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JANINE N. KING BSc Hons MA Hons PGCE Primary

**School-based interventions to address the stigma
associated with mental health problems**

Section A:

What is the role of school-based interventions in combating the stigma associated with mental health problems, and how can such interventions be optimised?

A review of the literature

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Section B:

How do primary school teachers communicate with children about mental health problems and what influences this?

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Critical Appraisal

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**A thesis submitted in partial fulfilment of the requirements of
Canterbury Christ Church University for the degree of
Doctor of Clinical Psychology**

JULY 2012

**SALOMONS
CANTERBURY CHRIST CHURCH UNIVERSITY**

DECLARATION FOR MAJOR RESEARCH PROJECT

JANINE N. KING

DECLARATION

This work has not previously been accepted in substance for any degree and is not being concurrently submitted in candidature for any degree.

Signed..... (candidate)

Date

STATEMENT 1

This thesis is the result of my own investigations, except where otherwise stated. Other sources are acknowledged by footnotes giving explicit references. A bibliography is appended.

Signed..... (candidate)

Date.....

Signed (supervisor)

Date.....

STATEMENT 2

I hereby give consent for my thesis, if accepted, to be made available to external users through the CCCU institutional repository and the British Library EThOS service, and for the title and abstract to be made available to outside organisations.

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Date

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Firstly, I would like to thank the headteachers who agreed to my research being carried out in their schools and, most importantly, the teachers who gave their valuable time to participating in the interviews thus making this project possible. Particular thanks to Amanda Bell and Freya Cioffi for their help with recruitment.

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Lastly, thanks to the librarians and Rochelle Scrivner for being so unfailingly helpful and efficient.

Summary of MRP Portfolio

Section A is a systematic review of the literature surrounding school-based interventions to address the stigma faced by people diagnosed with mental health problems. It asks the question of what the role of these interventions currently and potentially is and what is important for their efficacy. It begins by acknowledging the problem that stigma and discrimination presents, identifying what leads to and perpetuates this stigma. It then presents key theoretical and empirical contributions to our understanding of stigma and also to our understanding of how learning develops and attitudes form. The review goes on to look at what has been done in schools to date and highlights ‘active ingredients’ in these programmes, discussing the extent to which the current picture addresses theoretical and empirical contributions. Suggestions for further research are provided.

Section B provides the findings of a grounded theory study investigating how primary school teachers communicate with children about mental health problems. Individual semi-structured interviews were carried out with fifteen teachers in three state schools. A model of communication is presented, which explains why discussions about mental health problems are absent from the primary school classroom. The model is then discussed in relation to extant theory and research. Limitations of the study are identified before discussing potential clinical and research implications of the findings.

Section C is a critical appraisal of this research, including discussion of the experience of being a researcher throughout this process. Consideration is given to the skills developed, areas where they may need to be expanded upon, areas where things could have been done differently, as well as research and clinical implications of the findings.

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JANINE N. KING BSc Hons MA Hons PGCE Primary

Major Research Project: Section A

What is the role of school-based interventions in combating the stigma associated with mental health problems, and how can such interventions be optimised? A review of the literature

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Abstract

This review evaluates the literature surrounding school-based interventions designed to reduce stigma towards those diagnosed with mental health problems. It considers the current and potential future role of these interventions in combating stigma and, in light of theory and the extant literature, how such interventions can be optimised.

It begins with discussion of the problems caused by stigma and discrimination towards those diagnosed with mental health problems and what leads to and perpetuates it, including empirical and theoretical contributions. The review then examines understanding of how people learn and develop their attitudes, drawing on key theories and empirical studies, before discussion of school-based interventions which have attempted to address the stigma surrounding mental health problems. The potential 'active ingredients' of these programmes are then considered.

Finally, conclusions are drawn about what is known and what remains to be discovered about school-based interventions in addressing the stigma towards those diagnosed with mental health problems. Suggestions for future research are given.

Search methodology

See Appendix 1 for details regarding search strategy, databases searched, inclusion/exclusion criteria and number of papers identified and selected.

1. Introduction

Stigma towards people diagnosed with mental health problems (MHPs) is a major issue in today's society. Stigma can be defined as "a global devaluation of certain individuals on the basis of some characteristic they possess, related to membership in a group that is disfavoured, devalued, or disgraced by general society" (Hinshaw, 2007, p.23).

Numerous campaigns, interventions and strategies have been implemented in a drive to address stigma towards those with MHPs. These have included the Changing Minds anti-stigma campaign between 1997 and 2003 which targeted populations including the general public, the media, employers, doctors, children and young people and aimed to increase public and professional understanding of MHPs and reduce stigma and discrimination towards those with MHPs (Royal College of Psychiatrists, n.d). While revealing some promising changes in stigma towards MHPs, the impact was limited (Crisp, Gelder, Goddard, & Meltzer, 2005). In 2007 the largest ever programme in England to reduce stigma and discrimination associated with MHPs was launched - 'Time to Change' - funded for four years by the Big Lottery Fund and Comic Relief (Henderson & Thornicroft, 2009). In 2011, the Department of Health and Comic Relief granted further funds to continue the programme until 2015. This intervention, delivered by mental health charities Mind and Rethink Mental Illness, has involved an innovative and proactive approach to tackling stigma, including press releases, film production, poster campaigns highlighting how common MHPs are, testimonies of celebrities who are affected by MHPs, and a message encouraging open communication about MHPs (Time to Change, 2008). Evaluation of its impact has highlighted positive results in meeting the targets of reduced discrimination (Henderson et al., 2012). School-

based interventions seeking to shape attitudes early have also been introduced, including a curriculum resource developed in partnership with the ‘See Me’ campaign (Scottish Executive, 2005), aiming to generate positive mental attitudes towards MHPs.

Schools-based campaigns have been central to numerous campaigns that have sought longer-term changes in societal attitudes. For example, a meta-analysis of school-based smoking prevention programmes in the US found an 88% intervention success rate in changing students’ attitudes towards smoking and behaviour in the long-term (Rundall & Bruvold, 1988). The long-term impact of schools-based programmes for changing attitudes towards MHPs, however, is a relatively new area of interest, and there is limited research that discusses the role of these interventions in combating stigma, or that considers how such programmes can be optimised. The current review aims to critically evaluate the literature in order to address this gap. It does not focus on outcomes per se but considers key themes that were prominent across programmes in relation to theoretical understanding.

2. Stigma towards mental health problems (MHPs)

Those with MHPs are doubly challenged: as well as the debilitating symptoms and disabling effects of the MHP, they face distress as a result of the prejudice and stereotyping that comes from members of society holding misconceptions about MHPs (Corrigan & Watson, 2002). Independent factor analyses from England and North America, as well as media analyses of film and print, found that public perceptions of those with serious MHPs included: that those with MHPs are to be feared and separated from communities; are irresponsible and therefore others should make life decisions for them; and, are childlike and

need to be taken care of by others (Brockington, Hall, Levings & Murphy, 1993; Brehm, 1966). Indeed there is widespread misunderstanding of MHPs in society, which results in stigmatising and discriminatory knowledge, attitudes and behaviours (Hinshaw, 2007). This 'public' stigma often results in self-stigma, where public stigma is taken by those with MHPs and turned against themselves (Corrigan & Watson, 2002).

Service-user accounts have revealed experiences of being physically and verbally attacked by neighbours in the community, of property being vandalised, and of being barred from shops and pubs (Lyons, Hopley & Horrocks, 2009). Research has highlighted a strong and enduring effect of stigma on well-being (Link, Struening, Rahav, Phelan & Nuttbrock, 1997). Corrigan & Watson (2002) discuss how those with MHPs are commonly deprived of the opportunity for quality of life, facing discrimination in the areas of employment, housing and health care. Indeed research has found that those with MHPs are less likely to be given good jobs (Bordieri & Drehmer, 1986) or domestic rental agreements (Page, 1977). Self-stigma can have serious consequences on self-esteem and self-efficacy and can often lead to social withdrawal, and behavioural responses such as not trying to gain employment or independent living for fear of rejection and failure (Parle, 2012). The shame that is often associated with MHPs is highlighted in a study of service-users which found that only 12% felt able to disclose to their colleagues about their MHPs (Bos, Kanner, Muris, Janssen, & Mayer, 2009).

The World Health Organisation (2012) and World Psychiatric Association (1998) have pointed to the fact that stigmatisation surrounding MHPs is a serious problem, particularly due to the resultant social exclusion and breach of human rights.

3. What leads to and perpetuates stigma and discrimination?

In order to explore the role of school-based interventions in combating the stigma associated with MHPs, and how such interventions can be optimised, it is important to consider theories of stigma. Four relevant theories were identified, including mechanisms associated with social identity, attributions, labelling and contact theory.

3.1 Theoretical contributions

Social identity theory

Mechanisms associated with social identity theory offer one explanation of stigma. Tajfel and Turner (1986) sought to explain the psychological basis of intergroup discrimination, specifically the factors required for a member of one group to discriminate in favour of the 'ingroup' to which they belong, against members of the 'outgroup', often referred to as 'us-and-them' thinking. People come to believe that ingroup members are similar to themselves, holding increased empathy and positive emotion for them, which leads to heightened contrast with, and hostility towards, outgroup members. This results in improved self-perception and benefits resources, survival, and status (Hinshaw, 2007).

Attribution theory

Attributions are explanations given for the causes of a person's behaviour, typically made when behaviour deviates from expectation. According to attribution models, discrimination is more likely when an individual's behaviour or illness is perceived as being within, as opposed to outside of, their control (Weiner, 1995).

Biogenetic explanations of MHPs as a congenitally-acquired 'illness' should, therefore, elicit more compassion. Corrigan and Watson (2007) found that children who viewed others as responsible for their MHPs expressed more anger and less pity towards them. However, biogenetic explanations have been found to reinforce a negative outlook on prognosis (Lincoln, Arens, Berger & Rief, 2007) and to be related to perceptions of dangerousness, unpredictability, fear and desire for social distance. Causal attributions regarding MHPs have been central to the debate about how to address stigma and some have stressed the need for alternative approaches to treating MHPs like any other illness (e.g. Read, Haslam, Sayce & Davies, 2006). Descriptions of MHPs on a 'normal' continuum have been proposed (e.g. Bentall, 2004) and been successful in promoting tolerance and compassion (Hinshaw, 2007). However, some have argued that they ignore biogenetic contributions and have recommended a more balanced, myth-combating approach (Corrigan & Watson, 2004).

Labelling theory

Labelling theory emanated from social constructionist thinking about identity being strongly shaped by social processes (e.g. Scheff, 1974). When labels are ascribed to deviant behaviours to control or treat those behaviours, individuals with those labels may adopt attributes consistent with the label, fundamentally changing their identity and social role. Secondary labelling theory (Lemert, 1967) developed from this, placing more emphasis on negative consequences for the individual because of the connotations attached to the label. Negative connotations give rise to stigmatising responses from perceivers and internalisation of these by the perceived, leading to demoralisation, concealment and restricted social networks (Link, Cullen, Frank & Wozniak, 1987). The shame of having diagnoses, such as schizophrenia, can cause self-stigma (internalising others' stigmatising attitudes) which can result in further difficulties for the individual (Birchwood et al., 2006).

Intergroup contact theory

Intergroup contact theory (Allport, 1954) takes the premise that lack of contact with the discriminated-against 'other' contributes to stigma and proposes a specific mechanism for stigma reduction. It suggests that prejudice can be reduced between minority and majority group members through contact, enabling opportunity for shared communication and increased understanding. Certain conditions are necessary for efficacy, including perceived equal status, common goals, acquaintance potential and support of authority (Corrigan & Watson, 2007). Extended contact theory posits that stigma can be reduced by observing members of the ingroup enjoying positive relationships with those in the stigmatised group (Wright, Aron, McLaughlin-Volpe & Ropp, 1997).

3.2 How theories apply to schools

Social identity theory (Tajfel & Turner, 1986) has relevance for schools as children may perceive themselves as part of an ingroup, leading to rejection of others that behave in ways they do not understand. Schools may have an important role in providing messages to children that challenge ‘us-and-them’ thinking and normalise the experience of MHPs by, for example, by giving the message that they exist on a continuum (Bentall, 2004).

Attribution theory (Weiner, 1995) has relevance in schools as schools are a key environment for learning about ‘acceptable’ behaviour, the ‘rules’ to be followed, and why people behave as they do. Without direction children may be more likely to attribute the cause of others’ behaviours in ways that increase discrimination. Appropriate, balanced education about factors that can cause MHPs could be critical for impacting attributions and therefore attitudes and behaviours towards those with MHPs.

Labelling theory (Scheff, 1974) is relevant to schools as learning new concepts often requires a label on which to ‘hook’ information. However, if a child has MHPs and teachers apply a label with negative connotations to them, it could lead to rejection of that child by others, which is subsequently internalised by them resulting in serious consequences. Teachers may need input on ways to help children learn about MHPs that does not involve labels.

Contact theory (Allport, 1954) has relevance for school-based anti-stigma interventions (e.g. Yamaguchi, Mino & Uddin, 2011). Stigmatising attitudes may be

maintained by lack of contact with those with MHPs, exacerbating poor understanding and perceptions of 'other' as distinct from self. Labelling and contact theory are also interrelated in that contact needs to be with known others (in this case people with MHPs) who are viewed as representative of the out-group. School-based programmes could facilitate contact between children and those with MHPs or provide opportunities to observe positive contact between their teachers and those with MHPs. However, there has been resistance to this from teachers and parents who have objected to direct contact as part of anti-stigma approaches (Economou et al., 2011). Indirect contact has also been refused for reasons including schools' anxieties about parents' reactions to their children learning about MHPs (e.g. Pitre, Stewart, Adams, Bedard & Landry, 2007).

3.3 Empirical contributions

Negative attitudes appear to be perpetuated by: lack of knowledge about MHPs (Jorm, 2000); little experience of people with MHPs (Corrigan & Penn, 1999); viewing those with MHPs as dangerous and unpredictable (Link, Phelan, Bresnahan, Stueve & Perscosolido, 1999); and perceiving those with MHPs as responsible for their problems and unlikely to recover (e.g. Corrigan et al., 2000). The impact of this on the lives of those with MHPs can be devastating. When seen as dangerous, people are often feared, avoided and isolated from society (Corrigan, Markowitz, Watson, Rowan & Kubiak, 2003). Perceiving that individuals are responsible for their condition can foster anger and reluctance to offer help (Corrigan et al., 2003). Results from a cross-sectional survey found that stigma contributes to failure to seek help early in the course of MHPs when it is most needed, particularly amongst young people (Biddle, Gunnell, Sharp & Donovan, 2004).

4. When and how do stigmatising attitudes develop?

Having considered the problem of stigma, how it is perpetuated, and potentially reduced, discussion turns to when and how stigmatising attitudes develop. This is important for addressing the question of the role of school-based interventions in combating the stigma associated with MHPs by highlighting the ideal age to target and ways to approach interventions. In order to explore this, empirical and theoretical contributions regarding learning and attitude formation are drawn upon.

4.1 How do attitudes form?

Schema theory

Schema theory (e.g. Piaget, 1932) suggests that children develop knowledge about concepts which are organised into 'schemas'. A schema is a set of linked mental representations of the world used to understand and respond to situations. Individuals notice things that 'fit' with their pre-existing ideas and interpret new information in a way that minimises change to their schema by reinterpreting any contradictions or perceiving exceptions as distortions (assimilation). Where new information that does not fit cannot be ignored, the existing schema needs to change or a new one created (accommodation). Early formation of ideas about groups of people carries importance – where children receive negative messages about those with MHPs, they are likely to select new information from this position, thereby reinforcing stereotypes. If early information provided for a schema is positive, children will more likely draw on this in future information encoding. Teachers could be crucial for early formation of positive schemas about those with MHPs, meaning less need to challenge derogatory schema later.

Cognitive dissonance theory

Cognitive dissonance refers to having contradictory cognitions simultaneously. Cognitive dissonance theory (Festinger, Riecken & Schachter, 1956) proposes that people are biased towards having consonance amongst their cognitions and have a motivational drive to reduce any dissonance. They do this by: altering one or more of the beliefs involved in the dissonance; acquiring new beliefs to increase existing consonance; or reducing the importance of dissonant cognitions. This has some overlap with schema theory and explains how prejudiced attitudes are maintained. This highlights the need to encourage the formation of positive schema early. In addition, it might be important to provide children with the opportunity to explore dissonance between their emerging cognitions and new information being presented about those with MHPs so as to enable adjustment of schema and creation of new positive cognitions.

Incremental learning theory

According to incremental learning theory (Dweck, 1999), learning is fluid and malleable, developing in a continuous incremental fashion through the influence of key others (e.g. parents, peers). Incremental learning theory proposes that young children have no stereotypes or prejudice but learn and adopt their beliefs as they develop. In explaining higher rates of racial prejudice found in children aged three to five when compared to those aged five to seven, incremental theory proposes that children learn that certain views are socially undesirable such that they stop expressing them openly (Corrigan & Watson, 2007). This could be important for school-based interventions - withholding expression of beliefs does not mean they are not problematic. Measuring the impact of interventions could be

invalidated by children knowing what they should and should not express. Interventions that give children the opportunity to bypass social desirability and to express and explore their beliefs could be important.

Behavioural theory

According to behavioural theory (e.g. Watson, 1928) learning is achieved by way of associations between stimuli (classical conditioning) and behaviours are manipulated through reinforcement or punishment (operant conditioning). The pairing of either empathy or discrimination with reward or punishment will impact on learned responses. Given the group dynamics in schools, children who express support for outgroup members might experience 'stigma by association' whereby they are treated negatively for being sympathetic with an outgroup member; thus they would be less likely to do so again in the future. Helping to increase positive associations and reward for more compassionate and inclusive behaviour may serve to increase their repetition.

Social constructivist theory

Social constructivist theories perceive learning as embedded in social relationships and have resulted in a shift towards interactive, reciprocal teaching (Faulkner, 1995). Vygotsky (1978) suggested that cognition and learning is shaped by social influence and culture, adults being channels for the culture's tools. Teachers can help children to build new knowledge and achieve the next developmental step (zone of proximal development) through the process of 'scaffolding'. Vygotsky argued that teachers should observe carefully and plan

activities to challenge children's next level, emphasising the importance of facilitating conversations and opportunities for children to work collaboratively to clarify ideas and learning. Teachers may thus have an important role in anti-stigma campaigns.

Social learning theory

Social learning theory (Bandura, 1977) suggests that behaviour is learned from the environment by children observing those around them (models) behaving in various ways. Children then imitate the observed behaviours and attitudes when faced with similar situations themselves. This has relevance to schools as teachers who have stigmatising attitudes and behaviours are likely to model these in the classroom. Children may need to witness positive examples of modelling from their teachers towards children or adults in society who have MHPs so that they then mimic those behaviours themselves. This is of relevance in the delivery of interventions, as interventions bring issues of MHPs into the classroom, where teachers who are involved may subsequently model empathic or stigmatising responses.

Social psychologists have maintained the argument that early experiences with the social environment are central to attitude formation (Hewstone, Stroebe, Codol & Stephenson, 1988). Jorm and Wright (2008) found that attitudes towards MHPs in young people (aged 12 to 25) showed specific associations with those of their parents. **Teachers** also have a significant role in determining children's perceptions of themselves, others and the world (Atwool, 1999), although little is known about how they specifically influence

children's attitudes towards those with MHPs. **Children's media** is also influential and has been found to depict those with MHPs as violent, unattractive and criminal, teaching children to respond in avoidant, disparaging ways towards those with MHPs (Wahl, 2003)

4.2 When do attitudes form?

Theories of cognitive and moral development

Piaget's (1932) cognitive developmental stage model contributed to thinking about ages at which children can cognitively understand new concepts, including: the 'pre-operational stage' (ages two to six) when children develop language; the 'concrete operational stage' (ages seven to 11) when children begin to think logically; and the 'formal' stage (ages 12 to 15) when children develop abstract reasoning skills. Piaget recognised cognitive and moral development as closely connected; he proposed that between five and 10 years, moral understanding is directed by authority figures (e.g. parents, teachers), whose rules are considered absolute and unbreakable. As children reach 10 or 11, their ideas about morality become more autonomous, less concrete and they begin to view moral rules as socially-agreed-upon guidelines to benefit the group. Kohlberg's (1976) moral development theory also suggested that middle childhood was characterised by children's internalised culturally-prescribed rules about right and wrong and that by early adolescence moral decisions are made by anticipating how decisions will be judged by other influential group members and what is considered best for the majority. Kohlberg's suggested learning was built cumulatively from understanding and abilities gained in previous stages.

These theories may be important for understanding of stigma development and the optimal age for anti-stigma approaches: if logical thinking begins at seven then interventions may need to be targeted after this and if morality is cumulative, receiving positive messages about those with MHPs from authority figures when rules are considered absolute could be an essential step in shaping positive attitudes. Also, if morality is more autonomous as children approach adolescence, it strengthens the argument for early interventions to shape these attitudes in preparation for independent thought. Some researchers interested in reducing the stigma of MHPs have proposed that challenging negative attitudes to MHPs before they are completely formed is an important future educational direction (Wahl, 2002). This is, however, only a minority view - most interventions target adolescents and adults where constructs of and stigma towards MHPs are already present. Ideas about intervening at primary school age have limited discussion in the literature and there are arguments against intervening with younger children when they may struggle emotionally and cognitively to understand.

Weiss (1994) found that negative attitudes towards those with MHPs were apparent by age five, remaining fairly stable thereafter, while Wahl (2003) reported they were present in children as young as eight. Adler and Wahl (1998) found that children aged seven to nine experienced the label 'mentally ill' most negatively, followed by 'physical disability' and then no label, even though the children did not understand the term 'mental illness.' Fox, Buchanan-Barrow and Barrett (2004) claimed that it was not until age eight or nine that children develop a conceptual structure about MHPs equivalent to that of physical illness (acquired by age five). Davies (2004) argued of a shift at around age ten, enabling children to understand how someone could have thoughts and feelings different from their own, and

that inner experiences may not be shared or understood by others. Some consider adolescence an appropriate time to intervene due to the number of adolescents experiencing MHPs and the importance of minimising the duration of untreated symptoms (Stuart, 2006).

Despite some argument that children hold ingrained stigmatising attitudes as young as five it seems likely, based on the cognitive stage model, that children have not yet developed an adequate cognitive structure from which to conceptualise MHPs, that they merely mimic behaviours observed in others, and may have not yet learned that expressing such beliefs is socially undesirable (Corrigan & Watson, 2007). Perhaps the responses they receive from influential others towards expression of discrimination shapes what becomes considered ‘acceptable’. Schools and teachers are central to a child’s social environment therefore theoretical and empirical findings regarding attitude formation have implications for school-based interventions to address the stigma surrounding MHPs.

