

MANAGING AND SUPPORTING ADOLESCENT STUDENTS EXPERIENCING  
MENTAL HEALTH ISSUES; A CASE STUDY EXPLORING MOTIVATION AND  
CAREER CHOICE IN FURTHER EDUCATION

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## Abstract

This is a small scale, intrinsic case study conducted between 2007-2010 within a large further education establishment (Wenhill College). The college is located in the south west region of England encompassing a large geographical catchment area, offering full and part time programmes of study for 14 -19 year olds and adult learners aged 19 plus.

The choice of study topic was based on the primary motivation to explore adolescent student lives in relation to their further education experience and the impact mental health issues have had on their lives. As a clinical practitioner teaching adolescents in further education, I had the opportunity to conduct 'insider' research, leading to the collection of original and insightful data.

The study employed a qualitative research methodology underpinned by a social constructivist theoretical framework and included a diversity of participants through which data was gathered by differing means; life history interviews and life path continuums with student participants and semi-structured interviews with college staff. The former elicited rich, in-depth data (Sikes and Potts, 2008) and the latter created a flexible yet consistent structural interview framework. Both approaches facilitated the extension of ideas, opinions and perceptions; the results of which are presented and analysed narratively within the thesis.

The implementation of thematic analysis resulted in the contextualisation of participant experiences and events, bounded within the social setting of Wenhill College. The overwhelming sense of participant learned helplessness and experience of surrogacy (Peterson, 1993; Bloomer, 2005; Cherry, 2013) permeated the narratives, demonstrating the link between personal experiences of mental health issues and help seeking/non help seeking behaviour; motivating factors influencing a career choice in health and social care.

The outcomes of this study suggest further exploration across local and national levels around the experience of individual circumstances to enhance greater understanding of adolescent mental health and the provision of appropriate support. In addition, training for further education college staff to enable the effective management and support for adolescents experiencing mental health issues.

**Key words:** further education; adolescents; mental health; health and social care; narratives

*Managing and supporting adolescent students experiencing mental health issues;  
a case study exploring motivation and career choice in further education*

**Contents**

	Page
<b>Chapter 1</b> Introduction	
1.1 Introduction and context of the study	1
1.2 Background context and researcher autobiography	1
1.3 Research aims and questions	4
1.4 The value of case study research	5
1.5 Deciding on a research approach: my research journey and rationale	6
1.6 Defining the case	7
1.7 Restructuring the case: a case of a case	8
1.8 The study	8
1.9 Thesis overview	9
1.10 The policy context of mental health and further education	10
1.11 The mental health policy context	12
1.12 The further education context	14
1.13 The further education policy context	15
1.14 Mental health and further education: parallel worlds or cohabiting partners	20
1.15 Concluding remarks	20
<b>Chapter 2</b> The literature review	
2.1 Introduction and background to chapter	22
2.2 Defining terms: mental health an overview	23
2.3 Understanding mental health within the health context – a model approach	25
2.4 The social construction of mental illness	27
2.5 The social model of health	29
2.6 Mental health and further education: a growing preoccupation	32
2.7 The rise in use of new labels and language across further education	34

2.8 Adolescence, mental health and further education	35
2.9 Concluding remarks	44
<b>Chapter 3 Methodology and ethics</b>	
3.1 Introduction	47
3.2 Locating a philosophical position	47
3.3 The critical paradigm	48
3.4 The social construction of adolescence: the Foucauldian perspective	50
3.5 Arriving at a methodology	52
3.6 Case study as methodology	53
3.7 Narratives with life path continuums	56
3.8 Life path continuums	58
3.9 Semi-structured interviews with staff	59
3.10 Ethical considerations	60
3.11 Seeking organisational consent and gaining access	63
3.12 Researching from within	65
3.13 Anonymity and confidentiality	66
3.14 Identification and recruitment of participants	67
3.15 The student participants	68
3.16 The staff participants	69
3.17 Informed consent	70
3.18 Research methods	72
3.19 Balancing research risks and benefits	75
3.20 Disseminating results	78
3.21 Concluding remarks	80
<b>Chapter 4 Research design and methods</b>	
4.1 Introduction and context of case study	82
4.2 Student enrolment numbers	83
4.3 Staff data	84
4.4 Instrumentation	85
4.5 Raising awareness and gaining access	87

4.6 Seeking consent and gatekeeping	88
4.7 Pilot study rationale	89
4.8 Information leaflet	90
4.9 Consent forms	90
4.10 Demographic data forms	91
4.11 Biographical interviews	91
4.12 Staff interviews	92
4.13 Overall modifications	93
4.14 Procedure: the data collection phase	94
4.15 Student participants	94
4.16 Staff participants	97
4.17 Data processing and analysis	99
4.18 Analysis choice and rationale	99
4.19 The thematic analytical process: student data	101
4.20 The thematic analytical process: staff data	101
4.21 Ensuring internal and external validity	102
4.22 Concluding remarks	103
<b>Chapter 5 Exploring the lives of six further education students with mental health issues</b>	
5.1 Introduction	105
5.2 Debbie	105
5.3 Understanding Debbie	108
5.4 Emma	109
5.5 Understanding Emma	113
5.6 Grace	114
5.7 Understanding Grace	117
5.8 Rachel	119
5.9 Understanding Rachel	122
5.10 Tom	123
5.11 Understanding Tom	126
5.12 Jordan	128

5.13 Understanding Jordan	131
5.14 Concluding remarks	133

**Chapter 6** Managing and supporting adolescent students with mental health issues:  
the staff perspective

6.1 Introduction	135
6.2 Maria	135
6.3 Understanding Maria	137
6.4 Kate	139
6.5 Understanding Kate	142
6.6 Helen	144
6.7 Understanding Helen	148
6.8 George	150
6.9 Understanding George	152
6.10 Jane	154
6.11 Understanding Jane	156
6.12 Concluding remarks	157

**Chapter 7** Further analysis and discussion of results

7.1 Introduction	159
7.2 Problematising the themes	159
7.3 Learned helplessness	160
7.4 Learned helplessness: understanding the student perspective	161
7.5 The consequences and outcomes of learned helplessness	164
7.6 Career choice and motivating factors	167
7.7 Understanding the student participant's career choices	168
7.8 Understanding the student perspective: Alderfer's Theory of Motivation	171
7.9 The staff, learned helplessness and the culture of further education	176
7.10 Surrogacy: can staff help themselves?	180
7.11 Concluding remarks	183

<b>Chapter 8 Recommendations and conclusion</b>	
8.1 Introduction	184
8.2 Outcomes and achievements	184
8.3 The rise of therapeutic culture in further education	187
8.4 Methodological evaluation	189
8.5 Reflection and personal learning	190
8.6 Implications and recommendations	193
8.7 Concluding remarks	194
<b>References</b>	196
<b>Illustrations: examples of life path continuums</b>	224
<b>Appendices</b>	226
<b>List of tables</b>	
Table 1.0 Fulltime 16-19 year old Student Enrolment Figures (2006-2010)	83
Table 1.1 Student profiles and Ethnic Diversity (2006-2010)	84
Table 2.0 Number of Academic Staff Employed (2006-2010)	84
Table 2.1 Staff Profiles and Ethnic Diversity	85
Table 3.0 Student Participant Demographic Details	95
Table 3.1 Staff Participants Demographic and Employment Data	98



## **Chapter 1**

### Introduction

#### **1.1 Introduction and context of the study**

This chapter introduces the background and context of the study from the researcher and policy perspective. The initial part includes the researcher's autobiography and reasons for carrying out this study followed by an overview of the thesis content. The second part of the chapter situates the study within the policy perspective and why awareness and management of student mental health issues has gained prominence across further education since 2000. Having reviewed the range of policies generated from health and education, those included in the study are considered most relevant and pertinent; inclusion reflects the period between 2000 and 2010 and a small number of seminal policies which pre-date this period. This chapter is divided broadly into two policy contexts; mental health and education. This is followed by a discussion around the further education landscape and how it is influenced and structured by these policies.

#### **1.2 Background context and researcher autobiography**

My personal journey through compulsory and post compulsory education followed a 'conventional' academic route studying O levels in secondary school, followed by A levels in sixth form. I did not study within a further education college therefore my first experience of this environment was as a lecturer in 2001. Post school, I commenced my psychiatric nurse training. This decision was influenced by work and volunteer experience during my latter schooling years, gained at the large psychiatric hospital local to where I lived in Yorkshire. This exposure during my adolescent years to working with people experiencing acute and enduring mental health problems was fascinating and rewarding. I started my nurse training in 1989 during a period when many large psychiatric hospitals were being closed and community care provision was being cited as the way forward in mental health.

Post qualifying and registration in 1992, I worked for six months as a junior, grade D staff nurse in a community team specialising in the treatment and recovery of substance users. This was an eye opening experience for a person who had grown up in the suburbs. My role involved working with and supporting predominantly young

adults who lived in a large, densely populated housing estate where illicit drug problems were rife and the area significantly socially and economically deprived. This early professional experience ignited an interest in the sociological perspectives of mental health; the impact society had on the mental health of individuals and communities but also the impact mental health had on individuals and communities in society. This interest continued to interweave throughout my clinical nursing and teaching career.

In 1993, using my nursing qualification as a springboard, I joined the Royal Air Force (RAF). Although a relatively short segment in my nursing career, this proved an exciting career opportunity leading to experience in psychiatric aeromedical evacuation, inpatient alcohol treatment programmes, post traumatic stress disorder and behaviour therapy techniques, most commonly used in the RAF to treat people experiencing flying phobias. I also visited some interesting outposts including Ascension Island where I facilitated a series of alcohol awareness and harm minimisation seminars for serving personnel.

On leaving the RAF in 1995, I took up a post with the statutory community drug and alcohol treatment team in Swindon. This was a specialist role which predominantly involved working with female service users, some of who had a dual diagnosis; facilitating individual community detoxification programmes (drug and alcohol), developing local policies in relation to pregnant substance users, bespoke training for a range of statutory and voluntary organisations and mentoring student mental health nurses. During this employment, I commenced an MSc in Health Education with Health Promotion at the University of Southampton and conducted a dual purpose piece of research. This was a qualitative study reviewing the service provision for female service users and addressed the accessibility of the service in relation to need. The outcomes from this study contributed to a number of changes in service provision including the availability of appointments for women (time, venue and staff member), childcare provision and the development of satellite clinics co-facilitated by GPs and specialist substance misuse nurses. The completion of this study also contributed to the successful achievement of the MSc, leading to graduation in 1998. My son was born in July 1999 and I returned to work with the team in Swindon in 2000. Later that

year, I joined the statutory drug and alcohol treatment team in Bath where I continued to work in a specialist role similar to that in Swindon.

I have harboured a plan to pursue a career in nurse teaching for several years and in September 2001, was appointed to a lecturing role at Swindon Further Education College. This involved teaching and tutoring across various health and social care programmes with students aged sixteen to nineteen and access to nursing programmes with adult learners. It was during this period when my interest in the mental health of adolescents studying in further education developed and I started to become more aware of the role of further education in their wider lives. The opportunity to act on this awareness did not present itself at this time; I engaged in completing my Post Graduate Certificate in Education for Post Compulsory Education (PGCE PCE) and developing the City and Guilds Certificate in Mental Health (Level 3) within the college. When opportunities arose, I worked as a member of the nursing bank staff across a range of services; enabling me to keep up to date with developments in clinical practice.

On leaving Swindon College in July 2003, I joined Wenhill College<sup>1</sup> working fulltime as a programme leader, lecturer and tutor in the Department of Health, Social Care and Early Years responsible for level 2 and 3 programmes of study. In addition, the development, facilitation and programme leader role for the City and Guilds Certificate in Mental Health (Levels 2 and 3). This is when and where my interest in adolescent student mental health really started to develop. My mental health nursing experience heightened my awareness around this issue and led to some challenging aspects within my role. I consider myself first and foremost, a clinical practitioner and without my nurse qualification and registration, I would not be permitted to work in a lecturing role in further education (nor higher education) as this is a requirement of the job specification. Yet conflict arose; employed as a lecturer, not a clinical practitioner or therapist but on a day to day basis, witnessing adolescent students who were clearly experiencing difficulties with their mental health and exhibiting this through their behaviour.

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<sup>1</sup> All names used, referred to and contained within this study are pseudonyms

Being the only mental health nurse in the team (amongst colleagues with backgrounds in adult and learning disability nursing, health visiting and social care), I became a point of reference for my colleagues and other college staff at my base campus; on many occasions, an ‘informal supervisor’ for staff wishing to share their anxieties and frustrations about students who were behaving ‘oddly’ in class and students who had shared information during individual tutorials about how they were feeling, often disclosing information about complex personal social lives and their mental health. Staff wanted to know how to support and manage these students. I was often asked by colleagues to proffer a diagnosis and subsequently refused, citing the boundaries of my role and remit for clarification purposes. Consequently suggestions were made to refer the student(s) to the college counsellor. On reflection and having conducted this study, I now see this behaviour and experience was about many things including students seeking help and surrogacy and emotional labour for staff (Colley, 2006).

Experience gained working in further education helped me to recognise that for some adolescents, their learning journeys are frequently not neat, linear nor unproblematic and attending college forms part of their often complex and demanding lives (Jephcote *et al.*, 2008). These lives contain unpredictability and susceptibility to external pressures and tensions, played out across their learning journeys throughout compulsory and further education. Subsequently, I submitted a proposal to conduct a study exploring the support and management of adolescent students experiencing mental health issues within further education titled, ‘*How do we manage and support adolescent students experiencing mental health issues in further education?*’

### **1.3 Research aims and questions**

The aims of this study were to investigate the different types of mental health issues experienced by adolescents in further education from the student and staff perspective; to establish the support available for students experiencing mental health issues, if they utilised this and how students who have experienced mental health issues are supported by staff and the wider college network. The anticipated outcomes and benefits for participants were the opportunity to share their experiences, enhance other’s knowledge and understanding of their experiences and contribute to the ‘shape’ of support services within the college.

The study presented in this thesis provides valuable insights and evidence in answer to the research questions. It presents narratives from adolescent students and members of college staff; highlighting their personal experience of mental health issues and the management and support of students respectively.

In addition, given the exploratory nature of this study, other unexpected insights have been exposed and subsequently analysed, contributing to a greater understanding of the adolescent and staff experiences. Whilst I did not set out to explore the career choices of health, social care and early years students in further education nor the motivating factors influencing these choices, these were elements of my research which evolved throughout its duration, resulting in significant findings for me as a researcher and becoming central facets to the study and its outcomes (see chapter 8 for further discussion and evaluation).

#### **1.4 The value of case study research**

Before describing the structure and organisation of my case study, I wish to briefly explain why I chose to carry out my research in this way and to answer what I consider important questions about case study research in relation to its approach, relevance and generalisability.

Undertaking a case study enables the reality of implementation to be explored as part of the research process and uncovers influences, which may not have been anticipated to be exposed (Rowley, 2002). Case studies are particularly well suited to new research or research areas for which existing theory and understanding seem inadequate (Eisenhardt, 1989). I consider this a pertinent factor in relation to my study where there is a paucity of relevant literature and depth of understanding in respect of further education and adolescent student mental health issues. Case studies are often viewed as a useful tool for the preliminary, exploratory stages of a larger research project and as the basis for the development of the more structured tools, such as surveys and experiments (Rowley, 2002). Case study research is an empirical inquiry that investigates contemporary phenomena within its 'real life' context; an unquestionable strength if a researcher is seeking to explain the complexities of a case and to gain a deeper understanding of the research topic (Yin, 1994). Furthermore,

Simons (2009) suggests case study research offers other advantages which balance its small-scale against the depth of knowledge it can generate including rich, multi-dimensional data which reflects different perspectives (for further discussion see chapter 3).

One of the recognised challenges of case study research is that it is not always possible to predict exactly what will happen (McDonnell *et al.*, 2000) and this applies to my study when defining ‘the unit of analysis’ or case. Rowley (2002) suggests that the unit of analysis is the basis for the case and this may be an individual person, an event, an organisation, a team or a department within an organisation; recognising that identifying the case and the boundaries of the unit can be difficult and may change during the study. Arguably case selection should be determined by the research purpose, questions and theoretical context whilst recognising there may be constraints impacting on case selection. These may include accessibility, resources and time availability. In relation to this study, my sole researcher role and desire to ensure my selected topic remained contemporary and relevant, were determinant factors in defining the basis and boundaries of the case. Among social researchers ‘case study’ has a wide variety of interpretations and different commentators have different perspectives on what a case study is (Hayes, 2006). Defining ‘the case’ in question particularly in relation to my research is linked to what I originally set out to do and what I actually achieved based on the research outcomes.

### **1.5 Deciding on a research approach; my research journey and rationale**

I chose case study as my research strategy because my research questions were about ‘how’ and ‘why’. Yin (1994) suggests that the issue of types of research questions is the most significant factor in determining the most appropriate approach and case studies are one approach that supports a deeper, more detailed investigation that is necessary to answer ‘how’ and ‘why’ questions; however this was not my original plan. My original plan was to facilitate a much broader, qualitative research project. On reflection this plan was far too ambitious for a sole researcher and if it had not been brought to my naive attention relatively early on, the completion and outcomes of the planned study would have lacked insight, depth and relevance. When planning and exploring the literature around qualitative methods, I skirted around and past

literature relating to case study methods, dismissing this as irrelevant and assuming other research methods were my strength, based on previous researching experience.

An epiphanous moment occurred during my doctoral progression exam (approximately eighteen months after the commencement of this research journey), when my examiner asked me, what my methodology was. I recall now, with some embarrassment, how I provided a detailed account of my intentions and what underpinned my selected approach, citing literature to support my argument. *'Is this not a case study?'* responded my examiner. Pause. Silence. *'Yes, I think it might be'*, I replied. As a result, following further discussion and reflection, I re-directed to explore case study literature and methodology for the purpose of my research and learned a valuable lesson in how preconceived ideas can 'blinker' research judgement, narrow options and permeate the process (Baxter and Jack, 2008).

## **1.6 Defining the case**

Considering 'what is a case study' and within this, defining 'the case' may appear relatively straight forward yet can pose considerable challenges (Gomm *et al.*, 2008). As previously discussed and highlighted, different commentators have different perspectives on what a case study is and how to define the 'unit of analysis' or case (Rowley, 2002). In a case study, the research questions and researcher positionality are inextricably linked to defining the case and a contributing factor to the phenomenon. On reflection, within this study, these factors were significantly influential in re-defining the boundaries of the case.

My original intention was to study Wenhill College as a holistic single case (Hayes, 2006) and my aims were to seek participation from a range of student and staff from a diversity of programme areas across all four college campuses. Whilst this was the outcome with staff participants, no students from any other campuses other than campus one came forward to participate and only students studying within the programme area of Health, Social Care and Early Years where I was employed as a tutor and lecturer (please see chapters 4 and 8 for further discussion).

## **1.7 Restructuring the case - ‘the case of a case’**

Recognising and reflecting on my positioning within this study has contributed immensely to my research journey and subsequent learning and the recognition that doing case study research is iterative, unpredictable and evolves. On completing the data collection phase of my study, I was in possession of substantial amounts of transcribed and analysed data and I needed to decide how I responded to the research aims and answered the research questions. A case study involves spending time to understand the context and considering this when interpreting the situation is an essential element (Hayes, 2000). Utilising all the data from the participating staff with the student data was proving unwieldy and unmanageable. It also presented an unbalanced perspective, lacking direct relevance because of its breadth and consequently depth. Revisiting the data and participant profiles in conjunction with discussions in my doctoral supervision enabled me to be decisive and to re-configure the boundaries of the case from its original identity. As a result, my research became ‘a case of a case’ (Hayes, 2006); specifically a case study exploring the support and management of adolescent students experiencing mental health issues studying a programme of Health, Social Care and Early Years on a single campus within Wenhill College of Further Education.

## **1.8 The study**

This is a small scale, multi-dimensional intrinsic case study (Stake, 1995; 2006) conducted between 2007 and 2010 within a large further education establishment (Wenhill College). The college is located in the south west region of England, encompassing a large geographical catchment area, offering full and part time programmes of study for fourteen to nineteen year olds and adult learners aged nineteen plus. The choice of study topic was primarily motivated by an individual personal and professional desire to understand the nature of mental health issues experienced by adolescents studying within the further education sector and the relationships between adolescents, further education and mental health.

As a clinical mental health practitioner teaching and tutoring adolescents in further education, I utilised the opportunity to conduct ‘insider’ research (Riddell, 1988), leading to the collection of original and insightful data (Sikes and Potts, 2008). The



data was gathered by differing means; life history interviews with life path continua with student participants and semi structured interviews with college staff. This insightful data is presented and analysed narratively within the thesis and conveys ideas, opinions and perceptions expressed by participating adolescent students and college staff. The exploratory nature of this research seeks to enhance understanding of the adolescent and staff experiences (Flyvberg, 2006) and is not intended to draw any wide ranging conclusions that can be applied to all adolescents who have experienced mental health issues and are studying within further education (Yin, 1994). However, further exploration across local and national levels around the experience of individual circumstances would enhance understanding of adolescent mental health, the provision of appropriate support and the motivating factors which influence a career choice in health and social care.

### **1.9 Thesis overview**

This chapter (one) introduces the background and context of the study from the researcher and policy perspective. The policies reviewed within this chapter include a pertinent range generated from within health and education. This chapter is divided broadly into two policy contexts; mental health and further education. This is followed by a discussion around the further education landscape and how it is influenced and structured by these policies.

Chapter two reviews relevant literature and seeks to define the contested term ‘mental health’. In recognising mental health is a complex term and a difficult concept to define, this chapter reviews literature from a variety of fields including health, sociology, psychology and education because they are considered by me to have made a significant contribution to the debates around mental health and further education.

Chapter three discusses the epistemological and ontological foundations on which this research was constructed and offers an understanding of the forms of knowledge and beliefs which underpin the study. The purpose of this chapter is to create ‘a bridge’ between the contextual and literature chapters with the research design and methods and to demonstrate the methodological and theoretical reasoning which underpins the choice of these. The chapter also addresses the ethical considerations involved in this

exploratory case study where biographical/life history methods have been employed to gather data from adolescent students who have experienced mental health issues.

Chapter four explains the research design and methods; the context of the study including the setting and participants, the procedures and instrumentation used and data analysis, in addition to quantifying internal and external validity. Ultimately, it is about what, how and why I did it, the outcomes and dissemination of results.

Chapter 5 offers an account of the lives of six health, social care and early year students for closer analysis and examination. The student narratives are presented separately with a brief, individually theorised summary, revisited in chapter seven for further thematic analysis. The focus of this chapter is how adolescent students' experience of mental health issues have impacted on their lives, further education and a career choice in health and social care.

Collectively staff came into contact with students experiencing mental health issues in differing circumstances and environments within the college, depending on their role. Chapter six presents the narrative accounts of a selection of staff who participated in this study, and who have day to day contact with the students, some of whose narratives are included in chapter five.

Chapter seven analyses the research results in greater depth, extending the brief vignettes included within chapters five and six. The results are discussed in greater detail, engaging and assimilating them contextually within the literature.

Chapter eight, the final chapter, reports the research implications, offers an evaluation of the study methodology and methods including its strengths and limitations, a personal reflection and recommendations for future research.

### **1.10 The policy context of mental health and further education**

The development and implementation of policies across the fields of health and specifically mental health, in addition to education and more specifically further education, demonstrate a shift from prescriptive, negative connotations of mental health to a more inclusive approach. This is due to the acknowledgement from the

wider perspective of mental health as a public health issue (Friedli, 2004; Wanless, 2002; 2004). The closure of large psychiatric institutions in the late 1980s and early 1990s under the NHS and Community Care Act (1990) exposed more people across the wider population in the UK to the concept of mental health in the community. Historically mental health had literally been kept behind closed doors and excluded from most peoples every day experiences.

Changing agendas have extended across the further education sector, underpinned politically by New Labour (1997-2010) and the current coalition government. The mental health and emotional well being of learners is viewed as equivalent to in curriculum terms, the academic content of their learning experience. The policies which underpin the changes across the health and education sectors are created based on the concept of need; predominantly normative need and not the expressed needs of the consumer (Bradshaw, 1972; Ewles and Simnett, 2003). This maintains the prescriptive, paternalistic, centralised control extended by policy makers across macro, meso and micro levels.

Traditionally, mental health services and mental health promotion have been a low priority for both health and public health sectors. However this appears to be changing and is due to a number of factors including the changing role of the NHS; now more widely viewed as a treatment and preventative health promotion service also (Appleyby, 2004). In addition, the previous and current British governments have endeavoured to embed the development of children and young people's emotional states and problems into educational policies and practice, whereby welfare and educational institutions, including nurseries, schools, colleges and universities, are required to address and develop individual's emotional well being through the designated curriculum. A particularly high profile example of this is reflected in the prescriptive policy document Every Child Matters (DfES, 2003) embedded within compulsory and post compulsory curricula which seeks to ensure children are healthy and safe, able to enjoy, achieve socially and educationally; their mental health and well being paramount.

### **1.11 The mental health policy context**

During the past twenty years mental health has clearly been a key area of focus for the UK government and various policies and strategies reflect this; 1990 saw the implementation of the NHS and Community Care Act. This created a shift in health care provision which until twenty years ago, had been dominated by inpatient care and treatment. The Community Care Act (DH, 1989) led to a reduction in inpatient facilities across all spectra in health and social care, dispersing care provision and where possible, people being treated and cared for in their own homes. The key features of this included the reconfiguration of the strategic role of health authorities and their threefold responsibility for the health of their residents, the shift from central government in being the main locus of control and the introduction of measures to assess quality and effectiveness including cost. This latter move was designed to ensure health authorities adopted and discharged responsibility effectively and monitored and reviewed progress.

The Community Care Act was closely followed in 1991 by the Health of the Nation consultation/strategy document (reviewed and updated in *Our Healthier Nation*, 1999) the objective of which was to develop and set out a health strategy for England, underpinned by the health care reforms which had been effected prior to 1991. The policy objectives and guiding principles included the identification of the main health problems across the population, the recognition of the determinants of health and its promotion and to secure the best possible use of available resources. Sixteen possible key areas for consultation were proposed, including an overarching section for mental health. Of note and particular interest is the term *burdens* (my emphasis) employed within this strategy document in identifying the health issues. Statistics are employed to illustrate the problematic nature of each from both a medical and economic perspective, whereby the collusive notion in conjunction with the medical model curative need to rid the body of its dysfunctions, generates negative connotations. Yet this strategy attempted to reconcile the potential difficulties faced by mental health services in acknowledging that the target to “...*reduce the level of disability caused by mental illness by improving significantly the treatment and care of mentally disordered people*” (DH, 1991:86) would need to be implemented against a backdrop

of service realignment including the closure of “...large psychiatric hospitals – relics of an outmoded pattern of care – to be closed before 2000” (DH, 1991:87).

The notion that mental health is considered a disability in the wider public context is further reinforced by the Disability Discrimination Act in 1995 (updated 2005 and later revised to become The Disability and Equality Act in 2010), whereby the term ‘*physical or mental impairment*’ is used to contribute to the definition of disability. However the original act in 1995 created a key turning point for the inclusion of disabled peoples’ rights across a range of sectors including further education. What followed was a plethora of health based policies incorporating specific mental health policies that look at the broader implications of mental health in society. Key strategies include *Our Healthier Nation* (DH, 1999) of which a key target for example, is to reduce the death rate from suicide between 1997 and 2010 by 20% and the *National Service Framework (NSF) for Mental Health* (DH, 2001); mental health promotion being the key standard here whereby health and social services are expected to promote mental health for all, working with individuals and communities to combat discrimination against individuals and groups with mental health issues and to promote their social inclusion.

*Choosing Health : Making Healthier Choices Easier* (DH, 2004) the aims of which include the expansion of help for people with mental illness, improving the quality of patient experience, extended coverage of Child and Adolescent Mental Health Services (CAMHS) and to improve the mental health and wellbeing of the general population. The *National Service Framework for Child, Young People and Maternity Services* (DH, 2004) including all children and young people, from birth to their eighteenth birthday, who have mental health problems and disorders to have access to timely, integrated, high quality, multi-disciplinary mental health services to ensure their effective assessment, treatment and support, for them and their families.

*Making it Possible* (NIMHE, 2005) provided the framework for the delivery of the key standards of the *National Service Framework for Child, Young People and Maternity Services* (DH, 2004) and *Mental Health and Social Exclusion* (Social Exclusion Unit, 2004). This study by the former Office of the Deputy Prime Minister, produced an action plan to tackle the stigma and discrimination experienced by young

people with mental health issues. This action plan tackles six main areas including stigma and discrimination, the role of health and social care in tackling social exclusion, employment, supporting families and community participation and ensuring decent housing, and financial support. *Every Child Matters* (DfES, 2004) is a more recent, high profile approach to supporting the well being of children and young people from birth to 19 years. This programme places better outcomes for children firmly at the centre of all policies and approaches involving children's services and these outcomes are designed to promote children being healthy, staying safe, enjoying and achieving through learning, making a positive contribution to society and achieving economic well being.

*Our Health, Our Care, Our Say* (DH, 2006) links with the *Commissioning Framework for Health and Wellbeing Consultation Document* (DH, 2007) building on the results from the public consultation which highlighted that people wanted action to help them maintain mental and emotional wellbeing just as much as physical health and fitness; consideration was thereby given to public felt and expressed need (Bradshaw, 1972; Ewles and Simnett, 2003). In addition, addressing the external factors which contribute to people's resilience and the need for each local area to have a mental health promotion strategy with the wider acknowledgement across a number of facets; interlinking mental health care and promotion with current debates relating to happiness, well-being and quality of life and their relevance to social and economic policy making (Seligman, 2003; Marks and Shah, 2004; Huppert *et al.*, 2005).

### **1.12 The further education context**

The further education system is uniquely placed to improve employability and skills and to contribute to economic growth and social inclusion. It is also crucial in helping disadvantaged, underachieving and excluded people of all ages, to develop their identities as learners through initiatives to widen participation. Further education's positioning within the educational strata not only complements school provision, for example Diploma Development Partnerships<sup>2</sup> (DfES, 2005), but also access to higher

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<sup>2</sup> Diploma Development Partnerships aim to equip 14-19 year old learners with a range of widely applicable skills, relevant to a broad employment sector and as a route into higher education. Developed and facilitated across partnership consortiums, for example secondary schools with a local further education college for specialist teaching input; available at 3 levels - foundation, higher and advanced, across a range of subjects including Society, Health and Development.

education and skills for employability and employer demands (ESRC, 2008). Given the nature of what further education currently has to offer learners, including increased accessibility and opportunity despite possible educational failure elsewhere, opportunities for study have arisen for greater numbers of young people who were previously denied it. In general terms this is a positive development however it is probable these students are subject to more predisposing risk and vulnerability factors, including mental health issues, than students of twenty years ago (Royal College of Psychiatrists, 2003).

### **1.13 The further education policy context**

This topic has gained prominence across the compulsory education sectors and higher education however further education described as ‘the neglected middle child’ (Foster, 2005) and inequitably treated in comparison to schools and higher education (Jephcote *et al.*, 2008), has experienced broad changes, changing funding and inspection frameworks (Davies and Jones, 2003; Lucas, 2004). These continue to take place across the sector in the UK (Bloemer, 2005) leading to the sector being poorly understood (Foster, 2005) and is perceived as something of a ‘Cinderella service’ (Gleeson *et al.*, 2005). The initiatives include plans to further widen participation to help disadvantaged, under achieving and excluded people (*Success for All; Reforming Further Education and Training, 2002; 14-19 Partnership Planning, 2009*), post-14 provision (*Raising Expectations : Staying in education and training, 2007*) and Diploma Development Partnerships (*The Specialised Diploma Gateway, DfES, 2005; 2006a*). In addition, policy change with implications for funding and governance has lead to increasingly regulated frameworks across the further education curriculum, whereby addressing the mental health of learners has become an integrated part of their learning experience. The Social Exclusion Unit Report, *Mental Health and Social Exclusion* (2004) highlighted the challenges for the learning and skills sector, resulting in the Learning and Skills Council (LSC)<sup>3</sup> addressing the mental health needs of learners by way of publishing a strategy for *Improving Services for People with Mental Health Difficulties* (LSC, 2006b), refreshed and revised with the LSC *Mental Health Strategy – The Way Forward*, in 2009.

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<sup>3</sup> Learning and Skills Council (LSC) later replaced by the Skills Funding Agency (SFA) a partner organisation of the Department for Business, Innovation and Skills which exists to fund and promote adult further education (FE) and skills training in England.

Provision for the well being of students across the further education sector is underpinned by a number of key pieces of legislation and reports including The Tomlinson Committee's Report *Inclusive Learning* (FEFC, 1996), the *Special Educational Needs and Disabilities Act* (2001) and the high profile government strategy *Every Child Matters* (DfES, 2003). This latter strategy is now incorporated within Ofsted's<sup>4</sup> Proportionate Inspections (introduced in September 2007) and the Common Inspection Framework for Further Education and Skills (2009) in addition to the Care Inspection Framework which focuses on residential and pastoral care provision, in line with the *Education and Inspections Act* (DfES, 2006). Hence the inspection framework now incorporates the five key objectives of *Every Child Matters* under 'outcomes for learners' and is assessed under 'contributory grades' towards the overall inspection grade awarded to the (further education) institution ([www.ofsted.gov.uk](http://www.ofsted.gov.uk)).

In response to the *Every Child Matters* strategy (DfES, 2004), the NSPCC<sup>5</sup> lobbied the government for each school and college to have access to a counsellor, either on site or through a centralised service, whereby quality counselling services are accessible for young people up to the age of 19. Whether or not these centralised counselling projects can be provided by services such as Child and Adolescent Mental Health Services has been explored (Baruch, 2001; Leigh and Barron, 2001; McCurry, 2003; Mental Health Foundation, 2003; DH, 2008).

However Ryan (2007:553) suggests that, '*One of the obstacles to implementing a national (schools) programme with the National Health Service Child and Adolescent Mental Health Service was found to be the non-uniformity of provision across the country.*' The report *Commissioning a comprehensive child and adolescent mental health service* (DH, 2008), highlights that mental health issues in children and young people are associated with educational failure, family disruption, disability, offending and anti-social behaviour thus placing demands on social services provision, schools, colleges and the youth justice system. The report suggests that untreated mental health issues in childhood and adolescence, continue into adult life and affect the next

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<sup>4</sup> Ofsted (Office for Standards in Education, Children's Services and Skills) Responsible for inspecting and regulating services which care for children and young people, and those providing education and skills for learners of all ages.

<sup>5</sup> National Society for Prevention of Cruelty to Children



generation. The inclusion of the Public Service Agreement (DfCSF, 2007) *Improving the health and well being of children and young people*, and the *NHS Operating Framework* (DH, 2008/2009), describe four proxy measures to ensure a comprehensive child and adolescent mental health service whereby collaborative partnership working aims to provide early intervention and support services, delivered across a range of universal settings, including further education colleges. Yet the current positioning in the further education sector regarding the management of students with mental health needs has been directed by a range of educational policies, most notably between 2000 and 2010. However some key policies pre-date these, including the *Education Reform Act* (1988) and the introduction of *National Vocational Qualifications* (NVQs) also in 1988. The former introduced the market reforms and the National Curriculum, with key objectives outlined to raise participation in post compulsory schooling and the latter, a remodelled approach to vocational training in the form of modern apprenticeships ([www.cee.lse.ac.uk](http://www.cee.lse.ac.uk)).

In addition, the Department of Education and Employment (DfEE, 2001) publication *Promoting Children's Mental Health Within Early Years and School Settings* acknowledges that children who are mentally healthy have the ability to develop psychologically, emotionally, intellectually and spiritually, can initiate, develop and sustain mutually satisfying personal relationships, use and enjoy solitude, be aware of others and demonstrate empathy, play and learn, develop a moral sense of judgement, resolve problems and setbacks and learn from them. If children do not develop these skills or experience a range of emotional and behavioural problems that are outside the normal range for their age, they may be described as experiencing mental health issues or disorders. The Department of Education and Employment (2001) further suggest that some children will experience mild or transient issues, whereas other children may experience serious mental health issues with longer lasting effects. This suggests a continuum throughout an individual's compulsory education career, surmising that if they do not develop these skills early on, the effects may accompany them throughout their formal learning lives, into adolescence and beyond into adulthood (Mental Health Foundation, 2005).

In the wider context, the inclusion and promotion of emotional wellbeing and personal and social development within the nationwide curriculum, reflects the previous British

government's (New Labour 1997-2010) influence on what children and young people are taught (DfES, 2002). This included the introduction of statutory reforms to improve the wellbeing of children in society under the Children Act (2004) ([www.legislation.gov.uk](http://www.legislation.gov.uk)) and the introduction and implementation of the *National Service Framework* (NSF) strategy (DH, 2001). In addition, the Department of Education and Skills published various programmes designed to help schools and colleges address issues with poor behaviour and attendance and to raise awareness of mental health issues (DfES, 2001; 2003).

These policies are set against a backdrop of changing public, community and personal perceptions of mental health which include debates around defining mental health and how the concept is viewed. For example, from medical and social perspectives in addition to debates around whether mental health is viewed as a disability (for further discussion see chapter 2) and furthermore, consideration given to whether or not it is a public health issue and what are the determinants of positive and negative mental health. In turn this links with education but in particular further education. Further education is about transitions such as training, preparing to work, joining the workforce and contributing to the economy; therefore investing in preventing ill health and managing the future workforce's mental health, has economic advantages ([www.fph.org.uk](http://www.fph.org.uk)).

A study carried out by the Sainsbury Centre for Mental Health (2003) estimated the total cost of mental health care and treatment in England as being near to £77 billion; broken down into three parts to include the cost of care provision by the NHS, lost output in the economy and the human costs of reduced quality of life and loss of life. This is a considerably larger amount than suggested by the Faculty of Public Health (2007) reporting the total cost to society and the economy caused by mental health problems in England estimated at £25 billion; proportionately divided, this is made up of £13 billion in lost output and pay for absence due to mental health issues, carers' time totalling £4 billion and public services expenditure on mental health of £8 billion (FPH, 2007). Layard (2004) suggests that over a million people in the UK experiencing mental health issues draw incapacity benefits; the tax payer bearing £10 billion in payments to people receiving benefits as a result of mental health issues. Later figures published by the Royal College of Psychiatrists (2010) suggest an even

higher figure in attempting to approximate the cost of mental health issues in England totalling £105 billion each year. Whilst recognising mental health issues have human and social costs (Centre for Mental Health, 2010), the economic one represents the largest single cost to the NHS at £10.4 billion per year; eleven percent of the NHS budget (DH, 2010).

The Labour Force Survey 2005/06 found that as many as 420,000 people self-reported they were suffering from a range of mental health issues including depression, anxiety or stress, often caused or worsened by their previous or current work (Health and Safety Executive, 2007). Estimations suggest a figure of 91 million working days lost to mental ill health annually, including half of the days lost being due to anxiety and stress conditions. Comparably, the mental health charity Mind (2000) summarised statistically that around 300 people out of 1000 will experience mental health issues every year in Britain; 230 of these will visit their GP of which 102 will be diagnosed as having a mental health issue. Twenty four will be referred to a specialist psychiatric service and six will become in-patients in a psychiatric service facility.

Mental health issues affect one in three of all families in Britain and one third of all patients seen by GPs have psychological problems for example depression or crippling anxiety or for children, problems with behaviour. Less than ten percent receive any form of any psychological help; due in part to the lack of and access to, appropriate treatment services (Layard, 2006). Although the majority of these statistics have been known for some years, the previous government responded by launching a six year programme in September 2007 to improve accessibility to psychological therapies; Improved Access to Psychological Therapies (IAPT). During its first two years it was funded by ring fenced money. The remaining four years of the initiative have been financed by local primary care trusts. As the IAPT initiative reaches its final year (2013), the decision to set up and fund similar programmes for children and young people lies with the primary care trusts ([www.mind.org.uk](http://www.mind.org.uk)).

### **1.14 Mental health and education: parallel worlds or cohabiting partners?**

The context of health and education have existed parallel to one another yet there is clearly evidence to suggest the two worlds of mental health and further education have complemented each other with respective policies during the past decade. In the first instance during 2001, *The National Service Framework for Mental Health* and the Department of Education and Employment *Promoting Children's Mental Health within Early Years and Schools Settings*, both adopted a promotional approach in addressing the mental health and emotional wellbeing of individuals and groups and communities, such as educational settings.

Later in 2004, the *National Service Framework for Child, Young People and Maternity Services* (Department of Health) was launched, creating access to timely, integrated multi-disciplinary services and the high profile *Every Child Matters* strategy (DfES, 2004). This latter policy straddles health and education and I have included this policy strategy in both contexts. The key emphasis of this strategy surrounds the wellbeing of children from birth to nineteen, suggesting it should be considered from a health and social care perspective. Yet it has been incorporated across compulsory and post compulsory education, exists as a component element of the Common Inspection Framework (Ofsted, 2009) and is considered within the grading remit as 'outcomes for learners'.

Across the academic curricula, the development of children's and adolescent's emotional states and problems have become embedded in educational policies and practice, creating a care based, welfare approach to education which appears less academic, more pastorally centred (see chapter 2 for further discussion). What is happening in further education appears to be mirrored in the mental health sector, and vice versa. The impact of policies experienced by the consumer, in this case adolescent students, differs greatly in the lived experience in both contexts, whereby rhetoric and reality are poles apart.

### **1.15 Concluding remarks**

Both the mental health and further education sectors have undergone restructuring and reconfiguration of service provision and funding structures during the past twenty

years but more so in last decade since 2000. Historically, care of mental health was dominated by inpatient care facilities. Currently it is community based with minimal inpatient provision. Further education remains a broad and varied sector; colleges merging to create larger colleges with wider provision across the curriculum and geographical accessibility (Bloomer, 2005). This increases opportunities for the consumer and continues to provide opportunities and accessible pathways for those learners from disadvantaged backgrounds who have previously underachieved and may have experienced academic failure elsewhere.

Further education now overlaps its provision with compulsory education. Pathways include training and education for fourteen year olds upwards who may be disaffected at school, academically less able and therefore study vocational programmes within school and college via diploma partnerships at varying levels; spending time in each setting for their learning. Further education continues to offer programmes of study and apprenticeships for 16-19 year olds and adults, however the widening participation agenda has created an overlap. This is a result of the previous Government's normative need or in response to the felt and expressed need of the consumer, in these cases patients and students, or the recognition and changing perception of mental health and how this concept is perceived individually, within communities and across society.

The language used across the range of mental health and further education policies is about promoting opportunity, choice, raising expectations and success, some of which cross reference. With regard to the policies that underpin these sectors, does this mean the two sectors have comparative need and similar groups of people using them? The Royal College of Psychiatrists (2003) suggests that as a result of making further education more accessible to those who twenty years ago may not have progressed onto further education, the sector is more likely to see an increasing number of students with pre-disposing risk and vulnerability factors, including mental health issues. As a result, the policy driven curricula prescribed across further education including the promotion of mental health and emotional wellbeing, look set to remain firmly on the political, social, educational and public health agenda for the foreseeable future. The following chapter reviews relevant literature and seeks to define the term mental health.

## **Chapter 2**

Literature review

### **2.1 Introduction**

The previous chapter illustrates the policy landscape which has influenced the increasing prominence of political and professional interest with mental health across both the mental health field and further education sector. Therefore the aim of this chapter is two-fold; to outline rival definitions of the term ‘mental health’ and review a range of relevant, pertinent and seminal literature.

### **Background**

In recognising ‘mental health’ is a complex term and a problematic concept to define (depending on a variety of perceptions, models and positioning etc.), this chapter reviews literature from a variety of fields including health, sociology, psychology and education in addition to journal papers and books. I consider the literature included in this review as having made an important contribution to the debates around mental health and further education.

A paucity of literature directly relevant to ‘student mental health in further education’ was evident. Other fields of literature, for example mental health (often referred to as emotional wellbeing) in primary and secondary schools and higher education was, and is, clearly more evident as is literature debating the concept of mental health in the wider contexts of health and well being, society, therapy/counselling and psychiatry. This chapter reviews the literature in relation to understanding and defining ‘mental health’ and how it has become understood in terms of further education.

In exploring the definition of mental health and uncovering expressed views and opinions, what is apparent is the wide ranging use of differing terminology across diverse professional fields, in addition to those used by non- professional ‘laypeople’, who employ professional language and terminology in defining their own mental health on a day-to-day basis; because of these factors, mental health is a contested concept. The concept has been and continues to be influenced by a variety of internal and external factors, both across the wider societal context and by personal,

individualistic experiences (Holland and Hogg, 2001). In search of relevant literature, I explored a variety of fields including health, health promotion, psychiatry, therapy, sociology and psychology. The plethora of terminology includes mental disorder, mental health issues, mental health problems, difficulties and syndromes, emotional well being, mental illness, psychiatric problems and disorders. The contextual perspective appears to greatly influence the use of particular terminology, in addition to the imposition of identities through belief systems (Rosenhan, 1973; Jones, 1994). In continuing to explore definitions of this term, I am aware I share some of the views and opinions of other researchers whilst not necessarily agreeing with ideas put forward for consideration by others.

## **2.2 Defining terms - mental health – an overview**

Terminology attempting to define, differentiate and substantiate interchangeably used terms represents the differing views of commentators, adding to the debate around how to define ‘mental health’, ‘mental ill health’, ‘mental health issues’ and ‘mental health problems’. Kendall (2002) suggests that the most contentious issue is whether disease, illness or disorder can be scientifically explained and furthermore, whether these are biomedical or socio-political terms, involving a value judgment based on an individual and/or societal perspective. Arguably, the definitions used to formulate terminology influence many things, including shaping policies and the approaches to and the management of, mental health issues (Goldman and Grob, 2006).

Mental health is a contested concept which is defined in a number of ways. Layard (2005) suggests mental health and mental illness are two different concepts and the term ‘mental health’ is essentially a modern concept. Consequently I have sought and explored information relating to this from a variety of sources including UK based and international forums. The term ‘mental health’ is a broad, all encompassing term which is commonly used and refers to issues surrounding mental illness, often within the context of mental health services ([www.mentalhealth.asn.au](http://www.mentalhealth.asn.au)). However, it can cause some confusion for individuals and within communities when trying to comprehend the difference between the two terms. ‘Mental health’ or ‘mental well-being’ is considered a positive concept and not solely about the absence of mental illness or disease (WHO, 1986). Synonymous facets include resilience, independent functioning, happiness and lifestyle satisfaction. Mental health might usefully be

viewed as a continuum of experience, from mental well-being through to severe and enduring mental illness. Individuals experience changes in their mental health state and this is influenced by a range of factors. Some people may experience mental health problems to such a degree that it results in a diagnosed mental illness, requiring the involvement of specialist services ([www.liv.ac.uk](http://www.liv.ac.uk)).

