things like that. OCD, paranoid disorders, things like that...then with children, you never really hear of children with schizophrenia or OCD or anything like that.’ (Teacher X1)

2.1.3: Children should be protected from MHPs. Some teachers suggested that primary school children were too young to learn about MHPs:

‘I think you’re just exposing them to something that maybe they don’t need to know about yet.’ (Teacher H4)

‘I don’t think they need to know that there’s this thing called depression, there’s this thing called OCD...as an adult you like to know the names, the specifics, but as a child, because they’re not in contact with it...’ (Teacher X1)

2.1.4: Labelling children is unhelpful. Some teachers believed labelling should be avoided:

‘What bothers me...is the giving it a label...it’s like giving this child a label and we need to make allowances for them because they are X.’ (Teacher L3)

2.1.5: MHPs are difficult to teach and difficult for children to understand. Mental health was thought to be a more difficult subject to teach and for children to understand than physical illness:

'I think because that's more abstract, because it's not physical and it's not visual, so it makes it more difficult to talk about, but it's also harder for them to understand.'

(Teacher L3)

2.2: Beliefs about mental health in general

More general beliefs about mental health problems also appeared to contribute to the absence of conversations about them in school. These included the idea that MHPs only affect certain people, that they are stigmatised and that disclosure is likely to have negative consequences.

2.2.1: MHPs do not affect everyone. Some teachers appeared to hold a binary view of MHPs as only affecting certain people. :

'...it's more normal, physical disability compared to mental disability. Something people think might affect them more...' (Teacher L5)

2.2.2: MHPs are stigmatised. Teachers appeared to see MHPs as stigmatised and discussion of them as taboo.

'I sometimes know if you mention that word 'bipolar' it can be quite a taboo word whereas if you mention cancer, we had almost more sympathy for it but if you mention that she was bipolar people go, 'oh she was mental then'...' (Teacher H5)

2.2.3: Disclosing personal experience of MHPs is likely to have negative consequences. Self-stigma was apparent, causing teachers to withhold communication about their own experiences of MHPs with their colleagues:

'...you don't want to say because you're embarrassed and you don't want people to know, you don't want people to judge you...' (Teacher H3)

2.3 Beliefs about professional roles

Teachers' concerns about conforming to what was expected of them within their professional roles also contributed to the absence of conversations about mental health.

2.3.1: Teachers should follow the curriculum. Teachers stressed the need to stick to the national curriculum and that MHPs do not really feature:

'...with everything else that's in the curriculum, if it doesn't come through the SEAL or PSHE curriculum then it doesn't really get covered...' (Teacher X4)

Teachers felt comfortable talking about sensitive or emotional topics as long as they were part of the curriculum:

'...it scares the hell out of them but they have to realise that people do die, so we have to teach the unit, and it is part of the curriculum...' (Teacher H4)

2.3.2: Teachers should refer children to experts if they feel that their behaviours or emotions are unusual. Teachers believed that their role was to notice 'abnormal' behaviours or emotions and to refer on rather than becoming involved:

'But it's important that teachers sort of spot things...because if we miss it that can turn into a major thing.' (Teacher X2)

'...occasionally you get children telling you something about their home life that's distressing, and I refer that usually to our designated person without really talking in too much depth with the child...' (Teacher L2)

2.3.3: Teachers are not trained to teach about MHPs and so should not attempt to do so. Teachers felt that they lacked sufficient knowledge or experience to talk to children about the subject:

'I've not actually got the foundation to teach them about it. If I had relevant skills... then I would do it but I would not go ahead and start bringing up an issue if I haven't got concrete evidence or ways to teach it...' (Teacher X3)

Teachers wanted training about MHPs, including knowledge about types of MHP and their causes. They also felt they needed guidance on what was appropriate to discuss with children.

'I don't think I'd feel comfortable with that...I definitely would need to talk them through with somebody and have a consensus about what we could...what's helpful to say...' (Teacher L4)

2.3.4: *A teacher's role includes carrying out others' decisions.* Teachers often felt that they had little freedom and that their role is to implement decisions taken by those further up the hierarchy:

'I just kind of follow orders and keep an eye on them...but generally don't ask too much about it...so yeah, just trying to keep back...' (Teacher X5)

When it came to managing situations regarding individual children, teachers were often guided by parents:

'...you do get given a lot of guidance usually from family members, how to behave and what to say and what not to say basically...' (Teacher H4)

This suggests that teachers feel that it is outside their remit to communicate freely with children about MHPs or to decide what is communicated.