5. Implications of theory and evidence for school-based interventions

Empirical and theoretical contributions suggest that school-based interventions may be a valuable means for addressing the stigma surrounding MHPs. Stigma theories highlight the potential importance of addressing ‘us-and-them’ thinking, of careful consideration regarding causal attribution messages, and the importance of considering labels and their impact. It may also be necessary to help children understand MHPs on a continuum, using non-medical language, and to facilitate contact between children and those with MHPs.

Schema and cognitive stage models support the case for interventions pre-adolescence, backed by empirical studies (e.g. Fox, Buchanan & Barrett, 2004). Incremental learning theory (Dweck, 1999) suggests that learning is constantly developing and points to the potential that children learn to suppress beliefs if they are deemed socially inappropriate, perhaps suggesting that they need the opportunity to be open about their beliefs. Social learning theory (Bandura, 1977) supports teachers' involvement and exemplary modelling in anti-stigma programmes, particularly when children are younger and more easily influenced. Social constructivist theories highlight the role of teachers in providing opportunities for discussion and receipt of new information at the correct stage in the child's learning process.

Having considered what theory suggests may be important for school-based anti-stigma interventions discussion turns to what has and has not been done in schools.

6. What has been done in schools and has it been effective?

A search was conducted for school-based interventions that sought to address stigmatising attitudes regarding MHPs in school children (Appendices 1 &2). Results identified 32 articles that met inclusion criteria, plus three related review papers. Previous reviews have considered the benefits and harms of school-based interventions (Schacter et al., 2008), the effectiveness of secondary school interventions (Sakellari, Leino-Kilpi, & Kalokerinou-Anagnostopoulou, 2011) and of different types of programme (educational, video-based contact and direct contact) in a range of educational settings (Yamaguchi et al., 2011). The current review considers the key ingredients of school-based interventions in relation to theoretical contributions.

Outcomes from the 32 papers reviewed were, overall, positive: programmes were effective in addressing stigma in children towards those with MHPs. Interventions improved knowledge and attitudes at primary and secondary level. Little, however, was learnt about whether results were sustained over time; regarding attitudes, one found no long-term impact while others found improvements at one, six and 12 months post-intervention. Social distance and help-seeking showed some improvement, with mixed findings regarding maintenance at follow-up. However this review does not attempt to look at outcomes of interventions in depth. Instead it seeks to review the role that interventions have played in addressing stigma and the active ingredients that were prominent across programmes in relation to extant theory and evidence. This is important for informing a theoretical basis for future interventions.

7. What are the ‘active ingredients’ of school-based interventions?

7.1 When to deliver?

Taken together, theoretical and empirical studies seem to be in support of providing interventions pre-adolescence, and somewhere between the ages of seven to 11 based on cognitive and moral development. The literature search identified five primary-school interventions and 27 secondary-school interventions. Of these, only two were led by primary school teachers (Lauria-Horner, Kutcher & Brooks, 2004; Ventieri et al., 2011). Only one intervention was carried out in a UK primary school (Shah, 2004) and seven in UK secondary schools (e.g. Naylor, Cowie, Walters, Talamelli & Dawkins, 2009). Overall, the majority of programmes have targeted secondary schools. Most interventions to address stigma towards MHPs, therefore, are aimed at children who may already have well-developed schema regarding those with MHPs. Very few programmes involved teachers in primary schools

therefore their potential to positively influence attitudes towards those with MHPs is not being realised, and indeed modelling of stigma post-intervention may negatively influence longer-term outcomes. Current practice in schools does not follow recommendations from theory and evidence of early anti-stigma interventions. This highlights an area requiring redress in future initiatives.

7.2 Styles of delivery

Styles of delivering interventions ranged from short factual lectures (e.g. Husek, 1965) to interactive, collaborative sessions. Provision of factual information that challenges myths and stereotypes may be important for anti-stigma approaches (Corrigan & Penn, 1999) although merely increasing knowledge regarding MHPs, perhaps without shaping this knowledge, has been found to increase stigmatising beliefs (Read et al., 2006). If children are simply given information with the message that certain attitudes are ‘wrong’, it may lead to suppression of beliefs as opposed to effectively challenging them (as proposed by incremental learning theory). Behavioural theory proposes that conditioning can help to change attitudes, which requires interaction between a child’s behaviour and subsequent response from teachers and peers. For new information to be sufficiently dissonant to create discomfort (as proposed by cognitive dissonance theory) children may need to explore the conflicting cognitions openly. Indeed social constructivists posit that children learn through interaction and opportunities for discussion. Many studies adopted this approach, using a mixture of media and styles. For example, Ventieri et al. (2011) delivered key messages through role-play, games and activities. Opportunities for open discussion and collaborative, interactive learning could be important for successful school-based interventions to address the stigma surrounding MHPs.

All teacher-led and most outsider-led programmes were interactive. Teachers, due to their training, may be aware of the importance of creative, explorative, interactive methods for meeting objectives. Didactic presentations produced some positive results and could be important for ensuring children receive accurate facts. However, interactive approaches using varied media seem more likely to engage children and stimulate thinking through discussion and exploration of beliefs. Comparing studies did not provide answers about whether outcomes were better according to interactive or didactic style.

7.3 Who should deliver?

Social learning theories propose that children are influenced by their teachers and mimic what is modelled (Bandura, 1977); social constructivist theories point to teachers' roles in ensuring children are challenged appropriately at their 'zone of proximal development' (Vygotsky, 1978). The majority of school-based interventions have been delivered by outsiders (i.e. researchers or others external to the school). Of five primary school programmes, two (40%) involved teacher-delivery (Lauria-Horner et al., 2004; Ventieri et al., 2011), while three were outsider-led (DeSocio, Stember & Schrinky, 2006; Pitre et al., 2007; Shah, 2004). Of 27 secondary school programmes, five (19%) involved teacher-delivery while 22 were outsider-led (e.g. Ng & Chan, 2002; Economou et al., 2011). Teachers have, therefore, had a more significant role in delivering primary than secondary school interventions, but primary interventions themselves have been very limited. Overall, only 22% of interventions were teacher-led; Schacter et al. (2008) also found that most interventions they reviewed were brought in from outside the school and its curriculum.

Teachers currently have a minority role in delivering anti-stigma programmes for MHPs, although they are more involved at primary than secondary level. There are no studies that have compared teacher-led and outsider-led programmes in order to identify which is more effective. However, theory suggests their role could be critical. If teachers have enhanced knowledge about MHPs through teaching about it, discussions about MHPs are likely to continue across other areas of the curriculum. Teachers are also likely to appreciate the level of understanding in their class and so help to develop children's understanding about MHPs appropriately.

7.4 Should service-users¹ be involved?

Contact theory argues that children could overcome 'us-and-them' thinking through contact with someone who has MHPs (e.g. Yamaguchi, Mino & Uddin, 2011). However, only nine of 32 programmes (less than 30%) involved direct contact in schools between children and service-users. Contact was completely absent from primary schools, whilst in secondary schools nine programmes involved direct contact (e.g. Schulze et al., 2003) and nine involved indirect contact (e.g. Pinto-Foltz, Logsdon & Myers, 2011; Economou et al., 2011). All programmes which involved direct contact were outsider-led; secondary school teachers facilitated indirect contact in four programmes (e.g. Petchers, Biegel & Drescher, 1998). Thus no teacher-led programmes included direct service-user involvement.

Children currently have little opportunity for direct contact with service users, particularly in primary schools. Social learning theory highlights the importance of teacher-

¹ Referring to people with MHPs who use mental health services

modelling, enabling children to witness their behaviours. However, children do not have the chance to observe their teachers in collaboration with those with MHPs. This might reinforce children's perceptions of service users as an outgroup (Tajfel & Turner, 1986). Indirect contact is one alternative, although Yamaguchi et al. (2011) found that direct contact was more effective for improving stigmatising attitudes. In summary, it would appear that interventions involving direct contact between service-users and primary school children would be worth evaluating although, as mentioned earlier, this may be resisted by schools.

7.5 Structure of delivery

Incremental theory suggests that learning develops gradually by way of social influence. Social constructivist models suggest that learning is built upon and requires a teacher to ensure the next step is appropriate for the child's development. Empirical studies suggest that successful interventions to address stigma may need to be continuous as opposed to one-off (Crisp, Gelden, Rix, Meltzer & Rowlands, 2000) although this is debated.

Interventions ranged from single sessions, lasting less than half a day, and even less than one hour (e.g. Pitre et al., 2007), to two sessions lasting over an hour (e.g. Ventieri et al., 2011) to six sessions of approximately one hour (e.g. Naylor et al., 2006) up to regular weekly sessions over four months (e.g. Lauria-Horner et al., 2004). Theory seems to suggest that regular and continuous interventions will be more successful than shorter, one-off programmes. When programmes are part of the curriculum and delivered regularly over a period of time, teachers are more likely to be involved (more than half of the teacher-led programmes were incorporated into the curriculum), enabling learning to be built upon, with

longer-term impact. Considering the theory and some evidence for continuous interventions being most successful (Crisp, Cowan & Hart, 2004), future school-based programmes should aim for curriculum-incorporated lessons that are delivered continuously and regularly as opposed to at one point in time.

7.6 What should the key messages be?

Attributing a person's behaviour as being within their control appears to elicit less compassion, and more blame and hostility, than believing it is beyond their control. Much debate exists, however, about whether messages should move away from biogenetic explanations of MHPs towards messages of a continuum with 'normal' experiences (Bentall, 2004). The latter approach would be more consistent with the implications of labelling theory.

Watson et al's (2004) programme, led by biology teachers, was entitled 'The Science of Mental Illness', emphasising the biological basis of MHPs. Despite including psychosocial factors, the course title and the delivery by biology teachers suggests a biological emphasis. Two programmes discussed brain disorders with primary school children, positioning MHPs as being like any other illness (DeSocio et al., 2006; Pitre et al., 2007). Some studies stressed non-medical explanations, describing MHPs as resulting not from genetic, biochemical or organic abnormalities but from social and environmental influences (Morrison, Becker & Bourgeois, 1979; Pinfold et al., 2003; Schulze, Richter-Werling, Matschinger & Angermeyer, 2003). Addressing 'us-and-them' thinking and highlighting similarities rather than differences formed the central aim of a number of

programmes (e.g. Chan, Mak & Law, 2009; Spagnolo, Murphy & Librera, 2008), an important message in eliminating perceptions of homogenous in- and outgroups.

Messages that challenge ‘us-and-them thinking’ and provide balanced causal explanations are important for fostering compassion in children towards those with MHPs. However, such messages are sparse in current school-based interventions. If those delivering interventions could normalise the behaviours and emotions of those with MHPs (without labelling) and help others to relate to them, the negative impact of labelling could potentially be avoided (Spitzer & Cameron, 1995). However, whether children could learn effectively about MHPs without labels to help them grasp the concept is questionable. One possibility promoted by the Hearing Voices Network is to use ordinary language (e.g. distress, hearing voices) rather than medical labels (De Valda, 2001).

8. Summary and future directions

This review presented an outline of the literature regarding school-based interventions to target the stigma surrounding MHPs. It seems that these interventions currently have a small but promising role in the drive to diminish stigma towards those with MHPs, and the theory and evidence suggests that they may play a very important role in the future. Most interventions are currently carried out in secondary schools and are outsider-led. Interventions in primary schools are more likely to be led by teachers compared to secondary schools. There were no programmes that involved direct or indirect contact between primary school children and service users. No teacher-led programmes facilitated direct contact between children or young people and service users. While some programmes were purely didactic, most included a mixture of didactic and interactive methods. Interventions ranged

from single sessions, up to curriculum-incorporated programmes delivered regularly over four months. Messages were not explicitly specified in many studies but some gave more illness-based descriptions of the causes of MHPs while others attempted more psychosocial explanations to address ‘us-and-them’ thinking. Currently, school-based interventions fail to address many of the key things that are highlighted by the theory and evidence.

Based on what is known from theory and evidence, the influence of school-based interventions might be optimised through teacher-delivery of interactive programmes that are continuous and incorporated into the curriculum. They might also be best targeted at children in upper primary school (aged 7-11). Programmes should facilitate contact and avoid biological, illness-focused messages about MHPs. Providing balanced information on bio-psycho-social causes has been recommended although if ‘us-and-them’ thinking is maintaining stigma and discrimination, it seems that messages highlighting MHPs on a normal continuum could be very important.

The following areas for further research arise from this review:

1. *Learning about teachers’ understanding of MHPs, attitudes towards those with MHPs, and views on introducing this to the primary school curriculum.*

If teachers will potentially be delivering future school-based interventions, it is critical to understand their attitudes and views, concerns and training needs.

2. Communication between primary school teachers and children regarding MHPs.

To inform effective future initiatives it is vitally important to explore the communication that occurs between primary teachers and children about MHPs. There have been very few studies in primary schools yet they are potentially one of the most important sites for future interventions and long-term change at a societal level.

3. Longer-term impact of interventions that are part of the curriculum and delivered by teachers compared to short-term programmes by outsiders.

It is important to conduct longitudinal studies that ask whether curriculum-embedded, teacher-delivered programmes are more effective long-term than shorter-term one-off outsider-delivered interventions. This will be important in justifying funding and resources.

The findings of this review highlight a lack of primary school-based interventions to tackle the stigma faced by those with MHPs; the implications are significant. Targeting young children could ultimately lead to a measurable shift in public attitudes, supported by previous successful campaigns which have achieved this (e.g. anti-smoking). Research is needed into the information children learn at school and from teachers about those with MHPs, and to know what informs teachers' understanding, attitudes, and communication. Findings suggest that primary schools are important sites for addressing the stigma surrounding MHPs. Future programmes would benefit from incorporating what is known from the theory and evidence-base.

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Major Research Project: Section B

**How do primary school teachers communicate with children
about mental health problems and what influences this?**

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Abstract

This grounded theory study explores primary school teachers' communication with children about mental health problems, aiming to identify key factors influencing what is and is not communicated. The project offers a model of communication that could inform future initiatives to improve children's understanding and attitudes towards those with mental health problems.

Fifteen teachers from three primary schools were recruited and interviewed individually using semi-structured interviews. After transcription, interviews were analysed using grounded theory.

Results showed that conversations about mental health problems are largely absent from the classroom. There appear to be a number of reasons for this. Teachers have fears about the implications of talking about mental health problems with children. These are connected to their beliefs and fears regarding those with mental health problems, their beliefs about mental health problems in relation to children and its place in the classroom, and about their professional roles. Relating to theory, teachers perceive themselves as part of a homogenous 'in-group' as distinct from a homogenous 'out-group' with mental health problems. Fears, beliefs and ingroup perceptions lead teachers to 'play safe' and avoid conversations about mental health problems in the classroom. This absence of discussion may reinforce for children that mental health problems are taboo.

Greater links are required between schools and mental health services, and clinical psychologists need to be proactive in influencing policymakers by promoting the argument that teaching on mental health problems has an important place within the British school curriculum.

1 Introduction

Stigma towards people with a diagnosis of mental health problems (MHPs) is a serious problem in society (World Health Organisation, 2012) and urgently needs to be addressed. Theory suggests that stigmatising attitudes are likely to form in childhood through various social influences. Schools have been identified as a key target for interventions to address the stigma surrounding MHPs, aiming to influence knowledge and attitudes early (Department of Health, 2004). While a number of school-based programmes have been delivered, few have included primary school children or teachers and they are not mandatory within the school curriculum. Theory would suggest that teachers have a crucial role in shaping children's attitudes and are therefore likely to influence how children perceive those with MHPs (Bandura, 1977). In order to identify the best way forward for anti-stigma school-based interventions, it is imperative that baseline information is obtained about the current situation in primary schools regarding how and what teachers are communicating with children about MHPs and the factors influencing this.

1.1 Stigma surrounding mental health problems (MHPs)

MHPs are widely misunderstood, resulting in stigmatising and discriminatory attitudes and behaviours towards those affected (Hinshaw, 2007). The impact on the lives of those with MHPs can be devastating, including disadvantage regarding income, employment and housing (Thornicroft, 2006), as well as social exclusion and negative psychological effects (Baumann, 2007). Stigma and discrimination prevents those with MHPs from seeking help early, which can have serious consequences for treatment outcomes (Pinto-Foltz & Logsdon, 2009). The importance of addressing the stigma surrounding MHPs is increasingly high on the government's agenda; in 2011 it agreed to contribute £16 million towards 'Time

to Change', a leading anti-stigma and discrimination campaign (Department of Health, 2011). If schools are targets for future campaigns, it is important to consider the current situation in schools and what might be perpetuating stigma towards those with MHPs. Theories of stigma may be important for this purpose.

1.2 Theories of stigma

Social identity theory

Three key theories are described which enhance our understanding of stigma. Mechanisms of social identity theory (Tajfel & Turner, 1986) explain a psychological need to form 'ingroup' identifications which promote differentiation from those in the 'outgroup'. Individuals tend to perceive members of the outgroup as homogenous and distinct from the ingroup to which they belong. Separation of ingroups and outgroups ('us-and-them thinking') increases hostility and discrimination towards outgroup members and serves to enhance self-esteem related to belonging to the ingroup (Hinshaw, 2007).

Attribution theory

According to an attribution model, discrimination is more likely to result when an individual's behaviour or illness is perceived as within as opposed to outside of their control (Corrigan, Markowitz, Watson, Rowan & Kublak, 2003). Biogenetic explanations of an 'illness' would therefore seem to be the most helpful way to reduce stigma, however, studies have shown that they can reinforce the notion of hopeless states and result in increased discrimination (Hinshaw, 2007). Psychological explanations of MHPs on a 'normal' continuum have been suggested as more effective for addressing prejudice (Bentall, 2004).

Labelling theory

Labelling theory (Scheff, 1966) highlights the damaging impact of ascribing labels to a person. This is related to the negative connotations attached to the label, which are perceived by others and internalised by those to whom the label is attached. Labels can produce demoralisation, concealment and restricted social networks over and above the debilitating impact of the MHPs (Link, Cullen, Frank & Wozniak, 1987).

These theories are complementary and taken together suggest that stigma is perpetuated by 'us-and-them' thinking, messages that emphasise the biogenetic causes of MHPs or ascribe responsibility to a person for their problems, and ascribing labels which have negative connotations.

1.3 Development of stigmatising attitudes

There is no clear consensus regarding when stigmatising attitudes develop; however, empirical studies and theories of learning contribute to an understanding of how as well as when attitudes form.

Social psychologists have made important contributions to our understanding of how attitudes develop. **Social constructivist theories** perceive learning as embedded in social relationships. Vygotsky (1978) suggested that cognition and learning is shaped by social influences and culture, adults being channels for the tools of the culture. **Social learning theory** (Bandura, 1977) suggests that behaviour is learned from the environment through the process of observational learning, with children observing people around them (models) behaving in various ways. These 'models' provide examples of attitudes and behaviour which

children encode and imitate. Empirical studies confirm the role of the social environment in attitude formation, including the influential roles of parents (Jorm & Wright, 2008), siblings (Cicirelli, 1982), children's media (Wahl, 2003) and teachers (Atwool, 1999).

Piaget's (1932) **cognitive developmental stages model** can be used to consider when children's attitudes might be formed. He proposed that between seven and 11 years children begin logical thinking and that after the age of 11 children develop abstract reasoning skills. He proposed that learning is achieved by organising information into schemas, mental representations formed at an early age for various concepts and adapted as new information is acquired. Piaget's thoughts on moral development were closely aligned, with morals being guided by authority and considered absolute up to the age of 10, after which they are less concrete and increasingly autonomous. **Kohlberg's (1976) theory of moral development** suggested that stages of moral development were cumulative, with each stage built on previous understanding. Fox, Buchanan-Barrow & Barrett (2007) claimed that it is not until the age of eight or nine that children develop a sufficient conceptual structure for MHPs. Davies (2004) proposed that this shift occurs at around the age of ten, enabling children to understand how someone can have thoughts and feelings different from their own.

Taken together, theory and evidence regarding when and how children develop their attitudes support an argument for future interventions that focus on children at primary school level and their teachers, pointing to the need for more understanding in this under-researched area.

1.4 Schools and teachers' roles in addressing the stigma surrounding MHPs

The previous section suggests that schools and teachers have an important role in shaping children's attitudes. It is therefore important to consider their existing role in relation to influencing attitudes about those with MHPs.

The Social and Emotional Aspects of Learning (SEAL) programme, part of the British primary school curriculum, was designed to develop children's social, emotional and behavioural skills. It focuses on self-awareness, managing feelings, motivation, empathy and social skills and has been viewed positively by staff (Hallam, 2009). It does not currently incorporate reference to MHPs. However, a number of school-based interventions have sought to address the stigma surrounding MHPs. Of these, most have been in secondary schools and delivered by individuals who are external to the school. In the UK, only eight programmes have been delivered in total, including one primary school. A handful of non-UK interventions have been delivered by primary school teachers (e.g. Lauria-Horner, Kutcher & Brooks, 2004). While there is much design variation amongst interventions, results have been promising for shaping children and young people's attitudes towards those with MHPs in the short-term (Yamaguchi, Mino & Uddin, 2011). School-based interventions to address the stigma of MHPs currently, however, bypass important theoretical and empirical contributions.

1.5 Teachers' perspectives on addressing the stigma surrounding MHPs

Some studies have described teachers' reticence regarding involvement in such interventions. Ventieri, Clarke and Hay (2011) approached primary schools to recruit them

in a teacher-led school-based programme for addressing the stigma of MHPs. However, some schools refused to participate due to staff concerns about parents' reactions, the appropriateness of teaching children about MHPs, and uneasiness about responding to issues that might be raised by discussing MHPs. Askell-Williams, Lawson and Murray-Harvey (2007) described how teachers identified their own knowledge and confidence as needing consideration before implementing a MHP module in secondary schools.

Collins and Holmshaw (2008) used a questionnaire study to explore secondary school teachers' knowledge of psychosis. They found that while most teachers could recognise symptoms and identify causal factors, they felt uncertain regarding their roles and responsibilities towards pupils presenting with symptoms of psychosis. Rabkin and Suchoski's (1967) questionnaire study explored American teachers' views towards MHPs and concluded that teachers' understanding and attitudes needed to be developed, and become more positive, in order to implement programmes to shape positive attitudes in children. Graham, Phelps, Maddison, and Fitzgerald (2011) used a survey to elicit the views of Australian primary and secondary teachers regarding mental health education. They found that most teachers felt a lack of confidence and limited knowledge and skills, requesting the need for more training, resources and parental involvement.

1.6 Rationale for the current study

Stigma towards those with MHPs is a serious problem that needs to be addressed. Both theory and research suggest that primary school age may be an optimal time for interventions to shape positive attitudes towards those with MHPs before derogatory attitudes have developed. They also suggest that teachers have a significant influence on, and

contribute towards, children's knowledge, attitudes and behaviours. Discussion about MHPs is not part of the British school curriculum; this 'taboo' is in itself likely to send a message that MHPs are stigmatised and to reinforce negative perceptions of those with MHPs amongst both children and teachers.