In supporting this assertion, McCulloch (2005) and Layard (2005) agree there is a significant relationship evident between good mental health and positive life experiences. In agreement, Pilgrim and Rogers (1993) further argue that the state of an individual's mental health is not a random misfortune, but influenced by singular or collective external factors, unless it is of a biological or organic nature; whereas mental illness in one's life is a potential threat. 'Mental ill health/illness' is a term commonly referring to a diagnosed clinical condition, for example, depression, anxiety or psychosis. It includes other and various psychiatric conditions characterised by impairment of an individual's normal cognitive, behavioural and/or emotional functioning caused by physiological and/or psychosocial factors. The resulting impact may inhibit the person's ability to function independently, coherently and safely and whilst it may appear counter-intuitive, mental ill health and mental well-being can be experienced (by a person) and co-exist at the same time (<http://www.medical-dictionary.thefreedictionary.com>).

Various definitions underpin how mental health is viewed. The holistic concept of mental health is endorsed by the World Health Organisation (1946; 1986) in recognising that it is not simply the absence of disease and incorporates the physical as well as the social and mental well being of an individual. Modern definitions of mental health and mental health problems, consider the notion there is a state of positive health which can co-exist with illness (Jenkins *et al.*, 2002; McCulloch, 2005; Mental Health Foundation, 2005; 2005a; 2005b). The term 'mental health problems' is one that encompasses a range of experiences and situations. As with other terminology discussed here, it is a broad definition employed by a range of services and agencies ([www.mentalhealth.org](http://www.mentalhealth.org)). It is considered a positive term in that it acknowledges the individual as a person and not a psychiatric diagnosis; recognising that people may experience mental distress and this may be problematic without being a diagnosable illness.



Definitions of positive mental health remain under debate; recognising and acknowledging mental health is entrenched within social relationships, dependent on personal definitions and individual life experiences (Melzer *et al.*, 2004). A similarly employed term, to that of ‘mental health problems’, is ‘mental health issues’. This is also a broad definition interchangeably and frequently used (by individuals and others) to define temporary, short term reactions to difficult, painful, stressful and/or traumatic events. However it may also be used to define long term psychiatric, clinically diagnosed conditions significantly impacting on an individual’s functioning ([www.leeds.sc.uk](http://www.leeds.sc.uk)). The latter term (mental health issues) is my preferred terminology of use for the purpose of this research and thesis. It provides a broad, encompassing definition whilst recognising individual experience, acknowledging the positives and the potential for co-existence between health and illness.

### **2.3 Understanding mental health within the health context - a model approach?**

Current debates about defining terms are underpinned further by debates about public mental health and mental health promotion, including those around individual happiness, well being and quality of life, and their relevance to social and economic policy making (Seligman, 2003; Marks and Shah, 2004; Huppert *et al.*, 2005; Layard, 2005). Yet within the context of health care provision, the biomedical model approach to health and illness is ostensibly the principal way in western culture and widely accepted by the medical profession and the lay, non professional population. Its definitive characteristics centralise the individual in physical terms; the physical body rather than the problematic mind is the subject of medicine and the mind and body can be treated as separate entities (mind-body dualism). In addition, medicine within the context of this model sees the body as a machine (mechanical metaphor) and knowledgeable medical practitioners repair ‘dysfunctions’.

The curative nature of biomedicine often overwhelms other beneficial possibilities such as diet and lifestyle change, yet the technological imperative of pharmacological and/or surgical methods of intervention are used to treat the body, in turn curing it of its dysfunctions. Nettleton (1995) suggests biomedicine is reductionist as it reduces all explanations relating to health and disease to the physical functioning of the body and the origin of all diseases are specific and knowable. This model is strikingly rigid and

offers an accurate account of medicine which has predominated medical practice prior to the post modern and present historical climate yet should not be dismissed as redundant or out of date. Lupton (1995) suggests the medical model has developed and reinvented itself to the point where it can inclusively embrace social and psychological factors, acknowledging wider influential factors determining an individual's state of health. Wade and Halligan (2004) agree, suggesting there are more comprehensive, less biologically dependent accounts of illness and updated versions of the medical and other models which could be usefully employed in this arena.

The debate relating to the value of biomedical models of illness and their role in health care systems was further contributed to by Wade with Halligan in 2004. Their argument cited a number of key issues relating to the debate. Their expressed concerns surrounded the notion that medical models assume that all illness is secondary to disease and as a result, significantly influences the delivery of health care provision and individual patient experience, thus having important consequences. Their argument challenged the rigidity of the model where employment of such created diagnostic labels and the specific use of predominantly medicalised defining terms; allowing individuals to adopt the sick role (Parsons, 1951), absolving responsibility for their 'condition' and their eligibility for health care benefits validated by doctors or other health care professionals. This reinforces the position of patient and doctor. The 'sick' are expected to regard their condition as negative and to try to get well by following medical advice. Criticised by disability advocates for its disregard of social forces and support of medical intervention, as a means to normalisation, the 'sick role' points towards the dependence of the sick and socially embedded notions of devaluation. This results in the diminished identities of those who remain within this role (Barnes and Mercer, 2010). Wade and Halligan (2004) suggest disease is only one factor contributing to illness and illness behaviour. A move away from systems focused on pathology and recognising that social context, human behaviour and personal choice are central to the development of health care systems as social organisations.

The notion that disease, and consequently illness, is solely based on biological factors raises the question in relation to mental health – is it considered an illness, a disease or

both? In psychiatry from a professional perspective, it is considered an illness and is treated reactively in response to the presentation of an individual, or groups, with specific symptoms. Terminology employed within this field includes mental illness, psychiatric and/or mental disorder, the connotations of which are overwhelmingly negative, suggesting deviant non-conformist behaviour (Becker, 1963; Lemert, 1972; Busfield, 1996; Browne, 2002). In response, the experience of mental illness from an individual perspective, for example those in receipt of ‘treatment’, often describe themselves as having a ‘mental disease’. This is commonplace in services where individuals seek help for addictions such as alcohol and subscribe to the model proposed by Alcoholics Anonymous; their dependency viewed and treated as a disease, absolving the individual of all responsibility, thus requiring to be cured by others (Kurtz, 2013).

Graham (2010) suggests the term ‘mental disorder’ serves as an alternative to a number of other terms and not because the terms ‘mental illness’ and ‘mental disease’ are no longer used; they continue to be widely used. However these terms are used interchangeably. Graham argues the terms are different because of subjective and behavioural notions. He explains thus; *“Sometimes...the expression ‘mental illness’ is used to refer not to a disorder or behavioural condition as such, but to the subjective or personal experience of having a disorder.”*(2010:45). Here Graham is referring to ‘conscious phenomenology’, where an individual is aware of their predicament, perceiving an identity based on what the senses of the mind have observed. Whilst this philosophical perspective of ‘the disordered mind’ creates another useful facet for consideration in the defining terms debate, the use of such examples of terminology suggest diagnosis and subsequent labelling (Davis, 2006).

#### **2.4 The social construction of mental illness**

The decision about whether or not someone is mentally ill involves other people (Browne, 2002), making judgements about an individual’s behaviour, based on the boundaries influenced and created by wider society and what constitutes ‘normal’ behaviour (Barry and Yuill, 2002). Goffman (1963) discusses identities which are outside of the norm, as a reflection of negative attributes. As a result, a stigma is ascribed to those who are considered ‘not quite human’ (Davis, 2006:132), resulting

in shame, lack of self respect and self-consciousness. The definition of mental illness therefore rests on what people see as normal and socially acceptable behaviour.

The medical perspective of mental health defines it within the parameters of the biomedical model. This model adopts an illness/treatment approach rather than a person centred approach which is holistic in nature and views the whole person as a person experiencing mental health issues, not solely an illness, within (their) society. If society adopts the medical model approach in responding to people experiencing mental health issues/illness, this can result in a range of positive and negative consequences for individuals and communities. For example, as cited by Wade and Halligan (2004), during the First World War, soldiers who complained of symptoms after experiencing severe stress were sometimes shot as malingerers. However, in the post modern era, they are considered *victims* (my emphasis) of Post Traumatic Stress Disorder (PTSD), entitled to treatment and in some cases, a financial settlement. Social acceptance that a behaviour or reported symptom constitutes an illness bestows privileges on an individual, and formal duties on society. However this is a complex issue; what is regarded in one society as normal behaviour, maybe regarded as abnormal in another. Historically the label of 'mental illness' has been used to create societal benchmarks condemning non conformist (deviant) behaviour, resulting in the medicalisation and treatment of individuals (Lemert, 1972) and once a label has been attached to an individual, their career as a (psychiatric) patient, begins (Goffman, 1961).

Scheff (1966), Szasz (1972) and later Foucault (1976), argued that what society refers to as mental illness is a social construction, a label applied by those in power, for example doctors, to those demonstrating behaviour which is disapproved of or which goes against the dominant accepted norms of (any) society. Scheff argued that at sometime in most people's lives, they will experience periods of anxiety, stress or depression and in most cases this would not be labelled as mental illness. This approach to mental illness suggests Scheff believed that everyone has mental health, which is affected by internal and/or external factors and is more in line with current definitions of mental health as a 'positive sense of well being'; challenging the idea mental health is the opposite of mental illness where the two are conceptualised as parallel continua (Keyes, 2005). Friedli (2006:13) supports this notion further

suggesting many people may have symptoms of compromised mental health, “*that do not reach clinical levels*” and yet equally, many people who do not have a clinical diagnosis, have low levels of mental health (Gilleard *et al.*, 2005).

What is striking here is the use of the terms ‘clinical levels’ and ‘clinical diagnosis’, suggesting the biomedical model remains the principal, underpinning way of understanding illness and health employing specific strategies around the issues of power and control, diagnosis, and privilege. Yet there is a danger here of assuming it is merely the use of the medical model by doctors, psychiatrists and other health care professionals that creates categories depending on the diagnosis a person is slotted into because their presenting symptoms ‘fit’. Jones (1994) challenges this notion and suggests that categorising occurs in most areas of life as it is natural human behaviour. Therefore, have we legitimised how we behave in society, including how we behave in the context of individual and societal health? Is it us, the lay people who have generated the implementation of models, shifting definitions and subsequent interchangeable labels?

The work of Goffman (1961), Scheff (1966), Szasz (1972) and Rosenhan (1973), (the latter’s work confirmed the views of the previous three in that mental illness is a label attached to behaviour by others), were small scale studies and therefore could be criticised for not being representative. Their views that mental illness is solely a social construction promotes the way we think about defining and labelling mental illness and that social factors contribute to this debate. However it is important to recognise mental illness, in its organic, biological or chemical form, is a real illness requiring intervention.

## **2.5 The social model of mental health**

The social model offers an alternative approach in attempting to define mental health. Abraham and Shanley (1992:25) suggest that illness cannot be successfully combated solely from a biological perspective. This is because “...*its incidence and form are inextricably linked to lifestyle at both economic and personal levels.*” From a social perspective, this means understanding what people do to themselves and is essential to understanding patterns of health and promoting better health. To extend this notion and to include the development of this model further in relation to people with

disabilities, the social model of disability has been developed in response to the medical model and the subsequent impact it had on their lives (Swain *et al.*, 1993).

Historically, this model's roots can be traced back to the 1960s and in 1976, a UK based organisation, Union of the Physically Impaired Against Segregation (UPIAS), claimed that the way in which disability was perceived and responded to by society, was disadvantaging and restricting the activities of physically disabled people, resulting in social exclusion (Swain *et al.*, 1993). Oliver (1990) coined the phrase, 'social model of disability' focusing on the idea of an individual model, of which the medical element was a part, versus a social model which derived from the original distinction made between impairment and disability by UPIAS. The 'social model' claims disabled people are an oppressed group overpowered by medical authority, leading to devaluation of the lived experience (Barnes and Mercer, 2010). It has been developed and its range extended to include all disabled people, including those who have learning or mental health difficulties. The social model of disability proposes that systemic barriers, negative attitudes and exclusion by society, purposely or inadvertently, are the factors ultimately defining in a particular society, who is disabled and who is not. This challenges the traditional view of disability, upheld by the medical model (of disability) whereby people are viewed as (medical) problems rather than people. The social model encourages society to consider and respond to people with disabilities in a positive way by reducing barriers (not only in the physical sense) and creating equality of opportunity.

Shilling (1993) draws our attention to the body from a sociological perspective and to two concepts – the body as *körper* - objective, exterior, institutionalised body by way of viewing the body from an anatomical, physiological perspective, and *leib*, the animated, living experiential body (Williams and Bendelow, 1998). The *körper* perspective is underpinned by the medical model and in many ways this is how medicalised views of disability operate, defined variously as a deficit (Thomas, 2002), a personal tragedy (Swain and French, 2000), a condition requiring fixing (Hughes, 2002) and a socially imposed barrier (Oliver, 1996; Barnes and Mercer, 2010). The *leib* perspective embodies a holistic conceptualisation of disability, promoting greater understanding of the emergent characteristics (of disability), identity and feelings of self (Overboe, 1999).

An extension to the social model of disability includes the term 'hidden' or 'unseen' disabilities and is a, catch-all phrase meaning a person's impairment or condition is not obviously apparent or visible. Hidden disabilities may include people with visual or hearing impairments, mental health issues or other medical conditions for example, diabetes, epilepsy, asthma, HIV and AIDS, sickle cell condition and cystic fibrosis, and more commonly so in recent years, nut allergies. Disabling medical conditions can often have a considerable impact on a person's everyday life (NAT, 2010). This in turn may have an effect on how they function within their home environment, at work, at school and at college. However this is also dependent on a number of other factors, by which I mean the perception of a disability, or not as the case may be. Goffman (1968) and later Shakespeare and Watson (2002) suggest that visible disabilities trigger social responses, whilst invisible ones do not. This also raises questions about medical, social and individual perceptions, in particular whether a person views experiencing a mental health issue as a disability.

Symbolic interactionism provides a base from which to conceptualise how people perceive and understand themselves. This theory maintains that humans act towards others based on the meanings ascribed to them, developed via social interaction. The concept of Cooley's 'Looking Glass Self' (1964), describes the way in which individuals view themselves, based on how they think others perceive them. The 'theory of the self' is extended by Mead and Morris (1934) noting it is developed through communication, symbols and intersection of community values and attitudes with personal beliefs. Stryker (1980) and later Plummer (1991) develop this concept further acknowledging the role and influence of structures, power, history and culture; determinative forces in conceptions of who we are. Giddens (1991:54) argues that self identity is not found in the reaction of others but 'in the capacity to keep a particular narrative going', suggesting identities are bound within our stories and in order to have a sense of who we are, we need to have a notion of how we have become and the direction we are going; upholding the social basis of identity formation, connecting the social and the personal, within a collective context (Shakespeare, 1996).

Evidence across the literature, suggests the implicit, prescriptive negative connotations created by the implementation of the medical model, not only in its depiction of health, but of disabled people. Comparably, social models of health and

disability, acknowledge the social context of health, whereby determinants of health, including environmental, cultural and economic factors, are given due consideration, thus creating a positive portrayal of people with disabilities.

## **2.6 Mental health and further education – a growing preoccupation**

Ivan Lewis when Minister for Adult Learning in 2002, fervently argued that educational achievement plays a pivotal role in countering many forms of individual and social deprivation, in addition to promoting confidence, citizenship, economic prosperity and cultural regeneration. The political agenda directed by New Labour (1997-2010), welded together values and beliefs through social and educational policies, the notion that achieving in lifelong learning would lead to numerous individual and social benefits. In the wider social context, it is increasingly commonplace to read about emotional wellbeing, mental health and self esteem in lifestyle magazines; to hear and see ‘celebrities’ living out their emotional states and issues with self esteem across the media, and to read about members of the public telling their stories through autobiographical accounts sometimes referred to as ‘mis(ery)-lit’ found in the section titled ‘Painful Lives’ in Waterstones book stores for example (O’Neil, 2007). Furthermore, an array of ‘bibliotherapy’, more commonly referred to as self-help manuals to help those reluctant to seek professional help publicly, preferring to self-therapise in private (Milne, 1993) and in this age of the internet, the promotion of digitised self-help, often as linked advertisements creating even more discretion than a tangible self-help book (Prasad and Owens, 2001). These examples illustrate the increasing extent to which concerns about people’s psychological wellbeing and self esteem are slowly permeating many areas of society and furthermore, educational debates among policy makers, professionals and across the curriculum in further education.

It is difficult to pinpoint the exact date in history when adolescent student mental health and emotional wellbeing became a significant factor in further education, however a growing preoccupation was noted in the early years of the 2000s (Hyland, 2006; Ecclestone, 2007) and this has been set against a plethoric backdrop of educational policies which have influenced and underpinned the further education sector (DfES, 2005b; 2005c; Ecclestone and Hayes, 2009a). Shifting traditional radical pedagogy in favour of therapeutic interventions reflect cultural changes and



lowered expectations among professionals about whether or not people, in this case adolescents, are able to act autonomously, assess risk and deal with challenges independently (Ecclestone, *et al.*, 2005a). Ecclestone argues that this is turning education into a safe, comfortable and therapeutic experience. Challenging Ecclestone's view in support of this safe, comfortable educational experience is Storrs (2012), who argues that student emotions can significantly enhance or distract from (their) learning. By attending to their emotions, Storrs reports being able to affect her students' academic ability and enhance individual identities, and whilst acknowledging the challenges of 'an emotional curriculum' exist, invites others to consider adopting this approach to their teaching.

The increased interest in raising adolescents' self esteem in further education is linked to image perception and identity. People who are considered to be disadvantaged and/or marginalised are therefore at risk of exclusion, requiring formal education in order to improve their self esteem. These are not solely limited to political or professional concerns; welfare initiatives, for example, post 16-25 guidance and careers service Connexions<sup>6</sup>, suggest excluded young people lack confidence and skills and may well be suffering from a range of health issues in addition to emotional damage (Crimmens *et al.*, 2004).

Historically further education was outside the structures of target setting, inspections and regulation but is now characterised by all of these (FEFC, 1996; DfES, 2006; TLRP, 2008; Ofsted, 2007; 2009). Tangible outcomes for further education extend beyond the academic curriculum thanks in part to the implementation of the high profile Every Child Matters (DfES, 2003) initiative, amongst many other factors which have influenced the ever increasing therapeutic ethos in further education. The boundaries between further education and social welfare have therefore permeated one another, leading to the delivery of interventions for those in need, or considered at risk. In creating a climate where therapeutic governance exists, whether it be across society or within education, legitimising people's well being and emotional state

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<sup>6</sup> Connexions is a national service providing impartial information, advice and guidance (including careers advice) to young people aged between 16 and 25. Its role is to remove barriers to learning and progression, enabling young people to make the transition between adolescence, adulthood and working life.

shifts it from the personal to public concern, thus creating a moral capacity to be ‘emotionally well’ (Frost, 1997).

## **2.7 The rise in use of new labels and language across education**

In attempting to define terms, for example mental health, earlier in this chapter, labelling language has always been used across both the health and education sectors. Historically examples in education focused on the academic, such as, able, high achieving, intelligent and less able, average, below average ability. The shift in focus from the academic to the emotional needs of students has generated new labels such as vulnerable learners, at risk learners, academically challenged, disaffected and disengaged and these buzz words and labels used across the education sectors further demonstrate a shift in how students are viewed and how professionals assess them (Ecclestone and Hayes, 2008). Furthermore, these shifts are accompanied by an increase in student support services and initiatives, both internal and external to education including pastoral care, peer mentoring and rigorous personal and group tutorial processes which focus on the emotional rather than the academic abilities and achievements of learners. As the literature demonstrates, the perceptions of individuals’ emotional (in)stability or proneness to this by others, including professionals, permeates many areas of society and across the cultural, political and educational landscape. This extends to other areas of welfare policies and family life where the roles of Sure Start<sup>7</sup> and Bright Horizons – Family Solutions for example, provide initiatives in partnership working between families and helping organisations.

To return to the point in question around labelling language in education, does the use of this language and these labels change the role of teachers and lecturers? Ecclestone and Hayes (2009) agree it does and re-casts teachers as facilitators of learning; authority, rigidity, objectivity and power are replaced by the promotion of a shared learning experience created by an empathic, subjective approach. In addition, Rooney (2010) suggests this is not solely limited to education and the professional role of teachers and lecturers but includes that of parents, given the expectation of

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<sup>7</sup> Sure Start is a government initiative. The main aim of this national service is to offer support to parents from pregnancy and give young people from the most disadvantaged areas the best possible start in life. It aims to promote the physical, intellectual, social and emotional development of pre-school children; within their home environment and later when they start school

education's 'new' role in managing the mental health and emotional wellbeing of students.

Rooney (2010) argues parents have unprecedented levels of involvement across all sectors of educational provision and are expected to engage contractually with their son or daughter's educational establishment via home-school contracts and academic mentoring. This movement has been politically driven during the past ten years and is underpinned by policies interlinking education, health and welfare in an attempt to empower parents, shifting and extending responsibilities from education to parents to take greater responsibility for their children's learning. These actions are associated with many positive buzz words and terminology, for example 'empowering parents' and 'educational transparency'; further reducing the autonomy of those in authority (the teacher/lecturer) and erodes the trust between teachers, parents and students (Furedi, 2009). In support of minimising the growth of therapeutic communities within education is Furedi (2004) (building on the work of Nolan, 1998), recognising that learners' behaviour is increasingly portrayed through psychological labels. He argues that teachers should teach, and not provide therapy and schools and colleges should create learning environments, not therapeutic communities where learners are encouraged to take responsibility for their own learning. Anderson *et al.* (2009) argue that Furedi's 'bleak predictions' Britain would become a 'therapy culture' are unfounded. Although more adults and young people like to talk about their emotions and think it is a good thing to do so, compared to the past, there is no evidence more are seeking or using therapeutic support.

## **2.8 Adolescence, mental health and further education**

The work of theorists including Hall (1904), Blos (1962) and Freud (1966) contribute to the understanding of what adolescence is and its contextual relevance to defining and understanding the mental health of young people. All of the above have suggested that the period of adolescence is a tumultuous stage of development characterised by puberty, hormonal activity and bodily changes which create the catalysts for emotional upheaval. Challenging these views are sociologists including Davis (1940), Rice (1975), Clausen (1986) and Simmons and Blyth (1987) disagreeing and arguing that adolescence is a period of stress and family conflict, characterised by young people's changing roles, educational competence (or incompetence), the development

of intimate relationships outside of the family and in some cases, working and gaining financial independence (Aggleton *et al.*, 2000). These two dichotomous positions could be viewed thus; in the former example, Hall, Blos and Freud take the stance that adolescence is biological, whereas in the latter, clearly a social (model) approach, a view further supported by Ariés (1962) suggesting adolescence is a social construct defined by the society, its expectations and the cultural boundaries in which young people grow up in.

As previously discussed, the debates defining mental health are complex and extending this to include adolescence, further complicates the issue. Theories and definitions discussed and proposed, suggest a range of differing viewpoints and further evidence across the literature suggests self perception contributes to how an individual's mental health is viewed. The same could be said for defining adolescence and whether or not it is viewed as a physical, biological phase of development or social or, a combination of both. In recognising that adolescence is a relatively recent identified phase of development (Hall and Jefferson, 2006; Coleman and Hendry, 1990), Aggleton *et al.* (2000) and later Baker (2004) suggest that adolescence is a more stressful time for parents of adolescents, challenging the notion that the period of 'storm and stress' is more about the projection of adult fears, than those of young people themselves (Hall, 1904). This also colludes with the notion of what constitutes positive or negative mental health in adolescence suggesting this is derived from adult perceptions and constructs of adolescence (Aggleton *et al.*, 2000). These theories link to the wider discussion around mental health and the inclusion of managing the mental health of adolescents in further education (Ecclestone and Bailey, 2009b). Adults 'fears' about adolescence, in conjunction with a shift over the past twenty years in the predominant provision of mental health care in the community, has exposed mental health to the wider population, contributing to a growing interest in the field across political, social and educational agendas.

Hence, provision for the well being of students across the further education sector is underpinned by a number of key pieces of legislation (presented and reviewed in the previous chapter) in addition to The Tomlinson Committee's Report *Inclusive Learning* (TLRP, 1996), the *Special Educational Needs and Disabilities Act 2001* ([www.legislation.gov.uk](http://www.legislation.gov.uk)) and the high profile government strategy *Every Child*

*Matters* (DfES, 2004). The Social Exclusion Unit Report *Mental Health and Social Exclusion* (2004) highlighted the challenges for the learning and skills sector, resulting in the Learning and Skills Council (LSC) to address the mental health needs of learners by way of publishing a strategy for *Improving Services for People with Mental Health Difficulties* (LSC, 2006b), refreshed and revised with *LSC Mental Health Strategy – The Way Forward*, in 2009.

The latter strategy document is specific in its use of terminology relating to mental health. The LSC perspective is the recognition and use of the term ‘mental health difficulties’ across the literature. In addition, clear statements are made with reference to its positioning in relation to the perception and belief system of disability.

Categorically the LSC works within the social model of disability, acknowledging ‘...that while people may experience impairments, too often the disabilities experienced by people are socially constructed. Thus someone with mental health difficulties may be disabled by other people’s fears and prejudices.’ (2009:7)

Given the recommendations set out by the LSC to challenge negative assumptions surrounding people experiencing mental health difficulties and in doing so, encouraging the further education sector to adopt the social model of disability, raises two key questions for me as a researcher. Does this create a pluralistic environment for learners ‘experiencing mental health difficulties’ and do people with or who are ‘experiencing mental health difficulties’, see themselves as disabled?

The first question prompts consideration in relation to what organisations ‘do’ on an organisational policy level for people experiencing mental health difficulties and what really happens in practice. This resoundingly links to my study whereby interview data indicates pluralism exists within Wenhill College. The second question links to notions around disclosure, identity, the self and other and links to debates relating to inclusivity and the contested concept of defining mental health. Clearly the adoption of a specific model by an organisation will impact on how it responds to the mental health needs of its learners; the impact influencing whether or not an individual discloses their mental health issues and whether or not this a (clinical) diagnosis or a self report, in addition to its internal and external profile (Shakespeare and Watson, 2002).

Studies in the field of education help situate debates surrounding mental health and further education. There is a plethora of research available addressing the mental health and emotional wellbeing of children across the foundation curriculum and in compulsory primary and secondary education, as there is in relation to higher education. Yet there is limited research relating to further education and specifically adolescents aged 16-19. Bloomer (2005) suggests the culture of further education, with its shortage of resources, constant major changes and lack of professional space makes engagement with research very difficult; despite a strong rhetoric of willingness to engage. Consequently, there is limited evidence of research influencing further education practice (Scaife, 2004).

Epidemiological studies are useful in providing statistical data evidence and in relation to mental health, have been usefully carried out by a number of bodies (Royal College of Psychiatrists, 2003; 2006). However there are a number of difficulties in obtaining reliable rates of mental health issues among the UK further education student population and there is little longitudinal data to discern trends over time. How do we establish the 'problem of the problematic', if indeed we can only quantify those who seek help; what about those who do not? Further difficulties surround some issues already discussed in this chapter including definitions of a mental health issue and adolescence. Qualitative studies or those combining mixed methods data collection go some way to assisting the understanding and experience of mental health (Caldwell *et al.*, 2005), as do those studies which address the issue from other angles including ethical dilemmas (Sikes, 2010), student voice (McCloughlin and Tierney, 1993; Nightingale, 2006) and the wider learning culture of further education (Mays and Pope, 2000; Green and Thorogood, 2004; Bloomer, 2005).

Much is expected of the further education sector and of those who work and learn in it (Jephcote *et al.*, 2008). The inequitably treated 'neglected middle child' (Foster, 2005) continues to experience broad changes, including its funding structures and inspection frameworks (Davies and Jones, 2003; Lucas, 2004). The compounded impact of this 'shifting sands' climate has led to shortage in resources with increased pressure on staff and the wider further education landscape (Bloomer, 2005). Teachers, faced with ongoing change under pressure from college management and externally prescriptive policies, feel undermined; the cumulative effect leading to restructuring of their

professionalism and professional identities and classroom practices (Ecclestone and Hayes, 2008; Jephcote *et al.*, 2008; Furedi, 2009).

Methodologically innovative studies combining iterative qualitative and quantitative case study data, lead to descriptive multi-layered case studies of different further education college sites (Bloomer, 2005; Jephcote *et al.*, 2008; Warwick *et al.*, 2008). Bloomer (2005) and later Jephcote *et al.* (2008) value the engagement with existing communities of practice within situated learning environments, thus carrying out their research within authentic further education settings and by not detaching the research from the context leads to insightful research perspectives. Locating the research within further education as a whole, Bloomer (2005) and Jephcote *et al.* (2008) create comparative profiles and participant views. Furthermore, the inclusion of quantitative data provides a contextual overview of a site, enabling a better understanding of the statistical profile of a case study setting (Bassey, 1999; Stake, 2006). Combining qualitative and quantitative data leads to the composition of thick case study descriptions, where the subjective experience of participants, are uncovered (Geertz, 1993; 2000). I have drawn on this innovative methodological approach in a number of ways, transferring elements to my research. The benefits of engaging with existing communities of practice within a situated learning environment are valuable and by replicating this on a smaller scale, I can make good use of my insider researcher role (Sikes and Potts, 2008) and create a thick case study description of Wenhill College.

A desire to explore and gain a deeper understanding of the complexities of learning is evident across the literature, in addition to a growing interest in learner identities and the professionalism of further education staff (Bloomer, 2005; Colley, 2005; 2006; Gleeson, 2005; Jephcote *et al.*, 2008). Further education students experience complex lives and attending forms part of these. Their learning journeys are not neat, linear nor unproblematic, containing unpredictability, susceptibility to external pressures and tensions. The antecedents of these learning journeys are often rooted in disparate personal and secondary schooling experiences leading to negative learning identities and being ill equipped for learning in further education (Harkin, 2006). Some students explain their lack of academic progress with reference to the pressures in their wider lives, while others use the same pressures to explain their determination to succeed (Jephcote *et al.*, 2008). Yet there are social dimensions associated with being a further

education student with wider benefits to learning (Frykolm and Nitzler, 1993); this is paramount because it could change and improve their lives (Davies and Jones, 2003; Davies and Biesta, 2007). This links with notions of the role and culture of further education, and the belief by many (students, staff, college management and the government), in the transformative capacity of further education (Bloomer, 2005).

Complex student lives result in complex student/tutor relationships, where students engage in personal disclosure, revealing the external stressors affecting their engagement in classroom learning. Bloomer (2005) suggested the central significance of the tutor and pastoral care provided, is key to the student learning experience. Combined with the pressurised and destabilised environment within further education, tutors spend much of their time, striving to protect the learning culture from 'external damage', resulting in many teachers and tutors working beyond their job description (James and Diment, 2003). Yet it seems that many accept this as 'part of the job' within the culture of teaching within further education, investing heavily in emotional labour as a form of coping strategy to deal with the stress and pressures of their role (Colley *et al.*, 2003).

The mental health and emotional well-being of young people has become increasingly evident under the spotlight during recent years (Aylward, 2003; Warwick *et al.*, 2008; Mind, 2009), highlighting the extent of psychological and emotional problems experienced by young people. Consequently, the mental health and well-being of young people has a developing profile in the need for support and greater awareness amongst frontline staff, especially in further education (Worrall and Law, 2009).

Warwick *et al.* (2008) noted entering further education can be a particularly stressful time for young people. It is likely that students entering further education from school will be vulnerable, since study in further education is increasingly undertaken by young people who have found school difficult, or, who may require extra time to develop basic and employment related skills (Bloomer and Hodkinson, 2000; Jephcote *et al.*, 2008). For some of these young people, mental health issues may have featured throughout their childhood and secondary schooling career and whilst Warwick *et al.* (2008) report evidence of 'interest and goodwill' within the further



education system to support such students, Worrall and Law (2009) propose the time has come for 'purpose and action'.

Increasing staff awareness of rising numbers of adolescents experiencing mental health issues and the belief that greater attention needs to be paid to the mental health of students in colleges is evident across several studies (Royal College of Psychiatrists, 2003; 2006, Eaton, 2008; Warwick *et al.*, 2008; Worrall and Law, 2009).

Participating staff and learning providers suggest greater attention needs to be paid to the mental health of students in colleges because students experiencing mental health issues tend to be labelled, not as mentally unwell but as having behavioural problems; hence evidence of concern among health and education professionals about the prevalence of mental health issues in further education students.

Where students were involved via survey methods (Nightingale, 2006) they reported finding counselling staff, personal tutors and mentors useful and just as important as the college ethos. Learning centres incorporating the promotion of mental health within the provision of student support, did so via tutorials and drop-in services, reporting effective awareness raising in relation to the issue; the focus here being integral rather than detached. However, where access to counselling provision was available and offered, it was not necessarily used because students feared being stigmatised. This stigma could be minimised if students were able to talk with someone who has experienced mental health issues themselves (Worrall and Law, 2009).

Several themes identified the contribution of factors in the development of services to promote students mental health in further education. These include making use of national and college policy, strong leadership and commitment to student services, providing students with opportunities to make their views and needs known and sufficient resources with which to carry out the relevant work. However, evidence across the literature suggests that the minority of colleges have a mental health policy, many incorporating mental health into other policies rather than as a separate one (Warwick *et al.*, 2008; Worrall and Law, 2009). The lack of sufficient resources, including staff lacking awareness, training and time, resulted in detrimental effects; a view supported by Bloomer (2005) and Gleeson (2005), the latter suggesting the

resulting impact compromised staff professionalism and the learning environment in further education.

Eaton (2008) addressed the issue from a small scale case study perspective within her role as manager in supporting students with learning, physical and mental health difficulties at a further education college within the north west of England. Key staff responsible for pastoral support, were asked to log issues presented to them by students and other staff, over a five day period. However, the outcomes indicated confirmation of anecdotal concerns expressed within the organisation surrounding the adverse impact on staff, the need for training and skills development and furthermore, the organisational expectation of teachers as social workers, which they are not (Furedi, 2004).

Disparities occur across the literature between how and what young people view as mental health issues compared to the perception and knowledge of the problem from the providers (further education college and staff) perception (Worrall and Law, 2009). Participating learning providers were aware of this 'mismatch' and acknowledge capturing this data at point of student enrolment, limits the statistical validity of data. Indicative good practice suggests the opportunity for student voice and expression of independent personal experiences to be heard, not solely in relation to mental health but other issues too. In respect of the research, this was limited due to the methodological approaches employed (Warwick *et al.*, 2008; Worrall and Law, 2009).

There is little evidence across the literature of partnership working with statutory agencies external to college environments, for example CAMHS, other than Connexions and career services in helping colleges to support younger students with mental health issues and there is often no identified link person (Warwick *et al.*, 2008). Worrall and Law (2009:45) suggest where learning centres employed an 'ad hoc' approach to mental health promotion and managing students experiencing mental health issues, a more structured yet flexible process of education and support is recommended. However, the diverse nature of further education suggests no single approach is likely to engage all colleges but drawing out a variety of factors that create a positive progressive approach to success, contributes to sharing ideas and disseminating good practice.

Stanley and Manthorpe (2000) focus their study of '*Responding effectively to students' mental health needs*' within a higher education institution. It is included here because of its relevance to debates around student mental health, well being and education, linking to student transitions from further to higher education; a view supported by the Royal College of Psychiatrists (2003; 2006) who express concerns in the identification and management of further and higher education students experiencing mental health issues. Stanley and Manthorpe's study unveiled a number of issues and consequent recommendations generated from a staff perspective and to an extent these are confirmed and extended by those identified by Eaton (2008). The identification and profile of 'invisible disabilities' should be given a high priority; this suggests that HEIs<sup>8</sup> adopt the view that a mental health problem is an unseen disability within the context of the social model of disability, yet the management of which relies on self disclosure or diagnosis (Shakespeare and Watson, 2002). Furthermore, the stigma attached to seeking help for mental health issues inhibits accessibility to appropriate support, therefore reducing this and creating a non-stigmatised climate would prove beneficial to students. The recognition that academic and tutorial staff do not receive appropriate training in addressing the dilemmas encountered when responding to students with mental health issues is crucial, whilst recognising their pivotal role in supporting such students. A view later supported across the literature (Foster, 2005; Warwick *et al.*, 2008; Worrall and Law, 2009).

The research literature contributes to a wider understanding of the nature of student mental health from a staff perspective and the wider arenas of education and society. Evidence across the literature highlights the link between positively supporting students with mental health difficulties and retention, achievement and success in addition to the demanding roles further education teachers and tutors are expected to fulfil, within an ever changing environment. Transitions between secondary to further education (and beyond) are only a small element of complex student lives (Aylward, 2003; Warwick *et al.*, 2008), large proportions of which, are revealed in the learning setting through disclosure or behaviourally. Worrall and Law (2009) suggest it is a collective responsibility of the learning centre to support and maintain student mental

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<sup>8</sup> Higher Education Institutions

health, recognising that adolescence is a time when mental health issues can begin to manifest (Mind, 2009).

Further and higher education, are subject to widening participation and because of this, these sectors are experiencing greater numbers of students with mental health issues. Consequently, the need to recognise and appropriately support students is becoming increasingly featured across educational establishments; the collective acknowledgment that today's adolescents experiencing mental health issues, may become tomorrow's adults with enduring mental health needs.

## **2.9 Concluding remarks**

Mental health continues to be difficult to define because of contesting ideas from different perspectives. The post modern notion that we all have mental health may be changing and more widely accepted, contributing to a better understanding of what constitutes mental health and the experience of it. This is due to shifts across a range of fields. The closure of large psychiatric institutions in the late 1980s and early 1990s under the Community Care Act (1990), exposed more 'lay' people across the wider population in the UK to the concept of mental health in the community, where previously it had been kept behind closed doors (literally) and predominantly excluded from most peoples every day experiences. Changing agendas across the education sector are not solely limited to compulsory education and have been underpinned politically by New Labour and the current coalition government, whereby the mental health and emotional well being of learners is viewed as equivocal to in curriculum terms, the academic content of their learning experience.

In relation to my points raised as to how people categorise/label other people from personal and professional perspectives and how 'benchmarking' others is contrived, depending on their own previous experiences and judgement; from a medical/health perspective, practitioners assign individuals firstly a label in the context of their status, for example, patient, client, service user, and then 'good' or 'bad', depending on their initial presentation. This is not exclusive to physical health care, but mental health too (Jones, 1994). Browne (2002) cites examples of how labelling people, depending on whether or not their behaviour is conformist or deviant, contributes to how individuals and groups are responded to in wider society and once a label is attached,

they are 'marked out' as different, stigmatised by diagnostic categories, amplifying their 'deviance' (Goffman, 1963; Lemert, 1972)

Given the widening participation agenda and the role of further education in providing a 'second chance education' (McFadden 1995), are students who experience/are experiencing mental health issues viewed similarly to patients in health sector? The perception of these students could be viewed in a positive or negative way by their peers, staff and college on an organisational level. Given that further education college staff are not trained nor responsible for treating students experiencing mental health issues, the notion of label attachment, whether personally or professionally exists and this is substantiated in this study through interviews with staff. This also raises questions about individual identities and how these are constructed and prescribed, depending on disclosure, or not as the majority of cases may be, diagnosis (by others), self diagnosis (using professional language and terminology used amongst the peers and wider community) and self reporting (Asher, 1993).

Evidence presented here suggests that everyone has a state of mental health, the nature of which is very individual and that a positive health state is not merely the absence of disease. One's mental health state is viewed as an individual experience, yet one that is experienced within the context of the wider population and therefore it could be argued that personal health is a public health issue. The literature presented here does not solely view mental health as a social construct, yet sociologists argue that the label 'mental illness' is socially generated and applied to those displaying unacceptable forms of deviance, which transgress the dominant norms of society. This leads me to believe that an individual's mental health status is multi faceted and variously constructed by internal and external influences. Furthermore, definitions of mental health extend beyond those defining the experience of adults. Given the nature of further education provision, the differing aspects of such should consider the adolescence experience and the evidence which suggests mental health is linked to social and economic status; those from socially and economically deprived backgrounds are more likely to experience poor mental health.

And finally, there is clearly evidence to suggest that the growing pre-occupation with the mental health and emotional wellbeing of students in further education during the

past decade has a following of inclusion versus exclusion parties, arguing for and against this concept. For the time being, it looks fixed to remain a hotly debated topic across many sectors of society.

The following chapter discusses the epistemological and ontological foundations on which this research was constructed and offers an understanding of the forms of knowledge and beliefs which underpin the study. The purpose of chapter 3 is to create 'a bridge' between the contextual and literature chapters with the methodology and methods and to demonstrate the theoretical reasoning which underpins the choice and selection of these. The chapter also addresses the ethical considerations involved in this exploratory case study where biographical/life history methods have been employed to gather data from adolescent students who have experienced mental health issues.

## **Chapter 3**

### Methodology and ethics

#### **3.1 Introduction**

The purpose of this chapter is to create ‘a bridge’ between the contextual and literature chapters with the research design and methods, demonstrating the theoretical reasoning that support the choice and selection of these. This chapter also considers the anticipation and effective management of ethical issues encountered when carrying out a study using biographical research with adolescent students who have experienced mental health issues.

#### **3.2 Locating a philosophical position**

Nicol (2003) proposes that it is essential for researchers working in the field of education to be clear about their philosophical position before embarking on their research design. He further argues that the ontological and epistemological position of the researcher is not always apparent, leading to incongruent choices of methodology and methods, juxtaposing the (research) questions being asked. It may also make the interpretation of the data confusing for the researcher and even more so for the reader. A transparent ontological position illuminates the focus of the study and the approach adopted to demonstrate this. Grix (2004) warns that people wishing to conduct clear, coherent research and evaluate other’s research, need to understand the philosophical underpinnings that inform their choice of research questions, methodology, methods and intentions. According to Grix (2004:68), research is carried out proficiently by:

*“...setting out clearly the relationship between what the researcher thinks can be researched (ontological position) linking it to what we can know about it (epistemological position) and how to go about acquiring it (methodological approach)”*

Therefore, how I, in my role as researcher view the constructs of social reality and knowledge, affects how I approach uncovering knowledge of relationships among phenomena and social behaviour.

### 3.3 The critical paradigm

Critical theories share some ideas of the interpretative paradigm, but what makes it different is that critical paradigm focuses on oppression. Critical social scientists believe it is necessary to understand the lived experience of people in context. Persons are able to perceive reality external to themselves; representing reality through behaviour. Reality is also defined by the interaction between the 'knower' and the known. Critical approaches examine social conditions and uncover oppressive power arrangements. Theories found within this paradigm critique the known structure of social arrangement, whilst denying the existence of any true enduring one. Researchers adopting a critical stance within the social sciences are interested in how society reinforces oppression (Littlejohn, 2000).

According to Griffiths (2009), the critical research paradigm is an emerging paradigm in educational research, aiming to promote democracy by making changes in different social, political, cultural and ethical systems. Research for social justice is commonly understood as encompassed within this research paradigm. Crotty (1998) suggests we can understand this paradigm in two main ways. Firstly, that it offers a critique of the positivist and interpretivist paradigms in that whilst they seek to create a way of knowing the social world, they are not critical of the status quo. Secondly, that critical inquiry is based on a model of society whose main focus is that of change. Therefore, it seeks to explain social inequalities through which individuals can take action to change injustices (Griffiths, 1998); promoting the notion of social justice in order to create a world that is fair and more impartial. It is concerned with the power and justice of several issues in society including economy, race, gender and education (Kinchloe and McLaren, 2002). This 'type' of research has an agenda; to change the participants' lives or the structures of the institution (Mack, 2010).

Feminist theory is considered a critical paradigm the aims of which are to place the social construction of gender central to the agenda ensuring patterns of discrimination are challenged throughout all stages of the research (Richards *et al.*, 2001). Within this context, the research process should not reproduce the oppression of people; the empowerment of all people the central focus of the research process thus requiring the researcher to remain critical of the consequences of the research upon people's lives. Critical educational researchers employing such an approach aim to give an account



and understand behaviour in societies and ensure the facilitation of social change. Elements of feminist theory are applicable to this study and to the researcher role, and participants including students, staff and counsellors and mental health. Their approach and involvement has heightened self awareness around the need to explore the consequences of actions; of self and others (Richards *et al.*, 2001). However, whilst relevant, feminist theory for the purpose of my study as the sole theoretical framework and the central placing of the social construction of gender is too narrow; a broader approach is needed.

The phenomenological perspective falls within the interpretivist paradigm and is often referred to as the 'anti-positivist' paradigm because it was developed as a reaction to positivism. It is also sometimes referred to as constructivism because it emphasises the ability of an individual to construct meaning. The purpose of the phenomenological research method is to identify and highlight phenomena through the experiences and perspectives of the participants within a situation (Lester, 1999). This approach promotes the collection of rich, in-depth and informative data enabling the composition of a thick description (of events) represented from the perspective of the participant, emphasising the subjective nature of interpretation (Geertz, 1993; 2000). Phenomenological methods are effective in emphasising the experience and perceptions of individual and collective experiences/perceptions. Adding an interpretative dimension (to the phenomenological research method), effects its use as a foundation for theory; the outcomes being to inform, challenge and/or support, policies and action.

This philosophical positioning advocates the need to consider human beings, their subjective interpretations and their perceptions of the world, as the starting point in understanding social phenomena (Ernest, 1994). Therefore the ontological assumptions of interpretivism are that social reality is seen by multiple people. These multiple people interpret events differently leading to multiple perspectives of an incident or experience. The main tenet of interpretivism is that research can never be objectively observed externally and must be observed from the inside via the direct experience of people (Mack, 2010). Employing this paradigm seeks to understand in preference to explaining where events are distinctive and experiences are subjective and cannot be generalised. The epistemological assumptions of the interpretivist

paradigm focus on the accumulation of knowledge and how this is gained; inductively to create a theory, arising from particular situations and is not reducible to simplistic interpretation.

The challenge was to locate a philosophical position that accepts the constructivist view of the way social knowledge is developed whilst at the same time accepting other viewpoints enabling consideration of the personal knowledge and experiences of the participants in the research. The study of the social world on which this study is focused, is suited to a constructivist ontology and epistemology. Social constructivism emphasises the importance of culture and context in understanding what occurs in society. People construct their own understanding and knowledge of the world through experiencing events and reflecting on these experiences; constructing knowledge based on this understanding (McMahon, 1997; Derry, 1999). This perspective links with biographical/life history approaches because of the way people create meaning of their lives through narratives and is closely associated with developmental theories for example, Vygotsky (1978), Bruner (1986) and Bandura (1963; 1977). Constructivism within the interpretivist paradigm complements this study positively. From a phenomenologist perspective, the endorsement of the consideration of human beings in the research process reflects positive ethicism whilst recognising the contribution of narratives in understanding social phenomena.