2.3.5: It is *not teachers'* responsibility to teach about MHPs. Some teachers thought that teaching children about MHPs was not within a teacher's role and that headteachers should bring in experts to deliver such teaching. Others felt that the responsibility lay with parents:

'I think that's with their family to support if they want their child to understand what it is...' (Teacher W1)

3: *Teachers'* Behaviours

Teachers' fears and beliefs led them to act in particular ways, which within cognitive behavioural theory might be thought of as 'avoidance behaviours' and 'safety behaviours'. Key here is that while such behaviours are understandable and often appropriate in the circumstances, they also prevent beliefs (for example that discussion of MHPs might upset children or provoke difficult questions) from being tested out (see e.g. Clark, 1999).

3.1: Behaviours directed at safety

3.1.1: Stick to the curriculum.

Teachers were wary of addressing sensitive topics unless they were on the curriculum:

...if it's in the national curriculum and they've suggested that you talk about it, then you do because you're covered I guess...it's safer within the boundaries.' (Teacher H4)

Where a subject was incorporated in the curriculum, teachers believed that they would be covered by their unions should there be repercussions following classroom discussions:

‘...if you come away from that [curriculum] then you’re not really covered if something happens from something you’ve said in class, or something that you have talked about, then you could end up in a lot of trouble, whereas if it’s curriculum-based then I guess your union’s there to cover you.’ (Teacher H4)

This appears to lead to a situation where potentially sensitive topics not specifically part of the curriculum, notably including mental health, are not discussed, whilst other arguably equally sensitive issues such as death, alcoholism and homelessness are covered even when teachers are acutely aware of their impact, because they are part of the curriculum.

3.1.2: Stick to the facts. Teachers were worried about possible negative repercussions from opening up discussion of sensitive topics and so protected themselves by sticking to factual teaching.

‘...if you’re just dealing with facts then it doesn’t come back with ‘oh you’re giving your opinion’ or ‘saying this is that and it’s not’ and if I was just being scientific then I could say, ‘well they asked so I just gave them facts about’ (Teacher X5)

With respect to MHPs, teachers reported feeling unsure of the facts and so avoided the subject.

3.1.3: Stick to talking about ‘normal’ behaviours, emotions and diversity. Teachers made a distinction between MHPs and ‘normal’ emotions and behaviours, and felt safer discussing the latter:

‘We teach them how to deal with their anger and we teach them how to deal with certain situations’ (Teacher H5)

All participants felt safe giving children the message that everyone is different, diversity is to be celebrated, and everyone has equal rights:

'...to send out the message that everyone is different and being different is a good thing...it's okay to be yourself and be different; be an individual.' (Teacher H1)

However, mental health problems appeared not to be mentioned in these conversations.

3.1.4: Seek parental consent. Many teachers viewed education about mental health as analogous to sex education and felt that it would similarly require parental consent. It was viewed as a sensitive subject and teachers feared parental backlash.

'...you'd have to involve parents in that kind of thing.' (Teacher L4)

3.1.5: Consult with colleagues. Talking with colleagues helped teachers to feel safer in their communication with children, having a shared sense of how to manage certain situations:

'...with the knowledge of colleagues because, especially in education, you talk a lot to the other teachers.' (Teacher L5)

Teachers are influenced by their colleagues. If absence of discussion about MHPs is universal in classrooms, teachers are unlikely to have examples of helpful conversations about mental health to draw on, or to be able to access support in facilitating such conversations.

3.2: Avoidance

Teachers' beliefs and fears also led them actively to avoid certain types of conversations or encounters.

3.2.1: Avoid discussing MHPs. No interviewee described having such conversations:

'...I've never discussed with them about mental health problems to be honest.'

(Teacher L5)

Where one child had been identified as having a mental health problem, this was rarely if ever discussed with other children in the class:

'...children were kind of aware that he had, something was very wrong with his ability to control his anger, but I don't know if it was talked about really.' (Teacher L2)

3.2.2: Avoid certain topics in particular. There were commonly occurring topics that teachers were particularly wary of discussing: notably psychosis, schizophrenia and suicide:

'...if a child says they're hearing voices in their head or something like that, I definitely wouldn't [try to discuss it].' (Teacher X3)

'We've had like a few cases as well at our school of parents that have committed suicide as well, and it's kind of difficult because it did happen this year actually...we didn't really go into it with the other children because, you know, we didn't feel that that was really an appropriate thing to do.' (Teacher H1)

3.2.3: Avoid discussing difficulties in a child's home life. Talking about children's families was something most teachers avoided:

'I knew there were a lot of problems at home so you are talking around the problems at home because obviously you don't want to bring that up unless like...I think a lot of it was anger as well because of his home life situation so you tend to brush over that as well because you don't want them to bring that up.' (Teacher X1)

3.2.4: Avoid putting yourself at risk. Teachers chose not to communicate on subjects that felt in some way risky, including mental health:

'...if you put yourself in a position where you are exposing them to something that possibly they don't want their child to be exposed to, then you're putting yourself in a position of risk, which you can't really do.' (Teacher H1)

3.2.5: Keep safe by avoiding generating any discussion that might be *'unsafe'*.