Most MHPs commence in adolescence (Knopf, Park & Mulye, 2008); adolescents are also particularly likely to hold stigmatising views towards those with MHPs (Crisp, Gelder, Goddard & Meltzer, 2005) and are least likely to seek help for MHPs (Biddle, Donovan, Sharp & Gunnell, 2007). Messages to address stigma, therefore, need to start early and schools are a good place to start. While most interventions to address the stigma of MHPs in schools have been delivered by external agents, teachers' views and attitudes have been found to impact on uptake (e.g. Pitre, Stewart, Adams, Bedard, & Landry, 2007). Service users with psychosis have argued that having these interventions delivered by an external agent contributes to stigma and discrimination, and that a more normalising and inclusive approach would be to deliver interventions through teachers as part of the curriculum (e.g. Pinfold et al., 2003).

Research regarding teaching on sexual education, also considered to be a sensitive topic, has highlighted the importance of teachers' attitudes about teaching sexual education to how they approach and deliver interventions, and therefore to their efficacy in promoting healthy and responsible attitudes and behaviours towards sex in children and young people (Cohen, Sears & Weaver, 2004; Paulussen, Kok & Schaalma, 1994; Kirby, Laris & Rolleri, 2005). This highlights the need to understand the current situation regarding teachers and their communication with children about MHPs. If anti-stigma initiatives for MHPs are to be

introduced and supported in schools and delivered by teachers, it is important to understand the psychological processes that influence teachers currently in their communications with children about MHPs. Such information will be essential for informing successful future school-based interventions. It is also necessary to consider this in a way that is integrated with extant theory.

To date, no studies appear to have examined in detail how teachers communicate with children about MHPs and what factors might influence this. The present study sought to address this by interviewing primary school teachers. In view of the dearth of studies, a qualitative study and grounded theory analysis appears to be a suitable first step in developing the knowledge-base. It is hoped that the findings will inform not only further studies, but also effective school-based interventions to address the stigma surrounding MHPs.

2 Method

2.1 Participants

Fifteen participants were interviewed. Participants were practising primary school teachers with current or previous experience of teaching children in key stage two i.e. years three to six, ages seven to 11 (see Table 1 below and Appendix 3). Schools were recruited through related projects that the lead supervisor was involved in together with the researcher's teaching contacts.

Participant code	Age	Gender	Ethnicity	No. years teaching
L1	28	Female	White Irish	6
H1	35	Male	White British	11
H2	38	Male	White English	8
L2	50	Female	White British	6
L3	48	Female	White British	15
L4	33	Female	White English	9
H3	44	Female	White Welsh	20
H4	31	Female	White British	7
H5	26	Female	White British	3
L5	30	Male	Mixed/multiple ethnic group	3
X1	27	Female	White Welsh	5
X2	29	Female	Any other white background	7
X3	36	Female	Black African	4
X4	59	Female	Black Caribbean	35
X5	28	Female	White British	4

Table 1: Participant demographics

2.2 Design

A non-experimental, qualitative design was employed, using semi-structured interviews. This allowed open-ended questions to be asked, that were relevant to the research questions. These were then explored further where more information was required. This

facilitated the collection of rich data, essential for the chosen methodology of Grounded Theory (GT; Charmaz, 2006).

2.3 Procedure

Headteachers at three schools were contacted by letter or e-mail and given a brief explanation of the project (Appendix 5). This was followed by a face-to-face or telephone meeting and agreement on how best to recruit teachers. Headteachers were given the teacher information sheet, consent and demographics forms to distribute to teachers (Appendices 6-8). Interested teachers gave their names to the headteachers who provided names to the researcher. Teachers signed consent forms which were collected prior to individual interviews being conducted at the schools.

Teachers were reminded that they could terminate the interview and withdraw from the study at any point. Interviews lasted between 40 and 65 minutes and were audio-taped. The interview schedule (Appendix 9) was developed through discussion with the supervisor and was approved by a service user consultation group. Interviews were trialled in two pilot interviews. Key questions from the interview schedules were asked in all interviews and expanded upon where required in order to explore emerging themes. Questions were adapted over time to enable theoretical sampling and a move towards data saturation.

2.4 Analysis

Data were analysed using GT. Qualitative approaches are appropriate to under-researched areas and GT is appropriate for research that aims to understand subjective

accounts regarding attitudes, beliefs and behaviours of specific groups of people (Charmaz, 2006).

The process of analysis was informed by guidance in Charmaz (2006):

- Line-by-line coding was carried out on the first three transcripts.
- Focused coding was used to group key codes into categories. Subsequent data were examined using constant comparison.
- Theoretical coding was used to make connections between codes and to generate theory. Memos were kept throughout the analysis process, were used to reflect on category development and theory development (Appendix 11).
- The model generated was reviewed against transcripts to assess its credibility.

2.5 Quality assurance

In order to ensure quality and reliability of the analysis, initial coding was carried out independently by the researcher and lead supervisor. Codes were then discussed at length to ensure agreement. This auditing with the supervisor continued throughout the analytic process, with regular meetings to ensure agreement on coding, categorising and theory generation.

Respondent validation was obtained (Appendix 16) by e-mailing all participants a summary of the findings (Appendix 15) to check that the findings were a good reflection of what had been shared in interviews.

The researcher kept a research diary throughout the project (Appendix 12). Discussions were also held with peers/colleagues regarding the potential impact of the researcher's previous training as a teacher and how this may impact the process. By holding this in mind the researcher sought to bracket their own prior assumptions and experiences.

2.6 Ethics

Ethical approval for the project was granted by the Canterbury Christ Church (Salomons) Research Ethics Committee (Appendix 4). The British Psychological Society (BPS, 2006) and Health Professionals Council (HPC, 2009) code of ethics and conduct was adhered to.

3 Results

All categories, sub-categories and codes are listed in Appendix 14.

Constructed theory

The data revealed that discussions about MHPs are absent from the classroom and highlighted various factors influencing this. A model emerged which demonstrated a relationship between teachers' emotions and beliefs regarding those with MHPs and their communication behaviours with children. Teachers had fears about the implications of discussing MHPs with children as well as general fear surrounding those with MHPs, related to their beliefs about MHPs in the classroom, MHPs more generally, and their professional roles. These beliefs and emotions were inter-connected and led to safety and avoidance behaviours. The model is presented in a cognitive behavioural context, showing a relationship between emotions, beliefs and behaviours (Greenberger & Padesky, 1995).

3.1 Emotions

The overriding emotion was one of fear, which emerged in relation to two categories: fear of implications of talking about MHPs with children, and fear surrounding those with MHPs.

3.1.1 Fear of implications

Fear of implications was one reason for teachers not discussing MHPs with children and included a fear of backlash from parents, of triggering undesired emotions or behaviours in children, and of giving children the wrong information (expanded below).

WHY ARE DISCUSSIONS ABOUT MENTAL HEALTH PROBLEMS (MHPs) ABSENT FROM THE CLASSROOM?

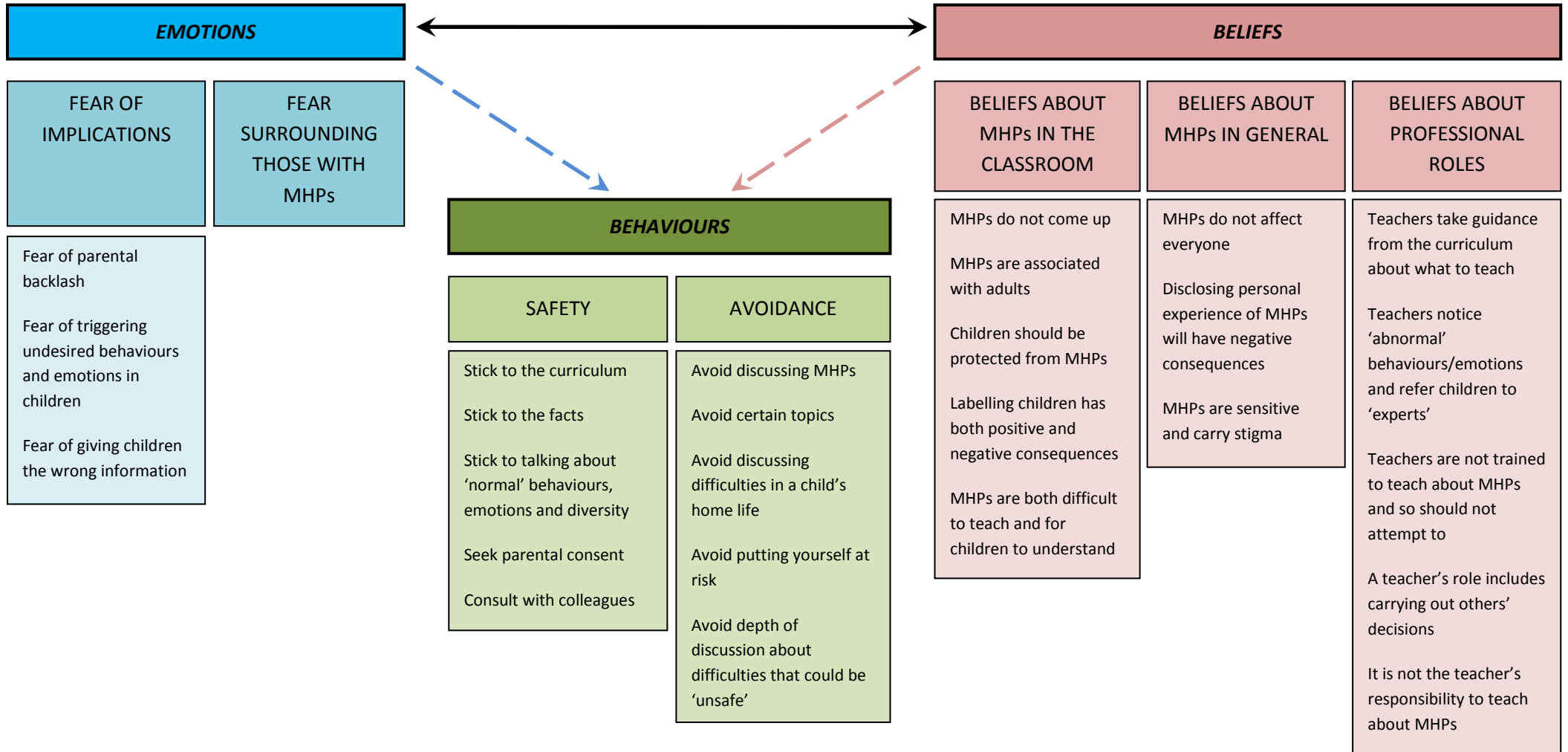


Figure 1. Model of communication including why discussions about mental health problems are absent from the classroom

3.1.1.1 Fear of parental backlash

Teachers frequently referred to fears about how parents would react towards their children having discussions about MHPs with teachers, commonly worrying that parents would disapprove and make 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...” (Participant H4)

There was an indication that this was particularly necessary in current day teaching:

“You’ve got to worry about that now...about how parents react to stuff like that.”
(Participant H4)

3.1.1.2 Fear of triggering undesired behaviours and emotions in children

There was fear that discussing MHPs with children would result in children thinking they had a problem or trying out behaviours associated with MHPs:

“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.”(Participant H4)

Another reason for not discussing MHPs was concern about scaring or upsetting children, potentially leading to something psychological that children could not cope with:

“...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...” (Participant X3)

3.1.1.3 Fear of giving children the wrong information

Teachers were scared of giving children the wrong information, largely related to beliefs about lack of knowledge, experience or skill in the area of MHPs. Due to lack of confidence in skills or subject knowledge regarding MHPs, teachers felt anxious at the prospect of having MHP-related discussions. One fear was that talking about MHPs would generate questions from children which they would not be able to answer accurately:

“...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...” (Participant X1)

Teachers seemed to think that ‘expert’ knowledge was necessary for having these kinds of 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/idea...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'...” (Participant X4)

3.1.2 Fear surrounding those with MHPs

Fear of those with serious MHPs was apparent and included reference to teachers' own fears and those of society. Media portrayal of those with MHPs as violent and dangerous was highlighted as influencing teachers' avoidance of discussions about MHPs:

“...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’...”

(Participant H5)

Teachers’ own fears of those with MHPs were also likely to influence avoidance of discussions about MHPs:

“...you just see kind of people that make you feel a little bit intimidated by their behaviour...” (Participant L4)

3.2 Beliefs

Three categories emerged describing teachers’ beliefs, influencing lack of discussion about MHPs with children, including beliefs about MHPs in relation to children and the classroom, about MHPs in general and about their professional roles.

3.2.1 Beliefs about MHPs in the classroom

Teachers beliefs about MHPs in relation to children, and discussing MHPs in the classroom, also explained absence of discussion about MHPs. This included five sub-categories, elaborated on below.

3.2.1.1 MHPs do not come up

Teachers frequently reported that MHPs did not come up and cited this as a reason for the absence of discussions about them:

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

(Participant X5)

This is treated as a belief as it is possible that MHPs come up in various indirect forms but is not identified as such. Teachers may hold a ‘black and white’ view of MHPs as distinguishable from ‘normal’ experience and might therefore not consider the subject of discussion to be ‘mental health problems’ unless it is clearly presented as such.

3.2.1.2 MHPs are associated with adults

Distinction was made between children and adults in terms of MHPs, with MHPs being more commonly associated with adults or seen as being different in adults and children:

“I think people do see it differently in children than you do in adults as well.”

(Participant L3)

Some teachers stated that they had not heard of or come across MHPs in relation to children; MHPs were seen as something that affects adults:

“...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.” (Participant X1)

3.2.1.3 Children should be protected from MHPs

A further factor that appeared to prevent conversations about MHPs was a belief held by many teachers that children should be protected from it. Some queried whether children in primary school 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.” (Participant H4)

Some were unsure as to whether children needed to know about types of MHP and thought children may be unlikely to be in contact with people with these diagnoses:

“I don’t think they need to know that there’s this thing called depression, there’s this thing called ODD, 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...” (Participant X1)

3.2.1.4 Labelling children has both positive and negative consequences

Labelling was considered by some to be something that 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.” (Participant L3)

However, positives of having a diagnosis were also considered, including making it easier for teachers to talk about the problem and teach the class about it, as well as enabling teachers and children to be more accepting and helpful towards the child with the problem:

“When we realised what it was, there are certain things you can do in the class to *help that child. When you don’t know what it is you treat them all the same because at the end of the day you can’t be making exceptions for some type of behaviour...because then it sets a bad example to the other children.*”

(Participant X2)

3.2.1.5 MHPs are both difficult to teach and for children to understand

MHPs were thought to be a more difficult subject to teach than physical illness, and harder for children to understand as they were considered ‘abstract’ and not visible:

“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.”

(Participant L3)

3.2.2 Beliefs about MHPs in general

Another category to explain the absence of discussions about MHPs with children was beliefs held by teachers about MHPs in general, including three subcategories: that it does not affect everyone, that disclosing personal experience of MHPs will have negative consequences, and that MHPs are a sensitive area carrying stigma (expanded below).

3.2.2.1 MHPs do not affect everyone

Some teachers believed that MHPs do not affect everyone (unlike physical illness). This added to a sense that physical illness is more relevant and important to discuss in the classroom:

“...it’s more normal, physical disability compared to mental disability. Something people think might affect them more...” (Participant L5)

3.2.2.2 Disclosing personal experience of MHPs will have negative consequences

Some self-stigma was apparent, causing teachers to withhold communication about their own experiences in relation to 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...” (Participant H3)

These beliefs about the impact of sharing experiences of MHPs appeared to heighten the sense that this was a subject that could not be freely discussed in the classroom. Indeed teachers appeared to feel that personal experiences in relation to MHPs were not appropriate to bring in to the classroom.

3.2.2.3 MHPs are sensitive and carry stigma

Also diminishing communication about MHPs, teachers made reference to beliefs about the sensitivity of MHPs as a subject, of the stigma surrounding it, and of the reactions from others towards MHPs compared to serious physical illness.

“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’...” (Participant H5)

3.2.3 Beliefs about professional roles

Teachers were led by a need to conform to professional roles, describing beliefs about how they should behave in order to adhere to expectations of them in their teaching role. These beliefs also influenced lack of discussion about MHPs.

3.2.3.1 Teachers take guidance from the curriculum about what to teach

It was clear from the interviews that what gets covered in the classroom largely conforms to the national curriculum.

“...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...” (Participant X4)

When a subject is part of the curriculum, teachers can cover topics that may feel sensitive or evoke emotion in children. The curriculum seems to remove personal responsibility and dictates to teachers what topics are covered:

“...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...” (Participant H4)

This belief about conforming to the curriculum may explain why teachers do not discuss MHPs with children, as it is not currently incorporated.

3.2.3.2 Teachers notice ‘abnormal’ behaviours/emotions and refer children to ‘experts’

Teachers seemed to believe that it was their job to ‘keep an eye’ and notice if children were exhibiting behaviours or emotions that exceeded what would be considered ‘normal’:

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

Where behaviours/emotions or children’s disclosures seemed ‘abnormal’, teachers referred the matter on to ‘others’ and avoided getting involved:

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

This demonstrates beliefs about the limits of the teacher’s role and what is expected of them: teachers do not consider it within their remit to go beyond spotting abnormal behaviours.

3.2.3.3 Teachers are not trained to teach about MHPs and so should not attempt to

Teachers felt they lacked knowledge and experience of MHPs, despite many having direct or indirect experience, which meant it was an uncomfortable area to address with children:

“I’ve not actually got the foundation to teach to them about it. If I had relevant skills that worked directly 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, make it more child-friendly...I couldn’t do that...” (Participant X3)

Teachers spoke of needing training and guidance about MHPs, including knowledge about types of MHP, causes etc. as well as boundaries regarding appropriate discussion:

“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...” (Participant L4)

3.2.3.4 A teacher’s role includes carrying out others’ decisions

Teachers seemed to hold beliefs that they were agents for others’ decisions and that their role was to take direction from management:

“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...” (Participant X5)

When it came to managing situations regarding individual children, teachers were told by parents about what to communicate:

“...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...” (Participant H4)

This suggests a lack of belief in teachers that they can communicate freely with children about MHPs – they do not consider it their role to decide what is communicated.

3.2.3.5 It is not the teacher’s responsibility to teach about MHPs

Some teachers thought that teaching children about MHPs was not part of a teacher’s role and that headteachers needed to bring in people with expertise in the area or else that parents held responsibility:

“I think that’s with their family to kind of support if they want their child to understand what it is...” (Participant W1)

This belief that others are responsible appears to maintain the status quo – teachers are unlikely to talk with children about MHPs unless they consider it their responsibility.

3.3 Behaviours

Behaviours refer to categories of ‘safety’ and ‘avoidance’ which result from the fears and beliefs that teachers hold, maintaining the status quo of not discussing MHPs with children.

3.3.1 Safety

Five subcategories emerged in relation to teachers keeping themselves safe are expanded below:

3.3.1.1 Stick to the curriculum

Teaching within the curriculum seemed to be more comfortable for teachers:

“...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. Yeah, it’s safer within the boundaries.”

(Participant H4)

Where a subject was part of the curriculum, teachers felt covered by their unions should anything arise from discussions they had with the children:

“I guess if it is curriculum-based definitely because if you come away from that 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.”

(Participant H4)

MHPs are not part of the school curriculum: sticking to the curriculum to ‘keep safe’ therefore means that MHPs are not discussed.

3.3.1.2 Stick to the facts

Teaching about facts seems to be much safer for teachers than sharing personal opinions or being too exploratory; this ensures they protect themselves should there be any negative consequences from something that they have talked with children about. Giving personal opinions seems to be something teachers often avoid:

“...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’” (Participant X5)

When it comes to controversial topics like MHPs, teachers do not want to influence how children think and are wary about giving personal opinions:

“...when you talk about your views, I wouldn’t be as direct as about what I actually thought...because I don’t want to guide their thoughts the way that I think is necessarily right.” (Participant H1)

Sticking to the facts reinforces the current absence of MHPs. Teachers reported feeling unsure of the facts regarding MHPs and are wary of sharing their opinions. MHPs are a subject that involves uncertainty and demands individual opinions and so it follows that it is safer not to talk about it.

3.3.1.3 Stick to talking about ‘normal’ behaviours, emotions and diversity

Talking about managing ‘normal’ emotions and behaviours seemed to be safe grounds for teachers:

“We teach them how to deal with their anger and we teach them how to deal with certain situations” (Participant H5)

Common to all interviews, teachers felt safe giving children the message that everyone is different, that diversity is to be celebrated, and also that 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.” (Participant H1)

3.3.1.4 Seek parental consent

Many teachers made reference to MHPs being similar to sex education, which requires parental consent. To feel safe talking about MHPs, teachers thought that parents would need to be in agreement:

“...you’d have to involve parents in that kind of thing.” (Participant L4)

This implies that MHPs are a sensitive subject and one where teachers fear parental backlash.

3.3.1.5 Consult with colleagues

Talking with colleagues also helps teachers to feel safer in their communication with children in their class, having a shared sense of how to manage certain situations and children:

“...with the knowledge of colleagues because of course, especially in education, you talk a lot to the other teachers.” (Participant L5)

Teachers are, therefore, influenced by their colleagues. If absence of discussion about MHPs is common to all classrooms, this means that there is little that is influencing or increasing the likelihood of teachers having open and frank discussions with their classes about MHPs.

3.3.2 Avoidance

The ‘avoidance’ category developed from five subcategories discussed below. Avoidance, along with safety, resulted from teachers’ beliefs and fears, and served to keep discussions about MHPs outside of the classroom.

3.3.2.1 Avoid discussing MHPs

No interviewee described having such conversations:

“...I’ve never discussed with them about mental health problems to be honest.”

(Participant L5)

Where one child in the class had mental health-related difficulties, there was typically avoidance of open discussion with the whole 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.”

(Participant L2)

3.3.2.2 Avoid certain topics

There were commonly occurring topics that teachers were especially wary of communicating with children about. One of these was schizophrenia and its symptoms:

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

Suicide frequently came up as something that caused teachers discomfort and one they would rather avoid having to communicate about:

“We’ve had like a few cases as well at our school of parents that have committed suicide as well, em, 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.” (Participant H1)

3.3.2.3 Avoid discussing difficulties in a child’s home life

Talking about children’s families and home lives was something most teachers avoided communicating about:

“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.” (Participant X1)

3.3.2.4 Avoid putting yourself at risk

Teachers chose what they communicated according to a position of avoiding risk to themselves as professionals:

“...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.” (Participant H1)

Such a risk-averse position could contribute to a closed-off and rigid communication system that perpetuates MHPs as a subject to be avoided.

3.3.2.5 Avoid generating discussion about difficulties that could be 'unsafe'

Teachers avoided generation of discussion when it came to MHPs:

“...in a way, 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...” (Participant L2)

Communicating with children was censored by their fear of criticism, including avoidance of leading questions:

“...you're not supposed to ask leading questions, so it's the idea that if anything is going on...I will say, 'oh how's it going?' or whatever like that but if they don't give you anything...if you ask leading questions you can be accused of leading a child to saying something that, I don't know, it's just the way it is with child protection.”