### **3.4 The social construction of adolescence – a Foucauldian perspective**

There are overlapping themes which emerge when exploring literature around youth in society and studies of adolescence. Of particular interest within the context of this study is how young people are seen by society (or socially constructed) and how they see themselves. This is because it links to their perceptions of ‘self’ and ‘other’ and how they see themselves as an adolescent but also as an adolescent who has experienced mental health issues. In addition, their ‘place’ in their surrounding communities; where they live, study, socialise and work (Ball, 2000; Knowles and Sweetman, 2004; Henderson, 2007). Furthermore, there is the issue of social difference. Roche and Tucker (2001) suggest young people are not a homogenous group in (this) society, and whilst they are unified by their age, they are differently socially located in terms of class, gender, ethnicity, sexual orientation and disability.

The theme of social construction is central here to how the concept of youth is understood and the assumptions made about what adolescents are like.

For adolescents there are factors which impact on the development of their identity individually and 'life stage' (Frydenberg, 2008) so when participating in a research study such as this it is important to consider these. Frydenberg purports three categories of identity – achievement/academic identity, social identity and personal/relationship identity and in this, how they view them 'self' and 'other' and where they fit in the wider context. Foucault's (1976) 'technologies of the self' extends this. One of Foucault's major contributions to academic thinking was his foregrounding of the human body as a site of power operations and recognition that power does not exist outside of or is separate from an individual body, as a repressive or an oppressive constraint. Foucault believed power is a complex force, which is ever present and enables us to develop our human nature in relation to other human subjects and to consider the notion that power works directly upon bodies whereby 'self' and 'identity' are always embodied. Foucault's work challenges the traditional concept that the 'self' is an inner essence or some sort of mental phenomenon which exists, 'inside the body'; drawing upon this challenge, he argues that the physical body is the surface, upon which our selves are constructed. Therefore our 'selves' are classified, managed, regulated and disciplined by others, but also ourselves.

To explore and extend this thinking further within the context of this study, and considering Foucault's idea of the conjoined relationship between knowledge and power and the belief that these are inseparable; *'Knowledge of ourselves and of others is never simply a neutral or objective understanding. Rather, this knowledge is always bound up with our specific historical and cultural location'* (Foucault, 1976:158). Foucault demonstrates an example of this in his analysis of the history of sexuality, which shows how within different cultural and historical contexts particular ideas about sexuality emerge and function as 'truths' (Foucault, 1976). Considering the implications in relation to this study, there are parallels evident between meaningful statements; he illustrates how something (sexuality) which is a private, personal and fundamental aspect of our being, is the product of a wider network of 'disciplinary practices'. In applying this in the context of this study, it becomes two-fold; in the first instance in relation to adolescence and identity and secondly, the classification of

mental health; particularly pertinent from a Foucauldian perspective given society's need to classify, regulate and discipline its population and whether an adolescent disclosing they have had a mental health issue, places them in the 'self' or 'other' category.

### **3.5 Arriving at a methodology**

The methodology was selected having considered the advantages and disadvantages of differing approaches and the qualitative approach adopted here shares some similarities with the broad aims of phenomenology, however it is not a phenomenological study. The phenomenological method is consistent with this study because phenomenological approaches can be applied to single cases or purposefully selected samples. Employing this method impacts positively in enabling the illustration of issues with a small sample of participants and is a robust method in illuminating factors and their effects in individual cases (Lester, 1999). A variety of methods can be employed in phenomenologically focused research; one specific to this study includes interviews with student and staff participants (Spradley, 1979). Other principles espoused include minimum structure with maximum depth, the establishment and maintenance of researcher and participant rapport, demonstrating an empathic, humanistic approach (Rogers, 1945); particularly where a participant has a significant personal stake (applicable here to both students and staff).

Hayllar (2000) suggests quantitative approaches lack sensitivity and whilst useful in creating statistical landscapes, provide a shallow picture of events. The rigidity of quantitative approaches, fail to match the fluidity of personal experiences qualitative approaches do. This latter approach promotes the collection of rich, informative data, enabling the researcher to compose a thick description (Geertz, 1993) and uncover the subjective experiences of participants. Analysis of phenomenologically gathered data is consistent with the data analysis method employed in this study (see chapter 4), the outcomes of which enable the researcher to make detailed comments about individual situations. What is significant about this method is the recognition and acknowledgement of researcher positionality and reflexivity; acknowledging the personal and subjective interpretation of the data and the exposure of phenomena which may or may not be occurring elsewhere, without proffering generalisable research outcomes. An emergent qualitative design was adopted for this inquiry

allowing the structural framework to be flexible (Brannen, 2005); an approach supported by Denzin and Lincoln (1998:2).

*“The multiple methodologies of qualitative research may be viewed as a bricolage and the researcher a bricoleur....the bricoleur produces a bricolage...a pieced together close knit set of practices that provide solutions to a problem in a concrete situation.”*

The solution (the bricolage) which is the result of the bricoleur’s method is an emergent construction that takes new forms as different tools, methods and techniques are added to the puzzle and the choice of these are not set in advance (Weinstein and Weinstein, 1991). Some elements of what Denzin and Lincoln and Weinstein and Weinstein propose are relevant to the development and selection of my research methodology within the paradigms of my ontological and epistemological position. From the outset when planning this study, a social constructivist approach was adopted from my (researcher) perspective enabling the facilitation of a congruent and transparent research process.

### **3.6 Case study as methodology**

Yin (2009) suggests as a research method, case study methodology is well established in the social sciences helping to inform practice by examining real life contemporary phenomena in depth, to elucidate detail (Flyvberg, 2006). However Stake (1994; 86) argues case study is not a methodological choice but a choice of object to be studied, suggesting the term ‘case study’ is emphasised because it draws attention to what specifically can be learnt from a single case (Tellis, 1997); in this case it is an intrinsic study (Stake, 1995; Denzin and Lincoln, 1998b) which is exploratory and descriptive (Yin, 1994), designed to optimise understanding of the case rather than looking for generalisations beyond it (Welsh and Lyons, 2001).

Among social researchers, case study research has a wide variety of interpretations including a deceptively simple definition provided by Johnson and Christensen (2008:406); *‘[case study] is research that provides a detailed account and analysis of one or more cases’*. A case may be an individual, a group of people or an institution, for example a school or college. It could also be an agency such as a local authority

childcare service or even on a far greater scale, a whole education system. Stake (2006:1) considers each of these kinds of cases as a 'bounded system', comprising complex interrelated characteristics or elements, which has clearly identifiable boundaries and its own codes of practice (Lave and Wenger, 1991). Furthermore, being clear about what constitutes the distinctiveness of the case to be studied avoids confusion between a case study and a research project, which simply comprises a small participant sample.

Case studies are firmly located within the category of qualitative research (Stake, 1995) but Yin (2003) opposes this position challenging the notion of solely qualitative location, suggesting case studies can be based on any combination of evidence including quantitative. According to Stake (1995) three categories of case study can be identified in terms of their broad purpose; intrinsic, instrumental and collective. In an intrinsic case study, the researcher's aim is to achieve a comprehensive understanding of a particular individual or agency. This corresponds to Yin (2003:3) who defines this example as 'a descriptive case study'. An instrumental case study according to Stake (1995) is where the use of the particular case is an attempt to understand something else and therefore the case study is a means to end, not an end in itself. Yin (2003) defines two further types of case study within this category; exploratory and explanatory. Bassey (1999) describes exploratory case studies as theory seeking and explanatory case studies as theory testing.

Stake's (1995) collective case study refers to research involving a co-ordinated set of case studies, later described Yin (2003) and Stake (2006) as multiple case studies. The advantages of studying more than one case are three fold; cases can be studied comparatively in order to explore similarities and differences, if the purpose is to test a theory, numerous cases provide a more convincing test than just one and generalisable claims can be made more substantially and convincingly, aggregating evidence from a number of individual case studies (Johnson and Christensen, 2008). Therefore, the choice to conduct a small scale, intrinsic case study is based on a number of factors. In the first instance, a desire to seek and gain a comprehensive understanding of, 'the particularity and complexity of a single case [Wenhill College]', (Stake, 1995:11); to examine in depth the intrinsic uniqueness of the individual case and not attempt to make or suggest generalisations. This decision was based on a

number of further contributing factors; sole researcher insider role, capacity, resources and accessibility.

Although the setting provides boundaries within which data can be connected, the researcher has to do the connecting as the social world does not have a ready made sense which the researcher simply needs to record. Therefore to help me make sense of the data, a multifaceted approach (triangulation) to data collection (and subsequent analysis) was employed; increasing and enhancing the validity of this qualitative study, achieving and comparing '*multiple perceptions*' of the same phenomenon (Stake, 1994:214). Using this approach creates a thick description of the setting and events. Geertz (1973; 1993) takes the use of thick description from philosopher Gilbert Ryle (1968). A thin description does no more than report the event (in limited terms) whereas, thick description goes deeper to analyse the meanings. In order to make interconnected meanings across the data, Geertz asserts it is about 'working the data' appropriately and that an essential ingredient is thick description – a notion adopted more so by qualitative researchers in recent years.

*“A thin description simply reports the facts independent of intentions or circumstances. A thick description in contrast, gives the context of an experience, states the intentions and meanings that organised the experience and reveals the experience as a process”*

(Denzin, 1994:505)

To arrive at a thick description, the researcher will consider many facets, which make up the full social complexity of a phenomenon (Stake, 1994; 2006) and data must therefore be collected to reveal all these aspects (Holliday, 2005), as is the case with this study. Bounded social settings, such as Wenhill College, provide an important *means* (my emphasis) for thick description. It is by seeing how connections between people, beliefs, images and traditions (Flyvberg, 2006) operate within a small social setting that the '*collective representations*', thick description aims to reveal (Atkinson and Coffey, 1996:52). Furthermore, Blaikie (2000), Mason (2002) and Cresswell (2003) argue that good methodological practice is to choose a method appropriate to the research question. They recognise that the research design is not only the plan made at the start of the study but includes changes made throughout the course of the study and in doing so, allowing the structural framework to be flexible (Brannen, 2005). This is applicable here, enabling answers to the primary research question

using life history interviews accompanied by life path continuums with student participants and a semi-structured interview schedule with staff.

This study included more than one sample group and a diversity of participants, through which data was gathered by differing means. Having considered various methods of data collection approaches and instruments, I opted to use two main data collection strategies; life history interviews and life path continua with student participants because I could engage with a smaller number of students thus eliciting in depth, richer data and semi-structured interviews with staff which created a structured yet flexible interview framework, creating consistency yet allowing for individual extension of ideas, opinions and perceptions (Baker, 1994; Denscombe, 2010). Demographic data was also gathered from each participant and contextual statistical data from the case study college (see later sub sections for discussion). In a qualitative study the decision regarding the number of participants in the study becomes a reflection of the study's purpose as is the case with this small scale, multi-dimensional, intrinsic case study (Yin, 1994; 2003; Stake, 1995). The following section discusses my reasons and appropriateness of the employed approaches.

### **3.7 Narratives with life path continuums**

Young people are arguably marginalised in terms of their social, cultural and ideological 'power' (Goodson and Sikes, 2001) and further marginalised or their voices absent from research and literature (Corbett, 1996). Recognising that some voices are difficult to hear because of lack of conventional communication resources, hesitant or inarticulate delivery and marginalised social status, links with the nature of this study and its relation to adolescents experiencing mental health issues (Charmaz, 2008). As interest in the voices of young people increases in popularity (LSC, 2002), so has the interest in methods for engaging with those voices whereby participatory methods aim to reflect, explore and disseminate the views, concerns, feelings and experiences of research participants from their own perspective (Swain and French, 1998), promoting expression of and celebrating hidden or 'silenced' lives (McLaughlin and Tierney, 1993) in addition to exploring the relationship between culture, social structures and individual lives (Dollard, 1949).



Using biographical research methods in the form of life stories and consequently producing narratives, provides a meaningful way for the student participants to tell their life stories retrospectively and contribute to a better understanding of their 'lived' experiences (Van Manen, 1990) through these stories and of their mental health, life and educational experiences (Admi, 1995). Family stories also feature in narratives, whether health or research focused (Clandinin and Connelly, 2000:112); stories handed down across generations about family members and family events, shared when giving an account of personal experiences and shaping personal identities. This approach lends itself positively to exploring the experiences of young people who have or who are experiencing mental health issues as it allows a humanistic relationship to develop between the researcher and respondent (Miller, 2000).

Pennebaker and Beall (1986) and later Pennebaker (2000) observed that when people put their emotional upheavals into words, their physical and mental health improved markedly, a view supported by Baikie and Wilhelm (2005). In health studies, when people are asked to talk about their health/illness experiences in their own terms, verbal and/or written expression of the story of what happened provides the context to what comes next – the actions of the patient and the care giver to facilitate healing, and recovery, very much carried out with treatment intentions at the fore (White and Epston, 1990). Beach *et al.* (2006) describe the telling of a life story benefits both the practitioner and the patient and the opportunity for an individual to tell, re-tell their story and express their emotions can be therapeutic in itself (Morgan, 2000). Furthermore, Frank (1998) reported how the act of patients telling their stories allowed them to distance themselves from their illness, in some cases allowing the patient to disassociate themselves from negative experience, even trauma and provided space to reflect on what was happening to them and how their life stories are changing. For many patients, the constructing of stories around illness provides the opportunity to describe illness as part of their overall story, rather than illness as the whole story (Egglely, 2002; Rimmon-Kenyon, 2002) and in thinking about stories as a platform for connecting patients and care givers. Fredriksson and Eriksson (2001) describe this encouragement and subsequent listening and 'taking in' of the patient's story as an interchange between the patient and caregiver; as a conversation where both can caringly explore the context of their conversation, to find meaning in the suffering described within.

### **3.8 Life path continuums (LPCs)**

Historically life path continuums have traditionally been used in a variety of fields including neuro-linguistic planning, spiritual studies (of the self) and career development; the latter embracing the philosophy that the career development process is continuous and constantly reshaping, being inexorably entwined in the personal development of the individual. Their use has gained prominence as a therapeutic tool, providing a focus for interventions in social gerontology, counselling, genealogy and health practice, in particular, mental health. Current debates in health include the potential disadvantages of not including life path continuums, whereby exclusion reduces ‘connection’ between the patient and caregiver, resulting in reduced communication, less accurate information and missed opportunities for meaningful therapeutic relationships (White and Epston, 1990). Comparably, by ‘acting’ narratively, patients are encouraged to extend control over their lives and bring shared meaning to their illness (Martin, 2010).

Furthermore, life path continuums could be considered an artefact, “...*an archaeology of memory and meaning*” (Clandinin and Connelly, 2000:114) because it is produced for purpose in the context of narrative inquiry and its contents remarkable to the individual – the conceptual contents of a person’s memory box, contributing to memories around which stories are constructed. By selecting to use this accessory, my aim was to combine the visual with the interview, thus creating visual data (Plummer, 2001). Each participant’s life path continuum was (and is), unique and created a visual representation of their life from birth to present, thus combining verbal and visual data, which McAdams (1985) refers to as ‘nuclear episodes’ often identified as specific (auto) events. Goodson and Sikes (2001) consider there is a need for providing an historical context and to contextualise changing lives in time and space. Life path continuums assist in contributing to the ‘construction’ of an individual’s personal history; assisting the researcher in locating the story as a life history or narrative within an historical context (Allport, 1942).

Ultimately, the life path continuums were employed for eliciting in-depth data and explanations whilst allowing the participants to maintain the central locus of control, assisting in the equal distribution of power (between the researcher and the

researched), effecting concerns that some, if not all the participants, may treat the process as if it were a therapeutic intervention; the strength of which lay in personalising the research approach and empowering the participants, rather than incapacitating them (Wiles *et al.*, 2008).

Employing these approaches draws on a variety of strengths, thus creating and exploiting the advantages in the methods employed. The transferability of these approaches from health to educational research assist the engagement of adolescents with the research, reducing power (researcher), eliciting rich, in-depth data from a small group of adolescents and helps '*...get a better fix on the subject matter in hand*' (Denzin and Lincoln, 1994:2). Furthermore, gaining 'a measure' of the individual's experiences, the peaks and troughs in relation to personal and education experience and cross referencing data between the narrative(s) with life path continua. The specific employment of life path continuums as a research tool creates a visual representation of one's life and a focus for the student participants assisting in allaying student nerves and anxiety. Preparation prior to meetings created some level of what to expect - that they would talk about themselves and their experiences. Each student was asked to prepare a life path continuum. The format was not prescribed and therefore a variety of different life path continuums were individually presented at interview. Some adopted a horizontal 'time line' from birth to present day, another, a vertical structure; others, a selection of cards, each one representing a year of their life (see list of illustrations on page 206).

### **3.9 Semi-structured interviews with staff**

A sample of staff were interviewed using a semi-structured interview schedule (Appendix 9) which has distinctive features and focussed on the participant's subjective response, allowing me to take an active role, introduce explicit verbal cues to stimulate discussion and probe for further information, where necessary, relating to the research topic (Merton and Kendall, 1946; Bell, 2005). As Denzin (2009) notes, data collection through interviews is an interactive activity which depends significantly on the variable personal and situational properties of the interaction between interviewers and participants.

Employing a semi-structured interview approach outweighed other methods of data collection as it allowed for opportunities to ‘access what was inside a person’s head’ (Tuckman, 1972) and encouraged participant reflection, within the appropriate context of ‘research intimacy’. An unstructured interviewing approach with staff was avoided as appearing too casual may question my professionalism, even though the intention was to maintain a relaxed and non-threatening process as possible (Gleeson *et al.*, 2005). Bochner (2001:152) suggests methodological rigour should be applied to encourage a sense of the author, their subjectivity and emotional credibility thus helping to create an agenda where ethical self-consciousness and respect for others are evident. Preparation was key to this approach and organising the structure, content and procedures in advance provided structure without rigidity and room for flexibility; an iterative style of eliciting data (Kerlinger, 1970; Moser and Kalton, 1977). As discussed earlier in this chapter, the purpose of interviewing staff formed part of the multi-faceted approach to compare multiple perceptions (Stake, 1994) and to create a thick description (Geertz, 1993; Denzin, 1994) within the bounded social setting of Wenhill College. Within this approach the ‘expert view’ of the college counsellors was also sought and formed a purposive staff sample.

### **3.10 Ethical considerations**

This section will consider a range of ethical issues and dilemmas relevant to this study, their contextual pertinence and how I as the researcher, positioned myself ethically within the research, giving consideration to employing elements of clinical theory in the context of this study. It is important to note that I have not employed psychological terms diagnostically in the thematic analysis of the data. My interest in mental health and critical theory has informed my interpretation of the interview material, but it has not been used to come to a clinical diagnosis of individuals. It is a speculative analysis of a psychosocial process as I see it in this case.

There are numerous accounts across the literature of challenges relating to ethics and how to manage these, including informed consent, confidentiality, anonymity and gaining access and there are particular issues that arise in relation to biographical research and narratives (Goodson and Sikes, 2001; Bathmaker and Hartnett, 2010; Sikes, 2010), working with adolescents (Corbett, 1996; Goodson and Sikes, 2001;

Haglund, 2004) and working with adolescents experiencing or have a history of, mental health issues (Fisher *et al.*, 1990; Hoagwood *et al.*, 1996; Frydenberg, 2008). I will address each of the ethical issues in turn; seeking organisational consent and gaining access, researching from within, anonymity and confidentiality, identification and recruitment of participants, informed consent, research methods, balancing research risks and benefits and disseminating results. However firstly, I wish to discuss and consider the contextual relevance of ethics in relation to my study.

What is not in doubt across research literature is the importance of ethical considerations when carrying out research (Levine, 1979), particularly where people are involved ([www.canterbury.ac.uk](http://www.canterbury.ac.uk)). Understanding and solving ethical issues by not viewing these merely as a set of professional procedures, acknowledges ethical issues and their solutions arise from and are determined by, the structure of the social situation and relationships in which the problems are embedded (Simon, 1989; Hoagwood *et al.*, 1996). Situated ethical approaches emphasise that ethical decisions are contextual and ethical issues are not neatly defined or delineated. Erikson (1967) suggests ethical issues have a social structure and meaning requiring interpretation and that research should be facilitated in an ethically correct and transparent manner, enabling all participants' fair and equal treatment. Simons (2009) proposes that ethics concerns the way we behave towards other people and how we conduct ourselves in the context of professional practice and research. Trust and respect are essential elements in developing positive research relationships with participants and meeting demands to facilitate high quality and ethically appropriate research is desirable (DH, 2005; ESRC, 2005).

Researchers working in academia enjoy a number of important freedoms and privileges, which are essential in maintaining the independence of the education research community ([www.canterbury.ac.uk](http://www.canterbury.ac.uk)). These freedoms include freedom of inquiry and to disseminate their findings, to challenge conventional thought and to conduct research on/with human participants. These freedoms carry significant responsibility and it is essential that such research meets high ethical standards and implies a duty to ensure veracity, integrity, objectivity, accountability and openness parallel to thoughtful inquiry, rigorous analysis and the application of professional standards (DH, 2005; ESRC, 2005; NMC, 2008).

Professional regulations and ethical codes, including those for research tend to include detailed rules and these are more specific and limited in scope than the philosophical principles which underpin them (Punch, 2013). These have evolved within the context of professional bodies and in response to variously scandalous and exploitive studies carried out during the mid twentieth century which would now be viewed as unacceptable research practice. Registering and regulatory bodies (such as the Nursing and Midwifery Council (NMC) who I am bound to professionally because of my mental health nurse registration) apply a deontological approach to ethics; essentially a duty based ethos whereby an individual's professional code of conduct, responsibility and accountability remains intact, regardless of the context they are facilitating the research within (Steinbrook, 2002).

One of the recognised challenges of conducting 'clinical type' research in educational (and other) settings (Eby, 1991), is that unpredictability is commonplace and applies to many elements of qualitative research including case study research (McDonnell *et al.*, 2000). Ethically sound research cultures support virtuous research practice and there are no singular sets of principles or codes to capture all this (Punch, 2013:40). Rosenfield (1992) suggests that interdisciplinary research may be a means to increase the validity and visibility of ethics (in) research; recognising that inter, multi and trans-disciplinary research enriches our grasp of the moral complexities of different professional views, acknowledging and accommodating various professions and developing a shared approach to ethics (Smith *et al.*, 1999). Research facilitated by nurses, for example in social research, recognises the diversity and transferability of research skills and ethical codes (Eby, 1991), and of the complexities involved in facilitating nurse led research in settings other than clinical practice.

Ethically sound research is about recognising your own values, attitudes, beliefs and perceptions and in doing so, acknowledging that as a researcher you are inextricably linked to the research phenomena, regardless of whether you are researching it as an insider (as is the case here) or from an external position. Furthermore, it involves respecting the ethical requirements of the participants and setting, abiding by professional codes of conduct and not harming or exploiting participants.

Hayes (2006) suggests that in practice, case study is complex, often employing a range of different research instruments and strategies, adding complex dimensions to the ethical considerations required when planning case study research. Hayes further suggests that case study research requires consistency with in-built flexibility to ensure the many facets of ethics are proactively addressed and coherently managed. As the researcher (and employed as a tutor within Wenhill College) I was inextricably linked and part of the phenomenon; as such, an active participant and Hayes (2006) suggests, case study method needs to take close account of the researcher, particularly in respect of participant recruitment, data analysis, research outcomes and dissemination of results.

### **3.11 Seeking organisational consent and gaining access**

Before any field work could commence, ethical approval was required from both the university and participating case study college. In the first instance, I applied to the School of Education and Faculty Ethics Committee as per the British Educational Research Association guidelines (BERA, 2004). These guidelines create a framework within which all educational research should be conducted, guiding researchers on their conduct in relation to their responsibilities to participants, sponsors of research and to the community of educational researchers. Study approval was granted on the condition that participating adolescents must not be actively experiencing mental health issues or be in receipt of any clinical treatment for their mental health issues, during the data collection phase of the study.

The interest shown in my study by Wenhill College was encouraging. However some concerns were expressed in relation to protecting the identities of participants, the wider student and staff population and the college as a whole. This institutional anxiety was understandable because ultimately the college was vicariously responsible for allowing access to its student and staff population and data, to carry out the proposed research. Furthermore, as a member of staff, I was an 'insider' and this contributed to the complexities around authority, responsibility and liability (Riddell, 1988). It became evident during this phase where the college's most heightened anxiety stemmed from. The main concern expressed by the college was the protection of participating adolescent students, some of who may be considered vulnerable or at risk from harm, by engaging in the research process. The conditions

stipulated by the University Ethics Committee helped create a climate of reassurance in protecting and safeguarding such participants. The college also upholds and works within the Fraser Guidelines (1985) in addition to assessing individual Gillick competency<sup>9</sup> if required. The implications of such indicate whether or not a child or adolescent has the maturity to make their own decisions, to understand the implications of these decisions and to participate voluntarily (Cornock, 2007; Taylor, 2007; NSPCC, 2009; 2012). The Fraser Guidelines are applicable to both fields of education and health and therefore my professional conduct as teacher, tutor and researcher, with a clinical background in mental health nursing, were bound by these. Whilst I did not intend to interview participants under the age of sixteen, awareness of and compliance with these guidelines was paramount.

Although not employed by Wenhill College as a Mental Health nurse, my active nurse registration and previous clinical experience contributed to the ethical considerations and expectations of my code of conduct within this research process. Not only bound by the University Ethics Committee which extended to Wenhill College as an educational institution, I was also bound by the Nursing and Midwifery Council Code which underpins standards of conduct, performance and ethics for nurses and midwives (NMC, 2008). Based on my nursing experience, I was concerned that by asking student participants to reflect on their life, including their experiences of mental health issues may result in some, if not all of them, needing additional support outside of the research process and also raised the question around personal disclosures. Whilst planning the research I recognised the methods employed for data collection may give rise to the resurfacing of emotionally provocative experiences. Therefore during the planning phase, I ensured that any adolescent participants requiring support during and/or after the data collection phase would be seen and supported by a college counsellor or where appropriate and expressly preferred, a staff member from the local Connexions Service.

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<sup>9</sup> Gillick competency and Fraser Guidelines refer to a legal case in 1982 which looked specifically at whether doctors should be permitted to provide contraceptive advice and/or treatment to girls under the age of sixteen without parental consent. The Gillick competency standards and Fraser Guidelines are widely used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.



It is not sufficient to consider ethical issues simply in terms of codes and rules. This is the case in this study where further steps were taken to ensure appropriate standards of conduct were maintained and moral dilemmas managed by recognising rules and principles are inherently part of the process; rules are 'more specific' whereas principles embody the values of the researcher and the environment in which the research is carried out (Pring, 2003). Burgess (1989) identifies ethical approval within the context of 'guidelines, codes and laws', and the role of professional bodies and associations in moderating research activity while protecting the participants of research investigation. Whilst it is important to note that codes of professional practice and research 'bodies' such as BERA and the NMC are evidently regulating individual practitioners and research groups, researchers must take responsibility for their (research) activities and be accountable for their practice (Gilbert, 2005). Self regulation is essential in maintaining professional conduct and integrity; avoiding deception and creating transparency, ultimately enhancing the validity of a study. The combination of the BERA Ethical guidelines, the University Ethics Committee approval, the NMC Code (of Conduct) accompanied by a clear research proposal and plan, reassured the College satisfactorily and approval was granted to go ahead.

### **3.12 Researching from within**

It became apparent early on that identifying, addressing and managing ethical issues would not merely be a set of hurdles to overcome in the planning and gaining approval stages but would emerge as an ongoing thread throughout the research process. Riddell (1988) discusses the concept of ethics and researching from within including privacy, confidentiality, honesty and power whereby the potential and real issues relating to the ongoing negotiation of access is strongly linked to her previous role of a teacher in one of the secondary schools in her study but also her positionality and the almost privileged opportunities she felt she could take because of her role within the institution. As an 'insider' I have been privileged with these opportunities although always endeavoured not to knowingly abuse the opportunities the role brings and be able to alternate between immersing myself in the research and withdrawing to reflect whilst carrying on with my 'everyday role' (Boucher and Smyth, 2004). In doing so, recognising that by undertaking research from this perspective, as a researcher I already had attachments to and involvement with the institution (Sikes and Potts, 2008) and a complex 'dual role'.

These attachments gave rise to opportunities which resulted in positive outcomes. I was able early on whilst seeking study approval to ‘make ground’ in raising awareness of the possibility my study would take place. This heightened awareness amongst the staff and student population, prompted queries and clarification. However, this activity also raised questions from people around trust. *Why was I planning to carry out a study of this nature and for whose benefit? If I take part, will my job be safe? Who will know I have taken part in this study?*

The timing of my study came when Wenhill College was experiencing a period of amalgamation and restructuring including compulsory redundancies; understandably staff were suspicious of my intentions and potential study outcomes. On reflection, this was not a particularly conducive period or environment for facilitating research (Scaife, 2004). There were also issues around trust for potential student participants including the possibility that participation may have negative individual impact on their programme of study and effect possible achievement and success.

### **3.13 Anonymity and confidentiality**

Protecting identity and ensuring anonymity and confidentiality is essential in my study because of the nature of the topic and were proactively managed in a number of ways; recognising this is not solely limited to individual participants is key. However, complete anonymity of informants is difficult. How can one completely anonymise someone you have met and interviewed? This raises issues around power and the role of the researcher as well as participant identity and vulnerability. (Goodson and Sikes 2001:91) refer to this issue “...*knowledge is power and knowing something about someone puts the researcher into a potentially powerful situation.*” in this example, their (physical) identity.

To ensure student participant anonymity and confidentiality, I encouraged them to decide on their own choice of pseudonym, which I could then use when referring to their story in the text. My reasons were two fold; in the first instance in an effort to protect their identity and comply with good research ethics, and secondly, it provided the student participants with (an element of) control, which I felt was important within the wider context of the research process and ‘researcher power’. In addition, when

writing about the college the pseudonym Wenhill College has been used. Protecting the identity of the college is more difficult because it is identifiable on a number of levels. In reality pseudonyms and other attempts to disguise identities can only really work in the wider context, where readers do not personally know, or know of, the people concerned. In all likelihood, anyone who is an insider will be able to work out who is whom.

Tolich (2004) usefully distinguishes between ‘internal’ and ‘external’ confidentiality, where the internal refers to the web of relationships which allows insiders to identify who is being described. Arguably, assurances of participant confidentiality can only be partial yet should be of paramount importance for consideration to the researcher. There is considerable potential for harmful fallout from identification of participants with serious consequences between the researcher, the participants and beyond (Sikes, 2010). Hence caution will need to be exercised in the external dissemination of research findings. Protecting anonymity and confidentiality extends to obtaining, recording, storing and using data generated by a research study; employing the Data Protection Act (1998) ensures good data handling practices and was employed throughout. This continues in the safe-keeping of all data collected and for reference purposes.

### **3.14 Identification and recruitment of participants**

Recruiting people for participation in research has the potential to violate participant privacy, especially when prospective participants are identified within an ‘exclusive’ population even though their participation is voluntary. Prospective research participants may also be at risk of harm from recruitment procedures inadvertently revealing socially damaging information. Researchers have a duty of care and responsibility to ensure prospective and actual research participants are safeguarded from harmful processes, ensuring good research practice and ethical procedures are abided by throughout (BERA, 2004; NMC, 2008).

A passive role in recruiting participants for my study was employed as I was aware that actively targeting specific ‘subject’ groups could be psychologically harmful for prospective participants and I wished to minimise this. The study was advertised across the college campuses, inviting potential participants to volunteer based on the

criteria given. Only then was a more active role of gatekeeper adopted to decide who could and would not be allowed to participate in the study. For student participants this was dependent on approved ethical study criteria; aged sixteen to nineteen, not actively experiencing mental health issues and not receiving any clinical treatment for their mental health issues. There were no specific criteria for staff participation.

The research participants in this study included students and staff; adolescent students studying programmes in health, social care and early years and staff variously employed across the college in a range of differing roles. The individuals selected for participation in the study are briefly introduced here and the following sections provide information about the participants and their recruitment. (Further detail is included in chapter 4; for students please see section 4.15 and table 3.0; for staff, section 4.16 and table 3.1. In addition, their individual narratives in chapters 5 and 6, respectively).

### **3.15 The student participants**

The research participants in this study included adolescent students aged 17-19 years studying full time within the department of Health, Social Care and Early Years. Six of them were pursuing a level 3, two year programme of study in health and social care and one, a level 1, one year programme in early years and childcare. Entry qualifications for the student participants onto their programme of study included direct access following GCSEs (5), GCSEs and a period in the Armed Forces (1) and the completion of the Pre-16 programme at the college (1). In respect of the non-intentional selection of health, social care and early years student participants, I acknowledge that my insider research positionality (Riddell, 1998) and established attachments to the department (Sikes and Potts, 2008) influenced the participation of these students because of the student – lecturer relationship (Lindsay, 2002).

The students who volunteered to participate were screened against the research criteria and selected because they fulfilled this (Silverman, 2006). The research was purposive (Denzin and Lincoln, 1994) and concerned with specific characteristics including the stipulations set out by the university research ethics committee. Whilst the parameters of my research guided me towards convenience and accessibility, life

history rarely involves a random sample of participants and this was the case here; the aim being to gain rich, in-depth data in relation to my research questions (Patton, 2002).

### **3.16 The staff participants**

The staff were selected owing to their willingness and availability to participate in the study. Their selection was in recognition of their experience in working with and supporting, adolescent students who had experienced mental health issues and of their expressed interest in the study topic. I had some experience of working with a small number of staff who participated, however most of those who participated were 'unknown' to me. In total, twenty three male and female staff participated, with ages ranging from 24 to 60 years. Their roles were varied and included lecturer, personal tutor, programme leader, student support assistants, learning support tutors, student liaison and retention officers, college counsellors and members of the college senior management team. The 'time in their current posts' ranged from 6 months to 9 years and of those participating, 18 were employed on a full time basis and 5 part time. All participating staff were employed on permanent contracts.

As previously discussed earlier in my thesis, my original plan was to facilitate a cross-college wide case study, including participants from all four campuses. The case in question evolved and was re-defined following completion of the data collection phase, resulting in the selection and use of data gathered from the students within health, social care and early years programme area and staff working with these student on campus one; five in total.

In some studies, incentives are offered for participation and used as a means of recruiting participants. However, offering inducements creates ethical tension between fair compensation for participant time and inconvenience and coercion to participate in research in which participants might not otherwise consent (Fisher, 1993; Grant and Sugarman, 2004). Should inducements be made, researchers should employ caution and awareness that 'payments', in whatever form they take, reflect the degree of risk, inconvenience or discomfort associated with participation in addition to the fact that there is little or no consensus on what constitutes fair incentives for research

participation (Macklin, 1981; Levine, 1986). No monetary inducements or similar (for example, taking part in a prize draw as a reward for participation) were employed in this study as it was felt to be inappropriate and coercive in nature. However, as detailed in the information leaflet for interested parties distributed during the recruitment phase (Appendix 1) highlighting to potential participants that *'by taking in part in this study young people and staff can help to shape the services and support networks within the college but also outside services too'* was.

There are other factors which could be viewed by participants as inducement, including the opportunity to have their voice heard, to influence policies and procedures and the potential therapeutic environment/ process in which they could tell their stories. These three factors were played out variously across the research process by differing participants and patterns emerged within specific subject groups. Most notably, student participants expressed their experience of participation as therapeutic and being able to tell their story (having their voices heard). For staff, including the college counsellors, the inducement for participants was the opportunity to influence Wenhill College policies and procedures.

### **3.17 Informed consent**

Informed consent procedures are required by regulatory and professional bodies to protect participant autonomy by ensuring the decision to participate is informed, rational and voluntary and researchers should be mindful of these requirements (Sikes, 2010). This should also include a comprehensive statement explaining potential risks and benefits to the individual participant (Hoagwood, 1996). Informed consent has become the primary means of ensuring participants are not victims of an imbalance toward greater risks than benefits (Freedman, 1975) and in protecting participants during the 'active' phase of data collection, to the dissemination of results and beyond. This study required informed consent on a number of levels including the University Ethics Committee, the college and individual participants.

Gaining consent in the context of research with adolescent participants who have experienced mental health issues is complicated because of the potential nature of their mental health state. Therefore information relating to the study should be presented in a manner that is appropriate to the language level and comprehension of the individual participant and where appropriate, his/her guardian. Sensitivity when

seeking consent is therefore paramount and researchers studying people with mental health issues or previous experiences of mental health issues, should be particularly sensitive to the potentially coercive nature of informed consent procedures.

Vulnerable potential participants may be concerned that failure to consent will result in the loss of services for themselves; researchers need also to guard against potential conflicts of interest that may impact on the perceived nature of participation. In relation to this study, some potential participants were wary and hesitant to participate because of several factors, including a possible invested interest in carrying out the research on behalf of and for the benefit of Wenhill College, and whether or not participating would influence their programme of study achievements/outcomes and accessibility in the future, to internal and/or external support services. This relates to the complexities of 'dual role' and 'researching from within' in addition to issues around trust.

Only when potential participants have insight into what the process entails can they make an informed decision and give consent. Enabling this to happen within my study, included available and transparent information via an information leaflet and in person (see chapter 4 for further information). This was extended to include professional, transparent and ethical codes of conduct, consent forms which were signed and countersigned to form researcher/participant contracts and clear statements assuring participants of their rights, including their right to withdraw without providing reason, at any stage of the study (Sikes and Potts, 2008).

However, participants wishing to withdraw from a study may find this difficult for a variety of reasons and particularly if the consent to participate has been sanctioned by an authority figure (Ford and Reuter, 1990). Once an individual has agreed to take part, they may feel obligated to continue, especially where they know the person carrying out the research and subsequently feel guilty about not taking part. In respect of my study, this may have occurred however I am unable to objectively state if this was the case as no student participants sought to withdraw or withdrew their participation. The blurring of boundaries across roles between students and researcher may present conflicting interests and therefore should be managed in a proactive and

coherent manner; I was at pains to ensure that all participants in my study were offered opportunities to withdraw under ongoing process consent where reiteration and reassurance provided key support mechanisms (Please see Appendix 3 for written clarification).

### **3.18 Research methods**

Two main forms of data collection were employed in this study; 1:1 semi-structured interviews with staff and biographical research interviews with student participants. My focus in this section is to identify and discuss the ethical issues which arise when using this latter method and how the ethical issues were managed within this study. Blaxter *et al.* (2003) suggest that ethical issues are not solely about protecting the privacy and rights of individuals but also relate to the methodological principles underpinning the research design. In my view, this reduces the compartmentalisation of privacy, protecting identity and ensuring anonymity and confidentiality and creates an interweaving thread of ethical considerations throughout the research process, including the methodological approaches and choice of methods.

Biographical research in whichever guise is a holistic, dynamic process incorporating the participants' retrospective life experiences and the researcher's interpretations (Admi, 1995). The level of intimacy involved in this form of research increases the potential for harm and as a result poses a batch of ethical questions (Goodson and Sikes, 2001). This method facilitates the gathering and study of lifelong data allowing researchers to explore a variety of experiences and relationships and to examine changes over time (Haglund, 2004). To use the metaphor of a life as a text suggests it is rooted in the work of anthropologists such as Winner (1978) Bruner (1986) and Brown (1987) whereby human experiences can only be expressed and understood through symbolic statements, which are in essence social texts (Muchmore, 1999).

There are methodological issues to consider when engaging in biographical research (Miller, 2000). Munro (1998) reflects constructively that he cannot 'collect' lives and that narrative does not necessarily provide a better way in locating the truth, acknowledging that '*all good stories are predicated on the quality of the fiction.*' He suggests that we all live many lives and that these lives cannot be presented in neat, chronological order as this would serve as an act of injustice by trying to fit these



lives into categories and cultural norms. This highlights a number of issues relating to methodology and ethical practice within the context of biographical research, in particular the importance of focussing on the person (participant) as a whole and in doing so, recognising that the research is not solely about an individual's experience in relation to their experiences (of mental health issues). It is about 'the other things' in their life. Therefore the significance of contextualisation and not separating elements within his/her story is paramount to understanding a participant's life. This view is supported by Dollard (1949) in that biographical research offers a way of exploring the relationship between individual lives, social structure and culture.

Goodson and Sikes (2001) cite five key concerns in the context of biographical research, suggesting that these are generally understood as what constitutes a 'legitimate' focus/topic of research, the conduct of all stages and aspects of the research, the behaviour of the researchers, the standards and/or codes of practice, the broad issues of voice, values and validity. In addition to this, Plummer (2001) considers ethical issues in conjunction with reflexivity and power and how adopting different roles and developing relationships or not in research, can influence the outcomes of a study.

Chase (1996:46) explores these issues further, highlighting the link between participant vulnerability, interpretive authority and ethics. '*The extensive use of individual's stories in narrative research clearly renders participants more vulnerable to exposure than conventional qualitative studies do. In turn, this greater vulnerability makes more acute the question of who should control the interpretive process.*' The relevance linking to this study with a number of facets; adolescents' individual stories, the nature and topic of their stories (mental health), how these have been 'told', 'collected', interpreted, selected, re-told and disseminated.

Attending to a narrator's vulnerability is a complex process and includes issues around researcher power, positionality and reflexivity. Goodson and Sikes (2001) refer to power in a number of ways and not solely on the part of the researcher. They also refer to 'colonising' when discussing moving a life story into a narrative, which ultimately gives the researcher a great deal of power and the respondent very little.

Therefore it is important to recognise power and influence in many different contexts and not solely in the research person sense.

Atkinson (1998) refers to four key standards as described by Spradley (1979) when carrying out biographical research interviews. He concludes of the utmost importance is the 'storyteller' (informant). It is the researcher's responsibility to consider and ensure the rights, interests and privacy of the person telling his or her story. Secondly, safeguarding the story teller's rights and not exploiting these, for example in published extracts of the study. Third, clearly stating your aims, objectives, purpose and agenda for carrying out the research and ensuring the storyteller knows and understands exactly what you intend to do with his or her story. Finally, respecting the storyteller's rights to remain anonymous also honouring their wishes should they wish to make their identity known.

Research practice cannot be disembodied and it is impossible to take the researcher out of any type of research or the research process (Sikes *et al.*, 2003). '*..reflexivity and honesty about one's positionality and its role in sense-making are integral components of ethical practice.*' (Sikes, 2010:13) and because of this 'presence', the process is arguably contaminated in some way. Therefore the researcher's conduct and behaviour in the process must be morally and ethically correct. Sikes moves on to discuss life history work in a personal context and how writing about ourselves involves talking about and implicating other people, because what we do as individuals is rarely done in isolation; recognising and acknowledging the epistemological relationship is paramount because the role of the researcher is privileged. Furthermore as a researcher, being aware of the pre-empted assumptions and personal biases held about an individual(s), in this case, adolescents who have experienced mental health issues and how this may influence the research process.

This challenges Robert's (2002) view whereby traditionally researchers have held an objective role, involving questioning, interpreting and presenting the finished research text. Notably and more recently, the emphasis has moved away from this traditional approach whereby the researcher's presence in the research process is given focussed consideration and the potential influence this may have. Dollard (1949) and McLaughlin and Tierney (1993) and later Rosenthal (2004) refer to biographical

research as exploratory and expressive, a means by which researchers can on behalf of the informant highlight and create an understanding of individual experiences but recognise that intrusion takes place and not solely through the interviewing process but also by transcribing, editing and interpreting the data (Sparkes, 1994).

Goodson and Sikes (2001:20) suggest that the reliability of biographical research relies on the relationship between the researcher and participant. It is best suited to people who can listen attentively and beyond what is being said whilst not seeking to 'collect lives' (see also Munro 1998), in addition to '*...the willingness to share one's own experiences, if this seems appropriate.*' This creates a dichotomous situation – what should a researcher disclose about themselves in the interview process? Sparkes (1994) believes this may lead to 'narcissistic intrusion', directing the emphasis of the interview away from the participant, influencing the situation detrimentally for the participant in the first instance but also the researcher and the research process overall. The questions surrounding the validity and ethical practice of 'personal investment' and knowing how much and what to reveal about the self in sharing stories, creates aspects of vulnerability for the researcher as well as participants, in addition to creating a platform of responsibility on the part of the researcher but also one of considerable power (Goodson and Sikes, 2001).

### **3.19 Balancing research risks and benefits**

Carrying out research designed to describe, explain or evaluate the experiences of people, some of whom have experienced mental health issues, presents both the probability of benefits and risks for the research participant and tensions may be present around balancing participant protection and welfare and the need for the researcher to produce and expand scientific knowledge (Fisher and Rosendahl, 1990). Ethical justification for the conduct of research rests on demonstrating a favourable balance of risks to benefits whereby the dual moral principles of beneficence and non-maleficence are applied and research risks are reasonable with respect to the anticipated benefits to the research participants or to the wider community (Veatch, 1987). Whilst this study is not of a clinical nature, it has engaged participants who have experienced mental health issues and contingency plans considered the various potential risks associated with such a piece of work before commencing any fieldwork. Due consideration was afforded to various ethical issues including the potential

possibility of a participant making a disclosure during interview. Contingencies were put in place should this issue arise including direct access to a college counsellor or where expressly preferred, a member of staff from the local Connexions service.

In the context of my research, risk arises directly and indirectly. Fisher (1993) suggests research with people who have experienced mental health issues can expose participants to experiences that result in harm that is minor or serious, transient or permanent. For example in the context of minimal and transient discomfort, negative feelings associated with questions about personally distressing events. On the other hand less transient more serious discomfort for example, guilt or (inflicted) insight from recognising negatively perceived self-attributes, gained through the research process. Other risk factors include withholding treatment or preventing access to services, invasion of privacy and failure to protect confidentiality (Hoagwood *et al.*, 1996). These are relevant to my study because I am in no doubt that by selecting biographical research methods of data collection I am taking risks; risks based on a number of factors including adolescent participants, previous mental health issues, power, subjectiveness and credibility (Munro, 1998). However, it is about balancing risks with benefits by asking participants to talk about and discuss difficult experiences (Hoagwood *et al.*, 1996,) pursuing knowledge (Gilbert, 2005), making efforts to secure the well being of participants from anticipated risks and giving voice to silenced or hidden lives (McLaughlin and Tierney, 1993).

As mentioned earlier during this chapter, my perception is that ethical issues do not present themselves at the beginning of the research process in a neat, tidy set. On the surface they may appear straightforward but acknowledging these are complex and are interwoven throughout the research process, has enabled me to anticipate potential issues and pre-empt. To enable the completion of this study, justification was required to substantiate its purpose by demonstrating the benefits and potential risks to the individuals, Wenhill College, the university and myself and in doing so, the need to be proactive rather than reactive to these factors was paramount.

The aims of this study were to investigate the different types of mental health issues experienced by adolescents in further education from the staff and student perspective and how students who have experienced mental health issues, are supported by staff

and the wider college framework. The benefits or outcomes for participants were the opportunity to share their experiences, enhance knowledge and understanding of their experiences and contribute to the 'shape' of support services within the college.