Teachers avoided opening up conversations about MHPs:

'...you kind of skate over them, you don't get too deep, because maybe the age of the children and what other children will take from it, especially if it's not a planned kind of lesson...' (Teacher L2)

Discussion

This study examined how primary school teachers communicate, or don't communicate, with children about mental health. Its major finding was that – at least in the schools represented here - such communication appeared rare. Discussions of mental health problems appeared to be largely absent from the classroom. This absence appeared to be related largely to anxiety on the part of teachers, leading to avoidance of the topic. Specific beliefs about mental health problems, for example that they are abnormal and the domain of experts, also appeared to be playing a role as did specific beliefs about the role of a teacher to stick to the curriculum and to what they are specifically trained to teach. Interestingly many of these barriers are also found in parents' communications with children about mental health. Parents also felt anxiety and believed that such communication was for experts, and people with more knowledge than themselves, such as teachers (Mueller et al. 2014).

In understanding the processes involved, the current social context appears important, both within schools and more widely. In particular, two factors may be relevant: on the one hand the current social narrative about mental health, and on the other the current political context of education.

The current social narrative about mental health

One factor that appears to drive teachers' fear is the current social narrative that people with mental health problems are different to 'normal' people, only understandable by experts and to be feared (Cooke & Kinderman, in press). This appears to be both a direct process (teachers share some of these beliefs) and an indirect one (teachers fear criticism from parents, and colleagues, for exposing children to this aspect of life). Ironically, a vicious circle may be at play whereby the dominance of this social narrative is one of the factors preventing interventions that could ameliorate it, such as effective mental health education in schools.

The current political context of education

One notable feature of the interviews was the fear expressed by teachers: in particular, fear of criticism from parents and from managers. This may reflect the current political context of education where decision-making regarding curriculum and teaching methods is increasingly centralised and teachers are required to conform and are subject to increased scrutiny and criticism (see e.g. Benn & Downs, 2015).

Limitations and future research

There were a number of limitations to the current study. Most obviously, it was a small, qualitative study and its findings cannot necessarily be generalised. Social desirability may have played a role in the interviews: for example it is possible that some teachers did talk

about mental health in the classroom but were hesitant to acknowledge it for fear of criticism. We are hopeful that the interviewer's (JK) previous experience as a teacher may have minimised this.

The experiences, beliefs and commitments of the research team undoubtedly played a role in the analysis: for example they are all familiar with and value both cognitive behavioural and critical approaches to mental health. An obvious next step would be a larger-scale survey-based study, perhaps using questions generated from the current findings, exploring primary school teachers' classroom communications on this topic.

Possible ways forward

Despite their limitations the findings have a number of possible implications for future mental health education and anti-stigma interventions. Firstly, it seems important to include mental health in the National Curriculum for young children. Secondly, teachers need training and support in order to deliver teaching on this issue. One possible model would be for psychologists, or indeed young people with mental health problems, as contact with mental health issues is important, to support teachers, perhaps initially delivering teaching alongside them. Thirdly, a psychological, continuum-based approach, stressing that everyone experiences mental health problems to some degree or at some points, is likely to be a more effective approach in promoting accepting attitudes and preventing stigma than one based on the idea of discrete 'mental illnesses' that only affect particular people (Cooke, 2003; Cooke & Harper, 2013, Read et al, 2006 Mueller et.al., 2105). Materials are available to support such an approach and could be adapted both for teachers and for children (see e.g. Basset et al., 2007; Cooke, 2003, 2014; Cromby et.al., 2013; Kinderman, 2014; OnlyUs Campaign, 2015; Sholl et.al., 2010). Direct input from people with lived experience of mental health

problems will also be vital if future generations are really to understand that ‘There is no them and us. There is only us’ (OnlyUs Campaign, 2015).

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Figure 1. Model of communication including why discussions about mental health problems are absent from the classroom

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