(Participant X5)

They were also wary about what their discussions generated in terms of children's questions:

"...you've always got to be a bit careful about some of the questions that come up."

(Participant H1)

4 Discussion

The present study explored what primary school teachers communicate to children about MHPs, and found that it is rarely discussed. The main reasons for this are teachers' fears about the implications of having discussions about MHPs, and fears surrounding individuals with MHPs. Beliefs about their professional roles, MHPs in general, and about MHPs in relation to children and its place in the classroom, were also important. Fears and beliefs led to teachers adopting safety and avoidance behaviours. These themes are now discussed in relation to theories regarding stigma and attitude formation.

Fear

Drawing on social identity theory (Tajfel & Turner, 1986), teachers may view themselves as a mentally-well ingroup in contrast to those with MHPs who constitute a homogenous outgroup. Fear is heightened by information received about some outgroup members (e.g. media depictions of those with MHPs as violent) which is generalised to all individuals with MHPs. This fear leads to avoidance of discussion with children about MHPs and gives subtle messages of MHPs as 'taboo'. This may heighten children's fear towards those with MHPs, as they learn a great deal by observing their teachers (Bandura, 1977).

To discuss those with MHPs in the classroom generates fear of parents disapproving about their children learning about the perceived outgroup. Fear of parents' reactions was proposed by Ventieri, Clarke and Hay (2011); the current study, therefore, adds validity to what was described but not researched.

Teachers worry that learning about MHPs may cause children to mimic behaviours symptomatic of MHPs. They also fear that making children upset may push them over a perceived line of 'normal' emotions and behaviours. This appears to be related to a view of MHPs as outside the normal range of experience and resonates with general assumptions in society that MHPs are categorically different from normality, only able to be recognised and 'treated' by experts (Cooke, 2008). To 'normalise' MHPs, continuum explanations have been suggested (Bentall, 2004) as well as normalising language, for example 'hearing voices' as opposed to 'hallucinations' (de Valda, 2001).

The current political climate might suggest some reality behind teachers' fears. An increasingly litigious society (Johnston, 2010) may push professionals to 'cover their backs' while an increasingly individualised society (Hofstede, 2001) could influence parents to assume a defensive position and trust less that teachers know what is best for their children. The UK may also be seen to increasingly resemble a 'nanny state' (Butler, 2009), perhaps apparent in the lack of individual influence allowed teachers within a rigid school curriculum. Where teachers move outside their designated role, the reality is potential threat to their professional standing. This was apparent during interviews, when some teachers mentioned a sense of restriction placed on them by the government in terms of what they can communicate.

Beliefs about MHPs in the classroom

Some teachers considered MHPs to be more associated with adults and to be different in adults and children. Many wanted to protect children from knowing about MHPs. This reinforces the notion that teachers regard those with MHPs as an outgroup in which the

children they teach do not belong. A number of teachers questioned whether primary school children were too young to learn about MHPs, resonating with Ventieri, Clarke and Hay (2011) who reported that some teachers refused to participate in their anti-stigma programme for this reason. However, theories of cognitive and moral development (e.g. Piaget, 1932) support the argument for interventions during upper primary school years as optimal for shaping children's attitudes towards those with MHPs.

Some teachers worried about labelling children, yet also described advantages of diagnosis in accepting and helping children with problems. Labelling theory (Scheff, 1966) highlights the potentially damaging impact of labels and points to the need for a more 'normalising' approach regarding MHPs. Pertinent to this debate, the BPS (2012) recently expressed concerns that the fifth version of the Diagnostic and Statistical Manual for Mental Disorders fails to encompass a 'normal' spectrum of psychiatric symptoms and risks over-diagnosis through lowering diagnostic thresholds. Indeed attributions regarding MHPs have significance for how those with MHPs are treated by society; a disease model is not the only way of conceptualising severe distress (Cooke, 2008) and can serve to reinforce 'us-and-them' thinking (Harper, 2001).

Beliefs about MHPs in general

Dichotomous thinking is further demonstrated in teachers' beliefs that MHPs are a sensitive, stigmatised topic area that is not universally experienced. It is considered dangerous to share personal experiences related to MHPs as this could lead to rejection and exclusion from the teacher ingroup, risking being seen as part of the outgroup (Tajfel & Turner, 1986). If teachers hold these beliefs, children may mimic them (as proposed by

social learning theory). This means they are likely to refrain from sharing their own experiences in relation to MHPs or to perceive teachers as sources of support and may suffer the consequences of self-stigma.

Beliefs about professional roles

To remain within the ingroup, teachers believe they must conform to perceived professional expectations, including teaching within the curriculum, as well as noticing ‘abnormal’ behaviours and referring on. Teachers may perceive children as belonging to a homogenous group until their behaviours reach a point at which they become ‘abnormal’. The child subsequently becomes part of the outgroup and teachers refer them to others perceived to have more expertise. What is modelled for children is that ‘experts’ are needed when someone crosses the realms of ‘normal’, influencing similar attitudes in children (Bandura, 1977).

Theories of conformity may also be useful for thinking about teachers’ beliefs about how they should behave. With conformity comes a yielding to group pressures (Crutchfield, 1955) proposed to occur for various reasons, including a desire to be correct, in order to ‘fit in’ or to conform to a social role (Kelman, 1958). For teachers to feel more comfortable communicating about MHPs with children, they may need to perceive that it is something that is acceptable and expected of them within their teacher roles.

Teachers believed experts were needed to explain MHPs to them before they could explain to children about MHPs, reinforcing MHPs as mysterious. This builds on the findings of Askeel-Williams et al. (2007) and Graham et al. (2011) whose questionnaire

studies found that teachers lacked confidence in their own knowledge and felt they needed training about MHPs before teaching about them.

Teachers perceive that they carry out the decisions of others yet social constructivists (e.g. Vygotsky, 1978) propose they have a crucial role in deciding the best way and stage at which to advance children's learning. If teachers believe they are unable to exert influence or make decisions regarding discussing MHPs, as findings suggest, they are prevented from helping children to develop positive schema towards those with MHPs. If children pick up that teachers are powerless in this arena and that MHPs are taboo, it is more likely they will develop negative schema.

Safety behaviours

'Playing safe' helps teachers to protect their professional reputation, advancement and ultimately their livelihood. Teachers are comfortable talking about emotions, behaviours and diversity up to a point, perhaps because this is part of the SEAL programme (Hallam, 2009), but when discussion approaches MHPs, communication is shut down. Cognitive models (Beck, 1976) highlight safety behaviours as central to the maintenance of emotional distress, proposing that they protect against danger (Wells, 1997) yet simultaneously prevent disconfirmation of problematic cognitions (Salkovskis, 1991). In line with this theory, teachers' fears about discussing MHPs with children are maintained through lack of challenge to their beliefs or behaviours and therefore lack of opportunity to disconfirm their fears.

Avoidance behaviours

Teachers try to prevent risk by avoiding discussing children's home-related difficulties, connected to fear of backlash from parents. Children's MHPs frequently relate to disturbances in family functioning (Sanders, 1999) therefore it seems concerning that this is avoided and begs the question about where children can discuss such things. It seems teachers avoid depth of discussion when it is possible the content could be related to MHPs. All this may serve to protect their ingroup status, at the same time modelling for children that MHPs should not be discussed openly (Bandura, 1977).

4.1 Clinical implications

Findings highlight a need for improved communication between clinical psychologists and schools. The early interventions model is a preventative clinical approach to identifying and treating symptoms of psychosis early so as to improve long-term prognosis (Joseph & Birchwood, 2005). This could be extended to primary schools and teachers, including establishing links and providing psycho-education. In order to have a significant impact, clinical psychologists should influence policy makers to incorporate MHPs in the national curriculum at primary school age, particularly if backed by more evidence of its importance and efficacy.

4.2 Research implications

To the author's knowledge, this study is the first of its kind, and therefore replication would be useful. Better understanding is needed about those who educate children and influence their attitudes about MHPs. We need a stronger evidence-base regarding what influences what teachers do and do not communicate so as to understand what is required for

positive change. Programmes need to be trialled and evaluated in primary schools, comparing teacher and outsider-led interventions in terms of their efficacy in shaping children's attitudes and behaviours. Longitudinal research would help to build the knowledge-base regarding what shapes long-term attitude change as well as providing evidence for where resources are best targeted. Further studies might also consider exploring communication between parents and their children regarding MHPs.

4.3 Study-level limitations

In reading the study title and knowing the researcher's psychology profession, teachers may have deduced the researcher's perspective that school-based interventions are important in facilitating anti-stigma initiatives for MHPs. Teacher's beliefs about the researcher's expectations may have introduced bias into the interviews if they tailored their answers to accommodate these expectations. Self-selection bias is also possible as teachers who volunteered to participate may have been more likely to hold certain views about MHPs being taught in schools or had a particular interest in the area.

The researcher decided to be transparent about her former career as a primary school teacher so as to facilitate better rapport and enable teachers to be open. However, this may have influenced teacher's answers and it was important for the researcher to keep her teaching experiences and assumptions aside during data analysis, as far as possible. It was hoped that quality would be ensured and such potential influences minimised through the supervisor also coding sections of transcripts.

Considering the model that emerged was set in the context of a cognitive behavioural model, it is acknowledged that the researcher and both supervisors have a background in cognitive behavioural therapy, which may have influenced how data were interpreted.

5 Conclusion

This study aimed to investigate how primary school teachers communicate with children about MHPs and what influences this. Findings suggest that conversations about MHPs are absent from the primary school classroom due to a number of factors. A model emerged in relation to these factors, highlighting how teachers' fears and beliefs contribute to safety and avoidance behaviours. It is proposed that much is communicated to children through the absence of discussion about MHPs. Reducing teachers' fears may be achieved if discussions about MHPs became acceptable within ingroup expectations through curriculum incorporation. Having teacher-led programmes about MHPs, informed by theory and evidence, could potentially help teachers to feel more knowledgeable, less likely to perceive MHPs as dichotomous, and increasingly confident to communicate openly with children about MHPs.

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Major Research Project: Section C

Critical Appraisal

Word Count: 2000

1. What research skills have you learned and what research abilities have you developed from undertaking this project and what do you think you need to learn further?

Conducting research, particularly using qualitative methods, was new to me commencing this project therefore I feel that I have developed a wide range of skills. Describing the process in terms of skills, however, seems inadequate as it has been a significant journey, intertwined with all aspects of life.

Having been introduced to my project idea at the Salomons research fair, I felt naively confident that it would somehow be unquestionable. However, I faced some hurdles having the project accepted due to concerns that the ideas were more akin to audit and not psychological enough. This required re-thinking the project and assuming a different angle. The research question that became the focus was how teachers communicate with children about mental health problems, yet it soon became clear that explicit discussion about mental health problems was absent from the classroom. Realising my prior assumptions, I had to refocus and try to understand why such conversations were not happening and to think about what might be being communicated through their absence. Being able to evaluate the fit between initial research interests and emerging data and to adapt accordingly is an important skill for grounded theorists (Charmaz, 2006).

Being a new area, my project naturally lent itself to a qualitative approach and I felt as though this was a best fit for my personal interests and perspectives. While I had some prior knowledge of the time-consuming nature of research, in hindsight my understanding was

extremely limited. I made numerous timelines in an attempt to manage the challenge of carrying out research alongside the competing time demands faced during clinical training; however, I have learnt that it is important to make allowances for things not always going as expected. I hope that this will place me in a stronger position for becoming a future research-practitioner.

My supervisor had connections with schools that were involved in related projects and it was planned that I would recruit teachers from both of these. However, it became unfeasible to continue travelling the long distances for interviews so I decided to find a school nearer to home. This proved to be more difficult than anticipated as it was impossible to speak with headteachers when there was no previous connection. In the end I recruited schools using contacts from my previous teaching days, revealing some truth for me regarding the power of who you know.

Initially I felt apprehensive about conducting semi-structured interviews, concerned that I would not successfully expand on questions or extrapolate rich data. However, after the first few interviews my confidence improved as I realised that it was a skill that was, in some ways, already developing through clinical practice. By the time I conducted my final interviews I felt I had honed the skill of being ‘...open-ended but directed, shaped yet emergent, and paced yet flexible’ (Charmaz, 2006, p.28). Conducting two pilot interviews was particularly worthwhile, highlighting where I needed to make changes and allowing me understanding of the emotional experience of being interviewed. Both teachers in the pilot commented on how the questions were difficult, showed concerns about whether they had got the answers right, and seemed to go into ‘interview’ mode. I addressed this in subsequent

interviews by reminding participants that there were no right or wrong answers and that I was interested in what they honestly thought.

I previously regarded qualitative analysis as an easier option than dealing with numbers in statistics. However, I have come to appreciate how challenging qualitative analysis, specifically grounded theory, can be. I tried hard to get to grips with key aspects of the method by reading extensively about 'how to do grounded theory' yet spent a large amount of my analysis time questioning whether I was doing it correctly. This is, apparently, very normal for novices and experts alike (Corbin & Strauss, 2008) and I was somewhat comforted to know my peers were also experiencing this. I feel that it is important as a psychologist that I gain some understanding of quantitative methods therefore I plan to carry out mixed methods research in the future.

Confidence in my own capacity to carry out research has come and gone in waves throughout the research process, although I believe that I am more able to perceive myself as a researcher now. I had not anticipated how issues of identity and experience of emotion could be triggered in relation to conducting research. There were times when things seemed to be progressing well, which could leave me feeling very positive about myself and things generally; however, these times were often followed by periods of hopelessness when nothing seemed to be going to plan. As well as my research impacting my personal world, I was aware of how much my personal life could affect my productivity in research. With regards to my role as a clinician, I also had to learn to 'put aside' emotion related to my research in order to be present when I was with clients, an important skill for practising clinical psychologists.

I am naturally inclined towards being reflexive although I had not appreciated that reflexivity had such a place in the ‘academic’ world of research. As my research was linked with my previous teaching career, my interest in early interventions for psychosis, and my passion and fascination regarding the stigma that surrounds mental health problems, I had to consider my Self amidst the whole process. Being reflexive involves awareness of our own personal responses and being able to make choices about how we use them, as well as understanding how our personal, social and cultural contexts impact on our interpretation of the world (Etherington, 2004). I was aware that pure objectivity was not possible but that what was needed was sensitivity (Corbin & Strauss, 2008). In other words, I had to acknowledge how my findings were a product of my experience as a teacher, a British woman, etc. as well as a product of the data and to hold in awareness how my Self might be influencing my interpretations.

At times I felt excited about my project, particularly when I was reminded that it addressed a new and pertinent ‘hot’ area of research. I have learnt how important it is to believe that your research contributes something important and may have an impact; without this it is hard to remain motivated.

2. If you were able to do this project again, what would you do differently and why?

If doing this project again, I would increase the time period over which I conducted interviews. I was keen to gather data from two of the schools while their interest was high and before they broke up for the summer. I therefore collected a large amount of data in the

space of four weeks, putting a lot of pressure on myself to transcribe, code and plan subsequent interviews within a tight time frame. However, while this had disadvantages, it allowed me to become focused on what was emerging from the data at an early stage.

A key debate in grounded theory is when you should carry out the literature review, with early grounded theorists arguing that it should be delayed until after the analysis so to avoid becoming influenced by previous ideas and theory during analysis (Glasser & Strauss, 1967). While my proposal required review of the theory and literature, I decided that I would resist giving this further thought until my model was fully developed. I believe this was advantageous in helping me to draw on my own ideas, however, this contributed to my experiencing a lot of pressure in the few months before deadline and I would be inclined to start the literature review earlier were I to do my project again.

During the analytic process I attempted to pull together all information from my interviews so that I could ensure I reported on and did not omit any interesting material that was emanating. However, at times I felt overwhelmed by the vast amount of material and found I lost direction. If I were doing this again I would try to keep more focussed on my question and would keep things simpler so as to avoid this. Charmaz (2006) describes how the process should be like a lens that initially scans broadly and then focuses and continues to refocus on specific areas.

As well as learning why teachers do not communicate with children about mental health problems, interviews explored what teachers thought might be important for potential future school-based interventions to shape positive attitudes towards those with mental health problems. It became clear that it would be a large task to include findings from this in my

results but I do think that this information would have been relevant had there been more time.

I have noticed my inclination to jump in and want results quickly. This meant that I was eager for a model to emerge early on. However, my haste meant that I missed a lot of detail and had to go back several stages in my analysis. If repeating this, I would be more systematic and would resist impulsive urges; doing grounded theory requires a slower, thoughtful process and by trying to override this, I ultimately slowed myself down. As part of this, I think I would keep much more detailed memos.

Finally, I would try to disseminate my findings earlier so as to elicit more respondent validation. Ideally I hoped to present my findings in person but due to challenges with the emerging model, there was not sufficient time for this.

3. Clinically, as a consequence of doing this study, would you do anything differently and why?

My project does not speak directly to clinical work in the way others perhaps do. However, the role of clinical psychologists is increasingly changing to incorporate broader positions (e.g. consultancy) therefore I may be more inclined in practice to take an active role in increasing the communication between mental health services and schools. I have become increasingly interested in community psychology and service-user involvement throughout my clinical training, and I think that the findings of this study lend themselves to these, especially in the campaign against the stigma surrounding mental health problems.

If I was to work in a Child and Adolescent Mental Health Service or Early Intervention team there may be a strong case for providing education to the multi-disciplinary team about the current situation regarding discussions about mental health problems in schools and to consider its potential impact. There may also be a role for psychologists in these teams to extend outreach to primary schools and teachers. However, being actively involved with policy makers would be most important if such drives were to have an impact.

4. If you were to undertake further research in this area what would that research project seek to answer and how would you go about doing it?

If undertaking more research in this area, I would want to learn about the influence that teachers have in shaping children's attitudes. While there is much theory supporting the notion that they have an important role, very little has been reported that specifically examines their influence. I would be particularly interested in knowing how this differs at primary and secondary level, and to learn how much influence and contribution there has been from teachers in the stigmatising attitudes held towards those with mental health problems.

Carrying out this research might involve identifying young adults from clinical and non-clinical populations who hold stigmatising and non-stigmatising attitudes about mental health problems, using self-report questionnaires such as The Stigma Scale (King, Shaw, Passetti, Weich & Serfaty, 2007) or the Mental Illness Stigma Scale (Day, Edgren & Eshleman, 2007). Interviews could then be conducted to explore what their experiences were of their teachers, including the messages they received either directly or indirectly about those with mental health problems and how much bearing it had on their current beliefs.

Triangulation by gathering data about their parents' attitudes towards those with MI could also be powerful in informing our understanding of teacher relative to parental influence.

Another project might involve piloting a large-scale anti-stigma intervention in primary schools, delivered by primary school teachers and compared to outsider-delivery. Subsequent longitudinal analysis of children's attitudes, explored qualitatively and quantitatively, could be informative for future interventions including providing data on the role of teachers in anti-stigma campaigns for mental health problems.

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JANINE N. KING BSc Hons MA Hons PGCE Primary

Major Research Project: Section D

Appendices

Appendix 1: Section A methods

Search strategy

To identify literature for this review, eight electronic databases were searched until May 2012 (week 1):

- Australian Education Index (ProQuest) 1977 to present
- ASSIA Applied Social Sciences Index and Abstracts 1987 to present
- British Education Index (ProQuest) 1975 to present
- Cochrane Database of Systematic Reviews
- Ovid MEDLINE (R) 1948 to present
- PsychINFO 1806 to present
- Teacher Reference Center
- Web of Knowledge: enabling access to Web of Science - Science Citation Index Expanded 1900-present, Social Sciences Citation Index 1970-present and Arts and Humanities Citation Index 1975-present.

Search terms included: 'school'; 'education'; 'interventions' or 'programmes/programs'; 'stigma'; 'mental illness' or 'mental health problems'. There were a total of 1088 hits before removal of duplicates. 231 duplicate records were removed. Abstracts were then screened and filtered according to eligibility criteria.

Eligibility criteria

Articles retained met the following criteria: written in English; peer-reviewed journal articles; discussed interventions that sought to address the stigma of MI; used primary, middle or secondary school children as participants. Studies were excluded if they exclusively explored the outcome of ‘help-seeking behaviour’ or did not seek to positively shape children’s knowledge, attitudes or behaviours towards those with mental health problems.

Twenty-four articles were retrieved this way. References were searched manually for other relevant papers; eight additional studies were found. Thirty-two articles are reviewed.

Appendix 2: Table of studies reviewed in section A

Authors (year), country	Design (participants, sample size, control, follow-up)	Intervention (length, methods)	Outcomes
TEACHER-LED (PRIMARY)			
Lauria-Horner, Kutcher & Brooks (2004), Canada	Pre and post, 158 years 4-7	Four x 1hr modules weekly (x16 wks), incorporated into curriculum Didactic and interactive. No contact.	Improved knowledge and attitudes
Ventieri, Clarke & Hay (2011), Australia	Longitudinal, 196 (69 intervention, 126 controls) grades 5&6, controls, 4-month follow-up	Two lessons, total of 165 minutes Didactic and interactive. No contact.	Improved attitudes, knowledge & social distance scores 1-week post-intervention, maintained at FU.
TEACHER-LED (MIDDLE/SECONDARY)			
Rahman, Mubbashar, Gater & Goldberg (1998), Pakistan	RCT, 100 aged 12-16, controls	Four months, incorporated into curriculum, didactic and interactive (daily lectures, essays, posters and plays), no contact.	Improved knowledge and attitudes
Naylor et al. (2009), UK	Clinical controlled trial, 149/207 aged 14-15, controls, six month follow-up	Six lessons, 50-minutes each, weekly Didactic and interactive, involved video-contact	Improved knowledge and attitudes
Stuart (2006), Canada	Pre-post, 330 high school children	2 lessons then 20-minute video Video contact plus didactic and interactive lesson	Improved knowledge. Social distance and behavioural intentions did not improve significantly.
Watson et al (2004), USA	Pre-post, 1566 middle-school children	5-6 lessons of 45 minutes, incorporated into curriculum Video contact and discussion	Improved knowledge and attitudes (most effective among those with more negative baseline attitudes).
Petchers, Biegel & Drescher (1998), USA	Post only, 46, controls,	6 lessons, incorporated into curriculum, video-based contact and interactive	Improved knowledge and attitudes
OUTSIDER-LED (PRIMARY/PRIMARY AND MIDDLE)			
DeSocio, Stember & Schrinisky (2006), USA	Pre-post, 370	6 sessions, 45 minutes each Didactic and open discussion, no contact	Improved knowledge
Pitre et al. (2007), Canada	Pre-post, 144	One-off, 45 minutes, Puppet plays, no contact	Improvement in separatism, restrictiveness and stigmatisation.
Shah (2004), UK	Observational, qualitative	One-off, 20-30 minutes. Interactive (story, games, role-plays, discussion). No contact.	Teacher questionnaires (four of eight teachers responded): Two thought they should be repeated, two felt children were better informed, one felt presentation was age-appropriate.