In terms of identifying and assessing potential risk, by far the biggest concern was engaging adolescents who had experienced mental health issues, in the process, particularly as this could trigger false memory syndrome or 'saying what they think you want to hear' (social desirability) and includes a number of key factors, linking strongly to the issue of power. The nature of biographical research is that of a personal approach, carrying out interviews with various individuals on a one to one basis. This situation allows for influential control on the part of the researcher, in particular non-verbal communication. If the respondent is overwhelmed or 'overpowered' by the researcher, the environment or nature of enquiry, there is a significant possibility they will respond by telling the researcher what they think they want to hear. This behaviour potentially raises questions around validity and bias, even though the behaviour of the researcher may be on a sub-conscious level. Through this research process and choice of methods, the intention is to 'empower' the adolescent participants by creating an opportunity for individuals to tell their stories, express their views and influence how young people who have experienced mental health issues are responded to and supported.

The question of memory and its fallibility in recollecting memories and past experiences creates other difficulties for the researcher (Roberts, 2002). Issues arise around selected and falsified memories, how they are reordered and constructed on the part of the respondent (and researcher) and whether or not some or all is fiction (Robins, 1995). In addition, some adolescents' memories of their early childhoods are less clear than their memories of their school-age and adolescent years. This might make it difficult to date early experiences, to track where families have lived and moved from, and to understand early household composition (Haglund, 2004).

In order to manage these issues during field work, clear ethical boundaries were created and demonstrated throughout via written and verbal communication (Appendix 2 and 3) with all potential and actual participants. The establishment of concise research criterion for participation ensured safeguarding for both me and the

participants. My mental health nursing skills were put to good use during the recruitment and selection phase, particularly where potential student participants came forward as I was able to assess their suitability for participation. The ensured caveat for all participating students was access to a college counsellor or member of the Connexions Service, should they need support external to the research process.

### **3.20 Disseminating results**

Ultimately, this research is a systematic inquiry with my intentions clearly directed towards making public the findings (Stenhouse, 1980). This intention was clearly communicated to all participants both in written format and verbally before the study commenced and throughout (see Appendix 3). Openness and honesty are essential elements in retaining the trust of respondents (Hayes, 2006). As an insider researcher, making public study outcomes takes on a number of forms including compiling results for the host institution in the form of evaluative reports, writing my thesis and publishing in the public domain.

The participants here are not solely the individuals who agree to meet with me to be interviewed. This extends to the college as well because whole participation on a wider scale is clearly evident. Guaranteeing protection of participant identity and anonymity in addition to maintaining credibility raises further issues in relation to reflexivity, positionality and gatekeeping. My role and that of the college was one of gatekeeping, deciding on whether the research could go ahead and who could take part. In addition to this, reflexivity and positionality and where our roles were in the context of involvement throughout the research process and in disseminating the results, ensuring a credible inquiry from within.

Murphy and Dingwall (2001) and Gordon (2003) are clear about avoiding harm to participants, however they acknowledge that being written about, can be upsetting even startling. Whilst the participants in my study have yet to read about themselves within the context of the whole research process, their responses when transcripts were returned for review and feedback, were. Recognising themselves and their stories within the data was probable yet inadvertent. Whilst this may be the case with transcripts, Coffey (1999) suggests this is not always the case when their words and

stories have been placed in an analytical context. This is course dependent on how these are presented and which model for dissemination, is used (Hughes, 2003). Within the pages of these chapters, it would not be difficult for participants to identify their own stories and possibly that of others.

Good ethical research practice is not solely limited to the data collection phase. It extends to the dissemination of results and beyond. Consideration needs to be given to potential impact on participants (individual and the college) and damage limitation. The extension of good ethical practice around protecting identities, ensuring anonymity and confidentiality through the use of pseudonyms has its place but cannot guarantee complete anonymity (Sikes, 2010). Punch (2013) agrees, suggesting that promising confidentiality is idealistic yet should be pursued as good research practice and particularly in qualitative research where the depth of detail of participants may make it difficult to disguise and protect identities. Offering confidentiality and anonymity by giving pseudonyms and amending minor personal details goes some way in protecting participants' identities. The publication of results might expose individuals or institutions therefore it is vital to build in safeguards such as pseudonyms, anonymity and 'a right of reply' from key subjects of the study.

A final report/study is usually a compromise between what the researcher wants to say and what the institution is prepared to allow (Hayes, 2006). The qualitative case study researcher will tend to produce an account characterised by 'thick description' (Geertz, 2000) to convey the richness and depth of evidence and this is applicable to my research. Hayes (2006) suggests that ethical considerations are a significant challenge when arriving at the stage of reporting, making public and disseminating results. The distinctiveness of case study research makes anonymising the data challenging and problematic and every attempt should be made to maintain confidentiality, minimise harm whilst maximising the benefits of the research outcomes.

Minimising harm, also referred to as non-maleficence, reflects the duty to avoid, prevent or minimise harm to others. In practice it means that research participants must not be subjected to any unnecessary risks of harm; their participation in the research must be essential to achieving scientifically and socially important aims that

cannot be achieved without the participation of human participants. The principle of minimising harm also requires that the research involves the smallest number of human participants and the smallest number of tests on these participants that will ensure scientifically valid data ([www.canterbury.ac.uk](http://www.canterbury.ac.uk)). This is evident in this research where small groups of participants were selected and their participation whilst active endeavoured to limit what was required to fulfil the research aims.

The maximisation of benefit (often referred to as beneficence), imposes a duty to benefit others and in research, a duty to maximise net benefits. Care must be taken to ensure that the intention of research is to generate new knowledge that will produce benefits for participants themselves, for other individuals or for society as a whole, or for the advancement of knowledge ([www.canterbury.ac.uk](http://www.canterbury.ac.uk)). The anticipated outcomes and benefits for participants in this study included the opportunity to share their experiences, enhance other's knowledge and understanding of their experiences and to contribute to the 'shape' and provision of support services within Wenhill College. Furthermore, within my research, all reasonable attempts have been made to maintain confidentiality and anonymity; pseudonyms have been employed within the thesis in addition to minimising the range and depth of demographic data provided across chapters 4, 5 and 6 where participant information and narratives are presented respectively.

### **3.21 Concluding remarks**

My intention in carrying out this research is to develop a deeper understanding of the experiences of adolescents who have experienced mental health issues and who are studying within a further education environment (Wenhill College). I am hopeful that the dissemination of study outcomes will influence the management of adolescent mental health issues across a wider field within the further education sector; avoiding 'grand generalisations' whilst recognising and acknowledging the possibilities and limitations of case study research (Stake, 1995). The following chapter explains the rationale for this study; the context of the study and research design including the setting and participants, the procedures and instrumentation used in addition to quantifying the internal and external validity of this study.



## **Chapter 4**

Research design and methods

### **4.1 Introduction**

This chapter explains the context of the study, research design and methods including the setting and participants, the procedures and instrumentation used in addition to

quantifying the internal and external validity of this study. The choice of study topic outlined in the previous chapter, is based on the primary motivation to explore student lives in relation to their education and experience of mental health issues. It is fuelled by a personal, individual and professional desire to further understand the nature of mental health issues experienced by adolescents studying within the further education sector and the relationships between adolescents, further education and mental health.

### **Context of case study**

Wenhill College is a large further education establishment offering full and part time courses for 16 to 19 year olds and adult learners aged 19 plus. These are predominantly vocational courses however some traditional academic routes, for example GCE A levels, are provided. The college is located in the south west region of England encompassing a large geographical catchment area. It includes four main campuses and several satellite centres across the county, the latter providing part time courses for adult learners. The college also enrolls a small percentage of full time international students each year across the main campus sites. The ethnicity profile for this regional college is predominantly White British but also includes a small percentage of Black Minority Ethnicities (BME : Data source identifies BME to include Asian, Asian-British, Bangladeshi, Black-African, Black-British, Black-Caribbean, Chinese & Any other) < 4.5% (see table 1.1). Students who progress onto post compulsory education within this college do so predominantly from numerous secondary schools in the locality, whilst others transfer from colleges within the region and some from even further afield. The following sub sections provide an overview of the college profile including student and staff populations.

### **4.2 Student enrolment numbers**

The table below (table 1.0) cites the total figures of fulltime enrolled 16-19 year old students for the academic years 2006-2010 inclusive at Wenhill College. These academic years have been selected for inclusion because they reflect the time frame in which this study was carried out. The sole inclusion of adolescent learners is because the focus of the study was to explore their views and experiences and not to carry out

a comparative study with adult learners. Part way through the academic year in 2007/08, Wenhill College merged with South College (campus number four in later tables). In addition, the end of that academic year saw a reduction in the provision of some courses including Performing Arts and traditional ‘A’ levels but an increase in the provision of construction courses including plumbing, brickwork and mechanical engineering; historically male dominated professions. This may be due to an increased accessibility to a wider range of vocational/trade training programmes made available under the specialised diploma gateway (DfES, 2006a) following a review of the role of further education provision (Foster, 2005). This may go some way to explain the increase in male students over the latter two year period.

Table 1.0 Fulltime 16-19 year old Student Enrolment Figures (2006-2010)

<b>Academic Year</b>	<b>Female</b>	<b>Male</b>	<b>Total enrolments</b>
2006/07	1706	1824	3530
2007/08	1715	1827	3542
2008/09	1671	1870	3541
2009/10	1728	2156	3884

The following table (table 1.1) shows the combined ethnicity profile of fulltime enrolled 16-19 year old students studying at Wenhill College between 2006 and 2010. (I have been unable to obtain figures reflecting ethnic diversity in respect of gender).

Table 1.1 Student Profiles and Ethnic Diversity (2006-2010)

<b>Academic Year</b>	<b>Female</b>	<b>Male</b>	<b>Total number of students not from a White British background</b>	<b>Ethnic Diversity %</b>
2006/07	1706	1824	132	3.75
2007/08	1715	1827	142	4.03

2008/09	1671	1870	140	3.97
2009/10	1728	2156	172	4.43

### 4.3 Staff data

Table 2.0 shows the total number of staff (including headcount and FTE for Academic and Business Support staff).

Table 2.0 Number of Academic Staff Employed (2006-2010)

	<b>Academic Staff</b>	<b>Academic Staff</b>	<b>Business Support</b>	<b>Business Support</b>	<b>Total headcount</b>	<b>Total FTE</b>
<b>Academic Year</b>	Headcount	FTE	Headcount	FTE		
2006/07	282	61.24	140	36.54	422	97.78
2007/08	525	106.53	261	94.84	786	201.37
2008/09	649	150.29	258	109.64	907	259.93
2009/10	598	84.93	311	200.31	909	285.24

As mentioned previously, in 2008 Wenhill College merged with South College, another further education institution in the geographic region leading to a significant increase most notably in the academic staff headcount; a total headcount increase in academic staff of 387 over a three year period between 2006 and 2009. This was followed by a significant period of restructuring across all academic and business support departments, divisions and faculties and a reduction of 51(65.36 full time equivalent posts) between academic years 2008/09 and 2009/10.

This is reflected in table 2.0 total headcount and staff headcount columns, respectively. Business support staff numbers however, see a year on year increase between the academic years 2006-2010; total full time equivalent increase during this period is 163.77 (total headcount 171). Interestingly, student learning support staff are included within business support and not considered academic staff. Therefore these statistics may reflect an increased number of staff employed to support students with additional needs in the classroom.

Table 2.1 Staff population reflects the ethnicity profile of the staff population across the academic years 2007 to 2010. I have not been able to obtain figures reflecting ethnic diversity in respect of staff and for 2006, nor have I been able to attain figures reflecting the staff ethnicity gender profile.

Table 2.1 Staff Profiles and Ethnic Diversity

<b>Academic Year</b>	<b>Staff headcount</b>	<b>Number of staff from BME</b>	<b>Percentage of total staff population</b>
2007/08	786	22	2.79%
2008/09	907	20	2.20%
2009/10	909	22	2.42%

(Source: Wenhill College, 2011)

#### **4.4 Instrumentation**

In the first instance, an information leaflet was created and piloted. The format included an overview and aims of the study with potential outcomes for participants and the college. In addition, this served as a means of advertising the study, raising awareness and assisted in locating participants for the research sample (Appendix 1). The information leaflet was available in hard copy format and on the college student intranet site, with a link from the homepage.

Demographic data forms were designed to enable the collection and collation of information about all the participants in this study. These were relatively simplistic and piloted along with other instrumentation (Appendices 4 and 5). In addition, consent to participate forms were designed, produced and piloted (Appendix 2 and 3). These were essential measures in ensuring, reassuring and confirming what the study aimed to achieve, participant and researcher rights and responsibilities and in this case, confirming as a participant they were not in receipt of any clinical treatment for mental health issues at the time of engaging in this study. This was a stipulation of the university's Ethics Committee, given the nature and methodology of the study.

In terms of the biographical interviews with the student participants, my intention was to employ a non-directive interview approach which is derived from the therapeutic or psychiatric interview, where minimal direction is created by the interviewer, allowing the participant to express their views subjectively and spontaneously (Noaks and Wincup, 2004). No questions were 'set' and I viewed my role as exploring and clarifying salient points raised by the participant (Moser and Kalton, 1977), whilst keeping my broad research aims and questions in mind throughout. The only requirement stipulated was the composition of a life path continuum as a visual accessory to the interview (Plummer, 2001) (For examples of the life path continuums, see Illustrations on page 225).

The design of the semi-structured interview schedule included questions determined by the aim of the study and primary research question (Appendix 9). I selected to ask a series of questions based on the primary research question including, '*what sort of mental health issues do you think young people studying within Wenhill College of further education are experiencing?*', '*what factors do you think effect or influence their mental health?*' and '*what do you think is helpful for adolescent students experiencing mental health issues?*' In addition, an interview protocol was developed to ensure a consistent process of data collection across all interviews (both student and staff) assisting in the internal validation of the research process and selected methodology (Appendix 6). This included all participants having access to and retaining a copy of the study information leaflet, letter(s) confirming appointment arrangements, confidentiality, anonymity and what to expect during the interviews including digitally recording the interview for transcribing purposes and completion of 'consent to participate' and demographic data forms. At the commencement of each interview, checking participants were ready to proceed and ensuring the recording equipment was switched on; this was followed by a brief verbal statement made by myself, stating the date, time, location of the interview and the interviewee's first name.

#### **4.5 Raising awareness and gaining access**

My 'insider researcher' role allowed me to make good use of the college communication network, including emails, webpage, intranet and information screens located throughout the college campuses, in addition to other facilities such as

meeting rooms and digital recording equipment. Consequently the staff interviewed presented from a range of sites across the college whereas student participants solely came forward from my 'base site', even though the study had been widely advertised through a number of college wide channels. Prior to commencing this study, I realised that it was important for me to be viewed as an independent researcher even though I was clearly 'an insider', in many ways. Throughout the data collection process, staff often enquired about whether taking part would impact on their employment and this proved a challenging element for me. By employing positive research ethics (for detailed discussion see chapter 3), I was able to reassure participants regarding my intentions.

The information leaflet (Appendix 1) was produced to raise awareness regarding the study amongst the college population. This was piloted and then distributed to all tutors across the college network and relying on the goodwill of my colleagues, requested the dissemination of these to their respective tutor groups. This measure also served as a dual purpose tool, exposing a large proportion of staff to the nature and intention of the study in question. The research topic lent itself well to an official launch across all four sites on World Mental Health Day, October 2008 and this was included as part of the college Community Campus Volunteer Programme (CCVP is one of the vehicles the college employs to deliver the Every Child Matters (DfES, 2003) directive across the curriculum), where students participate in relevant educational activities; this provided a forum to raise awareness and because I facilitated a session on each site, I was available in person to answer any queries. This event attracted significant interest from staff and students alike, some of who progressed onto participating in the main study at a later date.

These particular methods for communicating information were selected for a variety of reasons; the information clearly explained to the reader the purpose of the study and provided contact details should further information be required. It was also a blanket approach to raising awareness but allowing any interested parties to discreetly enhance their awareness whilst not singling them out. Furthermore, by facilitating information sessions, I became 'real', the face of the study; a person centred, humanistic approach (Rogers, 1945).

The use of ICT (emails, college website and student intranet) was selected because of its growing use and favoured preference, especially by students; very much a medium which society currently employs for communication exchange and gathering information and this was the case at Wenhill College across both student and staff populations. By creating a web link on the college web pages, interested parties could glean information about the study using internal or external access. Utilising a dual method of raising awareness, (hard copy format with electronic availability) promoted the opportunity for inclusion, rather than exclusion; certainly in the case of potential staff participants whereas the purposive sampling methods employed for selecting students, created a specific criteria for participation.

Not everyone who volunteered to participate could do so because of the research criteria and some of those who were selected withdrew for a variety of reasons at various stages of the research process. On these rare occasions, staff who withdrew did so because of time constraints and the demands of their jobs or because it was not logistically feasible to synchronise a convenient appointment to meet. For student participants, 'fitting' the research criteria was fairly critical; they must be aged between sixteen and nineteen and have experienced mental health issues. Those who were actively experiencing mental health issues and/or in receipt of treatment, by which I mean in receipt of external organisation input and/or prescribed medication, were not permitted to participate in the study.

#### **4.6 Seeking consent and 'gatekeeping'**

There were a number of gatekeepers within the college hierarchy from which permission to undertake this study needed to be obtained; the College Senior Management Team (SMT). This team included the Vice Principal of Curriculum and Students, the Director and Manager of Student Services and the Director of ICT Services. Consent was required from each and collectively to enable me to proceed and whilst this was not initially forthcoming, due to organisational anxiety about the potential implications of such a piece of work (Scaife, 2004), by demonstrating positive ethical practice and assurances to ensure the identity of the college, students and staff would be protected, permission to proceed was granted in September 2008.



Other gatekeepers are clearly evident in this study. Asking tutors to disseminate information to students about the study relied on their good nature and there was no formal way of assessing and measuring whether all or any of the tutors had done as I requested, other than asking students who volunteered, how they knew about the study. All but two of the students who approached me with a view to taking part had been informed by their tutor; one student 'had heard about it on the grapevine' and the other having directly discussed it with another student who had participated. Ultimately I was the gatekeeper who decided which students would take part (based on the research criteria) and aware that my 'insider researcher role' brought with it a great deal of opportunities and privilege, but also power (Riddell, 1988; Sikes and Potts, 2008). Some participants' involvement was purposively sought as I wished to gain an insight into their role and involvement in supporting and managing students experiencing mental health issues. These included the four college counsellors, as I wished to explore their 'expert view'. (One counsellor's account is included in chapter 6). Overall, a passive role in recruitment was adopted; I advertised the study and the profile of participants I was seeking to engage, allowing potential participants opportunities to self-identify then volunteer. Only then did I adopt a more active role of gatekeeper, deciding on the suitability of candidates to participate in the study.

#### **4.7 Pilot study - rationale**

A good research strategy requires careful planning and a pilot study will often be a part of this strategy; a 'trial run' done in preparation for the major study (Polit *et al.*, 2001) and normally small in comparison. For this study it was implemented on a two-fold basis. In the first instance to pre-test the selected research instruments (Baker, 1994); the student interview process and format, in addition to the staff semi-structured interview protocol and schedule, consent form and participant information leaflet. Secondly, to validate the effectiveness of the research instruments in eliciting the correct information in order to answer the primary research question, thus improving the internal validity of the research instruments and overall methodology (Holloway, 1997). Whilst it does not guarantee success in the main study, it does increase the likelihood of success by reducing risk factors (De Vaus, 1993) and gives advance warning about where the main research project could fail, where research protocols may not be followed or whether proposed methods or instruments are inappropriate or too complicated (Teijlingen *et al.*, 2001).

#### **4.8 Information leaflet**

This was piloted in January 2008 with mixed gender groups of level 1, 2 and 3 vocational programme adolescent students in addition to several colleagues from the Department of Health Social Care. Students were given the choice to participate in reviewing the information leaflet as it was not a compulsory activity. However the students present during the group tutorial sessions visited, were enthusiastic to feedback their comments. The students participating from the level 2 and 3 programmes provided positive feedback and demonstrated they understood by reiterating the aims of the study and opened up discussions around adolescent mental health and their opinions in relation to the study topic. Some even volunteered to take part. However, this experience was not repeated with the level 1 students who struggled to understand the content terminology in the information leaflet, needing clarification and explanation. In many cases, verbal simplification was required to explain the meaning of terminology such as '*substance misuse*' and '*emotional disorders*'. Staff colleagues canvassed voluntarily provided positive feedback including one colleague commenting that he thought level 1 students might struggle with some of the terminology used. This was reiterated and confirmed by the students themselves and in response the information leaflet was modified to ensure all levels of reading and comprehension ability, could do so. This leaflet was a requirement of the Wenhill College Senior Management Team as part of their consent for approval for this study to be completed. Study approval was granted in September 2008.

#### **4.9 Consent forms**

This documentation was piloted during the pilot interviews with students and staff participants as part of the overall interview procedure. This included a paragraph explaining the role of the pilot which read, "*The purpose of the pilot interview process is to 'test out' the proposed format, approach and tools chosen by the researcher. The outcomes of these interviews will help establish the final approach to the main study and further data collection.*" (Appendix 2). This helped to clarify the process for the students and staff, who had volunteered to participate in the pilot study and was omitted from the final draft and no further amendments were made to this paperwork (Appendix 3).

#### **4.10 Demographic data forms**

Again this was tried and tested as part of the wider interviewing protocol but for this, two different formats were employed; one for the student participants and a second for the staff participants. For students the differences being the request for data relating to their previous school or college, the level of course they were studying, whether they had any criminal convictions and whether or not they received learning support/assistance (Appendix 4). For staff, I wished to establish a collective profile of their current role and responsibilities including how long they had been in their post and whether they worked full or part time. Following the pilot study, there were no issues raised or identified with the proposed format and subsequently, no modifications were made. As I did not wish to constrain individual responses nor prescriptively categorise potential participants, particularly in relation to '*nationality*' and '*ethnic origin*', a tick box format was not used (Appendix 5).

#### **4.11 Biographical interviews**

In the first instance a second year group of GCE A/Level 3 Health and Social Care students were approached and appraised resulting in a positive verbal response. I asked those who were interested to make contact directly via email within a two week time frame, confirming their wish to participate in the pilot study. Three students contacted me and in response an appointment was emailed to each accompanied by an information leaflet and consent form, explaining this appointment would be to discuss the study in greater detail and if they decided to continue, to arrange a further meeting. Two of the three students who had originally contacted me responded by the deadline set and therefore I arranged to meet with them as detailed earlier. We met in November 2008 and both students independently offered to participate formally in the pilot study biographical interviews. Consent forms were completed at this stage in addition to alerting both students to the formulation of their individual life path continuums, which they were to bring with them, when we met the following month (Atkinson, 1998). These were arranged for December 2008 and took place as planned on the Wenhill College premises. These interviews provided valuable, insightful opportunities to determine what resources would be effective in eliciting data to meet the aims of the study and ultimately answer the research questions (De Vaus, 1993). In preparation for the two interviews an 'interview checklist' was drawn up to ensure I did not forget to carry out what I had planned (Appendix 6). This proved an

invaluable referral document, even reminding me when the recording equipment should be switched on and off! (Burns, 2000; Bell, 2005; Denscombe, 2010).

The two interviews were recorded using a discreet digital Dictaphone for transcription purposes and to ensure an accurate verbal record of the event in addition to detailed field notes to support and cross reference the data. Prior to the commencement of the pilot study, I was concerned student participants would be reluctant to tell their stories therefore I chose to experiment with cues and prompts. Areas for discussion were listed on a prompt sheet; statements relating to mental health issues and the factors influencing (their) mental health, family profile and mental health history in addition to internal and external support networks. In addition, the prepared life path continuums were employed as a focused discussion tool during the interview.

My initial concerns about students not wishing to talk about themselves were unfounded and in both pilot interviews this was not the case. Both students were uninhibited about telling their life stories and the need for prompts and cues was minimal. On reflection this was due to several factors including the use of the life path continuum as a data collection instrument.

#### **4.12 Staff interviews**

Staff pilot interviews took place in March 2009 with two colleagues from the Department of Health and Social Care who had volunteered their time. These interviews were similarly facilitated to the student interviews and were recorded for transcribing purposes. Using the prepared interview schedule and composing field notes for the duration, these pilot interviews identified the need to reorder the questions as the original format appeared to result in duplication of responses (Kvale and Brinkman, 2009).

#### **4.13 Overall modifications**

During post interview transcribing (which I completed) it became apparent that the recording equipment used was adequate but far from satisfactory. This was due to a number of factors including the acoustics of the rooms the interviews were facilitated in, the physical location of the Dictaphone during each interview and in some cases, where the participant was seated in relation to this. To ensure the eradication of these issues, the use of dual recording equipment and a visible microphone to pick up

conversation within rooms which were discreet ensuring a level of sound proofing away from busy areas in the college, were used in the main study (Branley, 2004). As part of the interview preparation stage, I ensured the role of the equipment was clearly and explicitly explained (Denscombe, 2002). The visual presence of the additional recording equipment did not appear to deter participant engagement; only one staff participant commented on their awareness of it and how it was making them feel. The remaining participants accepted it as part of the furniture of the room.

Prior to carrying out the pilot interviews, the plan was to complete all the transcribing for the pilot and main study interviews myself. However having transcribed the student and staff pilot interviews, I realised the enormity of this task and personal limitations (Bird, 2005). Subsequently the transcribing was outsourced to an independent service and although this was costly, it has proved an invaluable investment in terms of time and quality (Poland, 1995). There were issues to consider in this decision and whilst most were advantageous, there were potential disadvantages too (Denscombe, 1998). First and foremost, it would save valuable researcher time although depending on the accuracy and quality of the transcripts, this could prove counter productive involving revisiting transcripts to fill in any gaps (Burke, 2011). Poor quality recordings may make transcribing difficult and whilst I had addressed this issue post pilot interviews, the selection of a capable person to complete the task was paramount. I explored a number of options, including a transcribing company, eventually settling on an experienced independent person (Gay) for the task. This decision resulted in a personalised and accurate service. We met to discuss my research including ethical issues, data transfer and security, transcription format, priorities and time frames. Gay agreed to transcribe an interview; from this we were able to finalise the format required for data analysis purposes.

#### **4.14 Procedure – the data collection phase**

This section describes and explains how the data was collected from student and staff participants in the main study. My aim was to interview ten students and twenty five staff including the four college counsellors. This would prove to be a large enough group to offer a range of storied lives and involve the understanding of experiences and perceptions of participants within the constraints of this small scale, multi-dimensional case study. I also wished to ensure that if anyone withdrew from their

studies, left their employment or withdrew from the study, there would be sufficient data from a viable sample to fulfil the aims of the research (Baker and Edwards, 2012). In total eleven students volunteered to participate. However after verbal assessment and careful consideration applying the stipulated research criteria that participating adolescents must not be actively experiencing mental health issues or be in receipt of any clinical treatment for their mental health issues during the data collection phase of the study, seven were selected for interview (Fisher and Rosendahl, 1990; Goodson and Sikes, 2001).

Twenty four staff members originally volunteered to participate and of these, nineteen were interviewed. The five who did not participate did so due to a range of reasons; one proved difficult to contact and did not respond to attempts to follow their initial expressed interest up, another retired, two withdrew due to work commitments and a fifth due to long term sickness. The college counsellors were directly approached (purposive sampling) and all four were willing to participate and were interviewed in due course. In total twenty three staff were interviewed from across the four Wenhill College campuses. The period of data collection commenced in December 2008 (with student pilot interviews) and completed in December 2009. Student and staff interviews were facilitated parallel to one another and within the college premises.

#### **4.15 Student participants**

Life history research rarely involves a random sample of participants and this was the case here. The research was purposive and concerned with specific characteristics (i.e. adolescent students aged 16-19 and having experienced mental health issues), hence participants were selected because they met the study criteria; furthermore, the accessibility of the researcher to a convenient sample of participants and also the homogeneity, as this element of the research focuses on a small group, where participants share common experiences, attributes or characteristics (Goodson and Sikes, 2001). All the students who volunteered and subsequently participated in this research were studying within the Department of Health, Social Care and Early Years. Those studying at level 3 were pursuing a programme in health and social care, whilst Jordan, was undertaking a level 1 course in early years and childcare. The selection of health, social care and early year's participants was non-intentional; however it is acknowledged here as being influenced by insider researcher positionality (Riddell,

1988) and established attachments to and involvement with the institution (Sikes and Potts, 2008). Of these seven students, six identified their ethnic origin as ‘white British’ and one student, as ‘Black African Caribbean’.

Table 3.0 shows student participant demographic details. All students were studying at campus 1 during the period this study was carried out.

Table 3.0 Student Participant Demographic Details

<b>Name</b>	<b>Gender</b>	<b>Age</b>	<b>Nationality</b>	<b>Course level</b>
Debbie	Female	18 yrs	British	3
Amy	Female	17 yrs	British	3
Emma	Female	17 yrs	British	3
Grace	Female	17 yrs	British	3
Jordan	Female	17 yrs	British	1
Rachel	Female	19 yrs	British	3
Tom	Male	19 yrs	British	3

As expected, the student interviews were time consuming. Following initial contact made by a student expressing an interest to participate in the study, an information leaflet and consent form were sent in response. This was accompanied by an appointment time and venue, requesting receipt and confirmation of attendance to the appointment. Twenty four hours prior to the arranged appointment, contact was made with each potential participant (either by email or telephone) to reiterate and confirm their appointment. This helped to ensure effective use of time (for both parties) and avoid confusion or non attendance. It also provided participants with an opportunity to rearrange if necessary.

I met with each of the student participants three times; the first meeting was a preliminary interview and lasted thirty minutes. This was an opportunity for an exchange of information between the potential participant and researcher and to explain in detail, the purpose of the study and its requirements including how the data would be collected (recorded, transcribed and reported), assessing their ability to consent and participate in the study and ‘setting the task’ of composing a life path continuum. It was at the close of this interview where a decision was made by the researcher around participant suitability. Subsequently, four of the eleven student volunteers were not taken forward to the next phase. It was at this stage consent forms were signed and countersigned, demographic data forms completed, rights to withdraw were reiterated and a further appointment was arranged for phase two of the interviewing process.

Phase two involved two further interviews for each participant, lasting between 45 and 90 minutes each and in most cases, one week apart. The first of these two interviews is where the biographical interview techniques were employed (Appendix 7) including discussion around individual life path continuums. The second, to revisit, reflect and clarify any issues and comments requiring clarity (Seale and Silverman, 1997). All interviews were digitally recorded and later transcribed for data analysis purposes in addition to handwritten field notes to supplement the recorded conversations. Improving self proficiency in facilitating the interviews enabled these to be kept to a minimum so not to interrupt the flow of conversation nor miss any key points raised during the interviews (Lincoln and Guba, 1985). Copies of transcriptions were returned to each participant in due course; a copy for their reference to retain and a further to review, amend and return by a specified deadline, otherwise the original transcription would be used for data analysis purposes.

My reasoning for returning the transcripts was predominantly to allow for clarification and amendment and for participants to retain and remain in ownership of the data which I viewed as effectively ‘on loan’, a lease agreement, for the duration and purpose of the study. Whilst recognising there are issues with this in participants choosing to add, amend and clarify the content of transcripts and the potential impact this has on the ‘*here and now*’ whereby reflection and hindsight may alter their perception of their life story and how they recounted this, ultimately this is ‘their story’



and returning transcripts for this purpose, compliments to the locus of control and researcher power argument cited earlier. Hagens *et al.* (2009) suggest that returning transcripts to participants adds little to the accuracy of its contents and may create complications if the goal of researcher is to produce a transcript which reflects precisely what was said at the time of interview. None of the student participants made any corrections nor added or withdrew any information from their transcripts. A small number of staff clarified points they had made during our meetings and used the opportunity to verify content accuracy (McLellan *et al.*, 2003). A copy of the letter used to return transcripts is located in Appendix 9.

#### **4.16 Staff participants**

For the purpose of the staff interviews, a semi-structured interview format was employed (Appendix 8) and as with the student interviews, as the data collection phase progressed, so did my proficiency in facilitating and managing the interview process. In total twenty three staff were interviewed across the four college campuses (ensuring facilitation of interviews at their base campus so not to inconvenience them which proved time consuming because of the geographical region, however a necessary requirement of the task; see table 3.1). The staff interviews ranged in duration between 30 and 50 minutes and were digitally recorded for transcribing and data analysis purposes. Other than the four college counsellors, participants were interviewed on a volunteer basis, having expressed a direct interest in participating in the study. This was variously done through several mediums of communication including emails, phone calls and in person. Following initial contact, an information and consent form was forwarded in response, with an appointment time and venue, requesting receipt and confirmation of appointment. Twenty four hours prior to the arranged appointment, contact was made with the potential staff participant (either by email or telephone) to reiterate and confirm their appointment. This helped to ensure effective use of time (for both parties) and avoid confusion or non attendance. It also provided participants with an opportunity to rearrange if necessary.

In total, twenty three male and female staff participated, with ages ranging from 24 to 60 years. Of these, 21 identified their nationality/ethnic origin as 'white British'; 2 identified themselves as 'other white'. Their roles were varied and included lecturer,

personal tutor, programme leader, student support assistants, learning support tutors, student liaison and retention officers, college counsellors and members of the college senior management team. The ‘time in their current posts’ ranged from 6 months to 9 years and of those participating, 18 were employed on a full time basis and 5 part time. All participating staff were employed on permanent contracts.

As previously discussed earlier in my thesis, my original plan was to facilitate a cross-college wide case study, including student and staff participants from all four campuses. The case in question evolved and was re-defined following completion of the data collection phase, resulting in the selection and use of data gathered from the students within health, social care and early years programme area and staff working with these students on campus one. Table 3.1 shows the staff participants’ demographic and employment data; those whose data was selected and is presented in chapter 6. The detail provided in this table is minimal as I do not wish to compromise nor expose the identities of the participants when disseminating results (Hayes, 2006).

Table 3.1 Staff Participants’ Demographic and Employment Data

<b>Participant</b>	<b>Gender</b>	<b>Current role</b>
Maria	Female	Programme leader
Kate	Female	Programme leader
Helen	Female	Counsellor
George	Male	Senior Management Team
Jane	Female	Senior Management Team

On meeting, a period of time was spent with the participant checking their understanding around the aims of the study and what was expected of them in terms of participation, data recording, transcribing, analysis and reporting. If the staff member was in agreement with the terms of the study, the consent form was signed by the participant and counter signed by the researcher, a demographic data form completed and the interview was commenced using the semi-structured interview schedule. Following completion and transcribing, two copies of the transcription were

returned to each staff participant; one to be retained for their reference and a second for review and amendment, to be returned to the researcher by a specified deadline, otherwise the original non amended transcript would be used for data analysis.

As previously mentioned following the pilot study, a decision was made to outsource the transcribing of all the interviews to an independent service. This process was explained to each and every participant prior to interview so they understood who, other than myself would be listening to their shared information.

#### **4.17 Data processing and analysis**

Each interview was transcribed in full, verbatim, without editing in order to analyse the data as a whole piece in conjunction with the life path continuums (student interviews) and field notes (all participants). The study has resulted in two sets of qualitative data (students and staff). These are reported and presented separately in chapters 5 and 6 respectively (Richards, 2005).

#### **4.18 Analysis – choice and rationale**

Researchers employing thematic analysis approaches are interested in what topically and thematically surfaces in a story's content and do not tend to focus on the story's structure, sequential composition or how the dialogue has been performed. Thematic analysis is used in qualitative research as a means of examining the themes within the data. This method emphasises rich description in the data set and goes beyond simply counting phrases or words within the text by identifying implicit and explicit ideas within the data (Chase, 2005).

Thematic analysis draws on the concept of supporting assertions with data from grounded theory and whilst it should not be confused with grounded theory from the qualitative methods literature, the shared ethos across both elements is the construction of theories grounded within the data (Glaser and Strauss, 1968).

Thematic analysis can therefore be considered reflective because the process involves reading transcripts, re-reading, identifying possible themes, comparing and contrasting emergent themes to enable the identification of research outcomes.

Thematic analysis is diverse by its nature, suited to a wide range of narrative texts and is also related to phenomenology; focusing subjectively on the human experience, emphasising participants' experiences, feelings and perceptions (Lester, 1999). A key component of phenomenology is the humanistic facilitation of 'giving voice' to participants (McLaughlin and Tierney, 1993; Charmaz, 2008), allowing individuals to discuss the topic in their own words (Swain and French, 1998); a constraint imposed by quantitative study methods. Many studies in nursing and the allied health professions have adapted this approach to explore and thematically categorise individuals' experience of illness. Its use and application within the context of my study is therefore relevant as my intention was to seek and thematically categorise, the participants' data, within the context and experience of, mental health issues.

Thematic analysis was employed to search through the data to identify recurrent patterns and/or themes and to represent a view of reality via systematically working through transcribed texts in a methodical manner (Miles and Huberman, 1994) to identify topics and promote a more discursive interpretation (Attride-Stirling, 2001). The interviews generated a huge quantity of transcribed data creating the overwhelming sense to reduce this to a manageable quantity (Lee and Fielding, 1996) to enable me to 'work the data' (Geertz, 1993). The implementation of a bespoke thematic analysis model was implemented in preference to a prescribed approach and could be used to replicate the research methodology and data analysis elsewhere (Reissman, 1993).

The methods for data collection to elicit rich, in depth data within the multifaceted approach, further enabled me to gather multiple perceptions of experiences and events (Stake, 1994; Holliday, 2005) which could be analysed through thematic analysis. This has helped to create a thick description and contextualise experiences and events within the bounded social setting of Wenhill College (Geertz, 1993; Denzin, 1994) and a greater understanding of the research findings.

#### **4.19 The thematic analytical process - student data**

In the first instance, I listened to the recorded interviews without any other resources, for example field notes, to hand; the purpose being to put myself as the researcher

'back in the interview' and create an empathic positioning, from a reflexive standpoint (Coffey and Atkinson, 1996). Following this I then re-listened, on this occasion with field notes and life path continuums, to enable me to cross reference and begin to identify key themes, which I drew up as a bulleted list, for each participant. Turning then to the transcriptions I started reading the content and followed this by physically highlighting and annotating key themes within the data, which were either directly linked to the research question, recurrent or of interest to me as a researcher. The drafting and composition of 'a story' for each participant including quotes and statements followed inclusive of an '*understanding student X*' section. This latter section was in the first instance an effort to convey my understanding of the story being told, how I understood this and the literature which supported and/or challenged this and later refined to give a more accurate, conclusive account.

#### **4.20 The thematic analytical process - staff data**

Having worked through the vast amounts of student data, the quantity of staff data seemed minimal in comparison but still required the same attention to detail during the process of thematic analysis. Employing the same approach as I had with the student interview recordings completed in conjunction with the interview schedule (in place of the life path continuum) created a logical, structural framework for thematic analysis and could be cross referenced within the data set and across the other data set at a later stage. Presenting the data had its own set of challenges and where possible the words within the data presentation and analysis chapters, are the words of the researched (Sandelowski, 1991). Care has been taken not to deconstruct the narratives and to keep these whole (Goodson and Sikes, 2001), demonstrating individual experiences and commonalities (chapter 5; students and chapter 6; staff).

#### **4.21 Ensuring internal and external validity**

Throughout the course of this study, the aim was to select and employ methods that were straightforward and practical yet within the limitations of resources available in terms of time, skills and expertise; providing rich data, robust results and ensuring validity, were essential elements. These were ensured in a variety of ways and through a range of implemented measures. Ethical clearance was sought via the University's Faculty Research Ethics committee. The research methodology and study design was sanctioned with the following stipulation; "*All participating adolescents must not be*

*receiving any clinical treatment for a mental health issue at the time of actively participating in the research study*” This was clearly stipulated on the consent form and clear boundaries imposed for engaging the student participants (McFarlane, 2011). Furthermore this complemented the college stipulations in protecting vulnerable adults within the framework of the Fraser Guidelines and Gillick Competencies (DeCruz, 1987; Wheeler, 2006; NSPCC, 2009).

Corporate consent from the college was required and sanctioned on the basis that the identity of the college, the college population and all study participants would be protected by ensuring confidentiality and anonymity, employing the use of pseudonyms. Furthermore, that all participants understood the purpose of the research, how and where their data would be reported. This dovetails with the university research ethics committee requirements; being bounded by and assigning to, good ethical research practice. Seeking individual consent contributes to the internal validity of a study by demonstrating equality and consistency and a researcher who is ethically moral in their approach. It also creates a contract of agreement between the researcher and the researched, ensuring clear practical and theoretical boundaries throughout the research process.

In completing a pilot study, the researcher is assessing research risk (De Vaus, 1993). The pilot study forms part of the overall research strategy, demonstrating good practice by the researcher in preparing for the main study; ensuring the proposed instrumentation is clear and unambiguous and enables the researcher to make modifications to instruments based on pilot results (Bell, 2005). This study used a combination of approaches, some of which were established (biographical interviews) in conjunction with a tried and tested semi structured interview approach. Whilst using life path continuums is an established instrument in (mental) health and careers, it creates a new way of working within research with adolescents within further education, who have experienced mental health issues. The use of these instruments with different groups of participants across this multi-dimensional case study (Stake, 1995) resulted in a thick description (Geertz, 1973; 2000) and triangulation of the research data, contributing to the internal and external validity of the study. This promoted (my) confidence in the research design, methodology, methods of data

collection and data analysis and these can be replicated whilst recognising that the same results may not (Blaikie, 2000).

#### **4.22 Concluding remarks**

The methods described in this chapter enabled me to explore the experiences of adolescents and their perceptions of their mental health issues using biographical interviews to produce narratives in a non-directive approach, derived from the therapeutic and humanistic ethos espoused by Rogers (1945). These life stories were specifically solicited and gathered for the purpose of assisting me as a researcher to identify and understand the experiences of individual adolescents, their mental health issues and the impact this may have had or has, on their life and/or learning careers. In addition, a life path continuum was a useful way to organise the interviews, as the participants organised their experiences chronologically. This enhanced participant congruence. During the recruitment and consent processes, the participants were informed that they would be asked to tell their life story from when they were born to the present. This information helped them to prepare in advance of their first interview. During the interviews, they responded thoughtfully to questions about their lives and appeared to be making some connections or insights as they related their stories.

This ethos was further extended to the semi-structured interviews with staff, allowing interviewees to speak openly (some) revealing that they welcomed the opportunity to discuss their experiences (both students and staff). To an extent some used the interview as a confessional, confirming the view that *'...people tend to enjoy the rather rare chance to talk about their ideas at length to a person whose purpose is to listen and note the ideas without being critical...'* (Denscombe, 1998:136)

All interviewees presented as highly articulate, recounting detailed examples and anecdotes to substantiate their perceptions, opinions and experiences thus providing rich data for thematic analysis and thick description (Geertz, 1993). Furthermore, the adolescent narrators demonstrated they have the necessary skills, including recall, insight, interest, and attention span to narrate their life stories. They also had enough life experience to conduct a number of meaningful interviews, usually three and

totalling 3 hours collectively which on completion are considered short life stories as they are focused and are presented as one of a series (see chapter 5).

I was very aware throughout the data collection phase how my relationship(s) with participants might influence their involvement on several levels. Being an 'insider' has both advantages and disadvantages. Examples of variables in the research process include participant personalities, the nature of their relationship with me as a researcher and power balance (or imbalance), are difficult to control. However acknowledging such issues existed helps to promote reflexive awareness. Establishing a positive rapport between the researcher and participant is therefore essential in the research process, particularly in the case of biographical interviews, where sensitive information may be disclosed and shared. For both parties, it is about weighing up the risks (Hoagwood *et al.*, 1996) in pursuit of knowledge (Gilbert, 2005) and minimising harm (Fisher, 1994). Self regulation, being open, honest and transparent, offering reassurances around anonymity and confidentiality, helped develop rapport and trust with student and staff participants, generating a sense of shared equilibrium.

The following chapter, '*Exploring student lives in relation to their mental health, education and career choice in caring*' offers an account of six individual student lives for analysis and examination.

## **Chapter 5**

Exploring the lives of six further education students with mental health issues

### **5.1 Introduction**

The words within this chapter are those of six student participants selected from the seven students who originally took part. Amy enthusiastically expressed an early interest in participating in the research but failed to maintain her full commitment.



This was evidenced by her non-participation in providing a life path continuum (which was a stipulation) and lack of detail in her interviews which impacted on the process and validity of the thematic analysis. For these reasons Amy's data was discounted.

The narratives presented here demonstrate individual experiences and care was taken not to deconstruct the narratives enabling the data to 'speak for itself'. Each narrative is presented separately followed by a brief, individually theorised summary. The purpose of each summary is to provide an overview of the key themes arising from each student narrative. These themes are revisited in chapter 7 for further analysis and examination. I have chosen to start with Debbie's narrative because she was the first student to take part in the research, followed by Emma, Grace, Rachel, Tom and Jordan, in the order they each participated.

## **5.2 Debbie**

Debbie tells her story from two perspectives – what she can remember and what other people have told her and as she began to tell her story, it became apparent that Debbie's life has been 'troubled' from a very young age.

*"I was about 18 months old when Dad left, which obviously I don't personally remember it as such but I know Mum does...and they went through the fight of whose having custody of me and all sorts and Dad smashed a window which was nice of him...that's probably my earliest memory aged 3 although I vaguely remember it. I remember being taken away because my auntie took me away"*

Debbie remembers going to live with her maternal grandparents at the age of three as "...mum lost the battle to have the house because she didn't have enough money to buy it off of Dad". They lived at her grandparents for two years and she started playschool then primary school. When Debbie was five, she and her mum moved into a rented property, "...about 5 minutes down the road from my gran's house", it was during this time that Debbie recalled first witnessing her mum's drinking.

*“I rang Gran up in the middle of the night because I woke up for something and Mum had collapsed on the sofa from drink...Gran came round and the next thing I saw, she just slapped Mum to wake her up and I was taken from where I was to stay at Gran’s house which is sort of where I stayed then most nights until my step dad came on the scene when I was about six.”*

Unfolding here in Debbie’s life story, is the significant role her maternal grandmother plays in her life, adopting a surrogate mother role; taking her backwards and forwards to school, ensuring she has clean clothes and food. Debbie eventually goes to live with her grandparents on a full time basis until she is seven, when her mother’s drinking became *“out of control”*. Her grandmother died in May 2009. Debbie had never attended a funeral before and she did not know what to expect. She felt that her grandmother’s death left the family disjointed for a while, describing her grandmother as *“the family matriarch”*.

Debbie initially described school as a good thing where she made friends and was *“interacting”*. But after a while *“...I started to lose friends because I’d not really done much social skills previously and wasn’t very nice to them.... but I think that’s possibly because Mum was drinking as well, so I just sort of, I don’t know, I lacked social skills and all I ever witnessed was...shouting and that, so it was how I behaved towards my friends.”*

A relatively settled period in Debbie’s life ensued when her mother met her stepfather, started attending Alcoholics Anonymous meetings and stopped drinking. This was reflected on her life path continuum by a steep positive curve, peaking when her brother was born. During this period her father remarried and several months later her mother and stepmother were pregnant simultaneously, each giving birth to daughters just weeks apart. This signalled another downturn in Debbie’s life and she described it thus;

*“Having three siblings arrive in my life during a relatively short period was a great shock and I wasn’t happy. Not being an only child anymore meant I was expected to become more grown up and care for myself. I felt pushed out and ignored during this period of my life. This feeling towards my siblings has never really passed. I still to this day have a dislike towards my youngest sibling, my sister.”*

This downturn continued, interjected by short positive periods including a new primary school, new friends and relocation to her current address, where Debbie started the local secondary school and experienced a relatively settled first term; *“...my ‘best friend’ really wasn’t a person I should have been friends with... she was in all sorts of trouble and we caused all sorts of hassle together. That’s when I started being naughty and I continued to cause havoc for most of my secondary school years.”*

The following five years in Debbie’s life story are peppered with episodes of self harming behaviour, *“...from the age of about twelve...made me feel better”*, alcohol and cannabis misuse *“...to have timeout”*, underage sexual intercourse resulting in a sexually transmitted disease infection and a diagnosis of Irritable Bowel Syndrome. Parallel to these experiences were her ongoing issues in her relationship with her father, whom she lost contact with when aged 16 due to his repeated infidelity and an abusive relationship with her then boyfriend. However, her mother remained a constant factor during this period including, *“...physically delivering me to every one of my GCSE exams and sitting in the car, waiting, to make sure that I stayed there.”*

It was during her secondary school years that Debbie received help from the school counsellor, *“...my friend took me to see her...the school counsellor, she’d had enough of watching me refuse to go”*. She met with the counsellor on a weekly basis for *“a couple of months”* before being referred to the local Child and Adolescent Mental Health Services team on the recommendation of the school counsellor. Debbie was treated by this service for depression and her self harming behaviour until the age of eighteen, which included the period of her further education. This experience influenced Debbie’s career choice in caring;

*“Initially I wanted to go into counselling, mainly because of having experience of counselling myself...I think it is such a rewarding profession to go into...giving people their lives back...I don’t think I would be where I am now if I hadn’t had the counselling...but I’ve decided to do mental health nursing...I’ve had a conditional offer based on my exam results...it is broader than counselling and I feel I could make a difference and it’s not something that is perhaps given the reward it should be.”*

Debbie discussed the process of how she selected the university she wished to study at;

*“We looked round loads of universities me and mum...and we’ve selected the nicest one really and I like the way the course is run with good facilities inside and outside of the university...far enough away for me to feel independent but close enough in case I need support...mum is still thinking of my mental health...as long as I stay busy things don’t tend to bother me so much, it’s when I’m sat around not doing much...”*

### **5.3 Understanding Debbie**

Debbie’s life experiences have influenced her mental health and she has ‘used’ mental health issues including self harming behaviour and drinking to excess, to manage personal transitions; *“to feel better”* and *“to have time out”*. These experiences have negatively impacted on her mental health, affecting her learning career throughout secondary school and into further education, resulting in treatment with the CAMHS<sup>10</sup> until the age of eighteen<sup>11</sup>.

Her experience of mental health issues has also contributed to her career choice. She initially considered a career in counselling, later deciding that mental health nursing was her vocation of choice. Tillet (2003) and later Thomas (2006) suggest that choices around careers in caring can be conscious for practical reasons such as training, income and availability of work, and unconscious to gain a sense of belonging. Often career decisions are made in late childhood or early adolescence and the influences complex (Allen, 1988; Kniveton, 2004). Ginzberg *et al.* (1951) suggest that career decisions are based on the pursuit of a match between the self conceptualisation of one’s abilities and preferences with the job requirements. Law and Arthur (2003) develop this argument further in suggesting that a young person’s gender and ‘place’ in the family influence their career choice, specifically in nursing.

Whilst adolescents nearing the end of their compulsory education are encouraged to consider and make career choices, this task is not static but part of the developmental process (Alberts *et al.*, 2003; Kniveton, 2004). Debbie’s career choice appears to be based on a numbers of factors. She talks about *“giving people their lives back”* and *“a rewarding profession”*. This may be aimed at reparation and resolution of childhood experiences and events; the strength of her subconscious urge to ‘make

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<sup>10</sup> Child and Adolescent Mental Health Service

<sup>11</sup> Debbie had recently been discharged from the care of CAMHS prior to taking part in this study

people better', reflecting her own needs (Bowlby, 1977; Thomas, 2006). In addition, her exposure to a parent experiencing mental health issues may have led to her seeking to 'restore power' to the adult (her mother) and a compulsive care giving nature; giving to others what she seeks for herself (Malan, 1979).

Thomas (2006) suggests that family members and other role models strongly influence an individual's development particularly in adolescence when young people are starting to make their own life choices. Furthermore, the impact of gender may lead to academic stereotyping, popularising careers which have historically been seen as 'female', requiring the traits of empathy, altruism and a 'good bedside manner' (Miller, 2002). There have been influential females throughout Debbie's life, both positive and negative. These include her maternal grandmother "*the family matriarch*", who acted as a surrogate mother during her formative years, her mother, school friends, the school counsellor and a specialist mental health nurse from CAMHS. Whilst Debbie's mother was unwell during her early childhood, post recovery, she has remained a constant support during her adolescence investing herself in her daughter's life; emotionally and academically. This is demonstrated where Debbie reflected that her mother "*physically delivered*" her to all her GCSE exams and participated in the selection of a university.

#### **5.4 Emma**

Emma is the eldest child of three. She has a younger brother and sister from her mother's first marriage and step siblings from her parents' subsequent marriages. At the time of her interview, she lived with her mother and stepfather, brother, sister and step sister. Emma's early life was fraught with difficulties. Her mother was an adolescent when she gave birth to Emma, and this was followed by a period of post natal depression. As our conversation progressed, Emma told me that her mother suffered bouts of post natal depression following the births of all her three children and because of this, Emma was initially raised by her maternal grandparents. She talked about it reflectively thus:

*"I lived with my Nan for the first couple of years of my life because my mum went through some depression...I've been quite distant from my parents and until quite recently, I've been quite distant from my mum. I found it quite hard to bond with my*

*mum...I was two when my brother was born and it meant I was pushed out but I was still living with my grandparents but my mum was still pushing me away...I felt quite alone and was in depression quite a lot of the time....at three, I lived at home but at this stage I was hit on a daily basis by my dad and it was while my mum was at work so she had no idea. It was in front of my younger brother, which is why I think he's got anger problems."*

Emma then started school aged four, made new friends and talks about this period in relation to her education as being "*quite good*". When aged six, Emma's sister was born and she felt even further pushed out of her family, being expected as the oldest child to be relied on to do more and be more independent. During this period, Emma's father was given a custodial prison sentence. Emma has never been told why her father went to prison, even though she has asked her mother and grandparents on several occasions. She returned to live with her grandparents, this time accompanied by her mother and two younger siblings. Her parents separated later that year and she suggested she feels responsible for this, "*...I was upset and pushed out and quite angry because I thought maybe it was my fault.*"

When Emma was seven, her mother remarried and at eight, her father having been released from prison, also remarried. At this point Emma ceased contact with her father, "*...because I felt very emotional and I didn't really like his wife.*" Aged ten, Emma recalled "*starting puberty*" which on further exploration meant she started menstruating at this stage. She described this as a period of mixed emotions feeling body conscious, which continued to the time of our meetings and "*...I get quite stressy.*" Emma continued to talk about stress in relation to school, particularly exams including her SATs<sup>12</sup> and GCSEs, because she doesn't like exams but has achieved successfully. Year 7 at secondary school was a period of difficulty whereby Emma was bullied by older pupils, including her cousin. She subsequently started skipping school, falling behind academically and again described "*feeling depressed*" by this. This led to "*...missing about 3 or 4 months out of school.*"

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<sup>12</sup> Statutory Assessment Tests

Between the ages of thirteen and sixteen, Emma seemed to 'get back on track'. Life at home and school was more settled but as she approached her GCSE exams, she started to feel nervous. Her brother's anger issues "...started to get out of hand" at home. Emma came home from school one day and decided to pack a bag and leave. Without particular plans but money in her pocket, she ended up in Portsmouth and spent the following three days living on the streets, staying with people she did not know. It was during these few days away from home that Emma engaged in her first sexual encounter, which she regrets.

*"I didn't really want it, it just kind of happened, you know and I just...I knew straight away that it wasn't what I wanted to do. I wouldn't say I was forced. I'd say there was a little bit of pressure, but I wasn't forced."*

Emma's mum notified the police of her absence but by day four, she decided, "...I'd been silly. I thought about it and got really scared. I just phoned up my mum to come and get me." Emma acknowledges the effect her disappearance had on her mother, recognising the nature and history of her mother's depression and that it was not solely experienced immediately following the birth of her brother and sister, continuing to feature in both their lives for several years; *"I came to realise that mum would go up and down hill, you know with her depression...and I think I've been exposed to mental health problems for quite a long time."*

Following the successful achievement of her GCSE examinations, Emma commenced at Wenhill College aged sixteen, in September 2008. I asked Emma about her decision making in relation to progressing onto further education and pursuing a career in the health and social care sector.

*"I knew I would come [to college] straight away because I knew what I wanted to be when I was older and I knew what I needed to do...so I just didn't see any point in going through sixth form at school...I want to be a social worker."*

I asked Emma where her interest in social work had come from;

*"I think it's a combination of things...a bit to do with my life experiences I have been through...some of my decision is influenced by what I watch on the television...I don't*

*like seeing people suffering or in pain, it's unfair...I like helping people. During the periods when my mum has been depressed, I have looked after her and my brothers and sisters, taken on the caring role"*

She began her first serious relationship with her partner but her first year at college proved to be a challenging one whereby physical health problems including a miscarriage and weight gain in addition to the ongoing issues at home, contributed to her describing herself as a "stressy person". This created an opportunity for us to explore further Emma's mental health issues and how she perceives herself.

*"I just think like I'm a very emotional person...I just get really like emotional and detached and I think I find it very hard. I'd say like not mentally stable."*

Emma talked about her own mental health issues (stress, depression and anxiety) and what factors have influenced these (parental conflict, parental mental health issues, physical abuse, bullying, self image, lack of confidence) and how she has managed these. She demonstrated knowledge where she could seek help and support from, including her tutor, college counsellor and the Community Campus Volunteer Programme<sup>13</sup>. She concluded by talking about experiencing mental health issues generally and how these are often seen as a weakness.

*"When people say mental health then I just immediately think that's it's a bad thing, it's not because like everyone can be happy....I think like being happy and happy in yourself...having people around you that you can go out and have a laugh with and knowing, knowing what you've got and just like that really...I don't like showing people weakness, so that's probably why all of my emotion will happen at home...when you show someone your weakness, it's letting them in. I don't like doing that because I find it hard to trust people and I'm very picky about who I open up to."*

## **5.5 Understanding Emma**

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<sup>13</sup> The Wenhill College Community Campus Volunteer Programme is a vehicle designed by the College to ensure the Every Child Matters (2004) strategy is included within the core curriculum of programmes. It provides information and education around a variety of topics including health and well being and mental health.



Emma describes herself as a “*stressy*” and “*very emotional*” person who portrayed herself as vulnerable and emotionally neglected. She felt she had been ‘pushed out’ of her family following the birth of her siblings and endured an extended period where she did not feel able to bond with her mother (Bowlby, 1977). As a result, Emma’s mental health issues appear strongly influenced by those around her, particularly her childhood experiences including parental separation, a mother who experienced mental illness and her father’s physical abuse towards her.

Throughout her narrative, Emma used the term ‘depression’ freely, not only to describe herself but others too. The use of this term may be a self diagnosis due to her personal and observational experiences, and/or the use of the term amongst her peers in social and educational contexts. Ecclestone and Hayes (2009) argue that the use of professional terminology has permeated the everyday conversations of our culture, leading to the reduction of their meanings and value. This is accompanied by the expectation of seeing oneself as suffering from the emotional effects of diverse life experiences whereby emotional survival becomes an everyday goal.

Emma clearly conveyed her reasons for choosing a career in the caring professions (social work) and this is underpinned by “*a combination of things*” (Holland, 1985). In the first instance she reflected on her personal life experiences, quantified by the phrase “*...I don’t like to see people suffering or in pain*”. This suggests she made a conscious decision based on altruism accompanied by a personal desire to rectify unfairness and deprivation. Health and social care workers deal with a range of opposing pairings including health and sickness, wealth and poverty and power and impotence. Schein (1993) suggests these are uncomfortable pairings because the balance can shift within each. Therefore by placing oneself in the ‘caring camp’ it is possible to avoid negative experiences of illness, poverty and disempowerment (Thomas, 2006). Emma is also a compulsive carer, a trait described by Bowlby (1977) which is influenced by early life experiences. The emphasis focuses around parental presence and their ability or lack of it, to provide adequate protection, encouragement and secure boundaries. The inability or absence of a parent(s) to provide these responses results in the child feeling insecure. Consequently the roles of the child and parent are reversed (Harris, 1970). This occurrence is evidenced in Emma’s narrative

whereby she reflected on the lack of strong bonds with her mother and looking after her siblings during periods when her mother was depressed.

Emma's choice of career is not solely shaped by her personal life experiences but also her general social perception of mental health, "...when people say 'mental health' I immediately think that it's bad thing"; a view concurred by the Mental Health Foundation (2011) who suggest people are more comfortable interacting with people with physical and/or sensory impairments in social situations whereas attitudes towards people experiencing mental health issues remains worryingly negative and prejudiced. Wider public and social perceptions of mental health contribute to the development of individual personal perceptions, leading to stigma and discrimination based on naivety and ignorance (SCMH, 2006; NMH DU, 2013).

## **5.6 Grace**

Grace is the eldest child of her father's second marriage. Her brother is 3 years her junior (14 years old at time of interview). Her father has three adult children from his previous marriage. Grace described each of her older half siblings as, "*all having very good public sector jobs.*" Grace had felt pressured by her mum, who works as a therapeutic support worker in social care, to go to university, like her half siblings did; "*I just want to do like, really well*"

At the age of four, Grace tried to run away from home because she did not want to move house. She recalls the events thus;

*"I put my pyjamas in a carrier bag, along with my toothbrush, an apple and an orange. It was during the afternoon and I just wandered out of the house. I wandered round the streets near to my house for what seemed to be hours until an old woman stopped to talk to me then I felt really scared as I wasn't supposed to talk to strangers. I ran home, and guess what, nobody had even missed me!"*

Grace's family eventually moved house. It was at this point in the interview that Grace became very tearful but insisted we continue with our discussion. Now aged six, the family were living next door to "*...a creepy neighbour, who kept inviting me into his house and stuff and....*" She tailed off and then, "*I was quite shy and stuff when I*

*was younger, not like I am now...I don't think there was a positive way of dealing with what happened to me then.*" It was at this point when Grace disclosed that she had been a victim of sexual abuse, the perpetrator being her male neighbour.

In 2002 Grace started secondary school which she clearly did not like;

*"I hated school, I got really, really depressed and I wanted to kill myself"*

It transpired that Grace was bullied by other girls who she had not known previously in primary school and this made her experience of Year 7 very negative. *"The bullying was emotional abuse. I didn't talk to my parents about it or the school...I didn't feel I could."* The bullying stopped at the end of yr 7. Grace recalls Year 8 as an *"uneventful year."*

Grace described herself as *"growing up fast"* at the age of thirteen with her peer/social group predominantly being 17 and 18 year olds. At this time, she became actively involved with the local church, where her mother was very involved too. Grace felt that this was the only real time in her life when she has got on well with her mother, as they had a shared interest and a mutual social group.

What follows over the next two years in Grace's life is a period of significant change and personal loss. In April 2007, her friend Adam died of an accidental drugs overdose, followed soon after by another friend Liam, who committed suicide.

*"I've always been self conscious about my body image but at this time it was worse, I don't really know why but it was a confusing time and that's when I decided to opt out of church. I wasn't sure about my faith, especially after Adam died and I became more involved in the social scene at school. I realised at that time I wasn't such a loser, that I was like somebody, kind of thing and I wasn't getting on with my mum so the last place I wanted to be was in the same place as her!"*

Grace achieved well in her GCSE examinations attaining a range of B and C grades. She had originally planned to stay on at school in Sixth Form, however having returned to school in September 2008 and commenced AS levels, *"...I was pretty much stretched in sixth form, a bit like I had been all the way through school"*, she made the decision mid way through the month to enrol in college, *"...because I*

*wanted to be treated like an adult” and pursue a vocational programme of study whereby she could apply to access higher education to train as a “...paediatric nurse or a counsellor”.*

2009 proved to be a further challenging year for Grace following the death of another friend Callum, who died of a drugs overdose and who she feels guilty about not being able to help. It was at this point in her college course that she changed her mind about her career choice to social work. She also talked about how challenging she was finding college, in particular the amount of coursework required for assessment purposes and revisits the notion of pressure being applied by her mother to do well.

*“Sometimes I feel emotionally drained, like everything’s too tiring. I’ve had insomnia in the past, well that’s what my GP called it and I think it’s come back. I just find it really hard to sleep and stuff...I think I might have depression but you can’t exactly go along to your doctor and say I think I have depression.”*

The sharing of this information created an opportunity for us to explore further Grace’s mental health issues and related experiences and how she sees herself.

*“Sometimes I feel really anxious and often find myself crying for no reason. I get stressed and uptight easily, mainly with stuff at college and if I’m honest...sometimes I find it hard to like myself. When I go out I often drink so much I can’t remember anything, not even how I got home...I worry about how I look and what other people think of me, even though I pretend not to care.”*

Grace, when asked, knew about the existence of the college counselling provision and support services but had never used these. She was concerned her lack of sleep and feeling stressed would eventually have an impact on her academic achievements, whereby she would not achieve her predicted grades nor fulfil her mother’s expectations.

*“I don’t feel I could go and talk to the counsellor, I’d rather talk to someone outside of college....it’s not in a good spot here, you know, the counselling room... everyone knows that’s where you go for your counselling sessions. You see people waiting outside for their session with loads of people going by, how confidential is that?”*

## 5.7 Understanding Grace

A sense of fulfilling other's aspirations and feeling pressured to achieve well academically, permeates Grace's narrative. Dunn *et al.* (1994) and later Kniveton (2004) suggest siblings have a strong influence on career choice and this is demonstrated when Grace reflected her siblings "...all have very good public sector jobs". Grace's mother's employment as a therapeutic support worker in social care and the pressure Grace feels to progress onto higher education appears to be an extension of unfilled parental aspirations. Schein's view (1993) supported later by Small and McClean (2002) reported on the very strong influence parents can have on their children's career direction; often by providing an example or by projecting unfulfilled personal aspirations. This challenges Holland (1985) whose notion purports individual free choices around career choice and direction as being solely those of the adolescent.

There is perhaps a line of discussion around who is likely to have influenced Grace's career choice the most; her mother and siblings have made a significant impact. However her career choice in health and social care has also been influenced by her personal experiences during childhood and adolescence. Her choice to pursue a career in social work is driven by the desire to alleviate for others the problems she herself has experienced and in social care work, much emphasis is concerned with power or the lack of it and 'giving something back' (Thomas, 2006). For Grace, this may have stemmed from her experience of childhood sexual abuse and the lack of power experienced through this. This 'event' appears to have been a catalyst for her later experiences and mental health issues, influencing a career in caring.

The impact of being bullied (which Grace referred to as "*emotional abuse*") led to the vehement dislike of secondary school and compromised mental health state; "*I hated school...I got really depressed and wanted to kill myself*". Later Grace reflected on the loss of three personal friends; two of whom died of accidental drug overdose and a third committed suicide. She describes these experiences as "*a confusing time*" leading to an increasingly distorted perception of her body image. As her narrative progressed, she talked about "*suffering insomnia*" and "*depression*"; terminology used freely to self-diagnose and describe her symptoms. The influences surrounding

the use of this terminology and professional language are complex and not solely influenced by the wider environment amongst her peers and society (Ecclestone and Hayes, 2009). Colley *et al.* (2003:471) suggest learning cultures and the vocational cultures in which they are steeped, transform those who enter them where vocational habitus involves developing a 'sense of how to be' and 'sensitivity'; the requisite morals, feelings and capacity for emotional labour. What and how students learn on vocational and education training courses is key to the relationship between learning and identity and the process of identity transformation as part of the process (Hodkinson, 1999). Studying health and social care within further education exposes students to vocationally qualified teaching staff in addition to vocationally relevant literature (Bowl, 2003). Staff use and express professional language freely (see chapter 6 and 7 for further analysis and discussion) increasing its exposure in a vocationally relevant context. This leads to an 'osmosis effect' resulting in everyday student use of professional terminology and transformation of their identity.

Grace's expectations of further education are conveyed through her reflections around her experience of sixth form; "*I was pretty much stretched*" and the anticipation of college based further education where she would be treated like an adult (Davies and Biesta, 2007). Yet Grace continued to feel challenged by studying, seemingly experiencing poor mental health in response to the demands of the level three programme and feeling "*stressed*". This resulted in poor exam and assignment grades and failing to fulfil her mother's expectations. Grace's reluctance to seek help is expressed via preference and she questions the confidentiality of the college counselling provision. Her reluctance is underpinned by other people's potential knowledge and the implication she may be viewed as deviant; labelled for seeking help (Busfield, 1996; Browne, 2002).

## **5.8 Rachel**

Rachel started telling her story from when she was twelve. She recalled her mother was regularly socialising outside of the family home, consuming excessive amounts of alcohol, possibly drugs, and engaging in numerous different relationships, "*...Mum was present but at the same time absent because of her own problems...she's suffered a mental breakdown, tried to take me from school...*"

Rachel remembers “*getting very drunk*” whilst on her own one night and taking some of her mother’s medication then “*...running to my friend’s house because I didn’t want to die.*” Her mum took her to hospital where she was treated and seen by a psychiatrist. Following Rachel’s discharge from hospital, her mum told Rachel she was “*very disappointed*” with her. After her short stay in hospital, Rachel met with her GP who she says was “*...very negative about mental health problems*”. This led to a further appointment with another psychiatrist; following this, Rachel decided she did not wish to go to any further sessions as her mum was present and she wanted to go on own. She thought these sessions would have been different if she could have gone on own or with another adult but did not want to tell her mum not to come. Her mother remarried two years later when Rachel was fourteen to a man who she describes as “*mentally abusive*” and “*...Mum had previously been a confident and strong person... he completely changed her*”

Rachel then talked about her mother in some detail.

*“She’s always had mental health problems...she’s an only child. My gran told me that mum has suffered from depression since the age of 18. Before that she had an eating disorder and took two serious overdoses when she was 18. My gran doesn’t know why. Apparently mum had some treatment, some cognitive behaviour therapy and this seemed to help.”*

Rachel’s parents separated when she was a year old. She has a sister who is eighteen months her senior. Her father lives “*about an hour away*” and she has seen him every weekend since she was a baby. However Rachel feels her father does not know her very well. Her father remarried and Rachel has a half sister. She describes a difficult relationship with her stepmother and half sister, “*...they have my dad, I don’t*”. When her mother remarried when Rachel was fourteen, she says she was hoping for a father figure but this was not to be the case. It proved to be a difficult relationship “*...for all of us, especially when mum became pregnant. He made her have an abortion. She was really depressed after that. She looked dead behind the eyes for months.*” At this stage, Rachel and her sister looked after themselves but often missed school to look after their mother.

Rachel talked about her secondary school experience thus;

*“I wasn’t very focussed at school. I was an average student all the way through. I was never bullied but I was part of a group who were not very nice to other people – others would move out of the way when they saw us coming. I felt like I had to establish myself at school, you know, as an individual and as part of a group...I stayed on at school because it’s what I thought I should do. But I’m different here at college. It’s much more relaxed and I can be who I want to be in college – I feel more confident here.”*

Rachel talked about her experience of receiving counselling at school, firstly aged twelve whilst in year 7 following her attempted overdose, and then again in year 9 aged fourteen.

*“I felt like an idiot....nobody explained to me what counselling was about, not even the counsellor. I don’t think I was that bad and didn’t go just to get out of lessons but I knew the school had a counsellor and I needed to talk to someone about things at home, my mum, my dad, my mum’s husband. It was shockingly bad, a really patronising experience...she didn’t even mention anything about confidentiality.”*

Rachel describes herself as someone who gets easily stressed and uptight. She felt this was caused by key people and incidents and sometimes she found herself crying for no reason.

*“Sometimes when I feel really anxious and upset, I become hysterical and say things like ‘what’s the point’. I don’t recognise myself when I’m like this...it’s like an alter ego, like the incredible hulk! It can take ages, hours for me to calm down and be able to think rationally.”*

During these episodes Rachel recalled self harming, using this as a relief mechanism, whereby she would cut her upper arms and legs, “...places where other people wouldn’t see.” She talked about a recent incident at her place of part time work when she arrived late on one occasion. This led to a conflict between Rachel and her manager resulting in her not feeling valued, experiencing low self esteem and becoming hysterical, “...I locked myself in the toilet for about two hours. I was hyperventilating and I couldn’t stop crying. When I eventually did come out, my



*manager asked me if I was bi-polar.” To counter balance this she feels happy when “doing stuff with friends” and “when valued by others”, “...generally I like myself.”*

Rachel’s view of her own mental health and well being is expressed from two perspectives, “...good mental health is when [you’re] calm, balanced, no pressures, can think clearly, do things without difficulty like daily tasks, cognitively function” whereas, “...negative mental health is the opposite, constantly feeling stressed, not being you.” Rachel talked generally about other students at college in relation to mental health issues and expressed a view that other students were experiencing issues similar to hers but that their experiences were personal and individual to each.

Rachel was aware of the college counselling service and if experiencing mental health issues may seek help for the college counsellor however expressed she might feel “uncomfortable talking to someone I would see around the college everyday...that puts me off” and would like there to be an alternative venue, a differently located room. She felt that being “tucked under the stairs” had negative connotations and needed to be more accessible with increased counselling provision and “...maybe someone not connected to the college...people might then be more willing to seek help...I don’t know anyone who has used the counsellor here at college” In addition, someone to run drop in sessions as well as booked sessions and someone qualified, possibly a specialist in mental health work, “...someone who doesn’t make you feel, ‘aww poor you’”. Rachel explained this was based on her own experience of counselling at school and that the counselling provision within the college could be enhanced by “...having male counselling staff and staff from other (than white British) ethnic backgrounds.” (The role and provision of the college counselling services are revisited and discussed in chapter 7).

I asked Rachel if her personal experiences of mental health issues had influenced her career choice in any way. She responded thus;

*“I am hoping to do law, medical law and then mental health nursing...it’s just that quite a lot of people in my family have had really bad mental health problems...I think people should be made more aware, the problems it poses...I don’t know, maybe I am going to make a difference.”*

## 5.9 Understanding Rachel

Rachel's experiences are influenced by those around her and 'absent' people, even though they had been present. Her life experience has exposed her to other people's enduring mental health issues (her mother) and she has cared for them throughout her childhood and adolescence. As a very young child she experienced her parent's separation and divorce resulting in periods of emotional, social and financial instability and a degree of loss in respect of her relationship with her father. Rachel's mental health issues appear strongly influenced by her personal experiences, specifically in relation to her mother.

Rachel was exposed to her mother's mental health issues from an early age and variously described her mother as "*really depressed*", "*dead behind the eyes*" and "*[she] suffered a mental breakdown*". In conjunction she reflected on her own mental health and described herself as "*anxious*", "*hysterical*" and "*having low self esteem*". Rachel's use of professional language to describe herself, her experiences and potentially how other people viewed her was used freely and confidently across her narrative. Her use of professional terminology could be due to a number of factors including personal and social exposure. It is also interesting to see how Rachel labels her mother then counter labels herself.

The concepts of labelling and stigma derive from an interactionist sociological perspective, focusing on the symbolic meanings of health and illness (Becker, 1963). Thus for interactionists, it requires at least two people for a deviant act to occur; someone to commit the act/demonstrate the behaviour and someone to define or label it as deviant. Later, Lemert (1967) recognised the importance of the reaction of others in the explanation of deviance, distinguishing between primary and secondary deviance. The former consisting of deviant acts with any number of causes before they are publicly labelled and latterly, much more significant because it alters a person's self-regard and social role(s). In the case of mental illness, primary deviance represents the illness experience. Secondary deviance is constituted through diagnosis via a process of classification. As a result, a person is labelled ill (deviant from the 'norm') or healthy. Shared public and personal stereotypes are generated from such disease labels, resulting in the behaviour change characteristic of secondary deviance.

Browne (2002) cites examples of how labelling people, depending on whether or not their behaviour is deemed conformist or deviant, contributes to how individuals and groups are responded to in wider society. Once a label is 'attached', stigmatisation leads to the amplification of their deviance (Lemert, 1972). There is evidence in Rachel's narrative to suggest the existence of labelling on a micro scale within the family, influencing the construction of individual identities.

Rachel's choice of career in caring appears to be based on a combination of factors. In the first instance she expressed a desire to pursue a career in medical law. This suggests a desire for reparation and resolution; possibly based on unresolved childhood events and experiences (Thomas, 2006). Later, having stated she wished to pursue a career in mental health nursing, Rachel goes some way to further substantiate her career choice; "...quite a lot of people in my family have had really bad mental health problems...I think people should be made more aware [of] the problems it poses". Here Rachel is extolling her need to 'give something back'. Therefore a career in caring appears to offer a worthwhile and satisfying career, where "*maybe I can make a difference*" and gain a sense of fulfilment; a conscious decision (Tillett, 2003; Thomas, 2006).

### **5.10 Tom**

Tom started off by telling me he had been born the day the local church steeple fell off, "...so everyone says that's a bad start!" The youngest child of three; a sister six years and a brother two years his senior, respectively, born to parents who had met whilst his father was serving in the army and his mother was a groom at the military stables.

Tom has vivid memories of his early upbringing, this predominantly being monopolised by his father's aggressive and physically violent behaviour towards his mother, until the age of five when his parents separated. Tom recalled his mum being very upset by his father's departure but he was happy he had gone. After his father left, Tom's story is a mixture of positive and negative experiences featuring personal anger management issues, "*I had an anger problem...when I would lose my temper I would hit people. That was one of my releases, beating people up*". Tom reflects that this stemmed from witnessing his father's behaviour towards his mother, and occasionally

him and his siblings. The anger issue features from an early stage in Tom's life, whereby he employed this strategy from an early age. Tom talked of positive relationships between himself and his mother and with his brother, but of a difficult and strained relationship with his sister and the disclosure of the instigation of a game "of a sexual nature" when he was six.

*"I'm not sure where she got it from... she was only about twelve so that at that time she was quite young... I'm sure it wasn't anything malicious but she referred to it as a game and we would have to do things sexually to her...I think it happened to my brother as well but I haven't spoken too much about his side but I know it happened to him occasionally....that is why I think he is so withdrawn from people in general."*

This game came to an abrupt halt several years later when Tom then aged fourteen, challenged his sister and refused her demands. This incident was overheard by their mother.

Tom progressed onto secondary school in his home locality as expected aged eleven but later that year was withdrawn from school by his mother (as was his brother), following continued anger issues. Home tutoring then ensued until Tom was fourteen, when he asked to rejoin main stream education, "...because I wanted to get my GCSEs and go to university". Under close supervision from key mentors including his best friend's father, "my surrogate dad" and his head of school year, Tom was successful in achieving six A to C grades at GCSE. At this point he decided to join the Army, where he spent the next eighteen months. However, one day on exercise, he damaged both knees resulting in him being medically discharged just a couple of months later. Whilst receiving treatment and awaiting his discharge, Tom came into contact with a member of the WRVS<sup>14</sup> who helped in the military hospital;

*"...I used to talk to her and she was a good listener... she told me I was bright and should go to college and then university and then maybe even come back into the army as an officer...but I knew this last bit wouldn't happen after being medically discharged...I stayed up north for a while, found some building labourer work...made*

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<sup>14</sup> Women's Royal Volunteer Service

*a group of friends but looking back, that's when my alcohol use and anger issues got out of control...you see whilst I was in the army, I was doing well, in control and had structure...coming out made me feel a bit lost even though I got myself into work...I drifted back home to get sorted out, get another education and leave that all behind."*

Getting "another education" included exploring his post army career options and joining Wenhill College on a fulltime health and social care programme.

*"What are my aspirations for coming to college?...When I finish I am planning on spending a couple of months travelling to a third world country and working, you know helping...then I want to go to university and study youth justice and criminology...I see myself working with young people in rehab with substance misuse problems, bit like I had."*

Tom's interest in health and social care was also influenced by his mother's mental health issues which he describes thus;

*"After my mum had her last accident I was about eleven...she had a few, falling off horses and she used to ride a motorbike...she damaged her knees and back...she struggled to work after then and got classified as having depression...really difficult time...for us all."*

Tom recalled that it was at this point in his life that he became interested in psychology and his mother encouraged his curiosity, buying him books on the subject. This formed part of his home tutoring programme and continued throughout his (brief) military career and his health and social care studies at the college. Tom reflected on his time at college, his own current state of mental health and how he managed emotionally;

*"I'm out most nights which isn't good because I'll fail college if I carry on at this rate...but I'm a sociable person and I go out to relax, enjoy a few drinks...I'm dealing with my anger issues...not in a formal way...I get moods coming from depression sometimes but I try to deal with these myself, do something about these...I think I get these moods because of what has happened in my life...my dad's anger...my mum's*

*depression...my sister's behaviour...but if I can't deal with how I feel I will drink and this leads to me feeling angrier and can lead to me being aggressive, even violent...I guess it's a form of self harm as is my promiscuous sexual behaviour...maybe it's genetic or simply learnt behaviour."*

Tom suggested that if he were to seek help from within the college support network he would like to be able to talk to a male counsellor, possibly to address his anger issues, "*someone I can trust*". Tom also expressed a wish to see the inclusion of an anger management programme within the college in addition to a venue where students experiencing stress could access to relax. He also suggested the use of 'anonymous counselling' whereby counselling support and advice could be offered via mobile phone text messaging, "*...because some people are paranoid, possibly not wanting face-to-face but just wanting.*"

### **5.11 Understanding Tom**

Tom recalls his father's behaviour as being a defining feature of his upbringing, influencing how he himself learnt to deal with challenging experiences and managing personal relationships. Furthermore, it is evident in Tom's story that his dependency on alcohol fuelled his angry, violent temperament but also helped him cope with stressors. Tom's mental health has been influenced by external factors including parental conflict, his mother's physical and mental health issues and (sexual) abuse. This in turn has impacted on his social relationships and education, whereby he has employed strategies such as aggression, observed from role models in dealing with conflict (Bandura, 1977). He also talked of being 'rescued' by key people in his life. People who have provided positive role models for him – his mother and brother, his best friend's father, school head of year and learning support and a civilian woman from the Women's Royal Voluntary Service whilst serving in the Army. Tom's mental health issues are not separate or parallel to his life but run as an intrinsic thread throughout (Gilleard *et al.*, 2005; Friedli, 2006).

Tom's academic expectations of further education were clearly evidenced in his desire to "*get another education*" post discharge from the army (McFadden, 1995). This in conjunction with his various life experiences may have influenced a career choice in health and social care. This 'second chance' education (Jephcote *et al.*, 2008) viewed

as ameliorative and compensatory, is underpinned by Tom's aspirations to work with young people in rehabilitation for "...*substance misuse problems... like I had*" supporting the notion that a career choice in health and social care is often based on the desire to make a worthwhile difference to people's lives (Thomas, 2006).

Tom suggested the inclusion of male counselling staff within the college support network ("*someone I can trust*") and an anger management programme. Here he has suggested the provision of a service for others he would like to have available and accessible for himself. (The role and provision of the college counselling services are revisited and discussed in chapter 7). Malan (1979:139) refers to this as the 'helping professions syndrome' in which the professional "*compulsively gives to others what he would like to have for himself.*" Although Tom is a student and (not yet) a 'helping professional', Malan speculates that such behaviour perceives other people's needs as demands that the helper or carer tries to satisfy. Unsuccessful intervention results in projected vulnerability for the helper/carers. Tom's latter point made in relation to 'anonymous counselling' demonstrated insight into the potential labelling and stigma associated with mental health and seeking help (Jones, 1994). Adolescent's perception that sharing their mental health issues and expressing their related needs continues to attract overwhelmingly negative connotations, reflecting non conformist behaviour (Browne, 2002).

### **5.12 Jordan**

Jordan started telling me her life story from the point of 'where she was at' in terms of her college life and experiences during the past year in further education. She had come to the college as a Pre-16 student onto a programme of study for students excluded or considered disaffected at secondary school and progressed onto a fulltime foundation childcare course in September 2008. At this point in our meeting I drew Jordan's attention back to the life path she had constructed and asked her to 'talk me through it'.

*"I was told by my mum that I was born on a foggy evening because no-one came to visit her until the next day because she told them not to and then she cried about it. I*

*know that...my earliest memory was not wanting to go to playgroup. No-one wants to go to playgroup.”*

Jordan did eventually attend playgroup and then started primary school in 1996. Towards the end of her time at primary school, the situation at home became “*very difficult*” between her parents, resulting in her parents first period of separation when Jordan was eight. Prior to this her mum had taken an overdose but survived. Following her parents separation, Jordan’s maternal grandmother died.

*“I started not wanting to go to school for a couple of years and that was near the end of my primary school experience... I started having problems with school.”*

Jordan was being bullied and started to experience panic attacks, was unable to sleep in her own room by herself and feared going to school because she believed her mum would abandon her too, as her father had. However she completed primary school and in 2002 Jordan progressed onto secondary school. She used this life event as a benchmark for other memories in her life such as her mum, “*being put on antidepressants*”, her paternal grandmother dying and moving house.

*“I think mum’s depression started mainly with her bad back but my dad as well because he left, then came back when my [maternal] Nan died and he left after that. She got down because she lost her mum and then lost my dad. She struggles being a single parent with two kids on one salary...lots of money worries”*

She had close relationships with her grandmothers but described her paternal grandfather as “*an alcoholic*”. Her relationship with her dad was special which she describes thus;

*“I was very much a daddy’s girl. I absolutely love my mum to bits but I am very much a daddy’s girl. He would take me to school, pick me up and take me home. Sometimes we would go to the park...you know stuff like that...he was the one to make me laugh. He would ring me up just to say hello. Little things like that. Lots of little things like that. Special.”*



Jordan describes the “*complete and utter shock*” of going to bed one night and waking up the next day to find her dad had gone “*...my dad was the most important person in my life and I could not live without him.*” She was nine years old. Jordan attended secondary school close to home but the bullying continued “*for no apparent reason*” and every year got worse. Jordan received some support in year 7 and says to start with the school were “*really good about it*” but by the following year, she felt the school had “*given up*”, “*didn’t want to help*” and “*could not be bothered*” with her. Jordan responded to the experience of being bullied by engaging in self harming behaviour, “*...I have the scars from self harming [shows me her arms]*”, dropped out of school in year 9 and received no formal education throughout year 10 apart from some minimal home tutoring a couple of hours a week. During this period Jordan was referred to and seen by a psychiatrist on one occasion, “*...I only went once though – I didn’t go back because I didn’t like her*” and a counsellor who “*...the only thing she managed to achieve was to get me to sleep in my own room.*”

At this point, the school board in conjunction with the college agreed Jordan could enrol onto the Pre-16 programme of study, which Jordan says was because her dad “*put his foot down*”. Jordan found this period in college very difficult and talks about how her experiences at secondary school and college (as a Pre-16 student) affected her mental health.

*“I couldn’t cope. I was depressed. I became very suicidal...very, very suicidal and I started to self harm”*

Jordan was taken by her mum to see the doctor (aged fourteen) at which point her GP prescribed antidepressants. She told me that she would have gone to the doctor herself but probably not as soon if her mum had not made the appointment and accompanied her. Jordan felt the antidepressants were effective. The medication lifted her mood, stopped her feeling suicidal, reduced her self harming behaviour and improved her appetite although she later admitted that her eating had become disordered and remained so throughout her time in further education. Jordan completed the Pre-16 programme and progressed onto a fulltime course in childcare.

*“The year started out really bad because of a conflict with one, maybe two, of the girls on the course...she left thankfully and all that calmed down so it kind of panned out from there. It was a bit rough at first but now it’s good”*

She went on to talk generally about college and her plans following her current programme of study. Originally she wanted to do one of three things – be a vet “*but I get way too emotionally attached to the animals so I could not do that*”, an Egyptologist, or a Social Worker “*...because I’ve always liked helping people and people always naturally come to me with their problems so that is what I’d choose to do...I would like to help people, no matter how I do it.*” She then talked about her previous experiences in education including secondary school and as a Pre-16 student at Wenhill College the previous academic year.

*“It was very nerve wracking at the beginning having this other girl around. It wasn’t new to me because I’ve always had people like that through my whole school life but it was something I could just do without.”*

Jordan describes this experience variably as “*scary*” and “*horrible*” and then talks specifically about her experiences on the Pre-16 programme.

*“I hated that. I absolutely hated the pre-16. The time being a pre-16 wasn’t good at all. I hated it! Probably worse than school was and I left school because I got bullied but ended up going to pre-16’s with all the kids that had been kicked out of school for bullying, so it was bad for me. It wasn’t a good experience. I attended the lessons but I didn’t get on with the other people at all. They were too immature for me.”*

Jordan talked about her friends – friends of her mum’s and a small number of friends from school she had kept in touch with who she felt would offer her support. Having previously described herself as “*someone who struggles to make friends and get on with people my own age*”, she has formed friendships with people she has met via the internet and describes them thus;

*“...I’ve got friends dotted all over the world really...Egypt, Australia, America...and in England, in Manchester and London. I’ve actually become quite close to people on*

*the internet...I've never met them but it wouldn't stop me becoming close to them at all"*

Jordan talked about what influenced her mental health in the past and present.

*"Definitely parental conflict, mum, family history – she's been on antidepressants and tried to kill herself...definitely bullying and loss, definitely loss...pets, my dad, my grandparents....poverty as well – we've always been on the poorer side of things and sexism, my body image and self image"*

Towards the end of our second meeting, Jordan talked about 'where she is at' now. She talked openly about support and how she has "tapped into" this both in college and externally. Having been referred to the college counsellor by her personal tutor, Jordan had attended six sessions and given our meetings took place very close to the end of the academic year (June 2009), she talked about "needing support" over the summer before she returned to continue her studies in September when she planned to pick up with the counsellor again "...it's easier than getting a new counsellor every year". I asked her what sort of support she thought she needed and why. She was initially unable to say what sort of support she needed but could say why, "...otherwise I'll just crash and I can't afford to do that"

### **5.13 Understanding Jordan**

The influences surrounding Jordan's mental state of health, are complex and include external factors; parental conflict, loss, challenging social and academic experiences and her mother's mental health issues. What also arise are notions around the development of personal identity, including the period of time 'being a pre-16' (my emphasis), sexuality and self image. Clearly evident is the experience of mental health issues prior to and during further education from a significantly young age. What is also strikingly evident is Jordan's self awareness in relation to her mental health (issues) and personal 'cost', not only in the past but potentially in the future. She is aware that when her mental health state is compromised, this impacts negatively on a range of personal and learning experiences.

When Jordan expressed her ideas around career choice, it was evident she was not wholly in control of her decision and this had been influenced by others around her

(Schein, 1993). Whilst she suggested ideas relating to veterinary care and Egyptology, progressing through a developmental process which according to Ginzberg (1951) incorporates different phases, she settled on social work “...because I’ve always liked helping people...people naturally come to me with their problems...so that is what I’d choose to do.” Miller (2002) and later Kniveton (2004) purport for adolescent girls career choices are often focused on appearance and popularity, tending to avoid scientific careers. This is substantiated where Jordan reflects on her natural helping status and abilities (Colley, 2006). Jordan had also been a young carer of a mother experiencing episodes of depression and this cannot be discounted from the influential equation in career choice (Tillett, 2003; Thomas, 2006).

Jordan’s experience of further education had not been what she had expected (Harkin, 2006). She is the only student interviewed who had entered further education before her sixteenth birthday, via the Pre-16 Programme of study following a period of absence from secondary school, as a result of persistent bullying. Ironically she enrolled onto this programme only to discover that some of her bullying perpetrators had been excluded from school and were also enrolled onto the same programme as her. This experience contributes to her already held perceptions of adults and their view of her. Furthermore, the continued lack of choice and control around course, career choice and peers, a state referred to by Peterson *et al.* (1993), as ‘learned helplessness’.

Jordan expressed recognition of the ongoing need for support in relation to her mental health issues and this gives an insight into her expectations of further education. As a pre-16 student she referred to the other students as “*too immature for me*” suggesting she anticipated a mature, adult learning environment different to that of secondary school. Later in her narrative Jordan expressed a need for ongoing emotional support to bridge the summer break in her programme and appeared acutely aware of the personal collateral cost should this support not be forthcoming; “*I’ll just crash and I can’t afford to do that*”. These two facets create a dichotomous position. On one hand there is an expectation that the learner is taking responsibility for their learning (the adult environment) a view supported by Furedi (2004). In comparison, there is an expectation on the part of the learner that the provision of support, both in and out of term time will be provided, reflecting the growing perception that further education

provision is becoming a therapised environment rather than a learning one (Ecclestone and Hayes, 2009).

#### **5.14 Concluding remarks**

The purpose of this chapter was to present the student narratives and provide an overview of the key themes arising from each student narrative by means of a theorised summary for each. What is conveyed through these student narratives is their complex, often turbulent lives and the social impact of their wider lives on individual mental health states and further education (Jephcote *et al.*, 2008). Also evident here is the pursuit of career choices in the caring professions, motivated by an altruistic desire; in some cases to seek resolution and reparation but ultimately to ‘give something back’ (Wilgosh, 2002; Colley, 2006). Furthermore, the student narratives indicate varying experiences in relation to help-seeking behaviour both within the college and external to it, with evidence of learned helplessness, rooted in relation to cause and effect (Seligman, 1976; Peterson, 1993; Bloomer, 2005; Cherry, 2013). These themes are revisited in chapter 7 for further analysis and examination.

All the students who volunteered and subsequently participated in this research were studying within the Department of Health, Social Care and Early Years on campus one. Those studying at level 3 were pursuing a programme in health and social care, whilst Jordan, was undertaking a level 1 course in early years and childcare. The selection of health, social care and early year’s participants was non-intentional; however is acknowledged here as being influenced by insider researcher positionality (Riddell, 1988) and established attachments to and involvement with the institution (Sikes and Potts, 2008).