Janine King SECTION D: APPENDICES

Authors (year), country	Design (participants, sample size, control, follow-up)	Intervention (length, methods)	Outcomes
OUTSIDER-LED (SECONDARY)			
Brewer, Moore & Reid (2004), UK	150	Over two days Making music - direct contact.	Students' comments indicate that achieved aim of breaking down barriers (no formal evaluation)
Chan , Mak & Law (2009), Hong Kong	RCT, 255, three comparison groups, one-month follow-up	One off, 35 minutes. Didactic. Video-contact.	Improved knowledge, attitudes and social distance.
Chung & Chan (2004), Hong Kong	313, four conditions related to labelling	One session, no contact.	Psychiatric labelling - no statistically significant main effect on attitude measures. Students with religious beliefs were more accepting toward the individual with diagnostic label than no labelling.
Conrad et al. (2009), Germany	Quasi-experimental longitudinal control study, 210, follow-up three months later	One day Education, exploratory, and direct contact	Improved attitudes; not sustained over time.
Economou et al. (2011), Greece	Longitudinal, 616, controls, 12 month follow-up	One off, 1-2 hours Interactive. Indirect contact.	Positive changes in beliefs, attitudes and desired social distance; only changes in beliefs and attitudes maintained after one year.
Essler, Arthur & Stickley (2006), UK	Pre-post, 104, one-month follow-up	One-off , interactive, no contact	Improved knowledge
Esters, Cooker & Ittenbach (1998), USA	Longitudinal, 40, (20 treatment/20 control), 12-week follow up	270 minutes over four-day week Informational (didactic), video- contact	Improved help-seeking attitudes and conceptions of MI; maintained at follow-up.
Hoven et al. (2008), USA	Pre-post, 2472 students, one-month follow-up	Educational sessions using awareness manual, no contact.	Improved knowledge and attitudes. Improved MH awareness and willingness to discuss emotional problems freely.
Husek (1965), USA	Clinical controlled trial, 498 (including intervention and controls).	20 minute talk by users, one-off Didactic, no contact.	Improved attitudes.
Lake & Burgess (1989), UK	Pre-post, 14 sixth formers	Six weekly sessions, 75 minutes each Didactic and interactive, fitted into PSHE curriculum, no contact.	Improved knowledge.
Morrison, Becker & Bourgeois (1979), UK	Pre-post, 24, 5-week follow up	One-off, didactic, no contact.	Improved knowledge and attitudes, maintained at follow-up
Mound & Butterill (1993), Canada	Measurement unclear, 50-200, grades 11-12	One off, 2 hours, didactic and interactive, direct contact.	Claims to be effective and due to consumer contact with students. No evaluation or analysis described.
Ng & Chan (2002), Hong Kong	Clinical controlled trial, 117, comparison group, 7 month follow-up	Over 10 weeks for 1hr, mini-lecture, brief discussion, direct contact	Improved attitudes on separatism and stigmatisation

Janine King SECTION D: APPENDICES

Authors (year), country	Design (participants, sample size, control, follow-up)	Intervention (length, methods)	Outcomes
OUTSIDER-LED (SECONDARY) continued			
Pejovic-Milovancevic, Lecic-Tosevski, Tenjovic, Popovic-Deusic & Dragnic-Gajic (2009), Croatia	Pre-post, 63, follow-up 6 months later	Over six weeks for one hour, Didactic and interactive, no contact.	Improved social discrimination and tendency towards social restriction; social awareness of MH problems increased six months after programme.
Pinfold et al. (2003), UK	Pre-post, 472, 6 month-follow-up	One-two sessions, didactic and interactive; direct contact	Improved knowledge and attitudes at first follow-up. No significant change in social distance.
Pinfold, Thornicroft & Arboleda-Florez (2005), UK and Canada	Pre-post, 512 UK, 634 Canada	Over two days, didactic and interactive, direct contact	Improved knowledge and attitudes. Canadian students - significant improvement on all items of social distance; UK sample on two items.
Pinto-Foltz, Logsdon & Myers (2011) USA	Cluster-randomized trial, 156, control, follow-up at 4 time points over 10 week period: baseline then 1, 4 and 8 weeks after intervention	One off, 1-2 hours, indirect contact Video and interactive	Support for acceptability and feasibility. Did not reduce MI stigma or improve MH literacy at one-week follow-up. Did not reduce MI stigma but did improve MH literacy at 4 and 8 weeks follow-up.
Rickwood, Cavanagh, Curtis & Sakrouge (2004), Australia	Clinical controlled trial, 207/38 control	One-off, 1-2 hours, didactic, interactive and direct contact	Improved knowledge, moderate impact on stigma, weak impact on help-seeking.
Roberts et al. (2007) UK	Longitudinal, 1900, 6 month follow-up	Over 3 weeks for 4 hours. Interactive drama programme Some teacher-involvement, no contact	Improved knowledge and understanding, reduced stigma, improved awareness of help-seeking avenues. Schools subsequently developed supportive links with local MH services.
Robinson et al. (2010), Australia	Pre-post, 343, wait-list control group, follow-up at three time points	One-off, 2 hours, interactive and video contact	Increased likelihood of help-seeking and improved attitudes. Short-term improvements in mental health literacy and identification of several at-risk students.
Schulze, Richter-Werling, Matschinger & Angermeyer (2003), Germany	Clinical controlled trial, 90/60 controls, one-month follow-up	Project week with one lesson daily Solely interactive and direct contact	Significant reduction of negative stereotypes; Improved social distance. Improved attitudes – retained at one-month follow-up.
Spagnolo, Murphy & Librera (2008), USA	Pre-post, 277	One-off, 1-2 hours, didactic and direct contact	Significant differences for 7 of 9 questions (each corresponding to different attribute) and total score.

Appendix 3: Participants demographics

Participant code	Age	Gender	Ethnicity	No. years teaching
L1	28	Female	White Irish	6
H1	35	Male	White British	11
H2	38	Male	White English	8
L2	50	Female	White British	6
L3	48	Female	White British	15
L4	33	Female	White English	9
H3	44	Female	White Welsh	20
H4	31	Female	White British	7
H5	26	Female	White British	3
L5	30	Male	Mixed/multiple ethnic group	3
X1	27	Female	White Welsh	5
X2	29	Female	Any other white background	7
X3	36	Female	Black African	4
X4	59	Female	Black Caribbean	35
X5	28	Female	White British	4

SCHOOL CHARACTERISTICS

H. Non-denominational, rural, affluent

L. Catholic, inner-city, deprived

X. Non-denominational, inner-city, deprived

Appendix 4: Salomons ethics committee approval letter

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Appendix 5: Letter to headteachers



Sakorum Campus at Tunbridge Wells

[Name of Headteacher]
[Address of school]

[Date]

Dear [name of Headteacher]

Re: Clinical psychology research project

I am currently undertaking a doctorate in clinical psychology and am seeking a primary school to take part in my research. My project is entitled 'Promoting Positive Attitudes Towards Mental Health: Teachers' Perspectives on a Primary School-based Intervention'. This is part of a larger initiative for developing a new intervention to support the SEAL programme in promoting positive attitudes regarding mental health.

I am interested in learning about teachers' knowledge, attitudes, communication and teaching styles regarding mental health. Participation would involve one-to-one meetings with teachers for approximately one hour, and I am hoping to recruit five teachers at each school that participates (two other schools are involved). Teachers would be asked to sign a consent form and complete a demographics form, followed by discussion about mental ill health and ways of teaching that can encourage development of positive attitudes towards mental health in children. All views would remain anonymous and kept strictly confidential at all times. After the data have been collected, collated and analysed, teachers would be invited to a meeting, where I would share the results and ask them to provide feedback about whether they agree with the conclusions drawn. It is anticipated that the final results from this research will be published in a public forum.

If you think that teachers at your school would be interested in participating in this research, I would be very keen to meet with you. I will call you in the next week to discuss further and in the meantime please do not hesitate to contact me should you have any queries.

Yours sincerely

Janine King
Trainee Clinical Psychologist



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Appendix 6: Information sheet for teachers



Salmons Campus at Canterbury Wells

Information sheet for teachers

'Promoting Positive Attitudes Towards Mental Health: Teachers' Perspectives on a Primary School-based Intervention'

My name is Janine King and I am conducting this research as part of my doctorate in clinical psychology.

The research purpose and aims

I am interested in teachers' knowledge, attitudes, communication and teaching styles regarding mental health. This is part of a larger initiative and findings will be used to develop a new intervention to support the SEAL programme in promoting positive attitudes regarding mental health.

What participation will involve

Participation will involve a one-to-one interview which will require approximately one hour of your time. You will be asked to sign a consent form and complete a demographics form, followed by discussion about mental ill health and ways of teaching that can encourage development of positive attitudes towards mental health in children. All of your views will be anonymous and kept strictly confidential at all times. Your involvement in this project is voluntary and you may choose to withdraw at any time.

Post interview

After the data have been collected, collated and analysed, you will be invited to a meeting where I will share the results and ask you to provide feedback about whether you agree with the conclusions drawn. This meeting will take place at your school. It is anticipated that the final results from the research will be published in a public forum.

If you have any queries about the research at any stage, please contact me and I will be pleased to answer any questions.

Janine King
Trainee Clinical Psychologist



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Appendix 7: Demographics form



Salmons Campus of Tunbridge Wells

Demographics form

Age: _____

Gender: Male ___ Female ___

Ethnicity (please select code from table below): _____

Number of years teaching in primary schools (include NQT year): _____

Specific roles within school (e.g. SLNCO): _____

White	
1	English / Welsh / Scottish / Northern Irish / British
2	Irish
3	Gypsy or Irish Traveller
4	Any Other White background
Mixed / Multiple ethnic group	
5	White and Black Caribbean
6	White and Black African
7	White and Asian
8	Any Other Mixed / multiple ethnic background
Asian / Asian British	
9	Indian
10	Pakistani
11	Bangladeshi
12	Chinese
13	Any other Asian background
Black / African / Caribbean / Black British	
14	African
15	Caribbean
16	Any other Black / African / Caribbean background
Other	
17	Arab
18	Any other ethnic group

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Appendix 8: Consent form



Salmons Campus at Tunbridge Wells

Consent form

Janine King, Trainee Clinical Psychologist, Salomons
Major Research Project

Promoting Positive Attitudes Towards Mental Health:
Teachers' Perspectives on a Primary School-based Intervention

I give my consent to participate in the above research. I have been informed about what will be involved and that the information I provide will be kept anonymous. I consent to sessions being audio-recorded and transcribed, and have been made aware that I can opt out of the research at any stage if I no longer wish to be involved. Under such circumstances, the data I have provided to date will be destroyed and omitted from the research.

Name _____ Date _____

Signature _____

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Appendix 9: Interview schedule



Salmons Campus at Tunbridge Wells

Appendix II **Appendix E – Interview schedule**

Questions to prompt interview discussion:

1. How do you understand mental health problems?

2. What teaching approaches and **communication styles** do you use currently in teaching or talking about mental health with children? Could you give an example?

Do you ever model a response for children?

How much do you shape behaviour because you are in a teaching role?

How much is this an expression of your own views, and how much do you provide them or not?

Language use etc. – how much express own views or views based on role as teacher – does it make a difference?

3. What ideas do you have about the **best ways** to communicate and promote positive attitudes about mental ill health with children?

4. What is important to consider in the design of an intervention? *Form, different learning styles, boys and girls, age group.*

5. Based on the ideas for design and delivery of an intervention (Appendix D), what are your first thoughts? *Pros/cons, form, who to deliver, service user involvement, training, wider impact, cross-curricular links, homework.*

(Explain that I do want to know about their fears; encourage them to share any anticipated problems).

Thank you for participating in this research.

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Appendix 10: Uncoded transcript

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Appendix 11: Sample memos and early model

Difference is to be valued

The theme of difference being something to be valued is coming through in numerous interviews. I wonder if this is a message that is delivered to teachers, to deliver to children, via the curriculum. I'm interested in how much this idea of difference being valued is something teachers have given a lot of thought to as opposed to being something that they can feel safe saying to children when there are noticeable differences and children are questioning of them. Is it an easy message? Several teachers have talked about all children being the same but with differences...I really wonder how much this message has been thought through. Difference as valuable may not extend to mental health problems and would it be enough of a message to enhance children's understanding/compassion/tolerance? Does it apply? Difference is good, is positive – this is the message teachers want to convey...but how does it fit with their own views? Is what they tell them and what they model the same or different? This has the same feel as what teachers are saying about talking with kids about emotions and behaviours and relationships etc. – almost as if they have been told what to teach about and what is okay. I wonder whether this links with the curriculum and what it says to teach. Do the guidelines in the curriculum tell teachers to give this message and so they then generalise it to all other topics if they are unsure what message to give?

Not knowing

It seems there is a need to know the answers. I wonder if other topics where teachers do not know the answers feel a lot safer than mental health-related ones. If so, why might this be the case? Maybe it is part of being professional for teachers, that they feel as though they must have good knowledge before they teach something. There must be others areas where things come up and they explore or think things through with children, even when they don't know the answers. It is interesting that X, despite having had depression himself, talks about not knowing very much about MI. What do teachers think they ought to know? It seems there may be some kind of mystery around mental health problems – an idea from teachers that you need expert knowledge. Many seem focused on imparting knowledge versus eliciting understanding. Is informing schema development about imparting knowledge?

Fact versus uncertainty

This has come up before - it is easier to talk about factual things but where there is potential uncertainty combined with a controversial subject like mental health problems, it creates a barrier and a fear for teachers. I wonder why teachers feel so much uncertainty around mental health problems – they generally seem to have a firm grasp of biopsychosocial causes, impact on lives, symptoms, major types etc.

Inappropriate to share personal experiences related to MI

I'm interested in why teachers do not feel it is appropriate to share their own experiences related to mental health. Would they share physical health issues? What's the difference? I need to explore physical and mental health comparisons in future interviews to shed some light on whether the difference between the two (in terms of comfort discussing with children) is common to many teachers. Surely there are many facts related to physical health that they are unaware of. Is the stigma that surrounds mental health problems leading to

some kind of self-stigma? If so, how does this impact on their communication with children if they withhold and suppress these aspects of their experience? Surely there could be a lot for children to learn from knowing their teachers have had experience – directly or indirectly – with mental health problems. Quite a few teachers have said how much it engages children when they bring a bit of personal experience into discussion.

Drawing on personal experience

X is clearly drawing parallels and understanding children in the school and their experiences in relation to her personal experiences with mental health problems. X also spoke about his personal experiences with depression and the fact it had made him feel better able to understand children who had emotional problems. I wonder how teachers who have had personal experience with mental health problems and those who have not compare in terms of communication. Does the experience have to be first-hand to have an impact or does having a family member in itself enhance empathy? The two teachers at X school talked about family members having had mental health problems but this did not seem to make them more conscious or confident in terms of talking to children about it. Teachers might offer their views but not actively...not to guide thinking.

It seems a shame that teachers are so wary about influencing children with their own opinions and attitudes. They acknowledge how influential they can be with children yet are scared to exert that influence when it comes to certain topics. X said that she felt it was okay to give firm and direct messages about racism being unacceptable...so I wonder what it would take for similar messages in relation to mental health problems. At the moment this is not something that is really reaching primary schools it seems. Does it have to come from the government via the curriculum?

Preventing communication

It seems that what teachers are saying is that if you don't communicate with children about what is happening and allow a space for them to talk/explore, it generates further misunderstanding and makes a situation more difficult. This makes me think about the impact of repressing feelings and thoughts and how destructive that can be sometimes. If children are seeing that the teachers are uncomfortable and closed down and unable to answer their questions, do they subtly learn that mental health problems should not be talked about (rather than that they just don't think about it or have questions related to it as teachers are reporting). As teacher, they seem to be saying that they understand children's behaviours but don't say they do...they set themselves up as separate from their experiences. Is this creating a barrier: I'm an adult, you're a child, without 'I understand where you're coming from' being communicated?

Discussing death with children

Death scares them but they have to know about it as is a reality and is part of curriculum....yet mental health is also a reality and may scare them...but it is not part of the curriculum so is different. I wonder about the importance of the curriculum for taking away worries about causing children distress.

Scared of parents' responses

Practically every single teacher I have interviewed is making reference to parents and the fallout/comeback/potential consequences of talking to children about mental health problems. I wonder if teachers have always felt this unnerved by parents or if it is related to our increasingly litigious society. Parents used to be likely to support teachers entirely but this

seems to have changed and put teachers in a bit of a fearful and paralysed position which means they are overly cautious about what they say. Being scared of the repercussions of what we do keep us in a place of avoiding; I wonder what else teachers might be scared of that keeps them in a position of avoiding communication about mental health problems and how it might relate to this worry about parents.

Sex education and teaching about mental health problems as similar

Five teachers now have mentioned and almost compared talking about mental health problems with sex education, which they also seem to find controversial and which parents can object to. It seems to make teachers a bit uncomfortable in terms of knowing the boundaries of what to talk about, even though it is something they have to teach. Two of the teachers said that with certain questions from the children they advised them to ask their parents rather than trying to answer it. Is there something about 'shame' that is associated with sex and with mental health problems? Can teachers have truly free and easy conversations with children without this fear of parents? Having sex education as part of the curriculum means that the topic cannot be ignored but I wonder what it takes for teachers to feel completely at ease in their discussions with children, if it is something that is possible. Sex and mental health problems no doubt carry a lot of taboo historically but it seems to somehow still apply even though times have moved on a lot. And how does this connect with teachers' self-stigma that has been apparent in some interviews?

Curriculum

It seems to be coming up again and again that by staying within the boundaries of the curriculum, teachers are covered and safe should parents have a complaint about something they have said. Are teachers less able to give something of themselves in the profession these days? Are they just robots who administer what the curriculum says they should? If so, I wonder what children are missing out on. It might mean they have a more one-dimensional influence on them (parents) and their attitudes. Teacher's seem to say that they are okay if given materials but they do not know what to say if children ask questions. Does this show what teachers they think they need? Do they want a blanket piece of information that they communicate. Perhaps teachers less autonomous than in the past because they are so used to being told what to do, cover etc. They may realise on a personal level about mental health problems and the importance of communicating about it but they don't know how to. I wonder whether this is another example of feeling powerless in relation to the team management. Teachers are frequently reporting about parents and team management making decisions about what is communicated...there's a sense of not being a part of that. They are being told what to say and what not to say.

Diagnosis helps acceptance

This seems to be a new category with teachers at this school: having a diagnosis makes it easier for accepting and understanding and tolerating difficult behaviours. X said about how she did not like the idea of labelling children; I need to go back and see if diagnosis as helping acceptance is in other transcripts. Not liking to label children seems a bit contradictory with finding it easier to accept and help a child if there is a diagnosis...so teachers want a label but think it can simultaneously be unhelpful?

Need for understanding/acceptance

Is it helpful to make children include others or to try to make them accept someone if they do not understand what that individual's problems are? Is it genuine and can the children

perhaps see through that? Do they behave as they know teacher wants them to when teacher is around and then revert to not including that individual when teacher not there? At what level do messages have to be communicated in order for them to have a lasting impact? And does the teacher have to genuinely buy into them? I wonder how children's acceptance of people with problems is related to their actual understanding of what is going on...can they accept it without understanding it? Perhaps this is why stigma is perpetuated....children are told to be kind and nice and accepting about those with mental health issues, yet simultaneously there are not discussions about why someone might have those problems or how we could all be affected therefore it just widens the gap.

Fear of making things worse

How does X think that she could make things worse? If causes are from childhood and deeper rooted, which she and various others have said, I wonder how it then makes sense to her that she could make them worse by talking to a child about mental health problems. Is this again linked to the idea of there being something mysterious about mental health problems and that it is therefore something to be wary of?

Teacher's role is to comfort

Teachers do seem to see themselves as having a part to play in comforting children when they need it but will not explore too deeply – they refer them on to other people. Almost as if they nurture but only partially. This idea that as a teacher they do not deal with it and others do seems to be coming up a lot. Seem to be saying that they understand and relate but can't tell the children that. How does this impact on communication? Teachers seem to be avoiding having discussions in any kind of depth with children – they avoid and they refer on. Does that mean the teacher is off the hook? Do they expect parents to talk with kids about mental health problems? Do parents expect them to talk about it...if so, is it a case of passing the buck? Teacher's see their role as being to notice problems and spot at a distance rather than considering how the child interacts with them. How does the teacher role play into what they notice?

Contradiction

Interesting how embarrassed/uncomfortable/lacking compassion this teacher was in a personal situation with someone with mental health problems... - very different to the accepting behaviours she is trying to instil children? Perhaps the professional role and message is distinct from personal ways of behaving/making sense? Are teachers putting on an act about how to behave and children put on an act too? A whole barrier to having honest discussions...and are teachers' acts based on the school and what it expects of them? I wonder how much children pick up on – if teachers actually hold stigmatising views themselves yet do not directly express them, children may pick up a lot by what is not said and through body language/tone etc. To help children's attitudes be positive, perhaps teachers have to really believe in the message they are giving children – as opposed to teaching it because they have to.

Why different in children and adults

I wonder why so many teachers perceive mental ill health in children and adults as different? Something to explore further in later interviews.

Stigma

There are quite a few examples of teachers being aware of the stigma of mental health problems and allowing that to be the reason they avoid...as opposed to that awareness

enabling them to address something. Lots seem to be saying that mental health problems is 'tricky' to talk about. I wonder how the stigma surrounding it relates to their own attitudes/fears/beliefs.