The following chapter presents a reflection of the experiences of staff working with students who have experienced mental health issues studying on campus one within Wenhill College. Collectively staff came into contact with students experiencing mental health issues in differing circumstances and environments across four different campus sites, depending on their role. When analysing and reviewing the data, I decided to increase the focus on the group of staff from campus one; itself a bounded social setting within Wenhill College (Flyvberg, 2006). The collective staff representations (Atkinson and Coffey, 1996) create a more detailed, in-depth case

study (Stake, 1995) and thick description (Geertz, 1993). This complimented the student data and emergent themes could subsequently be cross referenced.

## **Chapter 6**

Managing and supporting adolescent health and social care students with mental health issues: the staff perspective

### **6.1 Introduction**

The purpose of this chapter is to present a reflection of the experiences of staff working with students who have experienced mental health issues studying on campus one within Wenhill College. I have selected to present the narratives starting with

Maria and Kate. These are two teaching/tutorial staff members from the Department of Health, Social Care and Early Years; those who have day-to-day contact with the students, some of whose narratives are included in the previous chapter. These are followed by the campus college counsellor Helen - an expert view and finally, two members of the college senior management team; George and Jane, because their roles are directly linked to the welfare and management of students and offer the college policy perspective. Each narrative is presented individually followed by a theorised summary. The collective key themes from these staff narratives will be revisited in chapter 7 for closer examination and further analysis.

## **6.2 Maria**

Maria joined Wenhill College on a substantial part time basis, working in the Department of Health, Social Care and Early Years. Prior to this appointment, she had gained a Diploma in Social Care, worked in older adult and dementia care, in addition to gaining a Certificate in Education. When we met, her role involved the programme management of the BTEC First Diploma (Level 2) in Care and encompassed the responsibility of personally tutoring the students enrolled onto this programme of study and a significant proportion of the teaching content. I asked Maria about her current role and whether or not she had come across any students she thought might be experiencing mental health issues;

*“I worked out the other day that out of my programme of eighteen students, which is reduced from twenty six at the start of the academic year for various reasons, that I possibly have one student who I haven’t managed to identify, as having a mental health issue...every single student on that programme has some sort of mental health issue and some are quite severe.”*

Maria continued;

*“...it is about 95% of the programme and I have never had a programme like it! You always have those with health issues, mental health issues, social issues...the one who seems normal, although I am reluctant to use that word, she’s the most average teenage girl in the class...the rest have huge issues, some of which are mind-boggling!”*

In terms of the figures Maria had suggested, we discussed how these apparent issues came to light; did the students disclose? Was it manifested through their behaviour?

*“Some students have disclosed...only one identified they had mental health issues when interviewed...the others have shared information during personal tutorials and on the other hand, the majority have been identified through their behaviour in class, which at times has been very disruptive.”*

The types of mental health issues Maria identified students experiencing were diverse and what became evident during our discussion, was her previous experience of working in social care and how this underpinned her use of professional terminology when describing and discussing individual student experiences. For example, she referred to one student as “...*she’s clearly depressed, very up and down and I have wondered if she’s got bi-polar.*”

Maria reported that collectively amongst this particular student group, their mental health issues included depression, anxiety, poor self esteem and self harming behaviour, caused by, in her opinion, various sources of pressure (parental, peer, academic), previous experiences of being bullied at school and the influence of substances such as cannabis and alcohol. As our discussion progressed, we refocused our conversation around the support available to students experiencing mental health issues and how staff could manage these cases arising. Maria responded thus;

*“Knowing about these issues before they [the students] came to college would be helpful, at least then we could plan support but it’s difficult because if they are experiencing mental health problems prior to coming, they might not want to share that information for fear of other people’s responses...and the reality is, that some students don’t know they are not well...others develop issues whilst at college...but it’s not my job to counsel them but send them in a helpful direction...to the counsellor although some of these kids have had such dire experience of counselling before, mainly at school, they’re reluctant to go... Connexions or if needs be, their GP, TIPS [The Independent Psychological Service] or professional people in the community.”*



Maria's closing remarks summarised a reflective view, whilst identifying what could be done to enhance her skills in her role as programme manager, lecturer and tutor;

*“Even though I have worked in health and social care, I'm not trained and don't feel equipped in my role here to deal with these students and the nature of their problems, particularly in the way it manifests through their behaviour and in the classroom...I don't have enough time, either in or out of the classroom and could do with some training and support...that would be the biggest help.”*

### **6.3 Understanding Maria**

Maria's use of professional language and potentially, the diagnosis and labelling of students displaying certain behaviour is employed freely across her narrative, yet she describes herself as having no specific professional training in mental health care, solely in health and social care. Maria's judgement around certain students and *“they do not know they are not well”* raises questions around what this is based on and whose standards and definitions; is this solely her individual perception or that of the college and the wider context, educationally and societally?

Maria's use of the term *“not well”* suggests she believes and perceives mental health as an illness; theoretically a contested concept defined in a number of ways.

Underpinned with negative connotations, this notion rejects the possibility that individuals can experience multiple health facets and views the whole person as unwell. A view ostensibly accepted by the medical profession and the lay, non professional population in western culture. Layard (2005) suggests that mental health and mental illness are two different concepts and the term 'mental health' is essentially a modern concept. Modern notions of mental health consider the notion that there is a state of positive health which can co-exist with illness (Jenkins, 2002; McCulloch, 2006; Mental Health Foundation, 2005a; 2005b). McCulloch (2005) and Layard (2005) agree there is a significant relationship evident between good mental health and positive life experiences. Pilgrim and Rogers (2003) support and agree that an individual's mental health state is not a random misfortune but is influenced by singular and/or collective external factors, unless it is of a biological, organic nature.

A sense of frustration, *her* frustration, permeates this narrative – too many students and not enough time (James and Diment, 2003); identifying the need for training in being able to support and manage students experiencing mental health issues, in addition to gaining insight to the behavioural tendencies displayed by those students, in the classroom. Further evidence across her narrative strengthens her argument and an example of this includes, “...*even though I have worked in health and social care, I’m not trained and don’t feel equipped in my role here to deal with these students and the nature of their problems.*” Carrying out and adjusting to a role she did not expect to play (Gleeson *et al.*, 2005; Avis and Bathmaker, 2006). However, prior to highlighting her lack of training and time, she freely employs professional language and terminology, “...*she’s clearly depressed...and I have wondered if she’s got bipolar.*”; the likes of which have permeated everyday social conversations and contexts in recent years (Ecclestone and Hayes, 2009) and presumably may be due, to her background working in care.

There is also the sense that she sees herself, in her role, as responsible for identifying those students experiencing mental health issues, almost as if it is a personal/professional venture, suggested and supported by the statement, “*I haven’t managed to identify...*” This suggests a number of key aspects. Firstly, the students’ behaviour is because of their (apparent) mental health issues and not due to their ‘normal’ adolescent behaviour. Secondly, the preparation for emotional labour and a career in caring (Colley, 2006) and furthermore, that students in further education require more emotional support than in the past, thus creating a more emotionally focused role for tutors and lecturers (Ecclestone and Hayes, 2009).

There is further evidence of contradiction within this narrative whereby expectations and judgement, wear the same mask; stigma. Maria suggests, “...*some of these kids have had such dire experience of counselling at school, they are reluctant to go [for counselling at college]*” and “...*they might not want to share [that] information] for fear of other peoples’ responses.*” Here she is extending an understanding of the students’ previous experiences and their reluctance to seek help whilst empathising that the sharing of information has risks, possibly attracting a label and stigma (Browne, 2002). Whereas, “...*you always have those with mental health issues*” projects a judgemental expectation about the ‘type’ of students who study within

further education and those who select a programme of study leading to a career in the caring professions.

My final point in this section relating to Maria's narrative reflects 'in her opinion' the various sources of pressure (Bloomer, 2005; Jephcote *et al.*, 2008). This includes academic, parental and peer group, in addition to student experiences of being bullied at school and the influence of cannabis and alcohol on their mental health, leading to anxiety, depression, poor self esteem and self harming behaviour. In recognising that adolescence is an identified phase of development (Coleman and Hendry, 1990; Hall and Jefferson, 1976), Aggleton *et al.* (2000) and later Baker (2004) suggest that adolescence is a more stressful time for parents of adolescents, challenging the notion that the period of 'storm and stress' is more about the projection of adult fears, in this case, Maria's, than those of young people themselves (Hall, 1904). This also colludes with the notion of what constitutes mental health issues in adolescence suggesting this is derived from adult perceptions and constructs of adolescence (Aggleton *et al.*, 2000).

#### **6.4 Kate**

Kate's career prior to joining Wenhill College as a lecturer involved working as an Early Years Practitioner within playgroup settings, including rising to the role of deputy manager of the Wenhill College nursery. With the opportunity to do, "...*a small amount of teaching, just a few hours a week*" and continuing to work part time in the nursery, Kate's role gradually developed to include Programme Leader, personal tutor and lecturer on a foundation in childcare course within the Department of Health, Social Care and Early Years which is her current role.

*"As Programme Leader, my job is to manage and oversee the programme on a day-to-day basis...the students [on the programme], don't see me as a programme leader but I am always their tutor...a nurturing role...I feel my role is listening to students, supporting their academic targets but predominantly at this level, it's about supporting their emotional wellbeing and we do a lot of touchy-feely stuff and on a Monday, after the weekend, we get together and have circle time...talk about our weekends, what was good, what wasn't so good. This helps minimise gossip and get them ready to do childcare related topics."*

Kate reflected on the college policy of setting SMART<sup>15</sup> targets in relation to students' academic goals whilst recognising, *"...at this level it seems to be that the targets we discuss are more personal ones...by this I mean personal and emotional, often prioritising these over academic targets"*

As tutor, Kate operates *"an open door policy"* which creates accessibility for students who, *"need to have someone to listen to them."* She reported that in the majority, these approaches from students are recorded and usually easily remedied, whereas sometimes, students present with *"serious issues"*, including health problems, of which some are mental health issues; *"...they come here with lots of baggage and need nurturing."*

*"I'm thinking of two particular students...one was a more mature student, aged twenty...had a very supportive family with both mother and father together and older brothers. She was four years older than most other students on the course and a history of mental health issues, mainly depression but some self esteem issues as well...the other student was very vocal, very loud and ready to go to war! She also had a history of mental health issues, including self-harming behaviour...but both students were very able academically, achieving outstanding results in their assignments and coursework."*

Kate's awareness of these students' mental health issues occurred in different ways. For example, the student who returned to (further) education aged twenty with self esteem issues and depression, disclosed to Kate during their initial meeting, at interview, her mental health issues, whereas the second case she has referred to would, *"...have her hair across her face and hide behind it...she could be very opinionated and personal about other people but actually was not able to cope with things and as it turns out, felt very low about her self esteem, her perception of life and her own abilities."*

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<sup>15</sup> Specific Measurable Achievable Realistic and Timed

Kate identified from her perspective, the types of mental health issues students experienced, including anxiety, poor self esteem, depression, anger management issues and self harming behaviour. Furthermore, issues arising in relation to self image and their relationships with, “...boyfriends, girlfriends and parents”, pressures “to do well and succeed on the course”, and stressors such as financial hardship and those of a sexual nature, as well as peer pressure and “generally feeling vulnerable”. The programme of study Kate is responsible for managing predominantly attracts female applicants, usually aged between sixteen and nineteen. However this programme has also recruited a small percentage of male applicants, on average one per cohort, per year, on which Kate reflects thus:

*“...most years we have one male student which is good because it means a more balanced group in terms of dynamics and that men can work with children too! But we did have one male student we’ve dealt with previously...turned out he was suffering from anorexia...the severe weight loss in a short period of time made us aware that something could be wrong.”*

Our discussion progressed to include Kate’s definition of positive mental health:

*“I want to say health and (their) stability...I think it’s about how you cope...how you cope with things in general and how you deal with your thought processes and deal with things that come into your life, different situations and how it affects you.”*

Kate was of the opinion, based on her experience of working with students in further education at Wenhill College, that there was a variety of support systems within the college network which were helpful including “a few counsellors in the college” where students can go to “speak on a one-to-one in confidence about any issues they may have.” Kate’s view was that students should seek to refer themselves however she had referred students in the past, “who felt unable to.” In addition to the college counsellors, Kate reiterated the role of personal tutors in contributing to the support network of the college, whereby “students can seek support and talk”. The Community Campus Volunteer Programme (CCVP) has also in Kate’s opinion, enhanced the support network for students on “an intrinsic but peripheral level” whereby this provision has been employed as an educational vehicle as part of the group tutorial programme in seeking to raise awareness of key issues, including those

relating to health and wellbeing. Furthermore, “...we also do stop the track weeks at various points throughout the academic year...this is where students can catch up on their work which I think is quite a good idea as students who are experiencing stresses and anxiety about issues, inside or outside of the college, can stop, steady things down and they can then concentrate on what needs to be done.”

In terms of external agencies and services to support students with mental health issues, Kate’s awareness extended to include the Samaritans and Cruse bereavement and was dependent on, “...what you class as being mental health issues” and the recognition that there was, in her opinion, a need to educate and train staff to have a greater, better understanding about supporting and managing students experiencing mental health issues.

### **6.5 Understanding Kate**

Kate has no specific training in relation to working with adolescents, nor in recognising, supporting and managing students experiencing mental health issues, yet is of the opinion her professional background, training, experience, knowledge and skills in understanding children’s development (social and emotional learning), has provided her with a foundation and transferable skills in working with students aged sixteen to nineteen (Colley, 2005). She clearly sees her main role as a pastoral care tutor, a helping, nurturing role, (“...the students on the programme don’t see me as a Programme Leader” and “we do a lot of touchy-feely stuff”) which is arguably an early years approach to interacting and engaging students within their learning environment in addition to, “we get together and have circle time”, which Ecclestone and Hayes state is not new to further education, having been a mainstream activity, ‘long before primary schools’ (Ecclestone and Hayes, 2009:76) This approach engages her childcare students in the preparation for emotional labour, whereby the content and delivery style of the curriculum, dictates the development of an overtly emotional identity and disposition (Colley, 2006).

In Kate’s opinion, the level of the programme she is responsible for overseeing and preparation for the profession the students are studying for, prioritises emotional well being over academic ability, success and achievement (Ecclestone and McGiveney, 2005), in addition to the need to develop other attributes within the wider context of learning (Department of Education and Skills, 2003; 2005c). This is emphasised by

Kate's reflection on the Wenhill College policy of setting SMART targets in relation to students' academic goals, whilst recognising that "...at this level it seems to be that the targets we discuss are more personal ones...often prioritising these over academic targets" in addition to her belief that "[these students] need someone to listen to them...as they come here with lots of baggage and need nurturing" suggests she has adopted a surrogate parental role and signed up to a therapeutic educational ethos, prioritising the subjective emotional over formal, objective learning (Frykolm and Nitzler, 1993); recasting her from teacher to facilitator of learning whereby authority, rigidity, objectivity and power are replaced by the promotion of a shared learning experience created by an empathic, subjective approach (Ecclestone and Hayes, 2009).

Kate is aware of the role of internal support mechanisms in supporting students with mental health issues, in particular the confidential service offered by the college counselling provision. There is further evidence here of her nurturing approach where she takes responsibility for referring students "...who felt unable to [refer themselves]" The notion of acting in lieu of a parent by referring students for counselling links with theories around who gives a person permission to be unwell whereby they are 'allowed' to adopt the sick role, absolving responsibility for their condition (Parsons, 1951). Browne (2002) suggests that the decision about whether or not someone is mentally unwell involves other people, who make judgements about an individual's behaviour, based on the boundaries influenced and created by wider society and what constitutes 'normal' behaviour (Barry and Yuill, 2002). This appears to be the ethos and approach adopted by Kate (in her role) and the wider college context.

Absolving responsibility is extended further here within the academic context whereby the implementation of 'Stop the Track Weeks'<sup>16</sup> "...is where students can catch up on their work". Furedi (2004) argues that learners should be encouraged to take responsibility for their own learning. He argues that teachers should teach and not provide therapy and colleges should create learning environments, not therapeutic communities, contradicting Kate where she suggests that Stop the Track Weeks not only provide students with the opportunity to catch up on their work but can

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<sup>16</sup> Stop the Track Weeks are scheduled at specific points throughout the academic calendar at Wenhill College to provide opportunities for students to ensure they are up to date with their academic work and meeting their SMART targets. Three weeks in total; one per end of term.

*“...steady things down if they are experiencing stressors and anxiety about issues, inside or outside of college.”*

The Early Years programme Kate leads recruits predominantly female students. The ‘caring professions’ have historically attracted female workers and is evident within this programme (Colley 2005; 2006). Given the gender imbalance, the nature of mental health issues experienced by these students may differ to those studying on other programmes where the gender profile is more equal. However Kate purports that mental health issues are not ‘gender specific’, demonstrated here by the experience of a young male student suffering from anorexia nervosa. This view is challenged individually and collectively. Busfield (1996) suggests that in order to understand an individual’s mental health issues, it is important to consider their gender (DH, 2003; Myers *et al.*, 2005). Piccinelli and Wilkinson (2000) report on the impact of gender difference in depression, notably with higher rates of incidence in women. Palmer (2003) supports this view agreeing mental health issues affect more women than men and Melzer *et al.* (2004) citing gender and social inequalities as a major influence on the distribution and experience of mental health disorders.

## **6.6 Helen**

Helen has a long history of working at Wenhill College in her role as a counsellor. With substantial experience, accompanied by a raft of professional qualifications and counselling accreditations, Helen is the longest serving staff member of the counselling team at Wenhill College. Her current role involves working substantive part time hours with the college in addition to one day per week at a local primary school.

*“It is very interesting to see what sort of problems and issues they (primary school pupils) have, compared with the student population here...although I can see how some individuals experience mental health issues throughout their education careers, arriving in secondary and then further education, with them.”*

Helen’s experience of working with students experiencing mental health issues developed over time and she admits she is not specifically trained to deal with these but has received training in recent years through the local Community Mental Health Team (CMHT) around obsessional compulsive disorders, self esteem, phobias and depression in addition to self harm and eating disorders. Helen’s experience included



coming into contact and working with students who presented with, “...quite a range of things.” She went on to explain thus:

*“I would say the majority possibly are relationship and family issues...of course there are always a minority that will present with things like eating disorders, self harming behaviour...self harming actually something we (the counsellors) have become more aware of. People are disclosing [this] earlier on in the counselling process; they never used to do when I first started and there is a higher proportion of people actually telling us they self harm...Depression...you have to work out who is saying there are depressed. There is a difference between actually being diagnosed as clinically depressed and somebody saying, I’m really depressed.”*

Helen added that in her experience working in further education, there are always students who seek help for issues such as alcohol and drug use/related issues and joint working initiatives with CAMHS<sup>17</sup>, employed to support students diagnosed with psychiatric disorders such as schizophrenia, bi-polar and personality disorders. However the majority are more likely to be family/peer issues, relationships problems, low self esteem and surfacing issues relating to experiences in the past, for example (sexual) abuse.

In terms of student knowledge and accessibility, Helen was keen to elaborate on how students access the counselling service and her preferences for students doing so:

*“Self referral...some of them refer themselves and they can do that through a variety of means; email is quite popular. They can leave letters in reception or a voicemail. Tutors can refer or any staff member for that matter...student welfare services will refer, careers, Connexions...I prefer them to self refer because that normally implies they want to come.”*

In addition Helen recognised that some students do not wish to use the student counsellor in college as she may not “*be the right person for them*” and “*it may not be convenient for them.*” She also believed that people’s previous experience of counselling influenced whether or not they would utilise the college’s provision.

*“It’s very interesting, we’ve had feedback from many younger students saying, I’ve had counselling, it’s rubbish...I don’t want to see the counsellor, they’re rubbish. It’s very interesting to see what their experience of counselling was like before.”*

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<sup>17</sup> Child and Adolescent Mental Health Services

Helen referred to individual's previous counselling experiences as creating barriers to further counselling whilst being clear that this particular provision in the college was facilitated in a very different way, "*...counselling, mental health...they're both taboo needing the myths dispelled around them.*"

And defining mental health?

*"...It's not straightforward and difficult to define... not just about mental health but includes physical wellbeing and the wider social context in relation to an individual's health...it's I think it's also about resilience, ability to cope, positive self esteem...if these become compromised for any reason, this may have a negative impact on the mental health facet of an individual."*

In her previous role, Helen worked as a careers advisor and counsellor which she described as, "*... a lot easier because they [the students] would come to see me under the guise of coming for a careers interview but nobody knew they were coming for counselling*", helping increase accessibility, promote discretion and maintain confidentiality.

In terms of location, Helen talked about the current counselling location whilst recognising there was still room for improvement.

*"Previously there were issues around leading into another room with partitioning and it wasn't sound proofed...not very confidential and students had to walk past lots of other people...this current room is better...it has a window with screening, it's built of brick which is very important but it can still be really noisy because of the corridor. It's ok when there are lectures going on but break and lunchtimes create a lot of passing traffic but when they do the new build, this will be relocated to a quiet, discreet place."*

We moved on to discuss how Helen's role is perceived by different people, starting with students.

*"One thing I am good at is boundaries and I am very clear on what my boundaries are in counselling. I am not here to be friends or anything like that. By being boundaried yet discreet, if I see a student client out and about, this reassures them. I think some students, whether they are having counselling or not, think I'm a bit weird but the feedback I get back is generally very positive and students seem to know who I am and what I do."*

And staff?

*“I think there are lots of new staff who don’t really understand what counselling services do, how we can support them in supporting students and managing their students and what we do with students.”*

What about the college management?

*“...management have very little understanding of what I do. They probably don’t know who I am or the other counsellors. I don’t think in the wider college terms we have a very high profile...I’ve never been asked individually or as part of the counselling staff to participate with regards to equality and diversity for example, yet the students are the cornerstone of what we do and this should include other than just face-to-face work with them.”*

In terms of evaluating her role, Helen referred to, *“...being visible but not wanting to be in the spotlight.”* Reporting statistically annually (See appendix 10 for Wenhill College counselling data) to her line manager prompted her to evaluate, *“...and nobody comes back and says we’re rubbish or anything like that.”*

Helen has been instrumental in assisting the college to set up a vehicle for delivering the Every Child Matters (DfES, 2004) agenda via the Community Campus Volunteer Programme (CCVP). This has seen Helen’s role develop beyond that of counsellor, to one in which she is actively engaged in promoting student wellbeing, *“...if you can’t give people their self esteem and emotional wellbeing as part of education, then what on earth are we doing? Education isn’t just to make sure you get an NVQ<sup>18</sup>, it is also about life skill learning and learning to cope....problem solving skills and having a more rounded life...being proactive around mental health, not reactive.”*

We also discussed ‘at risk’ students; those who are identified by personal tutors and/or programme leaders of being at risk of failing (academically) due to influencing factors and/or mitigating circumstances for example, due to health issues, specific academic needs, social problems or those students who are exceptional entrants onto a programme of study.

*“Being able to identify [them] is a tricky business because we (the counsellors) don’t have access to the data base system where at risk students are identified, recorded and tracked. This is confidential to tutors, programme leaders and senior tutors...so I have no way of correlating counselling data and at risk student data and whether those identified at risk are more likely to access counselling or are actively doing so.”*

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<sup>18</sup> National Vocational Qualification

As we approached the end of our interview, Helen talked about how she would like to see the counselling service develop across the college, specifically in relation to supporting and managing students experiencing mental health issues.

*“I think it would be great to have a welfare officer in addition to a mental health worker...key people with specialist knowledge....sometimes if a student needs support, there are so many people who get involved...there needs to be one person co-ordinating and clarity of role.”* Helen expanded on this thus;

*“...and a college mental health policy, enabling staff to grasp the issue and know how to manage such students in addition to a policy for the management of students who self harm. We have one for students with substance misuse issues...this is a much clearer issues in terms of the law, however mental health and self harm...very tricky.”*

### **6.7 Understanding Helen**

Helen describes mental health issues amongst the student population as “*a growing concern*”, therefore a continued need for counselling provision, based on increasing numbers of students seeking help for a variety of issues, including mental health (Royal College of Psychiatrists, 2003; 2006, Warwick *et al.*, 2008; Worrall and Law, 2009). Helen was insightful about the ‘types’ of mental health issues students presented with and about how others perceive her role; those students who have used the services have fed back “*very positively*” about it.

Helen views her role as a responsive counsellor in addition to educator and Community Campus Volunteer Programme (CCVP) facilitator. Within her role, Helen perceives policies as the key to creating structure; the absence of these creating uncertainty amongst staff, and a better understanding for staff, particularly tutors, about students experiencing mental health issues (DfES, 2001; 2002; 2004; NSPCC, 2004).

In terms of understanding Helen’s values, beliefs and practice, it is important to review how she perceives and defines mental health and in recognising it is a difficult concept to define, Helen’s view is that “*...it’s not just about mental health but includes physical wellbeing and the wider social context in relation to an individual’s health...*” and “*...being proactive around mental health, not reactive*”. Here Helen is adopting a holistic, Rogerian approach (1945) and dismissing the biomedical model

approach favoured historically in western culture which is predominated by reactive pharmacological responses. It is widely accepted by the medical profession and the lay, non-professional population, in favour of the relationship between good mental health and positive life experiences (McCulloch, 2005; Layard, 2005) in addition to the wider social context and personal, individualistic experiences (Holland and Hogg, 2001).

There is evidence within Helen's narrative where she employs professional language, which is to be expected of an experienced person in this role. However she also intimates her awareness of the changing use of language and terminology amongst the students she sees for counselling, "*...there is a difference between actually being diagnosed as clinically depressed or somebody saying, I'm really depressed.*" The terms depression and depressed have permeated our language in a similar way to the word 'therapy'. Often associated with 'American eccentricity' (Furedi, 2004), Ecclestone and Hayes refer to this as 'the rise of popular therapy' (2009:2) and how 'therapy' is everywhere; a term once regarded as a cure or treatment for people who were 'disturbed', 'troubled' or 'mentally unwell', no longer has negative connotations but positive value. Helen suggests that students use the term depression or depressed similarly but without the positive value, rather more often to describe they are feeling low, sad or simply having a bad day.

Helen prefers students to self refer for counselling, "*...that normally implies they want to come*" demonstrating willing participation in preference to adopting the role of victim (Furedi, 2004) and demonstrating they [the student] are taking responsibility for their emotional wellbeing (Asher, 1993). This approach casts Helen in a 'receiving role'. The student has identified a need; expressed this need by self referring, seeks counselling and Helen responds; a student led model to counselling (Ewles and Simnett, 2003). However compare this to another comment Helen makes in her narrative ("*giving people their self-esteem*") the focus and power balance shift. A counsellor's role is to facilitate a process not prescribe, employing a deliberate and structured agenda (Mills, 1959; 2010). This could be construed as Helen's personal and professional view of her role, her normative need (Scriven, 2010) within the wider context of the college and the current therapeutic turn in further education (Ecclestone and Hayes, 2009). An extension of this thinking is evident in Helen's

narrative whereby she identifies wishful future developments to the student support network across the college, “...to have a welfare officer in addition to a mental health worker...key people with specialist knowledge” and at college policy level “a mental health policy” echoing the wider policy landscape across further education and the increasingly regulated frameworks across it (Social Exclusion Unit, 2004; Learning and Skills Council, 2006b; 2009).

## 6.8 George

George’s role at Wenhill College is Director of Student Services. This includes various responsibilities and aspects of student support from admissions, enrolment, careers advice, counselling and welfare, student residential accommodation, student transport and child protection. Prior to his current role, George spent “many years” as a lecturer, senior tutor and careers advisor before branching out into a liaison role to develop a government initiative whereby schools and further education colleges tried to forge a common curriculum.

*“The TVEI<sup>19</sup> project had a lot of government money thrown at it...it was a huge project and this county was a pilot area. I was the college representative, going into schools trying to forge a common curriculum prior to the National Curriculum, which butchered it at a stroke actually...but a lot of good work was done doing the sort of diploma work we are now seeing re-emerging<sup>20</sup>.”*

Following a couple of years working in the school liaison role, George became manager of student services, “...when it was popular to have managers of student services” during the early 1990s”. He remained in this post until becoming Director of Student Services ten years later, “...and have survived two college mergers since”.

George then spent some time talking about the changes he had witnessed within the college over the past ten years and the impact these changes had on his role.

*“...my role [the role] has changed significantly...it has become more complex, more onerous, more about dealing with risk, more risky....we have the whole gamut of child and vulnerable adult protection responsibilities which is huge and getting bigger day*

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<sup>19</sup> Technical Vocational Education Initiative

<sup>20</sup> Here George is referring to initiatives such as 14-19 Partnership Planning (2009) and The Specialised Diploma Gateway (DfES, 2006a)

*by day and new minimum standards which are very much orientated around child protection...a shift in role and much more responsibility”.*

George talked about his role as lead manager and his responsibility to ensure the college has up to date policies and procedures around child protection and vulnerable adults including adolescent students presenting with mental health issues. In his role as child protection officer, George is approached by staff who report concerns seeking advice “*on the way forward*” in addition to actually bringing students to see him who appear to have symptoms of mental health issues. I asked George to tell me about the sort of issues he thought or knew students were experiencing in the context of their mental health and what if anything, were the staff telling him.

*“I have to make it clear, there are very few people in this college that have mental health training and we are certainly not medically trained...we only have an intuitive idea what a mental health problem is...we see people with symptoms of mental health concerns...who are self harming, others with eating disorders...we see people who are suicidal or apparently suicidal and those who are depressed...we see the symptoms... I’m in no position to actually diagnose whether that person has a mental health problem but if I suspect it, it is up to me, us [the college] to make an initial assessment that the person is worthy of a referral, and if it’s a referral, what sort of referral.”*

George added, “*...sometimes these [mental health problems] become more apparent if you’ve got the students in close proximity and you’re dealing with them in an intensive manner, small programme groups or group tutorials for example...the counsellors report they are seeing more people year on year with mental health issues.”*

George and I discussed internal support mechanisms for students who experienced mental health issues. During this part of our discussion, I became aware to what extent the further education sector had changed over the past two decades and George’s perception and experience of these changes.

*“I know it is not fashionable these days but a support network, a network that can identify their problems and that can assess to some extent their needs and support them in their wish to flourish at the college...a person or people who are well informed...having an individual they can talk to, a tutor, a counsellor or a senior tutor...an adult they can relate to and feel comfortable confiding in...maybe I’m a bit old fashioned but three key things...being on the right course and being happy... they may have lots of issues but I believe if they’re happy on their course that’s a huge help...friends inside and outside of college and a good team spirit within their course...and I think we can all play a part in that.”*

I reflected back to George that he had stated the importance of an adult in this process, possibly a tutor and in addition, the expectation of the college in staff to manage and support adolescent students experiencing mental health issues. George responded thus;

*“I think we have capable staff both as teacher tutors and support staff but I think we press our staff very hard...we expect a huge amount out of our staff and particularly of tutors...things have changed so much and we expect them to teach huge numbers of hours covering a wide spectrum of subjects and expect much higher standards in terms of their performance than was the case twenty years ago...we are failing to devote sufficient energy, resources and time in developing and training our tutors...”*

Our conversation progressed around training tutors, specifically in relation to managing and supporting students with mental health issues. George was adamant that if he were to ask tutors if they would like specific training around students and mental health, the majority would say no. However, he suggested that a different tack may work; by asking tutors if they wished to understand why their students behaved in a certain way. George felt this would be more effective.

We concluded our conversation on this final comment from George;

*“I think in general in further education colleges, it is perceived by people like me that adolescent students with mental health problems, is a growing concern...so whatever you find in this college is true it seems of all FE colleges...FE has changed and is continuing to change...”*

## **6.9 Understanding George**

George suggests that his role has changed and become “*more risky*”, set against a policy landscape of child protection and the changing role and learning culture of further education (Bloomer, 2005). Historically, further education was available for students aged 16 plus with a vocational training ethos. The instigation of specialised diploma programmes have created and developed strong links with secondary schools, lowering the age of some students to fourteen across some programmes of study (DfES, 2002; 2004; 2006a; LSC, 2006b; 2009).

George also suggests that Wenhill College is not unique in its experience and that there is “*...a growing concern*” around the management and support of adolescent students experiencing mental health issues. The ever growing responsibility around ensuring the college has up to date policies and procedures to effect appropriate action,



places a positive duty on the college (Broxtowe- Smith, 2007). Furthermore, he suggests that the counselling service reports substantiate a year on year increase in the numbers of students seeking help for (their) mental health issues (Appendix 10).

George was clear that he is not a mental health expert, nor are many of the staff in the college however he discussed freely his experiences of the ‘types’ of mental health issues students experience, how these are brought to his attention and the possible outcomes. *“I’m in no position to actually diagnose whether that person has a mental health problem but if I suspect it, it is up to me, us [the college] to make an initial assessment that the person is worthy of a referral, and if it’s a referral, what sort of referral.”*

This statement conveys a number of facets, none more so than the phrase, *“...that the person is worthy of a referral”*. This reflects the decision making process around who is ‘well’ or ‘unwell’ and involves other people (Browne, 2002). Furthermore, the decision to refer (for specialist input) is made on the grounds of what constitutes normal behaviour for an adolescent (Barry and Yuill, 2002) and is based on adult perceptions and constructs of adolescence (Aggleton *et al.*, 2000). Here George is engaged in a gate keeper’s role, creating a power imbalance between the potentially vulnerable student, his child protection role and the responsibilities of the college.

George verbalises high regard for teaching, tutorial and support staff whilst acknowledging their roles have become increasingly demanding in an ever changing climate. This responds to themes across Maria’s and Helen’s narratives, whereby they both identify the need for further training (Jephcote *et al.*, 2008) and more time to support and manage adolescent students experiencing mental health issues.

### **6.10 Jane**

Jane described her responsibilities as *“manifold”* within her role as Equality and Diversity Manager at Wenhill College.

*“It’s a complex role based here [at this campus]making sure we have an overall strategy for the college ensuring that in terms of equality, we understand legislation, practice compliance in terms of antidiscrimination but really it is about creating the*

*right kind of culture that is based on the values of dignity and respect and valuing diversity.”*

Jane explained how her role had been developed during and post merger with South College in 2008 and that Wenhill College was “*a step ahead*” of other further education colleges. She described her role as “*dedicated to contributing to achieving outstanding criteria*” in the next Ofsted inspection.

As our discussion progressed, I asked Jane to reflect on her contact with staff and students across the college and what sort of mental health issues, were arising. Jane remarked that she was surprised to learn, “*...how prevalent something like Aspergers Syndrome is*” and “*...there’s a lot of students with some kind of learning difficulty*” who come from “*...very challenging social backgrounds.*” She continued, “*...I’ve seen mental health issues, anti-social behaviour and young people on totally inappropriate courses if they are going to be in the caring profession bringing their personal issues [to college]...this isn’t therapy, this is actually education.*”

At the time of our meeting, Jane had been in post for fifteen months having previously spent twenty years working in the field of law; a relatively new member of the college staff, compared to the other staff participants. She used her experience in the differing environments to compare and contrast their respective approaches to equality and diversity and within this, perceptions of disability, specifically mental health.

*“The Disability Discrimination Act of 1995 defines disability as being a physical or mental impairment...therefore, if you have a mental health issue or a learning difficulty, they get clumped together under that piece of legislation and this leads to students being labelled...oh, you’re disabled you’ll go into that group and so on.”*

Jane expressed her concerns around this and how labelling and categorising students led to them abdicating responsibility for their learning as well as their health and well being. I asked Jane to share her definition of mental health; she reflected some of the themes she had already highlighted around responsibility and in addition;

*“I think if you don’t have the capacity to empathise with people and care for them when they need caring for and to respond to their needs, that can be poor mental health and clearly there are some clinical issues around mental illness...but I quite love madness because I think we need madness and I think our society thrives on innovation and the disruption that comes through people who are not considered to be well, by society.”*

Our discussion progressed around the role of further education and adolescent students. Jane reflected on her time in post and reiterated her views around further education being about education and not therapy.

*“I have a strong element of objectivity having joined the college last year...I’ve not been institutionalised like some staff have... I joined the college as I value [further] education but what I’ve seen isn’t really education...its teaching functional skills to people, getting them to do things so they can get work...developing the human spirit...that’s not our job.”*

Jane continued;

*“...within ancient Greek Philosophy, Aristotle says very clearly that vocational skills are for slaves and labourers...education is for a certain class of people because they will be the ones in charge, the learned ones...and I can’t help but feel we churn out labourers and slaves to society and if you are an unthinking, unconscious slave to society, you can still be ok but I think that’s there is something bigger about that...that’s just disabling.”*

Jane continued to discuss her thoughts on this latter point, suggesting that the further education curriculum is more about functional life skills than education and the ability to critically think. Furthermore, the high preponderance of students with learning difficulties across a range of abilities and *“...intelligent young people aged between 16 and 19 who come into further education after compulsory schooling who might not be traditionally academic and maybe that’s their strength and yet sometimes becomes their weakness.”*

We progressed towards the end of our meeting discussing the support available to students experiencing mental health issues and for staff, in managing such students. Jane was clearly aware of the support services available to students, including the college counsellors, tutors/tutorial system and CCVP<sup>21</sup>. In addition, the role of the college senior tutors in supporting tutorial and programme management staff. I asked Jane, in her opinion how well staff supported and managed students experiencing mental health issues. She responded thus;

*“Generally, I feel that a lot of staff are not trained and they feel out of their depth to deal with any kind of diversity that might express itself in that way”*

### **6.11 Understanding Jane**

Jane is explicitly open about the purpose of her appointment into the role of Equality and Diversity Manager; it is underpinned by the Every Child Matters (DfES, 2003) directive to ensure the promotion of equality and diversity for students across the college, with the ultimate aim of achieving an ‘outstanding’ Ofsted rating in the next college inspection.

Jane expresses objectivity around her perceptions about further education (within Wenhill College) and challenges the notion that further education is about formal education but is more about teaching students functional skills in preparation for the workplace, “...*this isn’t therapy, this is actually education*” reflecting Atkins (2007) view that the experience many students have, cannot be called education in any meaningful sense. A view supported by Ecclestone and Hayes (2009) in that further education is no longer solely about formal education but predicated by emotional attachment and nurturing, the subjective overriding the objective. Jane extends her view here where she refers to Aristotle and the notion vocational skills are for slaves and labourers, whereas education is for a certain class of people, the learned few. Further education has morphed through various guises since its inception but historically its focus has been rooted in trade and vocational education (Ecclestone *et al.*, 2005a).

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<sup>21</sup> Community Campus Volunteer Programme

Examples of courses which attract “*intelligent young people who might not be traditionally academic*” include in Jane’s view, the caring professions. Historically, these courses have attracted practical people who learn well vocationally, combining theory with practice. However whilst these programmes of study remain typically vocational within further education, the caring profession courses have seen a significant shift towards academic weighting in higher education, with all health and allied professions including pre-registration nursing, attaining compulsory degree status across the United Kingdom by September 2013 (NMC, 2008a). Jane also reflected her concerns around those students wishing to enter the caring professions bringing their personal issues to college challenging Colley (2006) who argues that designers and teachers of vocational courses need to enable learners to explore their emotional labour as a basis for resisting its oppressive characteristics, in an effort to understand them better.

Is mental health seen as a disability? In her narrative, Jane discusses the diversity of this issue, expressing her concerns around the generation of labels and categorisation of students deemed to have a disability. Jane argues the framework of the Disability Discrimination Act (1995) is useful but needs to be explicit around differing disabilities to enable staff to have a clearer understanding (Overboe, 1999). Whether or not mental health is viewed as a disability is dependent on a number of factors including their visibility or invisibility and their potential to trigger a social response (Goffman, 1968; Shakespeare and Watson, 2002).

### **6.12 Concluding remarks**

The narratives presented here convey a selected staff perspective around the student experience of mental health issues and of their own experience working in further education. The theorised vignettes which accompany each narrative provide some insight into the analysis of the themes, which have emerged from the staff data. Collective evidence across the narratives suggest staff feel frustrated by the expectations of the college; too many students, not enough time and feeling responsible for identifying and supporting students experiencing mental health issues. Trying to ‘do their best’ in the circumstances whilst recognising it is ‘not their job’ (Gleeson *et al.*, 2005; Avis and Bathmaker, 2006) yet expressing requests for training to enable them to fulfil their roles effectively in providing appropriate support

mechanisms for students experiencing mental health issues (James and Diment, 2003). Students in further education require more support emotionally than in the past, creating a more emotionally focused role for tutors and lecturers (Ecclestone and Hayes, 2009; Furedi, 2004) and their behaviour is because of their mental health issues and not their adolescence (Aggleton *et al.*, 2000). There is evidence suggesting an evolved pastoral care role provided by staff, requiring the investment of emotional labour to enable them to manage and support students experiencing mental health issues (Colley, 2006) ; extended to include the support and preparation for students pursuing a career in caring in preparing them emotionally for it.

There is ‘growing concern’ regarding further education student mental health and a continued expressed need (Ewles and Simnett, 2003; Scriven, 2010) for counselling provision, enabling support for those students ‘in need’ (Royal College of Psychiatrists, 2003; 2006, Warwick *et al.*, 2008; Worrall and Law, 2009). In addition, to appoint specialist workers to support students experiencing mental health issues and to have a mental health policy helping staff to understand the nature of (student) mental health, thus enhancing the support network across the college (SEU, 2004; LSC, 2006b; 2009). This is set against a landscape where further education is changing its role and learning culture (Bloomer, 2005), suggesting it can no longer be education, in an meaningful sense (Atkins, 2007; Ecclestone and Hayes, 2009).

The following chapter offers closer examination and analysis of student and staff data; the rise of therapeutic further education within Wenhill College, the role and changing provision of further education within the policy landscape, staff roles, experiences and expectations and the health and social care student experience (of mental health) in further education.

## **Chapter 7**

Further analysis and discussion of results

### **7.1 Introduction**

The narratives presented in chapters 5 and 6 are based upon interviews with the participants and their accounts reflect the values, beliefs and understanding of each of them. My position within this research is inextricably linked and this is a significantly

influential factor when considering how I have analysed the participants' data and consequently, what I 'saw' in the data. I do not claim to have discovered the truth about the management and support of adolescent students experiencing mental health issues in further education; this case study presents my viewpoint in response to the research aims and questions. I am in no doubt that if others had facilitated this case study research, they may well have gone about it differently and drawn different conclusions based on their interpretation of the data (Finlay, 2006).

This chapter presents an analysis of the research results in greater depth, extending the brief vignettes included in the previous two chapters; the focus being to assimilate the data contextually within the literature and suggest conclusions in response to the research questions. Selection for inclusion was based on thematic analysis, recurring and cross referenced themes, common to both students and staff participants. The research themes are presented for analysis under key sub headings starting with learned helplessness; the most strongly conveyed across the narratives.

## **7.2 Problematising the themes**

Crotty (1998) suggests that problematisation is a process which 'sits' within the critical paradigm and is a process involving critical thinking whereby pedagogical dialogue seeks to deconstruct myths. Rather than accepting the myth (common knowledge) of a situation without question, problematisation seeks to clarify the problem through conscious reflection; promoting new and different perspectives and facilitating the emergence of new viewpoints. What makes problematisation different from other forms of criticism is its focus, context and details and is beyond merely the evaluation (advantages and disadvantages) of an argument. This form of criticism does not take place within the original context, but steps away from it to enable reflection and (re) evaluation. Crotty further suggests that to problematise a 'problem' or statement, one should consider five key concepts; who is making the statement, for whom are they making it, why is this statement being made here and now, whom does this statement benefit and who does it harm?

The problematisation of the themes within the context of this research draws on Crotty's definition and understanding of the term, in particular the recognition that stepping away from 'the problem' enables the researcher to reflect, conceptualise and

evaluate definitions of the terminology and the understanding and interpretation of these. However within this context, it is also important to recognise there is a wider debate about using clinically derived concepts in non-clinical settings and that the themes presented within this chapter are considered by me to be emergent themes; unanticipated but overwhelmingly evident across the data.

### **7.3 Learned helplessness**

The notion of learned helplessness is rooted in psychological theories and sociological perspectives in relation to cause and effect. Learned helplessness within the context of psychiatry and mental health is considered a condition in which a person suffers from a traumatic event or persistent failure to succeed and is associated with ‘psychological disorders’. The concept has become defined through a process of experimentation to investigate the phenomena, with strong links to classical conditioning (Seligman and Maier, 1975). Learned helplessness develops through ‘cognitive expectation’ and conditioning resulting in a person learning that they are helpless against an/the aversive stimulus. It is characterised by decreased motivation and negative emotions, formally defined as disruption in motivation, affect and learning, following exposure to non-contingent outcomes (Schunk, 1984; Fincham and Cain, 1986).

It is also associated with mental health issues including depression, anxiety and phobias (Seligman, 1975); all of which can be exacerbated by learned helplessness (Cherry, 2013). Seligman and Maier (1967) and later Peterson *et al.* (1993) suggested when individuals feel they have limited or no control over their situation or environment, they begin to behave in a helpless manner. This inaction can lead people to overlook opportunities for relief or change. Both staff and student narratives convey a sense of helplessness. It is not solely the learning environment provided by Wenhill College that contributes to the culture of learned helplessness (Bloomer, 2005); it includes the participant’s perception of the environment (McMahon, 1997; Derry, 1999) and the staff working conditions too (Seligman and Maier, 1975). The following section explores the notion of learned helplessness as experienced by the participants in this study.

### **7.4 Learned helplessness – understanding the student perspective**



There is strong evidence across the student narratives of learned helplessness and its cause and effects. Each participant expressed an experience of personal mental health issues in addition to being the child of a parent who had experienced ongoing mental health issues; in all cases, this was their mother. Furthermore, each student had been the recipient of surrogacy; an individual(s) acting in lieu of a parent or parents in their absence due to their own mental health difficulties. These experiences have contributed to a number of outcomes including whether or not these students sought help through counselling or external services whilst in secondary school, their career choice in health and social care (Colley, 2006) and their help seeking behaviour or lack of it, whilst studying in further education. I will explore these concepts in greater detail below.

Debbie's life experiences have influenced her mental health and she describes herself as having 'used' mental health issues including self harming behaviour "*to feel better*" and drinking to excess, "*to have timeout*" to manage personal transitions. During her formative years she was cared for by her maternal grandparents in her mother's emotional absence because her mother was using alcohol; her first experience of surrogate care. Emma described her mental health as being "*strongly influenced*" by those around her and similarly looked after by her maternal grandparents during her early childhood in periods when her mother was unwell with post-natal depression and unable to look after her. Both Tom's and Grace's stories included the disclosure of sexual abuse; the sense of their helplessness during these episodes in their lives permeates their narratives. In addition, Tom witnessing his father's violence towards his mother; a situation he felt powerless to stop. For Jordan, the experience of being bullied lead to panic attacks, later discovering her bullying perpetrators had been excluded from school and studying within further education via the Pre-16 programme. Young carer Rachel, struggling to help her mother who was "*...present but at the same time absent because of her own problems*", whilst wrangling with her own developing mental health issues, employing self harming strategies "*as a relief mechanism*" because she often felt, "*what's the point?*".