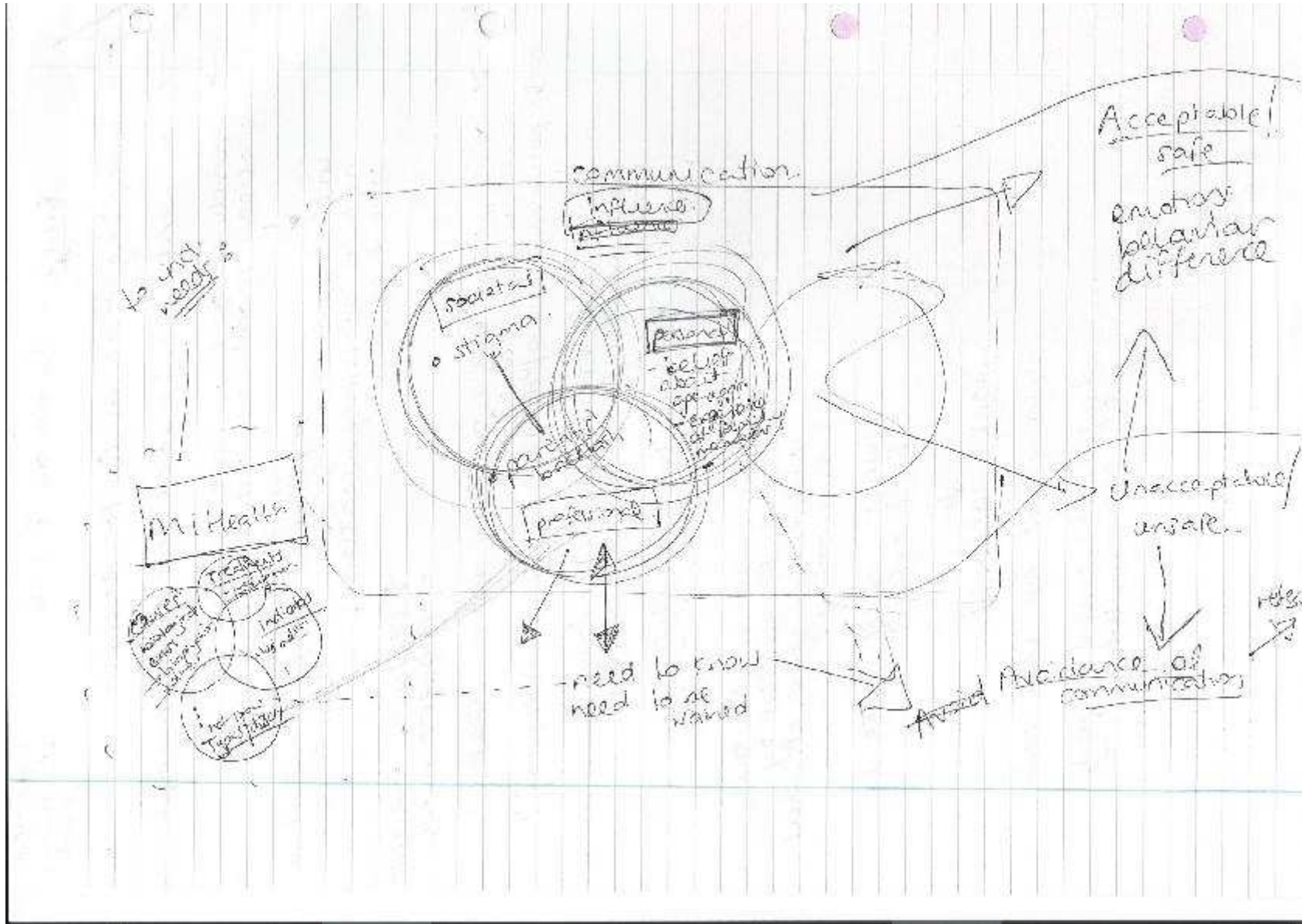
Risks

A common thread is an aversion to taking risks - risks of talking – some things okay, others not? Teacher anxiety seems to be a big issue: 'will I end up in paper due to nature of what I talk about and how it is communicated?'. Risks of talking: to one person, whole school, class...loss of control? Also a sense of responsibility – worried about what children might do. Fear of going off on tangent in 'risky' area. I wonder how this sense of responsibility, fear and risk aversion relate to one another. Seems that fear and beliefs about their own roles mean they adopt risk-averse behaviours, preventing any discussions about mental health problems with children.

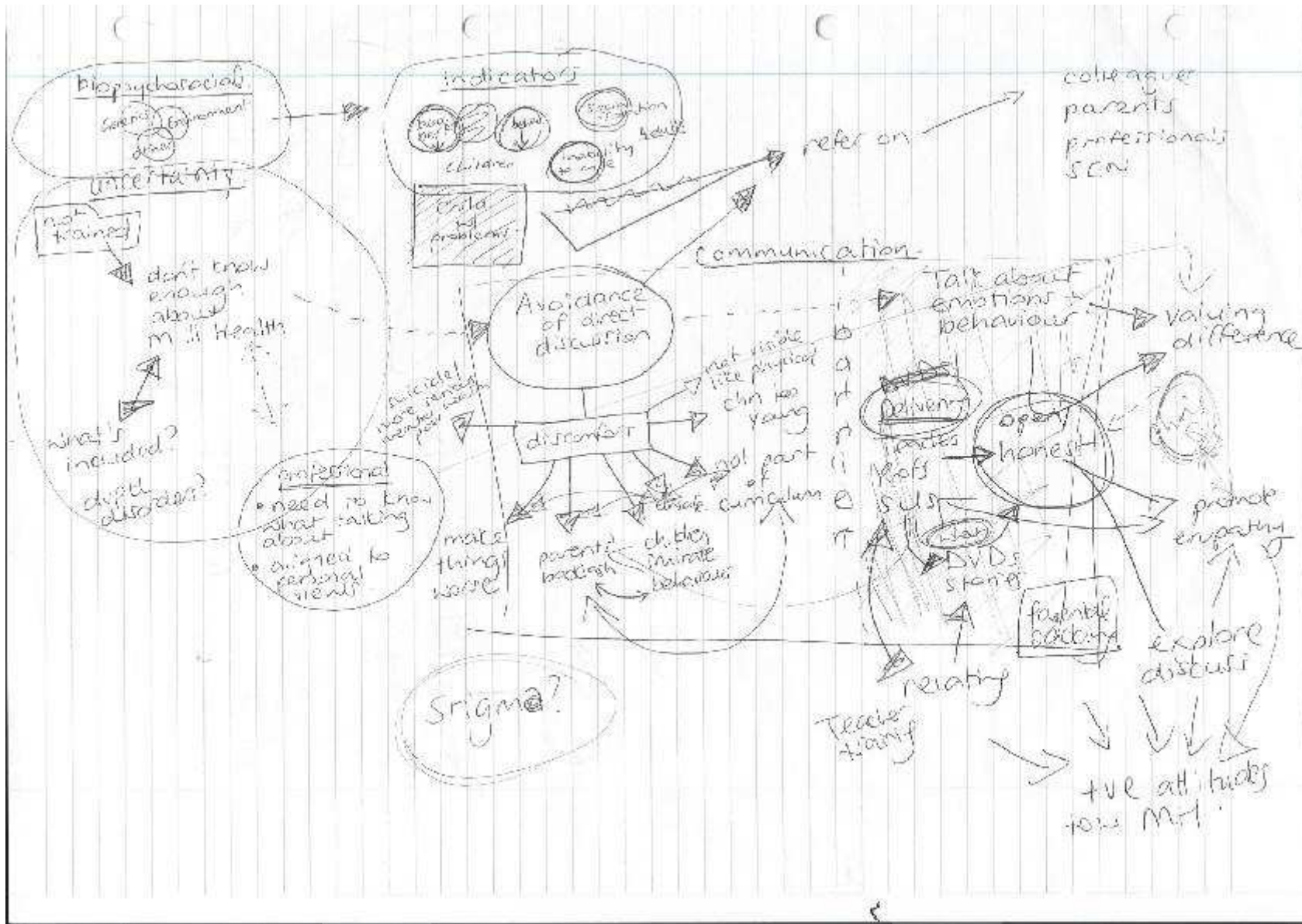
Acceptable and unacceptable things to discuss

I wonder what guides perceptions of the difference between taboo and non-taboo topics. Are we looking at continuums, e.g. upset and distress, memory and Alzheimers...lower threshold and greater understanding? Some issues seem to be easier to talk about than others. For example, teacher X seems to find multiple sclerosis and it's physical impact okay to discuss, which is an interesting contrast with her thoughts about the child with MH problems. Alzheimers could be upsetting for children but it seems it is okay to talk about. Continuum idea helps with communication – would this be the same for mental health problems if perceived on continuum? Suicide is one that has come up a lot as having been or to be avoided - avoidance of things 'not experienced' and 'lack of knowledge'; dealt with in newspapers, not discussed with child. Is it anxiety-provoking for teacher because they don't know...out of depth, worry is too big, don't know how to deal with. They seem to describe a fear that what they say might trickle from one class to another, therefore they avoid. If they encourage or allow questions to flow, things may spiral out of the teacher's control.

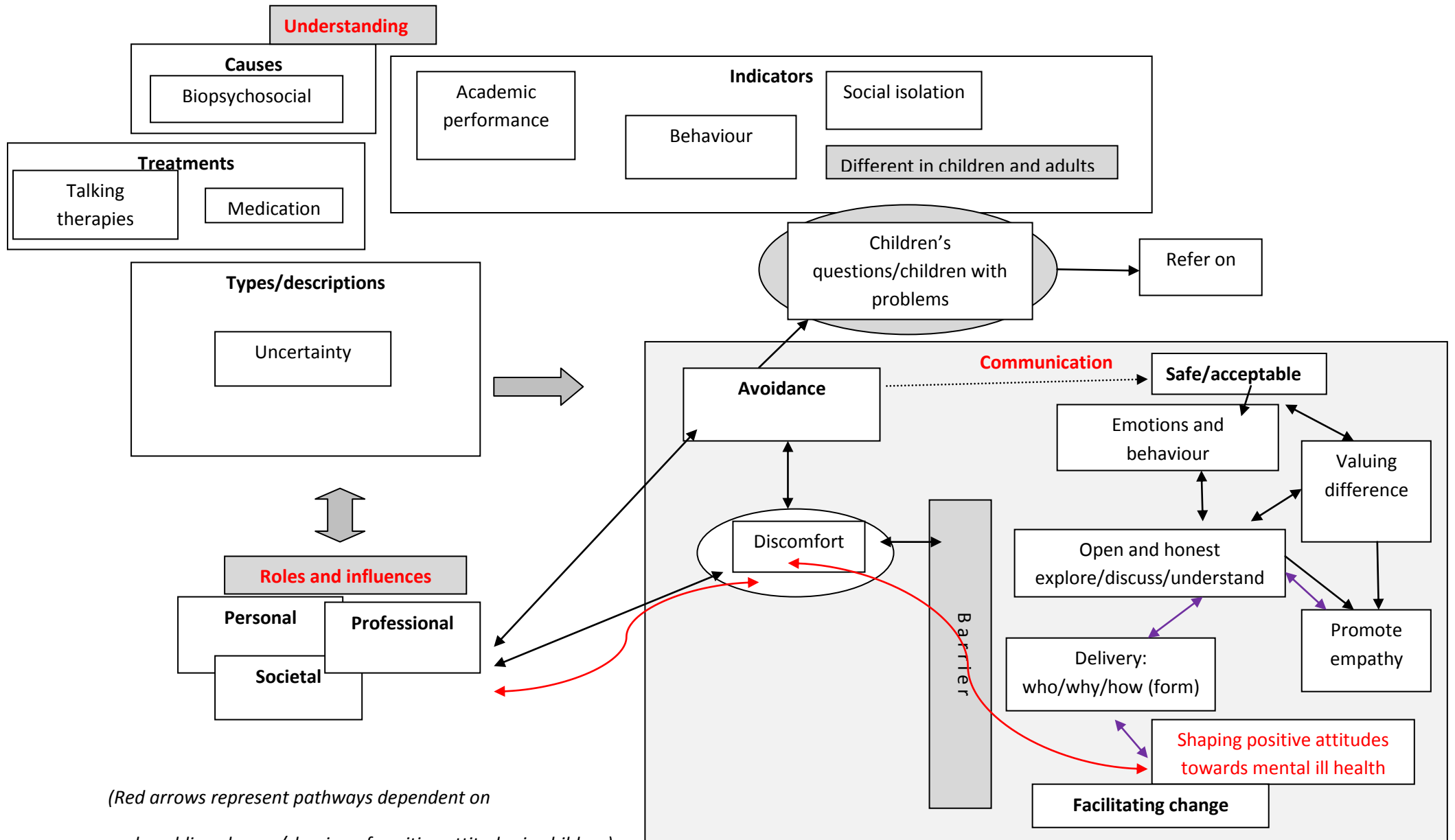
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Appendix 11: Sample memo and early models



Appendix 11: Sample memo and early models



(Red arrows represent pathways dependent on and enabling change/shaping of positive attitudes in children)

Appendix 12: Research diary

2010

January 2010

I went to the research fair at Salomons today and was particularly interested in one of the projects that was related to stigma and psychosis, and is linked with primary schools. Kathy seems as though she'd be good to work with and the project ticks lots of boxes in terms of my previous experience and interest; I'll email her to express my interest.

Emailed Kathy to indicate my interest in the project; heard back and meeting arranged with her and a few other trainees who are interested.

February 2010

Met with Kathy and other trainees. Seems there are three projects: interviewing parents, teachers and service-users. Agreed who had most interest where and as I used to teach, it was agreed that this might be suitable for me. Kathy asked us to have a think and confirm by the end of the week whether we wanted to commit to the projects.

Have given a lot of thought to it and definitely want to go ahead with this project. Emailed Kathy to accept the teacher project.

Kathy has asked us to find internal supervisors with qualitative experience to help with that side of things; an interest in stigma and children's schema development would be advantageous. Emailed various members of staff at Salomons to ask if anyone would be willing to supervise my project.

March 2010

Had meeting with Sue and Anne to discuss my project. They will have a think about whether either of them is willing to be my internal supervisor.

Anne has agreed to be my internal supervisor; am really pleased to have the basics of my MRP organised.

April to August 2010

Had various meetings with Kathy to think about methods etc. for my project. There are already two schools that she has contacts with, so I can recruit teachers from there. Thinking that focus groups and/or interviews would be appropriate and that thematic analysis would be suitable. Drafted proposal of project.

Sent proposal to service user group for their review; has been agreed by them.

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September 2010

Met with Anne and Kathy to talk further about the project and the proposal. Really helpful to hear both perspectives on what the project needs to focus on.

October 2010

MRP proposal form submitted. Decided that one-to-one interviews would be best as, from experience, it would be very difficult to arrange meeting with groups of teachers at once, what with their busy schedules.

Had review for MRP. Have been asked to make some changes before it can be passed. I feel a bit frustrated as spent so long thinking about and writing the proposal. I have been advised to recruit from three schools as opposed to two so as to broaden my study.

November 2010

Sent revised proposal form – really hoping it will go through this time.

December 2010

My project has been accepted – am delighted. Applied for ethical approval from Salomons ethics.

2011

January 2011

Heard back from ethics – got a few changes to make before it can be passed.

Sorted out research insurance. Ethics form resubmitted.

February 2011

Have been given ethics approval; am really pleased and am excited to start recruiting.

Had meeting with Kathy to think further about the interview schedule and contacting schools. Need to keep in mind throughout interviews that I want to know about their communication with children and use this to expand on my questions. Discussed and agreed that grounded theory was more suited to my project than thematic analysis.

May 2011

Kathy and I met with headteacher at one of the schools already involved in a related project. Has agreed to go ahead with my project; I will send her the information sheet etc. and she will organise for five interested teachers to email me.

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Previous colleague has agreed to pass letter to her headteacher to see if I can carry out interviews at her school. Followed up with call and went to meet with headteachers. Really pleased – she is happy to proceed. Have agreed that I'll email information, consent forms etc. to her, she will give to teachers and get five of them to email me.

Carried out two pilot interviews; a few changes to make to the schedule and need to ensure I make teachers feel at ease so that they don't go into interview mode (which seemed to be happening).

Have heard back from various teachers at both schools and got my interviews scheduled so that I can collect a large chunk of my data before the end of the school year. So pleased that I am getting things done so early although it is going to be tight on time with the number I am doing in a short space of time. Don't want to put any off until after the holidays as need to 'strike while the iron is hot' – teachers and schools are keen now so I want to be sure I don't lose them by leaving it too long.

June and July 2011

Carried out first three interviews, transcribed and coded line-by-line. Sent to Kathy. We spoke over phone and went through codes; seemed to be coming up with same codes. Will repeat this after next two and think about my questions and how they might need to be adapted slightly.

Met with Kathy and went through another interview in detail. Discussed how might adapt questions to find out more about some of the interesting areas.

Have found people who are willing to transcribe the rest of my interviews. Need to get them to sign confidentiality forms. This will save me loads of time.

Have decided against getting others to transcribe as find I am getting better acquainted with my data when I do it myself. Plus, I am getting faster with transcribing now I have a foot pedal!

Have collected all my data from the first school, which included teachers across the primary years. Spoke with Kathy about this. Other school is junior school so all teachers are key stage 2 anyway; have agreed I'll focus on KS2 in my final five interviews.

Finally received NVivo from Canterbury. Trying to work out it out using Youtube tutorials. Hopefully I'll get to grips with it!

Noticing some interesting codes coming out of the data; it seems that teachers are really scared about talking about mental health problems – they are totally worried about parents complaining and the potential consequences of this. I'm sure that parents used to always trust teachers to make wise decisions and backed them when I was a child. As a society maybe we are much more accountable and nervous about making mistakes; are we

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less forgiving of human error than used to be the way? Getting really into my data – is so interesting to see the same things coming up. Does take absolutely ages to go back through the transcripts again and again to compare newly emerging themes...hoping at some stage this will all become more coherent.

October-December 2011

Trying to organise my codes into themes and to have all quotes well-organised. I'm sure there must be quicker ways to do this – is taking ages.

2012

January 2012

The analysis goes on...have got a model. Met with Anne and Kathy; they advised that I rethink it and ensure it only includes data that is about things influencing communication as there is lots of stuff in it that is not very interesting. Need to go back a few stages and ensure I have grasped the detail in my data as Kathy thinks that the model I have misses some of the richness from the interviews.

Need to recruit a third school. Need to find one near to home so that I don't have to travel too far.

Getting really frustrated – have contacted three schools near to where I live but cannot get any response. The headteachers won't even speak to me – the receptionists are like their bodyguards. Have asked neighbours about their children's schools but am having no joy.

Need to ask teachers I used to work with if there might be a chance to interview at the schools they work in.

Previous colleague has asked her headteacher and he has said I can call him. Called and left message. Heard back from him – has agreed, so very pleased. It is not too far from home and is inner-city which is good – less far to travel and might be quite interesting – is a very ethnically diverse school and in quite a deprived area so I might find some new information.

February 2012

Carried out final five interviews. Feel as though I'm getting better at semi-structured interviews and was more interesting carrying them out now that I have some emerging ideas in my head to explore and try to saturate.

Am really pleased – my data is all collected and transcribed – what a relief!

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March 2012

Met with Anne and Kathy. They are pleased with how the project is progressing and think that the findings are interesting. Need to focus on pulling the themes and model together now and start sending drafts to Anne and Kathy for review.

April 2012

Have started to put in serious hours to Section A. Really wanted to do grounded theory properly and wait until I'd carried out my data collection and analysis but feel a bit worried about leaving it this late. Have a basic idea of what I will do anyway.

May 2012

Starting to feel the pressure of time. Not helped by computer virus which locked all my files and meant I couldn't access any of my work for four days. Luckily I managed to get it removed and I have now backed up my work - need to do this every day as would not be funny if I lost everything at this stage.

Meeting with Kathy; model is coming on...

June 2012

Met with Anne regarding my model and she thinks it is unclear and that I need to keep things simpler. Feels frustrating as I hoped that section B would be almost finished by now. Know what I have to do though. Am aware of the countdown and still a lot of work to be done; need to keep focused for the last six weeks.

Second draft of section A came back and have been advised to restructure again - wish I'd done section A a lot earlier.

July 2012

Have got three weeks to go and a lot to do. Am feeling quite burnt out but have got to keep at it. Anne thinks my latest model works well, have sent new drafts of section A and B and am hoping that this will all come together in time for 20th.

Appendix 13: Table of categories and subcategories

Category	Sub-category
EMOTIONS	
Fear of implications	Fear of parental backlash
	Fear of triggering undesired behaviours and emotions in children
	Fear of giving children the wrong information
Fear surrounding those with MI	
BELIEFS	
Beliefs about mental health problems in the classroom	Mental health problems do not come up
	Mental health problems are associated with adults
	Children should be protected from mental health problems
	Labelling children has both positive and negative consequences
	Mental health problems are difficult to teach and for children to understand
Beliefs about mental health problems in general	Mental health problems do not affect everyone
	Disclosing personal experience of mental health problems will have negative consequences
	Mental health problems are sensitive and carry stigma
Beliefs about professional roles	Teachers take guidance from the curriculum about what to teach
	Teachers notice 'abnormal' behaviours/emotions and refer children to 'experts'
	Teachers are not trained to teach about mental health problems and so should not attempt to
	A teachers' role includes carrying out others' decisions
	It is not the teacher's responsibility to teach about mental health problems
BEHAVIOURS	
Safety	Stick to the curriculum
	Stick to the facts
	Stick to talking about 'normal' behaviours, emotions and diversity
	Seek parental consent
	Consult with colleagues
Avoidance	Avoid discussing mental health problems
	Avoid certain topics (e.g. suicide)
	Avoid discussing difficulties in a child's home life
	Avoid putting yourself at risk
	Avoid generating discussion about difficulties that could be 'unsafe'

Appendix 14: Abridged table of quotes, initial codes, subcategories and categories

QUOTES	INITIAL AND FOCUSED CODING	SUB-CATEGORY	CATEGORY
<p>BELIEFS</p> <p><i>I don't really think it comes up really... (L2)</i></p> <p><i>They've never spoken about anybody with a mental health problem, it's never come up in any of the topics we're doing or any kind of work we're doing so I guess it would be a bit hard I guess to say, 'right today we're going to talk about MH issues' because it hasn't been related to anything that we're doing. (X1)</i></p> <p><i>...it doesn't really come as something they talk about or inquire about so I suppose it doesn't open up the thoughts about having conversations about it. (L1)</i></p>	<p>Mental health problems are not discussed because teachers do not perceive that they come up</p> <p>MHPS are not related to what is taught and children have not raised it</p> <p>Children don't ask about MHPS</p>	<p>Mental health problems do not come up</p>	<p>BELIEFS ABOUT MENTAL HEALTH PROBLEMS IN THE CLASSROOM</p>
<p><i>...experience as an adult with MH problems is going to be completely different from children with MH problems... (L3)</i></p> <p><i>I think people do see it differently in children than you do in adults as well. (L3)</i></p> <p><i>...you'd have separated children and teenagers – so you'd think of mental health of someone have an illness, you'd be an adult, you wouldn't think of a child as having that... (L5)</i></p> <p><i>Okay, so adults – my understanding with adults is that, you hear about adults that get the help in regards to clinics and institutions and things like that, and most of the adverts that are on TV or any media, it's always kind of related to adult</i></p>	<p>Mental health problems are distinct in children and adults</p> <p>You don't think of children as having mental health problems</p> <p>You don't associate children with specific MHPS</p>	<p>Mental health problems are associated with adults</p>	

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<p><i>mental health problems. And then with children you associate it more with disorders or I do, associate it more with disorders rather than specific mental health problems. (X1)</i></p> <p><i>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. (X1)</i></p> <p><i>in terms of adults - from what I've seen around - mental health is more within state of mind and it also comes across in body language, how people react to situations and how they've dealt with things and been unstable, but with children I've not yet seen any signs...I wouldn't know. (X3)</i></p>	<p>You don't hear of children with MH-related diagnoses</p> <p>You do not come across signs of MHPS in children</p>		
<p><i>I think children do need to know but I don't know whether they need to know at such a young age – I know that the rates of people having mental illness seems to be in the rise, so maybe it is something that they do need to know about but I just don't think at this age – I don't really think they need to know. (H5)</i></p> <p><i>you also don't want to give them too much information that they're too knowledgeable sometimes. (H4)</i></p> <p><i>I don't want them to know that that is an option really, [suicide] (H4)</i></p> <p><i>they shouldn't know that that can happen to you either [sexual abuse] (H4)</i></p> <p><i>I don't think they need to know that there's this thing called depression, there's this thing called ODD, there's this thing called OCD...I don't think things need to have...obviously as an</i></p>	<p>Children are too young to learn about mental health problems</p> <p>You don't want children to know too much about mental health problems</p> <p>Talking about something means children consider it an option</p> <p>Children should be protected from knowing about things that can cause MHPS</p> <p>Children do not need to know about MHPS because they may not be in contact with them</p>	<p>Children should be protected from mental health problems</p>	

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<p><i>adult you need to have the...actually it sounds really bad when you say it like that...as an adult you like to know the names, the specifics but as a child, because they're not in contact with it...or if they are then...I guess...I guess a lot of children do grow up in households where families – mums, dad, siblings may suffer with a MH issue... (X1)</i></p> <p><i>To be honest with you I think it was probably the right decision because she was in year six, so a lot of the younger children probably wouldn't have known her. (H1)</i></p> <p><i>who is this person, is he safe to come into the school, will he suddenly go - is he going to relapse, do you know, that whole thing – how in control are people and how...do you want children to get really friendly with someone who's schizophrenic, (L2)</i></p> <p><i>I guess committing suicide is something that makes me feel really worried – just the thought of explaining to children that there are ways that you can kill yourself – some children just cannot deal with that understanding at all, so when we had to talk about this little girl's father doing it, and they were, 'how did he do it?' (H4)</i></p> <p><i>...whereas with the medical thing there's no kind of taboo against medical conditions at all and, you know, you'd want children to know about medical conditions. (X1)</i></p>	<p>If children are not directly affected then they do not need to know</p> <p>Unsure whether you would encourage children to be friends with someone with schizophrenia</p> <p>Children may not be able to cope with learning about suicide</p> <p>You would not want children to know about mental health problems</p>		
<p><i>It's the children that haven't been diagnosed with anything that display sort of very challenging behaviours that the children find it very hard to accept because they see it as, 'there's nothing wrong with you' (X2)</i></p> <p><i>I'd be more comfortable telling them if there was a specific diagnosis, if you know what I mean, so then I could understand the...obviously there's a large spectrum of, you know, it's not</i></p>	<p>Children find it easier to accept others when they have a diagnosis</p> <p>Diagnosis helps contextualise and therefore teach about mental health problems</p>	<p>Labelling children has both positive and negative consequences</p>	

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<p><i>just one thing – it’s lots of different things – or there could be lots of factors that contribute to it, but if there’s something, if there was more...if it was a diagnosis or there was a kind of solid term or name that you could put to it then, yeah, I would feel more comfortable explaining that to them so that then they can understand a little bit better. (X1)</i></p> <p><i>it comes from the adults insecurities about not wanting to label somebody or not wanting to say anything out of turn or something that somebody might think that you shouldn’t have said, cos you know, we can’t medically diagnose somebody so if there’s no specific diagnosis, if it’s not written on paper, people generally feel uncomfortable saying it. (X1)</i></p> <p><i>almost naming, some mental health conditions and what the experiences are like, so perhaps, you know, this is Adam, he is being diagnosed with whatever it is, and these are some of the reasons why he might be like this, so I think to perhaps contextualise it... (H2)</i></p> <p><i>when you’re observing children and you see a child that’s not being included in a group, it’s... I’m not going to diagnose a 4-year-old with depression, but there’s a reason (L1)</i></p> <p><i>it’s very difficult working with children and thinking about mental health problems because a lot of the time I’m in the mind of not wanting to put a label on their condition or on a child’s behaviour but actually looking at the way they’re behaving and helping them find a way of dealing with situations that make them behave like that, or teaching them how to behave appropriately, cos I don’t always think labels are all that helpful for children. (L3)</i></p> <p><i>What bothers me with these is the giving it a label. Now I realise these children are older, but it’s like giving this child a label and we need to make allowances for them because they</i></p>	<p>People feel more uncomfortable if there is no diagnosis</p> <p>Labelling helps to contextualise MHPS</p> <p>Wary of diagnosing small children</p> <p>Diagnosis enables teachers to help children more</p> <p>Labelling is negative – it suggests you have to make allowances for the behaviours</p>		
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<p><i>are X (L3)</i></p> <p><i>Probably because if there is no solid term then it might just be other factors that you're not aware of – it could just be that the child behaves like that because of something at home, because of something in the personality or because...there might not be a reason as to why they behave like they behave, and I suppose you don't want to label the child or say, 'this is what they...this is why they behave like they do' (X1)</i></p> <p><i>When we realised what it was, there are certain things you can do in the class to help that child. When you don't know what it is you treat them all the same because at the end of the day you can't be making exceptions for some type of behaviour or if children say they don't want to work or, do you know what I mean, cos then it sets a bad example to the other children. But once you know for sure there's something wrong, that's the point when you can say to the class, 'oh actually'... (X2)</i></p>	<p>Not wanting to label children</p> <p>Diagnosis helps teachers know how to handle situations</p>		
<p><i>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 (L3)</i></p> <p><i>The physical one would be easier to teach because the children can actually see the disability, whereas I think it's going back to MH being almost invisible, because they can't really see it...they might be able to see it if they saw somebody talking to a tree – that sort of thing – but I think it would be harder to teach because it's not as visual and people learn by, most children learn by seeing things. (H5)</i></p> <p><i>...I think it's cos one of those illnesses that you can't really see, if you know what I mean. (H5)</i></p>	<p>Mental health problems are abstract and not visual therefore it is difficult to teach and help children to understand</p> <p>MHPs are not visible and so harder to teach</p> <p>You can't see MHPS</p>	<p>It is difficult to teach and for children to understand MHPS</p>	

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<p><i>, you can't see anything on the surface, often people think there's nothing wrong with them – they're just moody, they're just miserable, they're just this, they're just that, or... (B3)</i></p>	<p>People misunderstand MHPs because they are not apparent visibly</p>		
<p><i>...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... (X4)</i></p> <p><i>the curriculum kind of gives it a value. You know that that's in the NC so you've got to...and I'm not saying you can't do other things but it doesn't feel different...any less worthy, it's just focusing on it and then fitting it in to what we do. (X4)</i></p> <p><i>there's a professional, em, I guess discretion in knowing which year you're teaching and I'm not teaching this subject, you know we have circle times and there's SEAL, but em, I wouldn't go beyond what's in the, in my plan to study – I wouldn't go beyond what's there (L2)</i></p> <p><i>...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... (H4)</i></p> <p><i>...we've just got a topic coming up about growing old... and you know, that's quite relevant to them as quite a lot of them have grandparents who are losing their memory or Alzheimers, that kind of thing, and that does come up in conversation, and that would be something that I would freely talk about... (H1)</i></p> <p><i>it's just so hard to fit it in with an overloaded curriculum already and the training that's needed for everything else. (L3)</i></p>	<p>Curriculum gives priority</p> <p>Curriculum gives value and focus to a subject</p> <p>Curriculum gives boundaries about what can teach</p> <p>Curriculum removes personal decision-making and means difficult, emotional topics can be discussed</p> <p>Curriculum allows teachers to talk more freely about subjects</p> <p>Curriculum dictates time</p>	<p>Teachers take guidance from the curriculum about what to teach</p>	<p>BELIEFS ABOUT PROFESSIONAL ROLES</p>
<p><i>I think the observing is the real key thing to it. Because you're picking up on what the children are doing and you're picking up, say, "I've noticed that" and then discuss with the other</i></p>	<p>Teachers 'spot' unusual behaviours</p>	<p>Teachers notice 'abnormal' behaviours/emotions and refer children to 'experts'</p>	

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<p><i>staff, (L1)</i></p> <p><i>...occasionally you would get children telling you something about their home life that's distressing, and, em I refer that usually to our designated person without really talking in too much depth with the child, (L2)</i></p> <p><i>the questions need to be left for people that know what to question and how to question it. (X2)</i></p> <p><i>you have to get outside agencies in to talk to them rather than do it yourself, and that sort of thing, so it's, it's...because they're trained in getting children to disclose things in a way that we haven't had the training for. (H3)</i></p> <p><i>If a parent came to me and said, 'oh we're having problems', I'd rather they spoke to somebody else rather than me, and I'm happy to direct them to the other professionals. (X4)</i></p> <p><i>the end of the day you don't want to get yourself into a questioning – it's...they will tell you and if you're not sure, 'I will come back to you later on that one' or 'I'll see what I can do for you' and sort of get help from obviously senior staff. (X2)</i></p>	<p>If children report distress in relation to home, refer on to designated person in school</p> <p>Refer children on to 'experts' if further questions need to be asked</p> <p>Get others/'experts' to talk to children about their emotional or psychological distress</p> <p>'Experts' need to deal with problems related to a child's psychological problems</p> <p>Others are better placed to deal with children's problems</p>		
<p><i>...it was just that I had to follow formalities... – I was told what to do (X1)</i></p> <p><i>I just kind of follow orders and keep an eye on them...but generally don't ask too much about it because I'm under the assumption that the school and child protection and all that kind of stuff are dealing with it more so than anything else really...so yeah, just trying to keep back..I'll keep a watch and stuff and things like that but don't ask too... (X5)</i></p> <p><i>...you do get given a lot of guidance usually from family members, how to behave and what to say and what not to say</i></p>	<p>Teachers are told what to do</p> <p>Teachers follow orders, others deal with MHPS</p> <p>Parents decide what teachers communicate</p>	<p>A teacher's role includes carrying out others' decisions</p>	

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<p><i>basically... (H4)</i></p> <p><i>...other parents absolutely, you know, they want to know everything – why you’re doing it, what’s the point of that... (H3)</i></p> <p><i>we would be doing PE there [on common near mental hospital] so then they would switch...so they (the police) switched our days so that it wasn’t... (L4)</i></p> <p><i>..if anything does come of it, if you’ve...I’ll ask them how stuff is but it kind of comes from the top that they should only be telling one person their story if it is serious rather than lots of different people all of the time, so um...social situations I don’t know to be honest, how much it is my role to get involved in that because of confidentiality and things like that.. (X5)</i></p> <p><i>The government not being so strict in what you have to say in the class and giving teachers more of an opinion (X3)</i></p> <p><i>Again it was quite difficult cos the school that I was in didn’t recognise any problems - it was either, it’s bad behaviour or it’s not bad behaviour, so it was quite hard to deal with but that wasn’t my decision – that came from team management, that was a decision that was made, just to say that she’d died. (X1)</i></p> <p><i>obviously the school has expectations of certain things, like routines and systems the way they want things to be included and how they’re taught and delivered, and the topics you cover and the curriculum you cover and the SEAL programme that you cover, and that’s all laid out and you just have to follow that. (L1)</i></p>	<p>Teachers have to justify what they are teaching to the parents</p> <p>Police make decisions about teacher and class proximity to those with MHPS</p> <p>Headteachers dictate that children should not be talking freely about ‘personal’ issues</p> <p>The government dictate what teachers can say</p> <p>It is difficult to address a child’s problems if the school does not support you</p> <p>Headteachers decide what’s communicated</p> <p>Teachers follow the school’s expectations of them</p> <p>Headteachers deal with issues related to</p>		
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<p><i>the head teacher and the deputy would deal with a lot of things – so they would come in and talk to the class, deal with the situation and then leave, and that was it – it wasn't discussed after that, so, that I found even worse I think because they had so many questions after and I wasn't allowed to say anything (H4)</i></p> <p><i>time you've a child in your class who's involved with social services and you're not even aware that they are involved with social services until you have to write a report. Or you're not aware that they are on the child protection register until an incident occurs and then you have to do a report...you know half the time you're not made aware...it is kind of the sense that if there are problems at home, whoever the SENCo is, they never come to you and discuss what the problems are at home, you never get to read any of the minutes from conferences – I've never read that, and I know that there's problems at home but I've never got to read the minutes or the reviews (X1)</i></p> <p><i>it usually has happened, there's been the police involved, Social Services, the SENCo, the Headteacher...and then you'll know about it. It's usually like that. (X2)</i></p>	<p>MHPs</p> <p>Teachers are often not made aware of children's difficulties</p> <p>Teachers are last to know about children's difficulties</p>		
<p><i>I've not actually got the foundation to teach to them about it. If I had relevant skills that worked directly 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, make it more child-friendly...I couldn't do that (X3)</i></p> <p><i>I don't know how you would go about that because I don't know anything about it... (H4)</i></p> <p><i>I wouldn't feel confident to explain to the children what schizophrenia is without maybe a bit more knowledge about it...I mean I've got an idea, and like I said, with bipolar, I know</i></p>	<p>Teachers not trained to teach about MHPs</p> <p>Teachers feel as if they don't know enough about MHPs to teach about them</p> <p>Teachers need to be knowledgeable to teach about MHPs</p>	<p>Teachers are not trained to teach about mental health problems and so should not attempt to</p>	

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<p><i>what I know but I wouldn't necessarily feel confident to teach about that (H1)</i></p> <p><i>I think teachers would need training on all of the kind of MH issues that could affect children before they can discuss it because I wouldn't feel comfortable if children asked me questions and saying something that's not necessarily true and just saying something what my understanding is (X1)</i></p> <p><i>I don't think I'd feel comfortable with that, so I don't think I'd really...I definitely would need to talk them through with somebody and have a consensus about what we could...what's helpful to say... (X4)</i></p> <p><i>I think teachers would need training on all of the kind of MH issues that could affect children before they can discuss it cos I wouldn't feel comfortable if children asked me questions and saying something that's not necessarily true and just saying something what my understanding of it is. (X1)</i></p> <p><i>if a child said 'why does that child have that problem, why acting that way?' I think I would feel uncomfortable cos I wouldn't know what to answer to that child. I would not feel comfortable – I'd say, maybe I'd say to them we can have a look at something together but I certainly wouldn't want to give them the wrong information cos I know mental health can be such a wide thing and there's so many different stories and things that you hear that you'd always want to check your facts before you sort of told them anything. (L5)</i></p> <p><i>if it's something that I don't know much about or if I don't know why that child behaves like they behave then I wouldn't feel comfortable trying to explain it. (X1)</i></p>	<p>Would need to have guidance and training to teach about MHPs</p> <p>Teachers need to know what they can say about MHPs</p> <p>Teachers need training on MHPs to feel confident teaching about them</p> <p>Teachers do not feel comfortable answering children's questions about MHPs</p> <p>It is uncomfortable to explain to children about things that teacher does not know much about</p>		
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<p><i>...I would be scared cos I never dealt with before, so I don't know. (L5)</i></p> <p><i>if I was more knowledgeable of all of the kind of mental health issues then I would feel more, I don't feel uncomfortable, but if I don't feel secure talking about something and I don't have a solid knowledge of it cos 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 (X1)</i></p> <p><i>I've not had a great deal of experience with it. (H1)</i></p> <p><i>if someone said to me, right I want you to go off and plan a lesson on schizophrenia and it's an hour lesson, and you can teach it however you like, I personally would not feel very confident or comfortable doing that because of the way maybe that I might broach it in a different way. (H1)</i></p> <p><i>It was beyond our expertise, just didn't really know what to do. (H2)</i></p> <p><i>I don't know enough to know what underlying conditions are behind them... (H2)</i></p> <p><i>it's alright for me saying, 'I've been on the other side of things' but that doesn't make me an expert either, em, (H3)</i></p> <p><i>, I really don't know how, how you would go about dealing with something like that.... (H4)</i></p> <p><i>you also don't want to put ideas into their head about how to</i></p>	<p>Fear of dealing with unfamiliar situations</p> <p>Knowledge about MHPs would help teachers feel secure and able to give children well-informed answers</p> <p>Teachers' perceived lack of experience with MHPs</p> <p>Discomfort and lack of confidence about teaching MHPs 'wrongly'</p> <p>MHPs are beyond teachers' knowledge/skills/expertise</p> <p>Perceived lack of knowledge about MHPs</p> <p>Personal experience with MHPs does not make teachers feel more expert in talking to children about it</p> <p>A sense of not knowing how to deal with situations related to MHPs</p> <p>Not feeling confident in knowledge to give advice to children about to manage MHPs</p>		
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<p><i>deal with it because I'm not certain I do know what advice to give about how to deal with it. (H4)</i></p> <p><i>because I don't know what I'm going to say if he starts telling me about stuff that's happened to him – I really just don't know where I'd even begin, so that's something I really need to address before then.</i></p> <p><i>I guess mental health issues, if you would take in things like Autism – I don't know whether that is a mental health issue, I've had no experience of anything like this before. (H4)</i></p> <p><i>I don't know how you would go about that cos I don't know anything about it, (H4)</i></p> <p><i>I really don't – I don't think as a teacher you're taught how to deal with that...it's not covered – I don't know, I don't know how you would approach it. (L1)</i></p> <p><i>if children see things out in public where someone's behaving unusually or differently, they might not necessarily discuss it or discuss it in detail with the person around them so to have that experience in school would be good. But I think to have quite a close kind of guidance of how to approach it would be good. (H1)</i></p> <p><i>it would be good to have well, training is perhaps to big a word, but perhaps to get together with someone perhaps with more experience of having done this sort of thing beforehand rather than just going in to it coldly. (H3)</i></p> <p><i>In terms of what I was talking to the children about I'd need to make myself better informed, (H2)</i></p> <p><i>I think the main thing would be an understanding of the conditions you would be talking about, to have the confidence</i></p>	<p>Worries about not knowing what to say</p> <p>Perceived lack of experience</p> <p>Perceived lack of knowledge about MHPS</p> <p>Teachers are not trained to know how to deal with MHPs</p> <p>A need for guidance in knowing how to approach MHPs with children</p> <p>A need for training before broaching MHPs with children</p> <p>A need to be informed before talking to children about MHPs</p> <p>Confidence comes from having good knowledge of the subject you are teaching</p>		
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<p><i>of good knowledge base (H2)</i></p> <p><i>I think just for me it's, I'd always want to feel confident telling them rather than thinking, 'god, what am I going to say to them now?' so if you've got some idea then you can sort of work around it. (H5)</i></p> <p><i>I think they would need to have a course first – have to understand it better – because for more than you know or you read or you experience on, I think if you were on a training course you could learn a lot more and I think you could feel more comfortable and always be positive about it. (L5)</i></p> <p><i>I am confident explaining and talking about things that I have knowledge of, lack of understanding or confidence in knowledge would make me less likely to discuss it. (X1)</i></p> <p><i>it needs to be modelled – you need to know what sorts of questions you can ask, and what sorts of answers you can give, and how to go about explaining things to the children without either possibly giving too much away or scaring them (H4)</i></p>	<p>Teachers like to feel confident about what they are teaching</p> <p>Teachers need training to feel comfortable to teach children about MHPS</p> <p>If lacking confidence in a subject, teachers are less likely to discuss it</p> <p>Teachers need modelling from 'experts' about how to teach MHPs appropriately</p>		
<p><i>... I think that's with their family to kind of support if they want their child to understand what it is... (X1)</i></p> <p><i>– I feel that if the school wants children to know more about mental health then they need to bring in an expert who will come and work with the children and myself... I think an expert needs to be there for certain things. (X4)</i></p>	<p>Parents have a responsibility to talk to children about MHPs (not teachers)</p> <p>It's the school's responsibility</p>	<p>It is not the teacher's responsibility to teach about MHPs</p>	
<p><i>I don't know how you'd isolate them, cos it's not everybody, everybody could have an issue with drugs, everybody could have an issue with SRE but not everybody will have MH themselves... (X4)</i></p> <p><i>...it's more normal, physical disability compared to mental</i></p>	<p>Not everybody is directly affected by MHPs</p> <p>People are less likely to be affected by MHPS</p>	<p>MHPs do not affect everyone</p>	<p>BELIEFS ABOUT MENTAL HEALTH PROBLEMS IN GENERAL</p>

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<p>disability. Something people think might affect them more... (L5)</p>	<p>than by physical illness</p>		
<p>...part of that is 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, and all that sort of thing... (H3)</p> <p>...it wouldn't feel appropriate for me to bring that experience, although I've used a lot of personal experience, it doesn't feel like that would be one that I'd bring into the classroom... (H2)</p>	<p>Do not disclose personal experiences of MHPs due to negative reactions from others</p> <p>Inappropriate to share personal experience of MHPs in classroom</p>	<p>Disclosing personal experience of mental health problems will have negative consequences</p>	
<p>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'... (H5)</p> <p>It is such a sensitive issue...it's how it's appropriate to deal with it... (X5)</p>	<p>Serious mental health problems carry a taboo and elicit less sympathy than serious physical illness</p> <p>MHPs are very sensitive</p>	<p>MHPs are sensitive and carry stigma</p>	
<p>BEHAVIOURS</p>			
<p>I suppose having those sort of guidelines on what's appropriate, what's not...because some children will have a much more vast experience of it than others, so...yeah...just knowing where to take that discussion and what would be appropriate for the children to talk in a forum (X5)</p> <p>as a parent, if my child came to me...I'm a year three teacher, which is like 7 and 8, if my child came to me and said, 'oh Mummy, today we talked about MH issues' and I'd ask myself, 'why are you talking about MH issues – it's not part of the curriculum. I'd question...I wouldn't have a problem with it, I'd only have a problem if it wasn't part of the curriculum. (X3)</p> <p>if it's in the national curriculum and they've suggested that you</p>	<p>Curriculum helps you know how far to go and how to approach the subject area</p> <p>Subjects within the curriculum face less scrutiny from parents</p> <p>Curriculum is safe because of boundaries</p>	<p>Stick to the curriculum</p>	<p>SAFETY</p>

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<p><i>talk about it, then you do because you're covered I guess. Yeah, it's safer within the boundaries. (H4)</i></p> <p><i>I guess if it is curriculum-based definitely because if you come away from that 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. (H4)</i></p> <p><i>Yes, cos if you step outside those boundaries anything can happen...if you say certain things, even though you may want to be more open with the children, then they can always refer back and say, 'well if you read this in black and white' you know, so...it just stops you. (X3)</i></p>	<p>Topics within the curriculum mean you are covered by your union</p> <p>Curriculum is safe because it gives boundaries</p>		
<p><i>...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' (X5)</i></p> <p><i>I did this a lot – not for mental health - but where a child asked me something and I don't know, I said 'right let's research' so we sit together, look on the board, Wikipedia or whatever, get a definition, and so from the definition I try to explain to them in different contexts all that I feel comfortable with, and I don't think I'd feel comfortable with um, like a mental health issue like schizophrenia, I don't know if I'd be comfortable – I think I'd just read to them and say, 'look this is what it is' (L5)</i></p> <p><i>...I just teach it with an objective view on it all... (X5)</i></p> <p><i>so I try and keep myself separate from it so that they don't, as a person of trust, take on my opinions on things because that's not my role as an influence in that way...push them in the right</i></p>	<p>It is safe to keep to the facts</p> <p>With MHPs, safer to present facts and not to explore</p> <p>Staying objective is safer</p> <p>Avoid influencing children with your opinions</p>	<p>Stick to the facts</p>	