The student narratives indicate varying experiences in relation to help seeking behaviour. Two of the six students had received 'in-house' counselling provided by their secondary school; Debbie reported a friend took her along to see the counsellor,

“...she'd had enough of watching me refuse to go”. Debbie was later referred to her GP then onto specialist CAMHS<sup>22</sup>. Although Rachel did not comment on how she accessed counselling whilst at school, she felt able to rate her experience thus, “...shockingly bad, a really patronising experience”. Having been a victim of bullying in Year 7, Grace described feeling “really depressed” and “I wanted to kill myself”. She did not seek any support from either her parents or the school as “I didn't feel I could”. Emma and Tom dealt with their challenging educational experiences by ‘opting out’; neither of them sought professional help from their respective schools or services external to these. Jordan reported receiving “really good” support from her school in Year 7 when she experienced bullying. However thereafter, the school ‘gave up’, “didn't want to help” and “could not be bothered”, leading to an engaged period of self harming behaviour and a significant period of absence from school, similar to that of Emma and Tom.

Collectively there are shared experiences evident amongst the adolescent participants. These experiences convey a sense of helplessness influenced by a range of factors. Their early life experiences during the primary socialisation stage of their development (a period normally characterised by the development of values, morals and attitudes learned from immediate family members and the early formation of personal identity) has been compromised. The formation and later further development of their individual personal identities during a secondary socialisation phase, whilst not ‘fixed’ in terms of age, stage of schooling etc., is dependent on the influence of other agents and environments external to their immediate family. These ‘socialising agents’ in a constantly changing society include school/other formal education, the media, religion and peers. The student experience of parental mental health issues has evidently been projected or transferred from the adult to the adolescent and in some cases, counter transferred leading to a complex emotional entanglement<sup>23</sup>. The role of ‘young carer’ is evident and variously experienced by

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<sup>22</sup> Child and Adolescent Mental Health Service

<sup>23</sup> There is evidence across the narratives of transference and counter-transference; a complex phenomenon rooted in psychoanalysis and psychotherapy (Jones, 1994). The work of Penfield (1951), Berne (1958) and Patterson (1959) is considered foundation forming work contributing to the development and modification of later transactional analysis theories (Harris, 1970; James, 1971;1998; 2002). Recognising and acknowledging the valuable role of these theories in relation to this study are useful. However these are not discussed in detail because it is not the theoretical framework or focus for this research.

individual adolescents. Role reversals and shifting responsibilities are conveyed via the student voices. However exposure to their parents' mental health issues is not the sole influencing factor contributing to their learned helplessness.

Another perspective of surmising what factors have influenced the development of learned helplessness is to consider Bandura's Social Learning Theory (Bandura, 1977). This theory posits that people learn from one another via observation, imitation and modelling and creates a bridge between behavioural and cognitive learning theories in addition to theories of motivation. This is because its focus encompasses attention, memory and motivation. In learning through observing others' behaviour, attitudes and outcomes, individuals form ideas of how new behaviours are performed, later employing this coded information as a guide for action; the continuous reciprocal interaction between cognitive, behavioural and environmental influences (Bandura and Walters, 1963). The concept of 'we learn through what we see' helps us to understand the students' sense of learned helplessness and the root causes of this.

However Bandura's theory of social learning does not function in isolation when considering this concept; it creates a foundation for analysing in conjunction with significant other theories. Of particular relevance are theories of transactional analysis (Berne, 1961; 2010; Harris, 1970). The notion that we all have parts of our personalities which surface and affect our behaviour is based on how we learn to conduct interpersonal transactions; predominantly learnt during primary stages of development and socialisation in formative years. Theories of transactional analysis reinforce Bandura's theory because individuals, in this case adolescent students, draw on what they have learnt and what they know, in dealing with and responding to, arising situations. This may include employing the most appropriate ego state for a situation (ie. responding to a transaction stimulus) or projecting it (as an agent) to achieve a desired response. Examples evident across the student narratives include self harming behaviour, absence from school and the development of their own mental health issues.

### **7.5 The consequences and outcomes of learned helplessness**

In some cases, learned helplessness resulted in help-seeking behaviour both on voluntary and involuntary grounds within secondary and further education and for

some, external services. For Debbie, a friend who, “...*had enough of watching me refuse to go [to the school counsellor]*” suggests her reluctance and involuntary participation but later she engages with CAMHS voluntarily. Likewise, Jordan was taken by her mother to the family GP and whilst a student at Wenhill College, was referred to the college counsellor by her tutor; maybe because her tutor could sense Jordan’s helplessness and her unexpressed need (Ewles and Simnett, 2003).

For others, active non help-seeking behaviour pervaded their narratives based on their previous experience of ‘help’ and counselling whilst at school and their held perceptions of the counselling provision within Wenhill College. Grace for example, when experiencing bullying did not seek help from either her parents or her secondary school because she, “...*didn’t feel I could*”. Nor did she feel she could seek help from her GP; “...*you can’t exactly go along to your doctor and say, I think I have depression*”. Furthermore, she rejected the validity of the college counselling provision based on its physical location and perceived lack of confidentiality thus; “*I don’t feel I could go and talk to the counsellor, I’d rather talk to someone outside of the college...it’s not in a good spot here the counselling room...everyone knows that’s where you go for your counselling sessions...how confidential is that?*” This statement suggests Grace feared being labelled and viewed as deviant (Davis, 2006) resulting in being stigmatised for seeking help (Browne, 2002). A view concurred to some extent by Rachel.

Rachel’s demonstration of non help-seeking behaviour whilst at Wenhill College was two-fold. In the first instance, her experience of receiving counselling whilst at school, described by Rachel as “*shockingly bad*” and “*a really patronising experience*” and even though she sought this help on a voluntary basis, this experience appears to have influenced her perceptions of the counselling provision available at the college. She substantiates this by expressing her view thus; “*I would feel uncomfortable talking to someone I would see around the college every day*”. With Tom, a sense of him being rescued from harm on a number of occasions transpires, not only by his mother who withdrew him from school due to his anger issues but also by other influential people including his “*surrogate dad*” and a member of the Women’s Royal Volunteer Service whilst he was in the army. Although Tom’s help-seeking behaviour appears non-active on his part, he engaged willingly with the help he was offered. Emma’s

non help-seeking behaviour is based on a numbers of reasons including the notion that mental health issues are often seen as a weakness, “*a bad thing*” quantified by, “...*I don’t like showing people weakness so that’s why all my emotion will happen at home [because] when you show someone your weakness, it’s letting them in.*” This suggests Emma appears to be self aware and chooses to differentiate between where she is and is not perceived, as helpless (Becker, 1963; Lemert, 1972; Busfield, 1996; Browne, 2002).

For the student participants, progressing into further education was the key to reinforcing their learned helplessness and what is evident here is that the student participant’s sense of learned helplessness was not *caused* [my emphasis] by their engagement in further education but *confirmed* by it. Their sense of learned helplessness had already been developing prior to further education through various life experiences and secondary education. It could be argued the structure of further education colludes with their learned helplessness, conveyed through a variety of means and mediums including policies and procedures, behaviours (staff and students; transference and counter transference), individual and collective expectations around behaviour (both staff and students), expectations linked to programmes of study, of further education, of health and social care and the pursuit of career in caring (Stryker, 1980; Plummer, 1991).

Further evidence in the student narratives suggests a mirroring of some behaviour with that of learned helplessness in that there are links with the experience of surrogacy and whether or not, this is voluntarily or involuntarily received. Seeking a definition of surrogacy in the first instance is frustrating as much of the literature defines surrogacy in terms of assisted reproduction, conception and pregnancy (British Medical Association, 1996; Royal College of Midwives, 1997; Williams-Jones, 2002). Further exploration exposes definitions rooted in psychology collectively concluding a surrogate is one who takes the place of another as a substitute in a person’s unconscious or emotional life, often within a family or social role. In Freudian psychology, a surrogate is a figure of authority who takes the place of the father and/or mother in a person’s unconscious or emotional life. Other commentators contribute to the definition and understanding of this term suggesting a surrogate is one that takes the places of another, a substitute; a person that functions

as a substitute for another, as in a social or family role and in law for example, a judge having jurisdiction over the probate of wills and settlement of estates.

Others consider surrogacy as parentification; defined as a role reversal between parent and child and includes emotional and instrumental parentification (Hooper, 2007). A child's personal needs are sacrificed in order to take care of the needs of the parent(s), often giving up his/her own need for comfort, attention, and guidance in order to accommodate the needs and care of the logistical and emotional needs of the parent(s) (Chase, 1999). In parentification, the parent gives up what they are supposed to do as a parent and transfers that responsibility to one or more of their children resulting in the child becoming parentified; that child is the "parental child" (Minuchin *et al.*, 1967).

As children, these adolescents received surrogate supervision in lieu of parents who were absent, either physically and/or emotionally because of their own mental health issues. Debbie's surrogate mother was her maternal grandmother, described as "*the family matriarch*" who Debbie lived with until the age of seven, during the period when her mother's drinking was "*out of control*". Similarly, Emma lived with her maternal grandparents "*for the first couple of years of my life*" as her mother was unable to care for her due to bouts of post natal depression. Both Debbie's and Emma's mothers married other people resulting in a restructured family with 'step fathers' in lieu of biological fathers. Their initial experiences of surrogacy were during their formative years and period of primary socialisation, whereas other participating adolescents' experience of surrogacy is more complex and experienced during their secondary period of socialisation during adolescence.

Whilst Tom sought mentorship from his best friend's father, "*my surrogate dad*" in lieu of his absent father, and later the army in addition to the WRVS<sup>24</sup>, Grace sought surrogacy from "*the local church*"; this was during a period in her life when she felt she was 'getting on' with her mother as they had a shared interest and mutual social group. Rachel's narrative identifies 'absent' people who were present and a sense that she actively sought a surrogate parent(s) yet failed to appoint anyone successfully to the role. Jordan described "*close relationships*" with both her maternal and paternal grandmothers in the absence of her father (who separated from her mother when

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<sup>24</sup> Women's Royal Volunteer Service

Jordan was eight) and her periodically ‘absent’ mother due to episodes of depression. Interestingly indirect surrogacy is evident in Jordan’s narrative where she reflects on her therapy with a counsellor between the ages of fourteen and fifteen; “...*the only thing she managed to achieve was to get me to sleep in my own room*”; a task facilitated by most parents in a child’s formative years of development. Whilst the experience of receiving surrogacy as a child is not a choice, nor may it be it as an adolescent either; a career in health and social caring could be viewed as seeking therapeutic surrogacy either consciously or unconsciously.

### **7.6 Career choice and motivating factors**

The evidence across the student narratives demonstrates the motivating influences in career choice. Debbie initially wished to pursue a career in counselling, “...*mainly because of having the experience myself...I think it is such a rewarding profession to go into...giving people their lives back*” but changed her mind and decided to apply for mental health nursing as, “...*it is broader than counselling and I feel I could make a difference*”. Compulsive carer (Bowlby, 1977) Emma seeking to pursue a career in social work because, “...*I don’t like to see people suffering or in pain*”. Grace, like Debbie, changed her mind in relation to career choice from, “...*paediatric nurse or counsellor*” to social work; a decision motivated by her parents and siblings to have a “*good public sector job*”. Jordan had considered careers in veterinary care and Egyptology, later settling on a career pathway towards social work because, “...*I’ve always liked helping people*”; careers requiring engagement in emotional labour (Colley, 2006). Rachel’s choice of career in caring appears to be based on a number of factors. In the first instance she expressed a desire to pursue a career in medical law, suggesting the pursuit of reparation and resolution then changed her mind, quantifying a career in mental health nursing thus; “...*quite a lot of people in my family have had really bad mental health problems...people should be mad more aware of the problems it poses...maybe I can make a difference*”. Tom’s expressed aspirations to work with young people in substance abuse rehabilitation, “...*problems like I had*” fulfilling a desire to make a worthwhile difference to young people’s lives.

### **7.7 Understanding the student participant’s career choices**

Tillet (2003) and later Thomas (2006) suggest that choices around careers in caring can be conscious for practical reasons such as training, income and availability of

work, and unconscious to gain a sense of belonging. Often career decisions are made in late childhood or early adolescence and the influences complex (Allen, 1988; Kniveton, 2004). Ginzberg *et al.* (1951) suggests a decision to pursue a career in caring is based on the pursuit of a match between the self conceptualisation of one's abilities and preferences with the job requirements. Law and Arthur (2003) develop this argument further, suggesting a young person's gender and 'place' in the family influence their career choice, specifically in nursing. Furthermore, the impact of gender may lead to academic stereotyping, popularising careers which have historically been seen as 'female' requiring traits of empathy, a good bedside manner and altruism (Miller *et al.*, 2002; Wilgosh, 2002; Colley, 2006).

The student narratives convey individual perspectives and a collective combination of why they wish to pursue a career in caring; Debbie and Rachel talk about "*giving people their lives back*", in addition Debbie sees a career in caring as "*a rewarding profession*". "*I don't like seeing people in pain*" is one reason expressed by Emma for wishing to work in social care. Both Tom and Rachel express a desire "*to make a difference [to people's lives]*" and Jordan, because she simply, "*likes helping people*". These reasons may be aimed at reparation and resolution of childhood experiences and events, in order to rectify unfairness and deprivation with the purpose of redistributing power. The strength of their subconscious urge to 'make people better' reflects their own recovery needs and in 'giving something back' they are consciously seeking to gain a sense of fulfilment possibly lacking or not evident elsewhere; a conscious decision and therefore a career in caring appears to be worthwhile and satisfying (Bowlby, 1977; Thomas, 2006). In addition, for each of these students, their exposure during their early childhood and later adolescence to a parent experiencing mental health issues, may have lead to the student seeking to 'restore power' to the adult (in each case their mother). This behaviour is rooted in complex interactions experienced during and throughout their childhoods.

The parental personal experience of mental health issues and feelings of helplessness is transferred onto the adolescent student during their childhood, leading to counter transference and an emotional entanglement (Patterson, 1959). In response, the child (later student participant) adopts the role of 'young carer' taking on the practical and/or emotional caring responsibilities associated with such a role (SCIE, 2005).



This in turn leads to the development of their own sense of learned helplessness, via the projected emotions of their parent, shifting roles and responsibilities; drawing on what they have learnt, what they know and how they have learnt to deal with situations and experiences by employing the most appropriate ego state for a situation or projecting it to receive a desired response (Berne, 1961; Harris, 1970; James, 1998). Malan (1979:139) refers to this as ‘the helping professions syndrome’ in which a professional compulsively gives to others what he/she would like to have for him/herself and whilst the student participants are not ‘helping professionals’, each is seeking a career pathway in order to become one (Colley, 2006).

Thomas (2006) suggests family members and other role models strongly influence and motivate an individual’s personal development, particularly during adolescence when young people are starting to make their own life choices. Dunn (1994) and later Kniveton (2004) suggest siblings and parents have a strong influence on an adolescent’s career choice and this is often influenced by example (Schein, 1993; Small and McClean, 2002).

A specific example evident in the student narratives is that of Grace. She talked about feeling pressured by her mother (who works as a Therapeutic Support Worker<sup>25</sup>) to go to university as her older siblings had, resulting in them “*all having very good public sector jobs*”. The projection of unfulfilled personal aspirations permeates her narrative, transferred from mother to daughter. This challenges Holland (1985) who purports individual free choices around career choice and direction as being solely those of the adolescent. Schein (1993) disagrees saying that influences around adolescents removes direct control from the career decision making process linking strongly with notions of learned helplessness (Peterson *et al.*, 1993) particularly where exposure to ‘the helping professions’ has been experienced.

Adolescents nearing the end of their compulsory education are encouraged to consider and make career choices; a task which is not static but part of a wider developmental process (Alberts *et al.*, 2003; Kniveton, 2004). This is demonstrated here through

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<sup>25</sup> Therapeutic Support Workers are employed to provide care usually on a 1:1 basis for individuals with specific needs. This may include personal care interventions. They are not ‘formally qualified’ and registered practitioners like nurses are but contribute a valuable role in the delivery of care and therapy

shifting decisions around career direction and choice (see Debbie, Jordan, Grace and Rachel) and based on influential factors such as personal experience, observation and exposure to other people experiencing mental health issues and general social perceptions of mental health and the caring professions. Furedi (2004) questions the expectation and ability of learners in 'an adult learning environment' to take responsibility for their own learning and in conjunction with this, their career choice; can this ever truly be the case if adolescents are so heavily influenced by those and the (learning) environment around them (Rooney, 2010).

The compulsive caring trait as described by Bowlby (1977) is evident in some of the student narratives, particularly those of Emma and Jordan but also Tom and Grace. Bowlby suggests this trait is influenced by early life experiences, the emphasis focussing around parental presence or absence and their ability or lack of it, to provide adequate protection, encouragement and secure boundaries. Further definitions of compulsive caring link strongly across the literature to attachment and personality theories and are contextually situated among the practice of psychotherapy, psychology and psychiatry. Compulsive care giving is defined as a pattern of adult attachment behaviour in which the person emphasises the importance of giving care in relationships, rather than receiving it (West, 2001).

Whilst Bowlby's ideas are to some degree outdated, they have persisted through the decades and still influence child care, raising children and development theories today. Frost (2008) discusses whether Bowlby's ideas remain pertinent in light of changes to 'the family' since 1950, particularly in respect to the role of women and economic, social and educational structures. Frost concludes that even though Bowlby's theories are contested by others, including his colleague and contemporary Mary Ainsworth, they are still relevant today.

In her narrative Emma talked about being the eldest sibling of three children and with the arrival of each sibling, being relied on to do more (for her younger siblings) and be more independent. Whilst this is not an unrealistic expectation of children throughout their childhood, for Emma it was experienced in the absence of her mother. Emma also shared her experiences gained under the care of her father whilst her mother was out at work; "...I was hit on a daily basis by my father...my mum had no

*idea.*” The lack of protection expected of her mother, was absent (Bowlby, 1977). Similarly Jordan portrays compulsive caring traits, describing in her narrative that “*people naturally come to me with their problems*” and “*I’ve always liked helping people*”. However there is also evidence in Jordan’s narrative of parental absence even though present due to mental health issues (mother) blurring the boundaries of who was caring for who and inadequate provision of protection caused by parental separation. In the latter example, a possible contributing factor to Jordan’s experience of being bullied at school and her inability to deal with this; only to be rescued at a later stage by her father, “*who put his foot down*”, insisting Jordan be enrolled on the Pre-16 programme of study at Wenhill College (Rooney, 2010). For Tom and Grace, their compulsive caring trait as purported by Bowlby may be rooted in a combination of early life experiences. These include the lack of secure boundaries and the provision of adequate protection; their absence highlighted by their respective experience and disclosure of childhood sexual abuse. Therefore the conscious or unconscious choice to place oneself in the ‘caring camp’ suggests it is possible to avoid the negative experiences of illness, poverty and disempowerment (Schein, 1993; Thomas, 2006).

### **7.8 Understanding the student perspective - Alderfer’s theory of motivation**

Understanding what motivates people to engage in certain behaviour is complex. To comprehend what motivated each of these students to seek help (or not, in some cases) for their mental health issues, their progression from secondary to further education and their career ‘choice’ in the caring professions, Alderfer’s Theory of Motivation provides a useful framework. Alderfer’s theory is one of many theories in existence which address what motivation is and how this influences human behaviour. It also draws on a range of theories including instinct<sup>26</sup>, incentive<sup>27</sup>, drive<sup>28</sup>, arousal<sup>29</sup>

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<sup>26</sup> Instinct theory of motivation; people are motivated to behave in certain ways because they are evolutionarily programmed to do so (see William James’ work late C19th/early C20th century)

<sup>27</sup> Incentive theory of motivation; suggests people are motivated to engage in certain behaviours because of external rewards and behavioural learning concepts such as association and reinforcement play an important role in this theory

<sup>28</sup> Drive theories of motivation; people are motivated to reduce internal tension caused by unmet needs

<sup>29</sup> Arousal theories of motivation; suggests people take certain actions to either decrease or increase levels of arousal, aimed at maintaining an optimum level based on individual and/or situational factors

and humanistic theories of motivation<sup>30</sup>. Each theory has its limitations however there are key ideas in each; recognising Alderfer's theory is developed from a combination of these theories including Maslow's Hierarchy of Needs (McLeod, 2007). I do not intend to revisit 'other' theories here in depth because their direct inclusion detracts from the selected theory focus.

Alderfer's Theory of Motivation is also referred to as the ERG theory model; ERG representing existence, relatedness and growth (Alderfer, 1972). It is based on the work of Maslow and the main contribution to literature is its relaxation of Maslow's hierarchical assumptions. The ERG theory does not rank needs in a specific order and explicitly recognises that more than one need may operate at a given time (Alderfer, 1969). It has been acknowledged applicable across several fields including personal development, business and organisational settings and in relation to learning, (Williams, 2003). Alderfer's theory purports we all have needs (wants) causing us to do certain things (behaviour) which in turn fulfils our needs (satisfaction). Whilst Alderfer does not dismiss Maslow's basic needs criterion, he encompasses this within 'existence'; when these needs are translated into the workplace, they are considered motivating forces (Alderfer, 1972). Consequently, as needs are satisfied, new ones develop.

ERG theory explains the dynamics of human needs within organisations positively and provides a less rigid explanation of 'employee needs' than Maslow's theory; human needs cluster more logically around the three categories proposed by Alderfer, than in Maslow's five. In addition, Alderfer's ERG theory includes a 'frustration-regression process' whereby those who are unable to satisfy higher level needs becomes frustrated, regressing to previous attained lower levels, challenging Maslow's hierarchical one directional model approach in working towards and achieving self actualisation (Maslow, 1943; 1954). The combined process of 'satisfaction – progression' and 'frustration-regression' also provides a more accurate explanation why employee needs change over time and why employees have particular needs at various times. In satisfying the basic physiological necessities the

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<sup>30</sup> Humanistic theories of motivation are based on the idea people have strong cognitive reasons to perform various actions for example, Maslow's Hierarchy of Needs presents different motivations at ascending levels

adolescents' existence need is fulfilled, at home but also within the college surrogate environment where students spend the equivalent to a 'working week'. But more powerful motivating factors influence the individual and group desire to fulfil their relatedness need, to be 'part of something', for example a community within the college.

*"My earliest memory was, not wanting to go to playgroup...no one wants to go to play group..."* so by not wanting to go, Jordan fulfilled the perceived norm of childhood; the desire to remain in the care of a parent and maintain familiar social relationships. Later on during secondary school, Jordan left an environment where she felt she did not belong; enrolling at the college on the Pre-16 programme, only to feel she did not 'fit in', *"...I didn't get on with the other people at all (the bullies)...they were too immature for me"*. This conveys a sense Jordan's relatedness need never seemed to be fulfilled and her expectation that coming to college would be different to secondary school (Davies, 2005). Debbie's experience of *"feeling pushed out and ignored"* during her formative years when two siblings were born is an experience which may have underpinned her need for a sense of belonging later on; influencing her help-seeking behaviour and a career choice pathway in health and social care (Dunn *et al.*, 1994); the desire to be part of *"a rewarding profession"* stemming from a developmental process (Alberts *et al.*, 2003) influenced by variously complex factors (Allen, 1988; Kniveton, 2004). Emma, did not like showing people weakness, *"...when you show someone your weakness, it's letting them in"*. Emma's motivation to 'be strong' helped her fulfil her relatedness need; being perceived as 'able' challenges notions of disempowerment and avoids negative associations (Schein, 1993; Thomas, 2006) particularly in relation to mental health, to which Emma admits, *"...when people say mental health, I immediately think it's bad thing"*; her subjective interpretation of mental health (Ernest, 1994).

Aspiring to 'fit in' and be accepted by peers is underpinned by various factors including being aesthetically pleasing (Maslow, 1970). Grace worried about, *"...how I look and what people think of me, even though I pretend not to care"*. Being approved of by peers is therefore a complex, multifaceted experience and inspired by a desire to reject deviance, avoid being labelled and 'fit in' (Jones, 1994; Davis, 2006). This also links to Grace's expression of non-help seeking behaviour from the college services

whereby, *“I don’t feel I could go and talk to the counsellor....everyone knows that’s where you go for your counselling sessions...how confidential is that?”* Being seen to be seeking help reinforces Grace’s anxieties around other people’s perceptions of her and the possibility in seeking help, may lead to non-acceptance and stigmatisation (Milne, 1993).

Rachel’s experience studying at the college was different to Grace’s, expressing an increased sense of self awareness and contentedness with her own identity; *“I felt I had to establish myself at school...as an individual and as part of a group...I’m different here at college...I can be who I want to be...I feel more confident here...generally, I like myself”*. Rachel also projected a more fragile personal facet; *“I feel happy when valued by others”*, suggesting a motivating influence for her to feel she ‘belonged’ was expressed through approval and validation by others (Crimmens *et al.*, 2004).

For Tom, being part of something in order to gain a sense of belonging was first experienced at the age of sixteen when he joined the Army and thereafter reinforced during his ‘second chance education’ at the college (McFadden, 1995). His expressed objective perspective around help-seeking behaviour acknowledges why some adolescents choose not to use the college counselling services; anonymous counselling being a preference *“...because some people are paranoid”* demonstrates insight around adolescent perceptions that sharing their mental health issues and expressing their related needs, continues to attract overwhelmingly negative connotations, potential labelling and stigma (Jones, 1994) and reflects non-conformist behaviour (Browne, 2002). Whilst Tom’s expressed insights seem to encompass other people’s projected uncertainties and ‘paranoia’, there is a strong possibility these views are based on personal experiences; by presenting these as those of others, Tom maintains a fulfilled sense of relatedness (Aldefer, 1972) and non-deviance (Lemert, 1972).

With each student, the strength of their relatedness need influenced and motivated their help-seeking or non help-seeking behaviour and only Jordan had used the college counselling provision (having been referred by her personal tutor). This non help-seeking behaviour within the college could be perceived as non-conformist by

adults, in this case the college staff, and also in wider society. Helping to understand adolescence and what it is, includes the work of Hall (1904) and later Blos (1962) and Freud (1966) who defined adolescence as a tumultuous stage of development, characterised by physical and biological changes which create the catalysts for emotional upheaval. Disagreeing with these views are Davis (1940), Rice (1975), Clausen (1986) and Simmons and Blyth (1987), arguing adolescence is a period of 'stress and family conflict', characterised by young people's changing roles, educational competence or incompetence, the development of new, sometimes intimate relationships outside the family and gaining independence (Aggleton *et al.*, 2000). The latter perspective suggesting adolescence is a social construct defined by the society, its expectations and the cultural boundaries they grow up in. Aggleton *et al.* (2000) and Baker (2004) suggest adolescence is a more stressful time for parents, challenging the notion the period of 'storm and stress' is more about the projection of adult fears than those of young people themselves. This perspective is applicable to the adults (staff) view within the college environment; the projection of surrogate parental fears about adolescence and mental health. This in turn has an impact on a number of factors leading to a dichotomous position between the students and staff and the college.

As previously highlighted, for the students, choosing not to seek help for their mental health issues supports the notion of 'fitting in' and fulfilling their relatedness needs, by avoiding being labelled and possibly stigmatised. Their non help-seeking behaviour is further reinforced by their peers through acceptance and the perception that their behaviour is adolescently 'normal'. Selecting not to use the college counselling service also links with their growth needs and this is based on the perception, either projected by peers and/or staff, that disclosing the experience of mental health issues and seeking help, will create barriers to pursuing a career in health and social care; their ultimate growth need.

Alderfer (1972) purports employment is fundamental to the development of personal identity and ego satisfaction, contributing and leading to a sense of self. The fulfilment of student growth needs is multi-fold and rather than being an independent stage of achieving personal fulfilment, there are multiple connections throughout each phase which inter-relate. Whilst a career choice in health and social care appears

latterly in each of the student stories, the influential experiences contributing to these decisions are variously signposted throughout their lives.

### **7.9 The staff, learned helplessness and the culture of further education**

The staff's sense of learned helplessness is evident across their narratives and is variously influenced by differing factors. Alderfer's theoretical concepts of motivation (1972) transpose positively to the learning environment of Wenhil College where employee's needs can be contextually considered and analysed.

The staff perspective within this theoretical framework is complex. However, there are links evident to relatedness and growth. According to Alderfer (1972), existence is fulfilled through satisfying physiological needs and in this case, staff work to pay for their basic lifestyle necessities. Relatedness is the need for social relationships and for staff, employment forms parts of their personal identity and ego satisfaction; fundamental to the sense of self (Foucault, 1976). This is pursued through acceptance by peers, for example, within the department of health, social care and early years to 'be on par' professionally in their knowledge, skills and experience. Personal growth and development and the desire to fulfil professional aspirations, are also motivating influences, enhancing an individuals sense of belonging and being part of something (Maslow, 1970); a team and a wider community within Wenhill College (Williams, 2003).

Need based theories (Maslow, 1943; Alderfer, 1972) describe motivated behaviour as individual efforts to meet need; within a work environment, the manager's job is to identify what people want, ensuring the work environment becomes a means of satisfying their needs (Williams, 2003). Wenhill College as a work environment has expectations of the staff within their roles. These roles are influenced by the policy landscape external to the college and of those within it (Bloomer, 2005). Arguably some of these policies are positively motivating underpinning realistic expectations of staff; others less so, leading to reliance on self motivation due to the challenging work environment where staff are 'doing the best they can' (Jephcote *et al.*, 2008). By transposing the work environment to a learning environment (however remaining as a work environment for staff) and altering role descriptors, a different picture begins to



unfold; the *tutor's* (my emphasis) job is to identify what the *student* wants, making sure the *learning* environment becomes a means of satisfying needs.

Examples of staff learned helplessness arise across the narratives, underpinned by individual and collective perceptions of the environment within Wenhill College (McMahon, 1997; Derry, 1999). Maria reports “*every single student [on her programme] has some sort of mental health problem*”; the majority identified through the behaviour they exhibit in class. Kate suggests, “*they come here [to college] with lots of baggage and need nurturing*” (Bloomer, 2005), suggesting complex social lives external to college (Jephcote *et al.*, 2008). In response she adopts “*a nurturing role*” and composes SMART targets reflecting personal and emotional goals, “*often prioritising these over academic ones*” (Frykolm and Nitzler, 1993; Ecclestone and McGivney, 2005). Kate believes that the students on her programme are under pressure to do well and succeed on the course; a second chance at education success, following failure elsewhere (McFadden, 1995; Foster, 2005).

In Helen’s experience, “*some individuals experience mental health issues throughout their education careers, arriving in further education with them*”. In her role as college campus counsellor, she signs up to a therapeutic educational ethos, perceiving further education as a vehicle for developing life skills in addition to an environment where students “*learn to cope*” (Ecclestone and Hayes, 2009). Within this, an acknowledgement of the ever changing culture of further education and more students experiencing mental health issues; the need to have policies that reflect this trend and “*key people with specialist knowledge*” to manage the growing concern.

George’s comments reflect Helen’s views; “*the counsellors report they are seeing more people year-on-year with mental health issues*” and “*adolescents with mental health problems are a growing concern*”. George has worked in further education “*for many years*” reporting that “*further education has changed and is continuing to change*” (Davies and Jones, 2003; Lucas, 2004). These ongoing changes are in George’s opinion underpinned by “*the whole gamut of child and vulnerable adult protection responsibilities*” (Broxtowe-Smith, 2007), reflecting the changing culture and policy context of further education (DfES, 2004; Foster, 2005; Ofsted, 2007; 2009).

Whilst George appears resigned to the ‘helpless’ situation of his role, dominantly influenced by prescriptive policies, Jane’s perception of the learning environment within Wenhill College acknowledges helplessness exists but makes suggestions why this is the case and how this could be addressed. In her opinion, “*young people are on totally inappropriate courses*”, particularly where students pursuing a career in health and social care present with their own unresolved issues and additional needs, leading Jane to retort, “*this isn’t therapy, this is actually education*” (Furedi, 2004; Ecclestone and Hayes, 2009). Jane suggests the culture of further education engages in one of categorising students leading to a labelling climate (Goffman, 1961; Lemert, 1972; Jones, 1994), preoccupied with teaching functional skills to people; “*getting them to do things so they can work*”. She challenges her colleague’s perceptions that further education is about “*developing the human spirit*” and “*giving them their self esteem*” challenging them to consider, what further education is really all about.

According to Seligman and Maier (1975), the staff working conditions are also influential in the development and experience of learned helplessness (Peterson *et al.*, 1993). Maria’s sense of learned helplessness is conveyed through her assessment of the students studying on the health and social programme she leads which she expresses thus; “*knowing about these [mental health] issues before they came to college would be helpful, at least we could plan support*” suggesting she would feel more able to help her students if she could pre-empt potential difficulties. Furthermore, “*I’m not trained and don’t feel equipped in my role here to deal with these students*” suggests that if she were still working in health and social care, she would be appropriately trained to respond to these sort of issues and “*I don’t have enough time, either in or out of the classroom*”; a view supported by George, acknowledging “*we press our staff very hard*” and “*failing to devote sufficient energy, resources and time in developing and training our tutors*” (James and Diment, 2003).

Jephcote *et al.* (2008) concur that teachers in further education feel pressured by the expectations of their employing institution and the demands of the classroom, leading to conflict surrounding the boundaries and expectations of their role. Teachers invest heavily in emotional labour as a form of coping strategy to deal with stresses and pressures (Colley, 2006) displaying tolerance with the learners in the classroom,

belying their true feelings and accepting that the complex relationship of teaching and caring is part of being a further education professional (Gleeson, 2005).

Kate acknowledges her students' experience of learned helplessness is rooted in cause and effect, exacerbated by their experience of mental health issues (Cherry, 2013) leading them to behave in a helpless manner (Seligman and Maier, 1967; Peterson *et al.*, 1993), especially where they have no control over their situation or environment. Kate identified effective strategies for managing such students including “*an open door policy*” and “*circle time*” on Mondays. By focusing on the emotional rather than the academic, Kate takes (some) control of her students and environment in an attempt to minimise the impact of learned helplessness, both theirs and her own. Within this she perceives her role as a key resource projecting her pastoral caring nature over that of programme leader and teacher, maintaining an emotional focus over an academic one. This approach promotes an ethos of shared learning and empathy, mirroring the environment and climate of further education (Ecclestone and Hayes, 2009). Her response reduces her feelings of learned helplessness whilst reinforcing theirs.

Helen evaluates her role by confirming the overall response from students who have used the counselling services as “*very positive*” and “*nobody [the staff or college management] comes back and says we're rubbish*” yet counters these statements by reporting that some new staff and the college management have little understanding of her role and counselling service provision. This apparent lack of other people's insight conveys a sense that Helen has limited or no control in contributing to the college infrastructure, particularly in relation to supporting students experiencing mental health issues. This is highlighted further through the absence of a mental health policy even though strict professional boundaries are set and maintained. She clearly views further education as therapeutic and not solely academic (Storrs, 2012), suggesting part of its role is to “*give people their self esteem*” (Jephcote *et al.*, 2008) and the need to be proactive around student mental health (Warwick *et al.*, 2008; Worrall and Law, 2009) colluding with a therapeutic educational ethos and not challenging it (Ecclestone and Hayes, 2009). This approach enhances student and staff learned helplessness, reinforcing staff feelings they are helpless to support students.

Jane expressed concerns around how labelling and categorising students led to them abdicating responsibility for their learning, as well as their health. For staff, labelling and categorising led them to abdicate responsibility to teach, preferring instead to adopt a therapeutic ethos and facilitate learning instead (Furedi, 2004; Ecclestone, 2007). Jane suggested that, “*some staff have become institutionalised by further education*” resulting in them losing their focus and objectivity and becoming subjective. In addition, “*staff feel out of their depth*” to deal with any kind of diversity, closely linked with lack of training to develop tutors and teachers purported by George; collectively resulting in a climate of learned helplessness.

### **7.10 Surrogacy – can staff ‘help themselves?’**

The climate within Wenhill College influences staff to engage in the provision of surrogacy. This is a complex and conflicting perspective. Evidence within the staff narratives suggest they are consciously and willing (Kate and Helen) to act in a surrogate manner; others less willing to do so (Maria and Jane). Some appear to have no choice in the matter (George) and are influenced directly by policies and procedures ascribed to their role. In respect of surrogacy, Wenhill College is a multifaceted body. The complex external lives of students are variously expected to be played out within the classroom (Jephcote *et al.*, 2008) and staff expected to manage these often unpredictable learning journeys rooted in disparate personal experiences. These experiences reinforce staff perception of adolescence. Aggleton *et al.* (2000) and Baker (2004) suggest adolescence is a more stressful time for parents, challenging the notion the period of ‘storm and stress’ is more about the projection of adult fears than those of young people themselves. This perspective is applicable to the adults (staff) view within the college environment; the projection of surrogate parental fears about adolescence and mental health from a staff, College and national policy perspective.

The expectations further education has transformative powers, aimed at reducing social deprivation and raising aspirations (SEU, 2004; Bloomer, 2005) dovetails with the expectation that many students will present with mental health issues (Warwick *et al.*, 2008). Maria and Kate, with their vocational backgrounds in health and social care and early years respectively, appear to want to ‘fix’, ‘cure’ or act in a paternalistic manner towards students presenting with mental health issues. Maria perceived those

students experiencing mental health issues to be in the majority and whilst reluctant to utilise the word ‘normal’ to describe those who did not, her approach reflects a perception that students experiencing mental health issues are dysfunctional and outside the norm; adopting a reductionist approach in response (Nettleton, 1995).

There is also a significant link with the health and social care careers of staff prior to their engagement in further education in their role of teachers and tutors. This is extended further to consider the nature of the helping professions and the reasons individual staff pursued a career within this field. Whilst this is not the focus of the study nor the theoretical framework for analysis, it cannot be dismissed entirely from the process. What motivates staff is in many ways similar to the students and their reasons for wishing to pursue a career in the helping professions. The students were motivated by a range of factors and experiences and this is the case here too. Miller (2002) suggests that for many individuals, entering a career in the caring professions fulfils altruistic aspirations. A view supported by Thomas (2006) acknowledging the decision to place oneself in the ‘caring camp’ is a conscious decision.

A desire to help permeates the staff narratives, and this desire is not solely limited to Maria, Kate and Helen; Jane and George also convey a passion to help, but in a different way because of their roles within Wenhill College. Maria and Kate are ‘front line staff’ engaged on a day-to-day basis teaching in the classroom and tutoring students; the strength of their desire and passion to nurture students experiencing mental health issues as well as those who are not, is overwhelming. A sense of, ‘they cannot stop themselves’ from adopting this approach suggests a compulsive caring trait (Bowlby, 1977) and a need to engage in a satisfying and worthwhile career (Thomas, 2006), enabling the staff to gain a sense of belonging (Dunn *et al.*, 1994) and fulfil their relatedness need (Alderfer, 1972).

Alberts *et al.* (2003) purports the desire to be part of a rewarding profession is a highly significant factor when individuals are making a decision around career choices and pathways. A conflicting sense of being part of a rewarding career is evident across the staff narratives, particularly those of Maria and Kate. Colley (2005) suggests that a career weighed by emotional labour is not solely limited to practical, vocational careers. By making the shift from practice to education, the concept of

emotional labour is transferred; in the first instance by and with the practitioner and continually engaged within because of the emotional climate of further education and secondly, extended to the student either purposefully or non-intentionally, in preparing the student to engage in a career requiring the investment of emotional labour.

Whilst they are both engaged in a process of emotional labour (Colley, 2005), they project a sense of fulfilling professional aspirations and growth needs (Alderfer, 1972); supporting students on an emotional level, caring and nurturing them. Schein (1993) and later Small and McClean (2002) suggest the 'influence by example' is extended to students by staff and their choice of career in caring reinforces this and Law and Arthur (2003) suggest gender is also a strong influence, particularly in nursing. However, being part of a rewarding career is not extended beyond their roles within the Wenhill College environment. A sense of frustration permeates their narratives in relation to being teachers and tutors. Too many students, presenting with mental health issues, a lack of training, and not enough time; reflects the pressured climate in further education (Bloomer, 2005).

At the college level, the expectation of surrogacy is reinforced multi-fold and heavily influenced by the wider policy landscape across further education. The reported increase in students experiencing mental health issues has increased demand and pressure on the college student support services, in addition to tutors too. The college has high expectations of staff (Jephcote *et al.*, 2008) within a constantly changing, ever demanding climate (Bloomer, 2005). This 'more work, less time, minimal or no training' ethos is viewed by some staff as part of the role (Jephcote *et al.*, 2008) yet others reject this ethos (Bloomer, 2005) and the demands of an emotionally labour intensive job (Colley, 2006).

### **7.11 Concluding remarks**

An overwhelming sense of learned helplessness pervades the analysis, underpinned by conscious and unconscious engagement in emotional labour by students and staff. Students feel helpless to change their lives and learning environment, leading to their engagement in emotional further education and the pursuit of a career in caring. Staff also feel helpless; helpless to change their work environment. A climate influenced by

national level policies resulting in constant changes across the sector, leading to increasing work pressures and lack of training. The following final chapter responds to the themes and analysis presenting conclusions and recommendations for further development.

## **Chapter 8**

Conclusions and recommendations

### **8.1 Introduction**

The purpose of this final chapter is to review my research and explore the significance of my discoveries for further education, educational research and the management and support of adolescents experiencing mental health issues. This chapter returns to my research questions and answers them in relation to the outcomes of this study summarising the participants' experiences of mental health issues and further

education, and the possibilities these offer towards understanding their experiences. I will now present my outcomes and achievements, methodological evaluation, a personal reflection and recommendations for future research.

## **8.2 Outcomes and achievements**

The purpose of this study was to answer the primary research question, “*How do we manage and support adolescent students experiencing mental health issues in further education?*” and in doing so, this small scale, multi-dimensional intrinsic case study explored the nature of mental health issues experienced by adolescents studying within the further education sector, the support available to and utilised by adolescents and the relationships between adolescents, further education and mental health. The research questions aimed to provide valuable insights and evidence in response to the primary research question and whilst I am satisfied this has been answered, in addition, other unexpected insights have also been exposed. I did not set out with the intention of exploring the career choices of the student participants, nor the motivating factors, influencing these choices. These were elements of my research which evolved throughout its duration, resulting in significant findings for me as a researcher and becoming central facets to the study and its outcomes.

Whilst recognising and acknowledging that the phenomena described and presented here could be experienced and recognised in other settings, with similar or very different outcomes, my intention was not to draw any wide ranging conclusions and generalisations that can be applied to all adolescents who have experienced mental health issues, nor prove or disprove any theory (Yin, 1994). The methodological approach was adopted to develop knowledge and understanding from multiple perspectives (Stake, 1995; 2006) particularly those of the students, given the evident paucity of literature within this field of study. The strength and contribution of qualitative research lies in the way it can capture the diversity and complexities of the social world through (individual and group) lived experiences and in doing so, recognising the depth, richness and ambiguity of such a world. Finlay (2006) suggests that qualitative studies should be judged on their ability to draw the reader into the researcher’s findings, encouraging the reader to see the worlds of others in different ways from numerous perspectives. This study offers the reader a view, my view as the



researcher, into the lives and experiences of the adolescent participants and their experiences of mental health issues and of the staff, who are involved in managing and supporting the students. The anticipated outcomes and benefits for participants were the opportunity to share their experiences, enhance other's knowledge and understanding of their experiences and contribute to the 'shape' of support services within the college.

There is a predisposition increasingly evident across the literature relating to further education around adolescent mental health (Aylward, 2003; Mind 2009) focusing particularly on the experience of 'the providers and educators' with less emphasis on the experiences of 'the learners' (Warwick *et al.*, 2008; Eaton, 2008; Jephcote *et al.*, 2008; Worrall and Law, 2009). Whilst research focusing on the 'providers and educators' experience offers insights into the provision of further education in this context from a policy perspective (chapters 1 explores these trends) and a growing preoccupation with adolescent mental health in further education and defining terms (see chapter 2), it fails to devote attention to the culture and experience of further education from the adolescent learners perspective. This study focuses on this gap evident in the literature; key interests included the adolescent experience of mental health issues in further education and the contextualisation of participant experiences and events (Flyvberg, 2006) within the bounded social setting of Wenhill College (Atkinson and Coffey, 1996). Having highlighted the aims and focus of this study, it is important to revisit my research questions and establish what has been achieved.

This study's findings indicate that the culture of further education creates a climate of learned helplessness amongst students and staff (Bloomer, 2005). This is created by governmental legislation and national policies influenced by the expectant transformative nature of further education (Jephcote *et al.*, 2008); dictated from the 'top-down', it is translated into local level policies, permeating the teaching and learning culture within Wenhill College (Seligman and Maier, 1975; Peterson *et al.*, 1993; McMahon, 1997; Derry, 1999). The college environment variously provides triaged levels of surrogacy. Analysis of the data gathered from students and staff indicates its evidence across the narratives. Influenced by prescriptive national policies, the college is expected to perform compliantly to enable the facilitation of such policies, the resulting impact affecting the staff and how they teach, and the

students, in how they learn. The complex external lives of students are variously played out in the classroom, fulfilling the expectations of staff in that, students' learning journeys are often unpredictable and rooted in disparate personal experiences; reinforcing the staff perception of adolescence and their projection of surrogate parental fears about the students (Aggleton *et al*, 2000; Baker, 2004).

Quantitative data (see chapter 4 and appendix 10) usefully provides a statistical landscape within Wenhill College, confirming the qualitative data presented narratively; indicating there are rising numbers of adolescent students studying within further education who are experiencing mental health issues and who are seeking help via the internal counselling services. The analysis of the data gathered showed students talked candidly about selectively seeking help from the counselling services provided by the college. Their help seeking behaviour was influenced by a range of factors; these included a fear of being categorised and labelled (Jones, 1994; Browne, 2002) being perceived as deviant and stigmatised (Davis, 2006), possibly preventing the pursuit of a career in health and social care (Schein, 1993; Thomas, 2006) and it lacking discreetness and confidentiality due to its location. For others, they were reluctant to seek help because they felt helpless to change their situation and appeared resigned to it (Peterson *et al.*, 1993). Their way of seeking help was through engagement with further education because of its culture and climate (Holland, 1985; McFadden, 1995; Jephcote *et al.*, 2008).

The students who participated in this research were studying in health, social care and early years, pursuing a career in caring variously motivated by altruist reasons and the pursuit of a match between the self conceptualisation of one's abilities and preferences with the job requirements (Allen, 1988; Kniveton, 2004). The college supported these students emotionally and endeavoured to prepare them for work, helping them to form their 'caring identity' within a vocationally relevant habitus (Hodkinson, 1999; Colley *et al.*, 2003; Colley, 2006). However staff member Jane disagreed, suggesting further education has become an environment where diversity is categorised and functional skills are the priority, producing 'slaves and labourers' not 'critical thinkers' or 'learned people' (Ecclestone and Bailey, 2009b).