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<p><i>direction obviously, in terms of education and what not, and inclusive respect but other than that... (X5)</i></p> <p><i>...you know, personally I keep my personal opinions to myself where possible, em...just no place in the classroom really – it doesn't matter what my personal opinions are. (X5)</i></p> <p><i>I'm just very wary of my personal opinions cos as a child I remember my teacher's personal opinions becoming mine...being very young and influential...so I try and keep myself separate from it so that they don't, as a person of trust, take on my opinions on things because that's not my role as an influence in that way...push them in the right direction obviously, in terms of education and what not, and inclusive respect but other than that... (X5)</i></p> <p><i>but regardless of personal beliefs you have to teach it all so I just teach it with an objective view on it all ...personally I keep my personal opinions to myself where possible, em...just no place in the classroom really – it doesn't matter what my personal opinions are. (X5)</i></p>	<p>Teachers' personal opinions have no place in the classroom</p> <p>Avoid influencing children's opinions with own</p> <p>Teach objectively and teach children to make their own choices, not copy teacher's.</p>		
<p><i>I probably would have talked to the children about behavioural problems and the best way that they can react to not escalate the problem or not to antagonise the problem... (X1)</i></p> <p><i>I would talk about behaviour, about what the attitude, so I would say, I would ask them, try to find out what they think is right or wrong, um, for an action that they did or a word that they said, and discuss with them if they think that's the right or the wrong choice to do it, explain that they have the choice of...to stop and think if then do the action, what action they should take. (L5)</i></p>	<p>Talk to children about behaviours and ways to manage them</p> <p>Let children know they have choices about how to behave</p>	<p>Stick to talking about 'normal' feelings and behaviours and diversity</p>	

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<p><i>...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. (H1)</i></p> <p><i>I guess accept everybody for who they are, people have different issues...we talk about brains being different when you're born, the way you're raised being different, and things just happen to people that makes them different from others... (H4)</i></p> <p><i>Well through the SEAL programme we talk a lot about belonging and how to be positive and not body language formally but how to sit up and look confident, be confident, communicate when you're talking to the class, and just have more of a positive outlook... (X4)</i></p> <p><i>Not mental health. We talk about dealing with certain feelings but I don't think it's under that mental health umbrella. (H5)</i></p> <p><i>we teach them how to deal with their anger and we teach them how to deal with certain situations (H5)</i></p> <p><i>might be going to talk about being kind to each other or what makes you sad, or what do you do in certain situations, so you'll start it off and then they get to join in on the discussion (L3)</i></p> <p><i>... there's a lot of self-esteem building, self-image – those kinds of things...um...sort of, I find it's a good age for confidence building, things like that...and there's been a few children done some anger management stuff with, em...but in terms of MH, we don't really cover it as a unit – like we do SRE, we do drugs</i></p>	<p>Talk about diversity as valued</p> <p>Give the message that everyone is equal</p> <p>Talk about personal development</p> <p>Talk about feelings</p> <p>Talk about managing emotions</p> <p>Talk about how to behave towards others</p> <p>Talk about self-development and emotional management</p>		
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<p>education, (X5)</p>			
<p><i>If parents were more comfortable with the kind of terminology or if there was more understanding coming from home, then I would feel more comfortable... (X1)</i></p> <p><i>I also think if you did start to have that conversation with children then you need to get the parents involved cos then they know that if these questions come up at home the parents go, 'okay, they've learnt this at school so that's kind of..' cos I think the parents are sometimes scared by it as well cos it's so wide (H5)</i></p>	<p>Parents' agreement makes mental health problems safer to talk about</p> <p>Parents need to be involved for discussions about MHPs to feel safe</p>	<p>Seek parental consent</p>	
<p><i>...talking to other colleagues who've worked in that kind of situation as well – I think it's about sharing that information. (L3)</i></p> <p><i>..with the knowledge of colleagues because of course, especially in education, you talk a lot to the other teachers and it's like, 'how was it like before last year' so you know out of the blue...I'm gonna do this... (L5)</i></p>	<p>Talking with colleagues helps teachers feel safer in their communication</p>	<p>Consult with colleagues</p>	
<p><i>we didn't really talk about it as a class, it was just what she would tell you really rather than tell the whole class (H5)</i></p> <p><i>I'd probably talk to that child separately rather than a whole class, just because if it is something they're experiencing then maybe it's something they'd want to keep private...or their family would want to keep private – that's the trouble....knowing what information to discuss and what information not to discuss...so...yeah... (X5)</i></p> <p><i>...I've never discussed with them about mental health problems to be honest. (L5)</i></p> <p><i>...it's not something that we've talked about in PSHE or</i></p>	<p>Avoid talking about mental health problems with the whole class (in reference to one child)</p> <p>MHPs are not talked about</p> <p>MHPs are not talked about within the</p>	<p>Avoid discussing mental health problems</p>	<p>AVOIDANCE</p>

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<p>anything like that. (L4)</p>	<p>curriculum</p>		
<p><i>I guess committing suicide is something that makes me feel really worried – just the thought of explaining to children that there are ways that you can kill yourself – some children just cannot deal with that understanding at all... (H4)</i></p> <p><i>...if a child says they're hearing voices in their head or something like that, I definitely wouldn't [try to discuss it]. (X3)</i></p> <p><i>We've had like a few cases as well at our school of parents that have committed suicide as well, em, and it's kind of difficult cos it did happen this year actually, and that was with a girl in year three, so 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 (H1)</i></p> <p><i>schizophrenia, I wouldn't like, cos I don't know at lot, but if you talk about it children are going to think straight away about murderer (L5)</i></p> <p><i>I suppose PSHE is where those tricky questions come up cos in other subjects you can just relate it to fact and if you don't know the answer to a question you can encourage them to go and research it...but then if they go home and start looking up paranoid schizophrenia...on Wikipedia... (X5)</i></p> <p><i>...use a word, like schizophrenia – that would be too much... (L4)</i></p>	<p>Talking about suicide is uncomfortable</p> <p>It is unsafe to enter into discussion about problems related to serious mental health problems</p> <p>Avoid talking about suicide</p> <p>Schizophrenia would be avoided</p> <p>Wary of asking children to explore schizophrenia on the internet</p> <p>Use of the word schizophrenia in class would be 'too much'</p>	<p>Avoid certain topics</p>	
<p><i>I don't probe to say who do you live with, but have sense of whether there's a mum or a dad on the scene there (L1)</i></p> <p><i>occasionally you would get children telling you something about their home life that's distressing, and, em I refer that usually to our designated person without really talking in too</i></p>	<p>Avoid probing about home life</p> <p>Don't discuss distress related to home life</p>	<p>Avoid discussing difficulties in a child's home life</p>	

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<p><i>much depth with the child, (L2)</i></p> <p><i>I don't feel I'm really qualified to speak in depth about what's going on in their home life, (L2)</i></p> <p><i>sometimes you have a circle time and they say something, you know that you think, 'oh gosh, I don't know that it should be brought up in a circle time' – be it referring to something that a parent has said or done, then I would kind of stop it (L2)</i></p> <p><i>I mean I don't think I'd want to talk about their parent, if you felt their parent, there was something wrong...often at the door you see this parent and think, 'oh gosh, this parent is...', but you wouldn't ever want to talk to the children about their parent in any kind of way. (L2)</i></p> <p><i>I knew there were a lot of problems at home so you are talking around the problems at home cos 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 cos you don't want them to bring that up. (X1)</i></p> <p><i>I wouldn't feel comfortable talking about their parents or their family...em, I wouldn't feel comfortable talking about that. I'd be fine talking about their feelings (X4)</i></p>	<p>Teachers don't feel qualified to talk about children's problems at home</p> <p>Prevent children from talking in class about problems at home</p> <p>Avoid talking to children about potential MHPs in parents</p> <p>Avoid talking about problems at home for children</p> <p>Teachers feel uncomfortable talking about children's problems in relation to parents/home</p>		
<p><i>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. (H1)</i></p> <p><i>I'd rather steer away from that...I've known a lot of colleagues who've lost their jobs because a child has gone home and said something that was taken inappropriately...I'm not paranoid but I just try and avoid things like that. (X4)</i></p>	<p>Teachers put themselves at risk by discussing MHPs</p> <p>If children repeat things at home inappropriately, teachers job is at risk</p>	<p>Avoid putting yourself at risk</p>	

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<p><i>, if you suggest something you're putting words into their mouth, and then that puts you in a very awkward position, you know, legally and everything else that, you know (H3)</i></p> <p><i>it's just better to play safe, I think nowadays it's playing it safe. (X2)</i></p>	<p>Teachers are at risk by communicating with children</p> <p>It is best to play safe</p>		
<p><i>...in a way, 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... (L2)</i></p> <p><i>...you're not supposed to ask leading questions, so it's the idea that if anything is going on...I will say, 'oh how's it going?' or whatever like that but if they don't give you anything...if you ask leading questions you can be accused of leading a child to saying something that, I don't know, it's just the way it is with child protection. (X5)</i></p> <p><i>...they say let the children tell you what they want to tell you and not probe so...you don't really hear much about their feelings and what's going on. (X5)</i></p> <p><i>...you need them to feel comfortable that they want to talk to you at school and open up to you, and that's fine, but you have to be very careful about what you are saying to them – you don't want to put words in their mouth or push them into saying things that they don't want to (H3)</i></p> <p><i>you've always got to be a bit careful about some of the questions that come up. (H1)</i></p> <p><i>and had been chatting to him a bit, hoping he would open up, but not wanting to probe too much' (H3)</i></p> <p><i>I don't probe to say who do you live with, but have sense of</i></p>	<p>Do not get too deep about 'abnormal' problems that a child brings up</p> <p>It is unsafe to ask probing questions so just stick to surface-level questions/take the child's lead.</p> <p>Children take the lead on what they tell or don't tell you</p> <p>Avoid pushing children to tell you things causing them problems</p> <p>Be careful about questions children might ask</p> <p>Avoid probing children about their problems</p> <p>Avoid 'digging' about children's emotional</p>	<p>Avoid depth of discussion about difficulties that could be 'unsafe'</p>	

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<p><i>whether there's a mum or a dad on the scene there, (L1)</i></p> <p><i>often you feel you have the role of the comforter, you can tell if some children, the ones who always come in late, they haven't had their breakfast, you can tell maybe they're upset by something, so you are kind of more of a comforter without digging into what's really going on, (L2)</i></p> <p><i>you kind of go, 'well maybe they had some problems or maybe they were angry about something' but you wouldn't really go into, I wouldn't go into. (L2)</i></p> <p><i>Um, probably tiptoeing around the topic a little bit... (X1)</i></p>	<p>problems</p> <p>Avoid talking about things in too much detail</p> <p>Avoid going in to depth when explaining to children about why people have MHPs</p> <p>Talking 'around' MHPs</p>		
<p><i>EMOTIONS</i></p>			
<p><i>...that's probably the main concern – that the parents would go, 'well my child's only eight or nine – what are you doing talking to them about this sort of thing – they don't need to know'... (H5)</i></p> <p><i>he teacher might have said something and the children might have mentioned it to the parents so you have to err on the side of caution with what you talk about in the classroom (H1)</i></p> <p><i>they might cause upset, you know because then, child goes home and says someone was saying this, what does that mean?... (H1)</i></p> <p><i>some parents kind of want to shelter and protect their children and, you know, 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. (H1)</i></p> <p><i>I remember the next day after school this mum came and she</i></p>	<p>Fear of parents' reactions</p> <p>Children may repeat things at home and teacher ends up in trouble</p> <p>Talking about MHPs might generate questions at home</p> <p>If you talk to children about MHPs and their parents are not in agreement, teacher is at risk</p> <p>Parents can be attacking of teachers if they</p>	<p>Fear of parental backlash</p>	<p>FEAR OF IMPLICATIONS</p>

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<p><i>was shouting at me, saying, “you know my daughter’s been really upset about that”, and it completely took me by surprise because I didn’t think that what I’d said was really all that shocking – I thought that that was common sense...and you know, not particularly just because of that, but I suppose always as a teacher you’re thinking about what you say and the way you broach things and approach things, because you’ve got to be careful (H1)</i></p> <p><i>teachers would worry about how parents would react (H3)</i></p> <p><i>You’ve got to worry about that now – you’ve got to worry about how parents react to stuff like that. (H4)</i></p> <p><i>so they might complain about a conversation that you’ve had, in maybe sex ed or something, where they don’t think was relevant for their children to know about that just yet, but 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. (H4)</i></p> <p><i>, 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 – that’s just what happens – they just worry that their child’s been told something that they shouldn’t and so they blame the school for anything that happens and then...especially at SCHOOL NAME – we have parents that complain all the time (H4)</i></p> <p><i>That it might sort of come back - that the parents would come in and go, ‘what you doing telling my child that? I don’t want my child knowing that’ (H5)</i></p> <p><i>I’m just quite anxious with some parents cos you don’t know what reaction you’re going to get from them (L1)</i></p>	<p>upset their children</p> <p>Teachers worry about parents’ reactions</p> <p>Parents complain about teachers’ discussions with children although teachers covered if in the curriculum</p> <p>Parents complain about teachers discussing things they should not have</p> <p>Parents may complain if they don’t want their children to know about MHPs</p> <p>Parents’ reactions are unpredictable</p>		
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<p><i>then the parent might interpret that in a different way – they might come in and make a complaint (X3)</i></p>	<p>Fear of parents making complaints</p>		
<p><i>so if we say talk to the child about schizophrenia, for example, they are going to go home and start acting like they have the problem, like, you know, cos for them it's the fashion, oh like that's a good idea, I think like the impression of a child's mind, they could think of that, of course they couldn't, but it's like there's a possibility of them trying to act because they thought it was cool. (L5)</i></p>	<p>Worries about children 'trying out' behaviours if you teach them about mental health problems</p>	<p>Fear of triggering undesired behaviours and emotions in children</p>	
<p><i>...you could ask the wrong thing and you could trigger something that maybe wouldn't be good for them at that age – I don't know, yeah, I guess that's a worry of mine. (H5)</i></p>	<p>Fear of triggering something negative in children</p>		
<p><i>asking a question that's inappropriate that then opens up a whole can of worms – I just don't know, I don't know what it is I'm scared of. (H4)</i></p>	<p>Fear of 'opening up a can of worms'</p>		
<p><i>Cos a lot of the kids are emotionally disturbed already and some of them may even feel like something is not right with them, and I say something is not right with them they might think I mean they have some sort of issue going on in their heads, and talking about it they might think, 'well Miss has been saying things and if she's talking about...?' I don't want to make them feel like they've got a problem when they haven't got a problem. (X3)</i></p>	<p>Fear of making children think they have a problem</p>		
<p><i>...you wouldn't want to make things worse for the child or the class... (H3)</i></p>	<p>Worries about making things worse for a child</p>		
<p><i>...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... (X3)</i></p>	<p>Fear of having a negative impact on children's lives by talking about MHPs</p>		

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<p><i>For one, it's something within their experience and two, it's not as se...serious isn't the word I'm looking for, but not as potentially upsetting to tell children that as you grow older sometimes you do lose your memory. (H1)</i></p> <p><i>teachers, need to have some guidance or training on what we can actually tell kids cos we don't want to say, we don't want to scare them (H5)</i></p>	<p>Fear of upsetting children and them being unable to handle it</p> <p>Fear of scaring children</p>		
<p><i>...if I was more knowledgeable of all of the kind of mental health issues then I would feel more, I don't feel uncomfortable, but 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... (X1)</i></p> <p><i>if they started coming in asking about certain illnesses that I didn't have any real knowledge about – I wouldn't want to give them wrong information, (H5)</i></p> <p><i>I would not feel comfortable – I'd say, maybe I'd say to them we can have a look at something together but I certainly wouldn't want to give them the wrong information cos I know mental health can be such a wide thing and there's so many different stories and things that you hear that you'd always want to check your facts before you sort of told them anything. (H5)</i></p> <p><i>I feel that if the school wants children to know more about mental health then 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/idea, and I'm happy to work with but some things I just think, I can't go any deeper cos I just feel out</i></p>	<p>Feeling insecure about giving children the wrong information if they ask questions</p> <p>Fear of giving incorrect answers to children's questions</p> <p>Importance of giving children the right information</p> <p>Worries about future implications of giving children incorrect information about MHPs.</p>	<p>Fear of giving children the wrong information</p>	

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<p><i>of my depth and I'm worried that twenty years on children will turn round and say, 'Mrs X told me that', I think it's just not correct. (X4)</i></p> <p><i>I wouldn't feel comfortable if children asked me questions and saying something that's not necessarily true and just saying something what my understanding of it is. (X1)</i></p>	<p>Feeling uncomfortable about sharing own understanding without it definitely being true</p>		
<p><i>– it only really comes on the news when some psychotic killer has been released early and then gone and stabbed someone that the whole mental health thing comes up (H5)</i></p> <p><i>I used to work in a school...that was near a mental hospital, you know, like one of those where they can go out for the day, they can go out but have to be back at a certain time, and em, we weren't allowed to go on school trips on a Wednesday because, and it was really awful to see but it was quite alarming how walking around – it did feel quite intimidating at times... (L4)</i></p> <p><i>who is this person, is he safe to come into the school, will he suddenly go - is he going to relapse, do you know, that whole thing – how in control are people and how...do you want children to get really friendly with someone who's schizophrenic, (L2)</i></p> <p><i>there's always such a fear around mental health, (L2)</i></p>	<p>Mental health problems are associated with violence in the media</p> <p>Those with serious mental health problems are intimidating</p> <p>Those with MHPs are unpredictable</p>		<p>FEAR SURROUNDING THOSE WITH MENTAL HEALTH PROBLEMS</p>

Appendix 15: Summary report for participants and ethics

Summary report: July 2012

How do primary school teachers communicate with children about mental health problems and what influences this?

Stigma and discrimination towards those with mental health problems is a serious problem in society with devastating consequences for those affected. Schools have been identified as a key target for health promotion interventions; to date, most programmes to address stigma surrounding mental health problems have been carried out in secondary schools. Theory and research suggests that by intervening when children are younger, it may be possible to shape positive attitudes before derogatory ones have developed; also, that teachers have a critical role to play in shaping children's attitudes. School-based interventions may be most effective if introduced as part of the primary school curriculum, which would mean that teachers would be delivering them. It is, therefore, essential to learn about how primary school teachers communicate with children about mental health problems and the factors that influence this.

Methodology

The sample consisted of 15 primary school teachers from three schools. Data were gathered through semi-structured interviews and analysed using Grounded Theory methodology.

Findings

Most teachers reported that direct and explicit discussions about mental health problems are absent from the classroom. This was due to fears about the potential implications (e.g. parental backlash) and fear surrounding those with serious mental health problems (e.g. depictions in the media of people with mental health problems being violent and dangerous). Fears were related to beliefs that were held, including beliefs about mental health problems in the classroom (e.g. whether children should be protected from knowing about mental health problems), beliefs about those with mental health problems generally (e.g. perceived negative implications of disclosing personal experience with mental health problems) and beliefs about professional roles (e.g. that teachers do not know enough about mental health problems to teach about it). Beliefs and fears were interrelated and led to behaviours including safety

(e.g. sticking within the curriculum) and avoidance (e.g. avoidance of putting job at risk by having discussions with children about those with mental health problems).

While teachers do not seem to be having direct discussions with children about mental health problems, it is possible that absence of these discussions models and sends messages that mental health problems is a taboo subject and that ‘they’ (those with mental health problems) are somehow mysterious and separate from ‘us’.

This can be summarised as follows:

A: Discussions about mental health problems are absent from the classroom

B: Factors influencing this:

EMOTIONS

1. Fear of implications
2. Fear surrounding those with mental health problems

BELIEFS

3. Beliefs about mental health problems in the classroom
4. Beliefs about mental health problems in general
5. Beliefs about professional roles

BEHAVIOURS

6. Safety
7. Avoidance

Implications for practice

It is recommended that there is increased communication between mental health services and schools in addressing the current situation. Early intervention services should expand their model to incorporate early detection at a younger age. Clinical psychologists need to be actively involved in influencing policy change so that discussions about mental health problems are mandatory and incorporated into teacher training and the school curriculum from primary school age. Such moves could be powerful in beginning to address the stigma surrounding mental health problems from a new angle.

Appendix 16: Respondent validation

Dear Janine,

I entirely agree with your findings, in the sense that mental health is overlooked at school- especially primary school. To be honest I don't think this is related to any kind of ignorance on behalf of the teacher, as I am sure your research indicates most teachers would agree that they would like to see a curriculum that somehow incorporated mental health issues.

As most schools are now deemed to be inclusive, it is more important than ever to address the issues that are arising in schools, mainly prejudice and fears forming toward people who seem different. I do feel that elements of these issues are touched upon, especially through SEAL and emotional education, elements of identifying similarities in each other and then differences and then celebrating these. However, these are only scratching the surface.

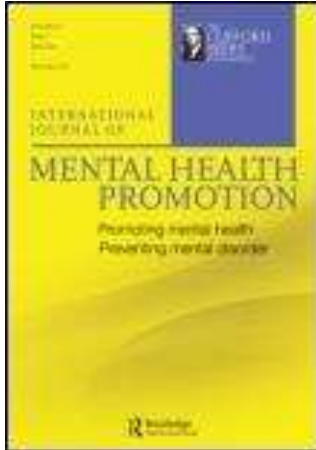
I feel it is the lack of a solid frame-work or scheme which hinders the development of this kind of teaching as at least at early stages teachers would like some sort of support in teaching in this sensitive subject. Again this would link to what you said about teachers being uncertain and fearful of backlash from parents, governors should they touch upon mental health. I feel teachers would be far more confident and adept at teaching tolerance and awareness of mental health, if guidance was provided, or better still for this kind of provision to be built into the National Curriculum, so that teachers would feel more supported and in a sense protected, in the knowledge that educating on mental health was mandatory and could be justified to parents as such. This has worked well for other "difficult" or "sensitive" subject matters, for example drugs and sex and relationship education. I agree that mental health professionals should work closely alongside schools to improve awareness. I agree that the earlier the intervention the better. I hope that this research contributes in some way to changing the way mental health issues are addressed in school, to ensure more accepting and better educated citizens of the future.

Teacher

PSHCE Coordinator

Appendix 17: Journal guidelines

International Journal of Mental Health Promotion



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