Alderfer's theory of motivation (1972) provides an understanding of what motivates people to engage in certain behaviour and whilst these can often be complex, this theory provides a useful framework. Staff relatedness and growth needs are expressed across their narratives, conveying a strong sense of pressure and frustration (Jephcote *et al.*, 2008); the need for more time to fulfil their roles effectively and training to enhance their awareness and ability in supporting and managing students experiencing mental health issues. Staff feel they are not appropriately trained to deal with presenting issues (James and Diment, 2003) and subsequently invest heavily in emotional labour to carry out their jobs (Colley, 2006).

### **8.3 The rise of therapeutic culture in further education**

Debates surrounding the rise of a therapeutic culture within further education link closely with the growing preoccupation of adolescent mental health evident across the literature from the early 2000s (Hyland, 2006; Ecclestone, 2007) and set against a plethoric backdrop of educational policies which have underpinned and influenced further education since (Ecclestone and Hayes, 2009a). The perception, where shifting traditional pedagogy in favour of therapeutic 'interventions' reflect cultural changes and lowered expectations among professionals in relation to adolescents (Ecclestone *et al.*, 2005a), suggest these influences have contributed to further education becoming safe, comfortable and therapeutic.

Supporters of providing a safe comfortable educational experience argue that attending to students' emotions results in an enhanced learning experience (Storrs, 2012). Yet others disagree, citing evidence across further education which is contributing to the rise of changing cultures, whereby teachers are recast as facilitators of learning (Ecclestone and Hayes, 2009), who are adopting and promoting a shared learning experience (Rooney, 2010) whilst recognising that learners' behaviours are increasingly portrayed through psychological labels (Nolan, 1998; Furedi, 2004; 2009). Debates surrounding the rise of therapeutic further education are not isolated from other factors; changing perceptions around how to define adolescence contribute to these debates. The concept of 'youth in society' is arguably underpinned and influenced by multiple factors, contributing to what we understand adolescence is and our response (within further education) to it (Aggleton *et al.*, 2000).

Studies in the fields of further education during the past decade contribute to the wider understanding and situate debates surrounding adolescent mental health and further education (see Bloomer, 2005; Foster, 2005; Jephcote et al, 2008; Warwick *et al.*, 2008; Worrall and Law, 2009) and also how further education has experienced significant change during this period, becoming a key player in widening accessibility and participation. As a result of this, greater numbers of students experiencing mental health issues are studying within further education (Stanley and Manthorpe, 2000; Royal College of Psychiatrists, 2003; 2006).

There is clearly evidence across the student and staff narratives presented in chapters 5 and 6, suggesting the inclusion of adolescents who are experiencing mental health issues within Wenhill College; an acknowledged contributing factor in the changing culture of further education. Furthermore, the adoption of the institution's vocational habitus when engaging in their respective roles (Colley, 2006) and for these students as scholars in health, social care and early years and for staff, as facilitators of learning, signing up to the ethos that "...education isn't just to make sure you get an NVQ...it's also about life skill learning and learning to cope...problem solving skills...being proactive around mental health, not reactive...if you can't give people their self-esteem and emotional well being as part of education then what on earth are we doing?" (Helen). Further evidence across the narratives is provided by Kate, "...we do a lot of touchy-feely stuff" and "...we get together and have circle time" suggesting that a mainstream activity, once the preserve of primary education but acknowledged to have been evident in further education 'long before primary schools' (Ecclestone and Hayes, 2009:76) collectively contributes to a climate of emotional labour, emotional identity and disposition; ultimately all these factors contribute to a therapeutic culture within Wenhill College.

#### **8.4 Methodological evaluation**

As a practitioner teaching adolescents in further education, I have been able to conduct 'insider' research, leading to the collection of original and insightful data. The methodological approach was adopted to develop knowledge and understanding from multiple perspectives (Stake, 1995; 2006). The biographical life history methods accompanied by life path continuums provided the adolescent perspective which was paramount in understanding the type, range and nature of mental health issues in

conjunction with their impact, connections, personal and education transitions; furthermore, the need to gain insight and explore the perceptions of those involved in their support (counsellors, personal tutors) and those involved in their academic engagement, achievement and success (teaching staff, student services). Generalisation was not the aim of this study as the sample was too small and not a representative proportion of the whole further education system. Selecting solely to focus on campus one, has provided a thick description of a bounded, multi-layered case study and the implementation of thematic analysis has resulted in the contextualisation of participant experiences and events.

In recognising there are methodological strengths, I acknowledge there are also limitations. In order to result in a greater impact, for example, changing the culture and climate of further education, this study has not been facilitated on a broad enough scale. Furthermore, because it has been carried out within a case study setting, it does not provide a representative sample that can seek to make generalisations across the further education sector. Therefore the outcomes are unlikely to impact on a national policy level unless further research on a wider scale is conducted enabling the reinforcement of study outcomes and implications. Whilst there are advantages of being a sole insider researcher, there are disadvantages too. Working solo creates demands on the researcher especially in relation to resources and time, and limits to some degree the capacity of the role. There are also other barriers to overcome, including the culture of further education; with its shortage of resources, constant major changes and lack of professional space. Gaining access and ethical consent partnered by institutional anxiety make for engaging with research very difficult; despite a strong rhetoric of willingness to engage.

### **8.5 Reflection and personal learning**

My original idea in doing this research was underpinned by various influences including my own positionality regarding ‘therapeutic pedagogy’ and acknowledging there is evidence of a therapeutic ethos entering further education. I recognise that the use of therapeutic language and/or psychosocial concepts have proved useful tools in understanding my research data and answering the research questions. Thus in the first instance, an increasing anecdotal awareness of the experience of mental health issues amongst adolescent students studying within further education and the apparent

growing preoccupation of colleagues with such students. Secondly, the students relatedness needs and their behaviour and subsequently, staff responses to arising and presenting issues. Thirdly, the college response and support infrastructure, its accessibility and use and whether or not, the apparent growing problem (anecdotal at that time) of student mental health, was a reality or a subjective assumption. In addition, the changing provision of further education; historically a provider of education for adult learners and vocational training, shifting more towards partnership models of facilitating education including provision for 14-16 year old learners via diploma pathways and becoming less adult focused and more adolescent in nature. And finally, the complex influences across macro, meso and micro levels, where a triaged top-down approach influenced what happens on a local level within further education, regardless of local need and student profile.

From the outset, I was aware of my personal and professional values and beliefs and the potential (later actual) reflexive positionality; acknowledging from the outset that it is difficult to dismiss and detach entirely from previously gained experience. Insight and knowledge encouraged an active determination to remain unbiased throughout the research process whilst recognising I was inextricably part of it.

Seeking and gaining ethical consent for this study proved a challenging aspect on many levels. Managing the (understandably) heightened anxiety of the Wenhill College senior management team was undeniably the most difficult element of the process and at times, seemed protracted and onerous leading to feelings of frustration. However, it proved to be an insightful and valuable learning experience, developing individual knowledge and skills which will be effectively later employed. It was essential with this study to ensure safeguarding and minimise potential risk to participants, particularly in light of the nature of the 'therapeutic interview'. Revisiting difficult childhood experiences, some of which were personally traumatic and adolescents experiencing active mental health issues were personally a professional concern. Contingencies were established as part of the ethics application to ensure access to appropriate support and criterion included so not to compromise participant integrity. The cathartic, therapeutic emotions and responses evoked by participating adolescents conveyed a strong sense of their understanding and insight

into their personal experiences, challenging the notion that adolescence is a period of ‘storm and stress’; ably competent to narrate their retrospective life stories.

Participation raised numerous issues for the adolescent and staff participants. Concerns were most notably raised in relation to the potential impact of participation, confidentiality and anonymity. Adolescent participants were concerned that by taking part, they may compromise their course outcome and progression and for staff, the potential compromise of job security. The nature of case study research on a small scale such as this does make ensuring confidentiality and anonymity more challenging; this in conjunction with an insider researcher role required effective and proactive management.

The facilitation of the student interviews extended research privilege; being party to listening to participant stories proved a humbling and grounding experience, one which remains with me to the present day. Facilitating the student interviews reignited a sense of compassion, most personally experienced during my clinical nursing career. Recognising the importance of fostering positive research/working relationships, I endeavoured to treat each adolescent participant individually and equally as an adult (Berne, 1961; Harris, 1970) whilst ensuring and maintaining research boundaries. However this was difficult because of my ‘insider’ research role (Riddell, 1988; Sikes and Potts, 2008) and the perception of my ‘everyday role’ by the students. Listening for long periods of time, was tiring; a reflection of how this may have felt for the students (Jones, 2004). In addition, the overriding sense of being left feeling helpless; again a reflection of the student experience and associated emotions, transferred from narrator to researcher during interview. The pervading sense of helplessness was not solely limited to during and post student interviews; it was evident post staff interviews too.

The staff interviews were facilitated in a more ‘equal medium’; adult colleagues engaged in semi-structured interviews. Each interview had a schedule and was time limited. The process of constructing the student and staff narratives without deconstructing their meaning proved to be another challenge, and the importance of their content being the words of the individual was paramount. On reflection, the composition of the narratives has been constructed thoughtfully, respectfully and

truthfully. The interviews with the students and staff fulfilled outcomes beyond expectation. Each participant spoke openly and candidly about their experiences. I was and remain, particularly impressed by the adolescent narrators who shared their life experiences with me. This research is not solely shaped by those narratives analysed and presented throughout the chapters but by all those who took part. Further reflection helps me to recognise a recurring theme from a different perspective. Student participants expressed their wish to 'give something back'. This is not solely limited to their choice in a career in health, social care and early years but compliments the nature of their participation in this study and by taking part, they are 'giving something back' to the research.

I have also considered 'what's next'. Plans to publish excerpts from this thesis are currently under personal review. I am also considering publishing using data not included in its entirety within this thesis. A publication I am currently working on explores the role of the college counsellors in supporting and managing adolescent students experiencing mental health issues; working title *'It's not just tea and sympathy!: the role of college counsellors in further education'*. I have also considered the potential transferability of this study from further to higher education and I am exploring this possibility within my current role; working with students pursuing a career in mental health nursing.

Completing my doctoral research has provided me with advanced research training and since commencing this study as a novice researcher my research journey has been widely varied. At times and for most part, it has generated motivation, determination and much satisfaction. It has also proved frustrating, challenging and confusing. I have made mistakes along the way and learned from them. These experiences have enabled conceptual threshold crossing (Wisker *et al.*, 2006; Kiley and Wisker, 2009); enabling me to answer the research questions and gain self-confidence in my research skills and abilities.

## **8.6 Implications and recommendations for further research**

Bloomer (2005) suggests the culture of further education, with its shortage of resources, constant major changes and lack of professional space makes engagement with research very difficult and limits its transformative potential; despite a strong



rhetoric of willingness to engage. A view previously purported by Anderson *et al.*, (2003) arguing that research can deliver real improvements in the quality of teaching and learning in further education; however to enable this improvement to take place, colleges need to culturally shift in how they perceive research by building and extending research capacity. Consequently, there is limited evidence of research influencing further education practice (Scaife, 2004). Whilst acknowledging Bloomer's and Scaife's assertions, I wish to recommend the following for further research following this study.

For educational research there is clearly much more to do and further exploration across local and national levels around the experience of individual circumstances would enhance a greater understanding of adolescent mental health issues, the provision of appropriate support and the motivating factors which influence a career choice in health and social care. In addition, training for further education staff, to enable the effective management and support for adolescents experiencing mental health issues.

Research should investigate 'what works' for students experiencing mental health issues from their perspective in relation to support; the employment of qualitative research methods would provide rich data and a greater understanding, thereby giving voice to hidden and silenced lives (McClaughlin and Tierney, 1993). Is Wenhill College responding in the 'best' way? Students suggest not. The analysis of data gathered from the students expressed preferences in the provision of and access to support. They suggested the college should provide male as well as female counsellors and counselling staff from ethnic backgrounds other than 'white British'; a variety of suggested means to help reduce barriers. Preference was also cited in relation to seeking support from a 'specialist' person external to the college; a more discreet service to enhance trust and confidentiality based on previous experiences of counselling and how the college counselling service is 'overtly visible'. Further research and the exploration of collaborating with external support services may help to provide more appropriate support for students and change the culture of learned helplessness in further education. In conjunction and given the current economic climate, further education institutions would benefit from a greater understanding of the full costs of in-house and external counselling provision. A thorough evaluation

would provide robust and relevant data on which to base counselling provision in the future.

Further investigations to explore appropriate training (James and Diment, 2003) and support for staff would be worthwhile. Staff expressed a need to have ‘more time, less pressure’ (Jephcote *et al.*, 2008) and to gain better insight into adolescent mental health issues. A view evidently supported across the literature (Foster, 2005; Warwick *et al.*, 2008; Worrall and Law, 2009). Bloomer (2005) and Gleeson *et al.* (2005) suggest the resulting impact of no training and lack of awareness, understanding and insight, compromises staff professionalism and the learning environment in further education. Conducting a thorough training needs analysis would enable further education institutions to have a better understanding of their staff training requirements. This could be facilitated using a combination of quantitative and qualitative research methods; whilst quantitative approaches fulfil their role in providing a landscape of trends, qualitative methods elucidate in-depth data, enabling us to gain a deeper understanding of the participants’ experiences, beliefs and values. This would provide further opportunities for participants’ voices to be heard.

## **8.7 Concluding remarks**

This study has explored the management and support of adolescent students experiencing mental health issues in further education and in doing so, highlighted the significance of the current culture in further education and its impact on those learning within it as well as those teaching and working in it. It creates opportunities to consider how the culture of further education contributes to a climate of learned helplessness and how students and staff engage in emotional labour in order to fulfil the expectations of their roles; those of themselves and of others.

This thesis has introduced a different perspective. It has highlighted the value of seeking the ‘student voice’ as a means of identifying ‘what works’ for young people needing support for their mental health issues. For future research in further education, there is clearly exploration required from the student perspective, which will impact upon further education and how this sector manages and supports adolescents experiencing mental health issues. By involving ‘front line’ staff, this study has also

identified the need to explore further, the roles and expectations of teachers in further education. Recognising that whilst reorganisation and changes to funding and inspections renders further education 'the neglected middle child' (Foster, 2005) creating its existence as such in an educational and funding context, there is no need for it to be so in relation to research. I hope this thesis will encourage discussion and debate. Further education needs to consider how it manages and supports its adolescent learners, particularly if it is to secure its position within the educational landscape.

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## **Illustrations**

Good  
OK  
Bad

Life Path

11th December 1991 at 12.15am 6 pounds 2 oz in Bath Hospitale

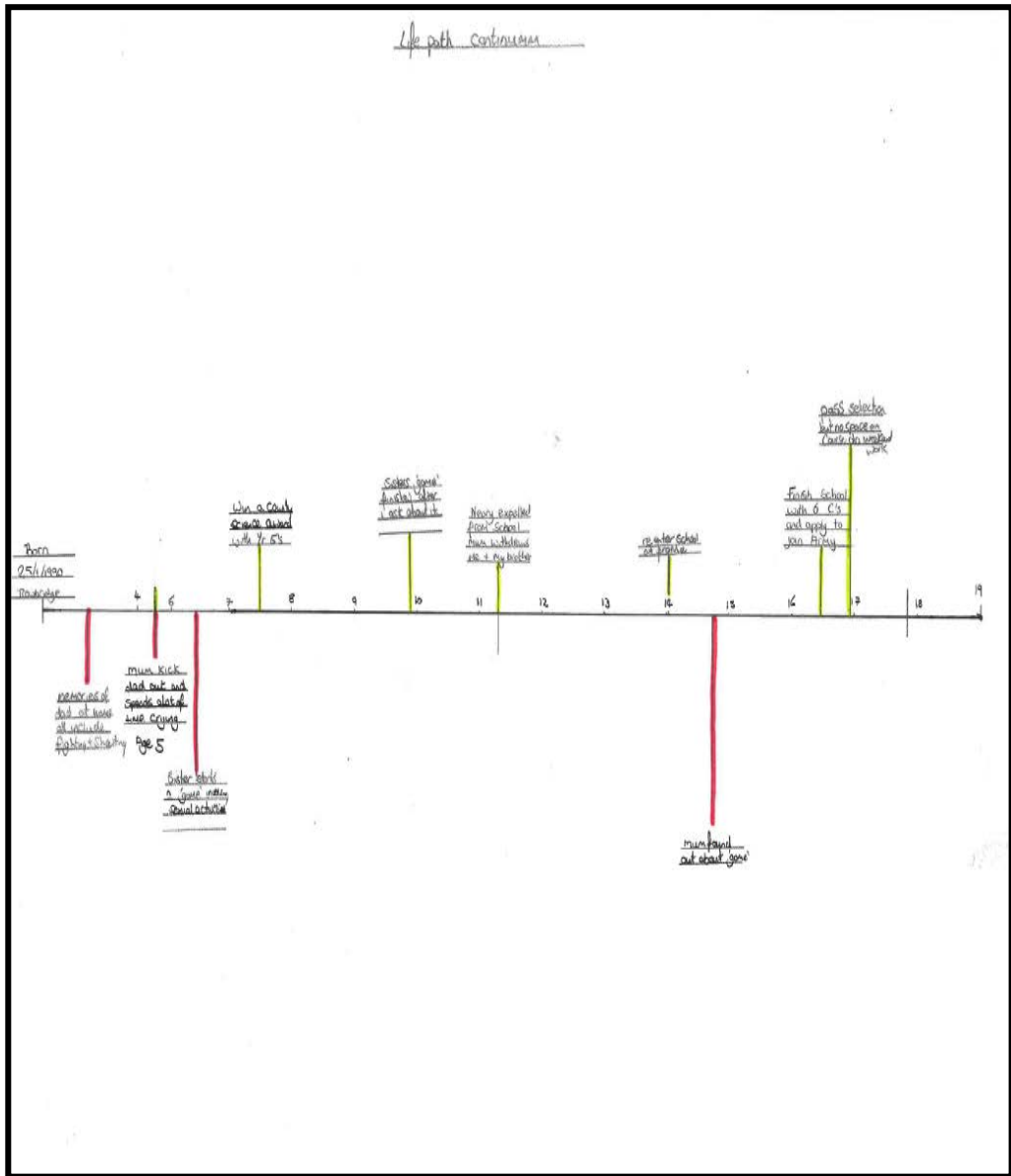
Earliest Memorie: ~~Not wanting to go to play group~~

- Play dates with other children
- Brother hit me over the head with a cricket bat
- 1996- Going to Ivy Lane
- -Not wanting to go to school
- -Mum OD survived
- 1999-Parents Split & Nan died & First Air Tattoo
  - Begining of Anxiety Attacks
  - Mum attacked dad had police round
  - Majorettes
- 2002-went to Sheldon School & Mum put on anti depressents
- 2002/03- Grandma died
  - Badly Bullied in school
  - Became very depressed and self harmed
  - Stopped going to school all together
  - Family arguments
  - Brother got expelled from school
  - Fell in love
- 2004- Moved houes
  - trouble with teenagers
- 2006- Mum went back on Anti deprents
- 2007- Lottie died & Left school
  - lost conatact with some friends
  - took up art and poetry
  - Got the cats
  - Step brother dignosed with Leukiemia
- 2007/08- went to college pre-16
  - Firs Real Relashonship
  - First kiss
  - First boy sleep over
  - Got dumped by the same person twice
  - Gained a stalker
  - Friend got pregnant
  - Got my rabbit and fish
  - Dad moved houes
- 2008/09- Started A Child Care Coures
  - Became suicidal
  - Started to self harm again
  - Got put on anti-depressents
  - Close friend tried to kill them selfs
  - Friend had her Baby
  - Mum lost her job and became very depressed
  - Mum found a job
  - Fish died
  - Fell out with my best friend
  - Dad moved houes twice
  - Moved in with my step mum for a week
  - Step mum got engaged

Page 1

Jordan's life path continuum





Tom's life path continuum

## Appendices

Content

Appendix 1  
Study information leaflet

Appendix 2  
Pilot study consent form

Appendix 3  
Main study consent form

Appendix 4  
Student demographic data form

Appendix 5  
Staff demographic data form

Appendix 6  
Interview checklist

Appendix 7  
Biographical interview prompts

Appendix 8  
Semi-structured interview schedule

Appendix 9  
Top covering letter for return of participant transcripts

Appendix 10  
Wenhill College counselling data

## Appendix 1 (Study information leaflet)

### *How do we manage and support adolescent students experiencing mental health issues in further education?*

#### **Overview**

The Mental Health Foundation (2006) suggest 6% of adolescent boys and 16% of adolescent girls aged 16-19 are thought to have some sort of mental health problem. These problems vary in many ways but include young people who are experiencing emotional disorders such as anxiety and depression, eating disorders, drug and alcohol abuse, self harming behaviour and stress.

Some young people are more likely to develop mental health problems because of risk factors. These include influences such as a family history of mental health problems, communication difficulties, other health problems for example a physical illness, parental conflict including separation/divorce, death and loss, abuse, neglect or bullying, poverty or crime.

#### **Aims of the study**

- To investigate the different types of mental health issues experienced by young people in further education
- To find out about young people's experiences of mental health issues and the support they have received to help them
- To assess what staff know about student mental health issues and how they support students experiencing mental health issues
- To examine the ways in which the College uses support services in helping students who are experiences mental health issues

#### **Outcomes – for students, staff and the College**

It is important to involve young people in this study as I want to find out about the experiences of students with mental health issues. I hope this study will help me to identify what types of mental health issues young people experience, how they are helped and supported and if there is anything else adults can do to help them. It is also essential to gain staff's perspective and by taking part in this study, young people and staff can help to shape the services and support networks within the College, but also outside services too.

#### **For further information please contact:**

Jo Williams\*

[Joanne.Williams@wenhill.ac.uk](mailto:Joanne.Williams@wenhill.ac.uk)

Professor Ann-Marie Bathmaker; School of Education, University of the West of England, Frenchay Campus, Coldharbour Lane, Bristol BS16 1QY

[Ann-Marie.Bathmaker@uwe.ac.uk](mailto:Ann-Marie.Bathmaker@uwe.ac.uk) or telephone 0117 32 84 151

\*Contact details omitted and college pseudonym inserted for confidentiality/anonymity purposes

Appendix 2 (Pilot study consent form)

**Consent to participate in pilot study interview**

*‘How do we manage and support adolescent students experiencing mental health issues in further education?’*

Thank you for agreeing to participate in a pilot interview for the above study. Please read the accompanying information leaflet for further details relating to this study. If you have any queries, please discuss these with me at interview.

The purpose of the pilot interview process is to ‘test out’ the proposed format, approach and tools chosen by the researcher. The outcomes from these interviews will help establish the final approach to the main study and further data collection.

Please be assured, all data collected will be treated in the strictest confidence and the participant’s identities will remain anonymous. If at any time during the interview process you wish to withdraw, this remains your right to do so.

The interviews will be digitally audibly recorded for transcribing purposes. The researcher will also make handwritten notes as required. You will have the opportunity to review the transcribed interview in due course.

I..... (insert initials) have read and understood the purpose of this research and agree to participate in the pilot interview.

I am not receiving any clinical treatment for my mental health at the present time.

Signed.....(participant) Date.....

Signed.....(researcher) Date.....

Appendix 3 (Main study consent form)

**Consent to participate in study**

*‘How do we manage and support adolescent students experiencing mental health issues in further education?’*

Thank you for agreeing to participate in an interview(s) for the above study. Please read the accompanying information leaflet for further details relating to this study. If you have any queries, please discuss these with me at interview.

Please be assured, all data collected will be treated in the strictest confidence and the participant’s identities will remain anonymous. If at any time during the interview process you wish to withdraw, this remains your right to do so.

The interviews will be digitally audibly recorded for transcribing purposes. The researcher will also make handwritten notes as required. You will have the opportunity to review the transcribed interview in due course.

I..... (insert initials) have read and understood the purpose of this research and agree to participate in the interview(s).

I am not receiving any clinical treatment for my mental health at the present time.

Signed.....(participant) Date.....

Signed.....(researcher) Date.....

Appendix 4 (Student demographic data form)

**Student demographic data**

*‘How do we manage and support adolescent students experiencing mental health issues in further education?’*

Participant I.D.....(insert initials)

Gender.....

Age.....(in years and months)

Town/postcode.....

Nationality.....

Previous school or college.....

Current campus.....

Are you ordinarily resident in the UK?.....

Is English your first language?.....

Ethnic origin.....

Do you have any criminal convictions?.....

Course level you are studying (eg, 1,2,3 or 4).....

Full or part time.....

Do you currently receive any additional learning support or assistance?.....

Appendix 5 (Staff demographic data form)

**Staff demographic data**

*‘How do we manage and support adolescent students experiencing mental health issues in further education?’*

Participant I.D.....(insert initials)

Gender.....

Age.....(in years and months)

Town/postcode.....

Nationality.....

Current role.....

Time in current role.....(in years and months)

Full or part time.....

College campus base.....

Are you ordinarily resident in the UK?.....

Is English your first language?.....

Ethnic origin.....

Appendix 6 (Interview checklist)

**Interview checklist**

*‘How do we manage and support adolescent students experiencing mental health issues in further education?’*

Before the interview begins:

Activity	Checked and completed
Does the participant have a study information leaflet?	
Has the participant read and signed a consent form?	
Has the researcher counter signed the consent form?	
Has the participant completed a demographic data form?	
Does the participant have any questions in relation to the study?	
<b>Applicable to student participants only</b>	
Has the participant brought their completed Life Path Continuum (LPC)?	
Start recording equipment and commence interview	

After interview:

Activity	Checked and completed
<b>Applicable to student participants only</b>	
Arrange further meeting	
Explain the data downloading and transcribing process	
Returning transcripts for participant review	
Data analysis	
Potential publication of research outcomes	
Any questions?	
Stop the recording equipment	



## Appendix 7 (Biographical interview prompts)

### **Biographical interview prompts**

*‘How do we manage and support adolescent students experiencing mental health issues in further education?’*

- Tell me about yourself (general)
- What are your plans for after college (current course/predicted grades/work/HE)
- Refer to and discuss life path continuum
- Describe your family profile
- Parent’s occupation
- Any mental health problems in your family
- Tell me about your mental health – issues and experiences (link to LPC)
- What influences your mental health
- Tell me about any services you have used in/outside of the college
- The wider student population experience and mental health
- Future support – idealistic and realistic
- Definition of mental health
- Comments and questions
- Close interview

## Appendix 8 (Semi-structured interview schedule)

### **Semi-structured interview schedule**

*‘How do we manage and support adolescent students experiencing mental health issues in further education?’*

- Tell me about your current role and responsibilities
- Your previous employment including other roles in education (formal/informal)
- In your current role have you come across any adolescent students experiencing mental health difficulties?
- If yes, please explain and discuss
- How did you know – did the student disclose or other?
- What sort of mental health issues do you think adolescent students are experiencing?
- What help (either in your experience and/or opinion) do you think is useful/helpful for adolescent students experiencing mental health issues?
- Are you aware of any internal systems/support services for adolescent students experiencing mental health issues?
- If so, please tell me about these
- To your knowledge, does the College use any external services to support adolescent students experiencing mental health issues?
- If so, please tell me about these
- How do you define mental health?
- Comments and questions
- Close interview

Appendix 9 (Top covering letter for return of participant transcripts)

**Letter for return of participant transcripts**

<Insert date>

Dear <insert participant name>

Re: Research study '*How do we manage and support adolescent students experiencing mental health issues in further education?*'

I hope you are keeping well.

Thank you for participating in the above study earlier this year. As you may recall, the interviews were digitally recorded for transcription purposes. The recordings have now been transcribed and the documents available for individual participants to review.

Enclosed is a copy of your interview transcription. Please take this opportunity to review its contents. Gaps in the transcription identified by a dotted line, question mark or numbers in brackets, indicate difficulties arising from the quality of the recording process and do not in any way reflect the views of the participant or researcher, by their absence.

Therefore, should you wish to add, exclude or modify the contents in any way please annotate the change you wish to make in the margin on the document and return the whole document to me in the envelope provided. If you do not wish to amend any of the contents, please retain the document for your reference.

If you have any queries relating to this documentation or to the overall research process, please contact me directly:

\*Telephone:

\*Email: [Joanne.williams@wenhill.ac.uk](mailto:Joanne.williams@wenhill.ac.uk)

\*Mail: Jo Williams

If I do not hear from you by <insert date>, I will assume you are satisfied with the contents of the transcription document and proceed with data analysis.

Thank you

Yours sincerely

Jo Williams

\*Contact details omitted and College pseudonym inserted for confidentiality/anonymity purposes

## Appendix 10 Wenhill College Counselling Data

Academic years 2007/08, 2008/09 and 2009/10

### 1. Total number of students who made contact with the college counselling service

Academic year	Campus 1	Campus 2	Campus 3	Campus 4	Wenhill College total
2007/08	108	73	43	75	299
2008/09	108	118	66	59	351
2009/10	117	137	55	97	406

### 2. Total number of students seen for 1:1 counselling (at least one session)

Academic year	Campus 1	Campus 2	Campus 3	Campus 4	Wenhill College total
2007/08	83	63	33	49	228
2008/09	85	104	50	40	279
2009/10	83	137	44	66	330

### 3a. Student gender (of those seen for counselling @ Campus 1)

Academic year	Male	Female
2007/08	19	64
2008/09	25	59
2009/10	20	63

### 3b. Student gender (of those seen for counselling @ Campus 2)

Academic year	Male	Female
2007/08	19	44
2008/09	21	83
2009/10	33	104

3c. Student gender (of those seen for counselling @ Campus 3)

Academic year	Male	Female
2007/08	14	19
2008/09	13	37
2009/10	12	32

3d. Student gender (of those seen for counselling @ Campus 4)

Academic year	Male	Female
2007/08	19	30
2008/09	12	28
2009/10	24	42

4a. Age range of students (seen for counselling @ Campus 1)

Academic year	Pre-16 (14-16)	16-19	19+
2007/08	5	64	14
2008/09	2	59	23
2009/10	4	54	25

4b. Age range of students (seen for counselling @ Campus 2)

Academic year	Pre-16 (14-16)	16-19	19+
2007/08	13	39	11
2008/09	12	78	14
2009/10	5	100	32

4c. Age range of students (seen for counselling @ Campus 3)

Academic year	Pre-16	16-19	19+
2007/08	1	26	6
2008/09	2	39	9
2009/10	6	26	12

4d. Age range of students (seen for counselling @ Campus 4)

Academic year	Pre-16 (14-16)	16-19	19+
2007/08	0	31	18
2008/09	0	21	19
2009/10	0	42	24

5. Total number of appointments offered for 1:1 counselling

Academic year	Campus 1	Campus 2	Campus 3	Campus 4	Wenhill College total
2007/08	453	282	249	317	1301
2008/09	486	Data not available	299	244	1029
2009/10	540	539	349	340	1768

6. Retention data (no data available for Campus 2)

6a. Campus 1

Academic year	Seen for at least 1 session	Retention %
2007/08	14 of the 83 seen did not complete course	59%
2008/09	9 of the 85 seen did not complete course	89%
2009/10	7 of the 83 seen did not complete course	89%

6b. Campus 3

Academic year	Retention %
2007/08	82%
2008/09	100%
2009/10	97.7%

6c. Campus 4

Academic year	Seen for at least 1 session	Retention %
2007/08	9 of the 49 seen did not complete course	82%
2008/09	5 of the 40 seen did not complete course	87.5%
2009/10	10 of the 66 seen did not complete course	85%

7. Issues presented (note: students seek counselling for a combination of issues – data presented reflects key presented issue)

7a. Issues presented @ Campus 1

Issues presented	2007/08	2008/09	2009/10
Relationships	8	4	9
Relationships with violence	2	0	0
Family relationships/breakdown	23	16	16
Substance misuse	2	3	0
General coping at college	3	4	6
Depression	5	4	4
Homelessness	1	2	5
Bereavement	2	4	6
Sexuality	3	0	0
Self esteem	15	14	10
Self harm	2	4	4
Eating disorders	4	3	1
Mental health issues	4	4	4
Phobia	1	0	0
Contraception	1	0	0
Finance	1	0	0
Anxiety	3	1	2
Anger	3	1	8
Alcohol concern re-family member	0	1	0
Health/illness	0	2	2
Abuse	0	10	3
Stress	0	1	5
Pregnancy/miscarriage	0	1	1
Family issues (overseas)	0	1	1

Interview nerves	0	1	0
Bullying	0	4	2
Procrastination	0	0	1
Foster care	0	0	1

7b. Issues presented @ Campus 2

(Note: specific numbers per issue not recorded, merely whether specific issues were presented)

Key = ✓ presented

Issues presented	2007/08	2008/09	2009/10
Relationships	✓	✓	✓
Family problems/breakdown	✓	✓	✓
Substance misuse	✓	✓	✓
General coping at college	✓	✓	
Depression	✓	✓	✓
Homelessness	✓	✓	
Bereavement	✓	✓	✓
Sexual matters	✓		
Bullying		✓	✓
Low self esteem		✓	✓
Pregnancy		✓	✓
Abuse		✓	✓
Neglect		✓	
Confidence/self image		✓	✓
Exam stress		✓	✓
Anger		✓	
Panic/anxiety		✓	
Suicidal thoughts		✓	
Transition			✓
Self harm			✓
Eating disorders			✓
Parenting			✓
Divorce			✓
Physical health			✓
Sleep disorders			✓
Gender issues			✓



7c. Issues presented @ Campus 3

Issues presented	2007/08	2008/09	2009/10
Relationships	10	4	6
Family relationships/breakdown	4	3	2
Substance misuse	2	4	3
General coping at college	1	0	2
Depression	2	4	3
Pregnancy	1	0	0
Bereavement	2	3	1
Sexuality	1	0	0
Self esteem	4	7	6
Self harm	1	5	7
Eating disorders/issues	2	1	4
Mental health problems (specific)	3	4	4
Homelessness	0	1	0
Abuse	0	2	1
Anger	0	9	4
Bullying	0	3	1

7d. Issues presented @ Campus 4

Issues presented	2007/08	2008/09	2009/10
Relationships	7	5	11
Relationships with violence	0	1	3
Family issues/breakdowns	8	2	3
Substance misuse	2	4	4
General coping	4	2	3
Depression (incl low mood)	6	5	7
Homelessness	0	1	2
Bereavement	2	2	5
Sexuality	1	1	2
Self esteem	5	4	6
Self harm	3	2	2
Eating disorders	2	2	1
Mental health issues	3	6	5
Phobia	1	0	0
Contraception/pregnancy	0	1	2
Finance	0	0	0
Anxiety/panic attacks	5	2	8
Anger	1	0	2

## 8. Referrals onto external agencies

### 8a. Campus 1

Agency	2007/08	2008/09	2009/10
CAMHS	✓	✓	✓
Housing	✓		
GP	✓	✓	✓
Drug & alcohol	✓		
TIPS	✓		✓
Adult MH		✓	
Richmond Fellowship		✓	
Connexions		✓	
Guidance services		✓	✓
Customer services			✓

### 8b. Campus 2

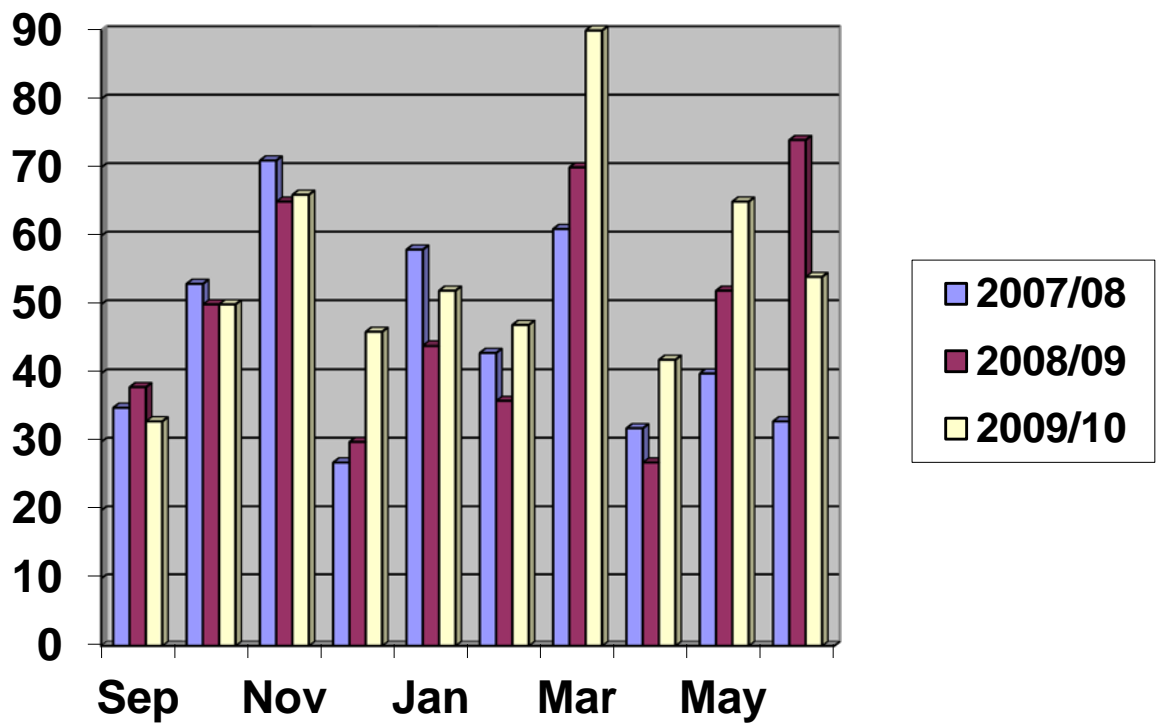
Agency	2007/08	2008/09	2009/10
Drug & alcohol	✓	✓	✓
Connexions	✓		✓
Housing	✓		✓
GP	✓	✓	✓
CAMHS	✓	✓	✓
Adult MH	✓	✓	✓
Social Services		✓	
TIPS		✓	
Other counselling		✓	✓

### 8c. Campus 3

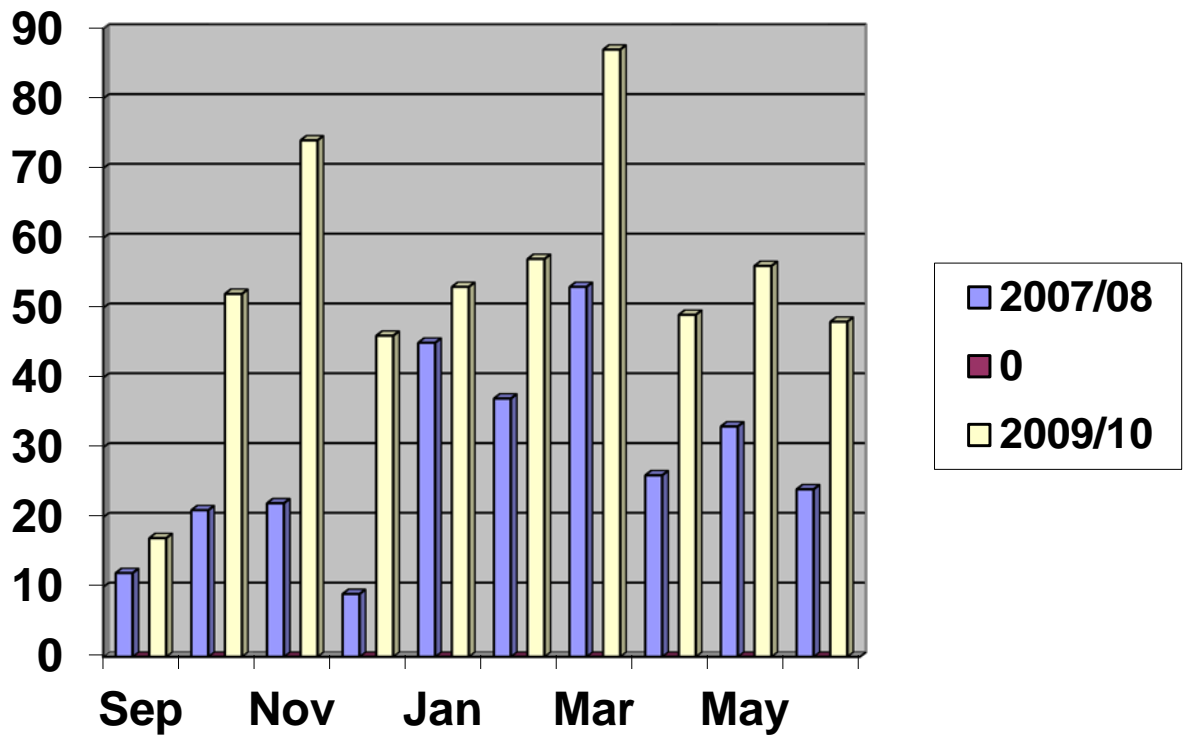
Agency	2007/08	2008/09	2009/10
Adult MH	✓		
CAMHS	✓	✓	✓
GP	✓	✓	
Drug & Alcohol	✓		
TIPS	✓		✓
CBT		✓	
Samaritans		✓	
The Priory			✓

8d. Campus 4

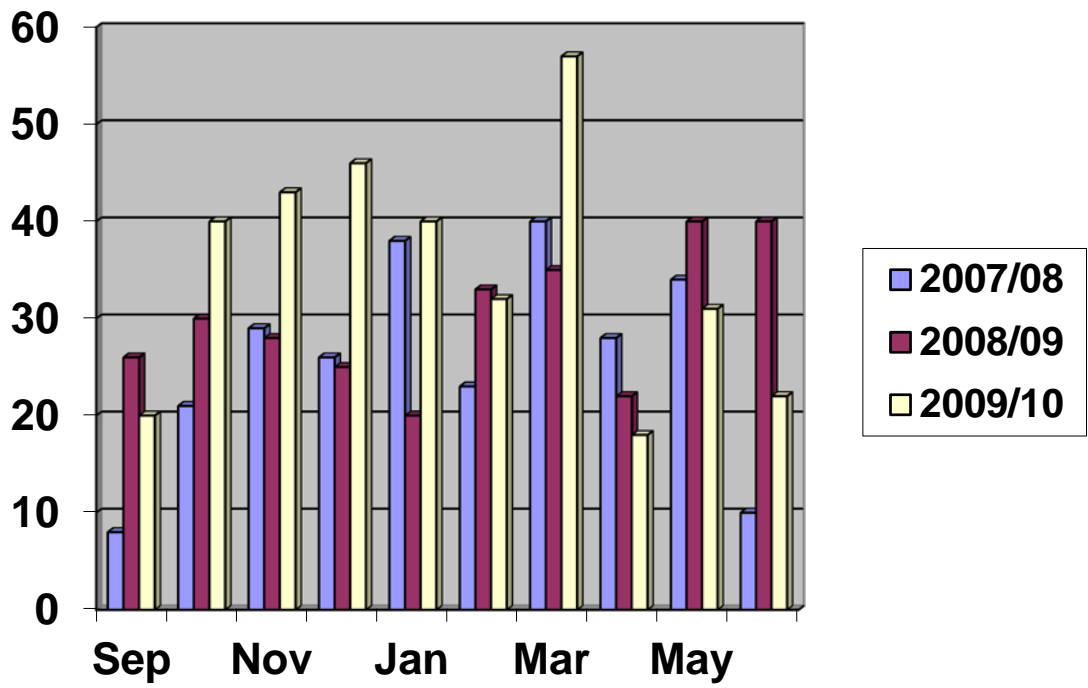
Agency	2007/08	2008/09	2009/10
GP	✓	✓	✓
Other counselling	✓		
Adult MH	✓	✓	✓
CAMHS	✓		✓
Young Carer Support Service	✓	✓	
Connexions		✓	
TIPS		✓	
Sexual Health			✓



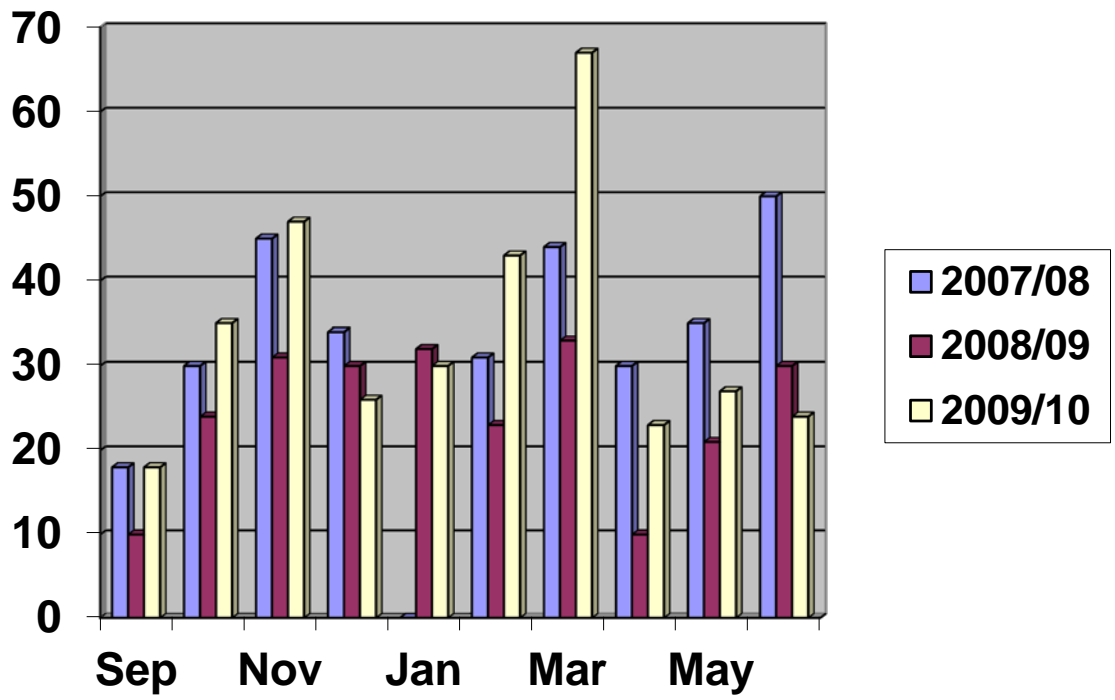
Graph 1 shows: Monthly breakdown of attended 1:1 counselling sessions at Campus 1 (Academic years 2007/08, 2008/09, 2009/10)



Graph 2 shows: Monthly breakdown of attended 1:1 counselling sessions at Campus 2 (Academic years 2007/08 and 2009/10 – no data available for 2008/09)



Graph 3 shows: Monthly breakdown of attended 1:1 counselling sessions at Campus 3 (Academic years 2007/08, 2008/09 and 2009/10)



Graph 4 shows: Monthly breakdown of attended 1:1 counselling sessions at Campus 4 (Academic years 2007/08, 2008/09 and 2009/10)