

# PSYCHOLOGY *for* TEACHERS

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## CHAPTER OBJECTIVES

- Outline the wide range of MWB sources available to the teacher.
  - Understand the need to develop personal MWB and facilitate development in the classroom.
  - Differentiate between a range of support systems and their integration into the wider educational system.
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## TEACHERS' STANDARDS

A teacher must:

- 4 Plan and teach well-structured lessons
    - reflect systematically on the effectiveness of lessons and approaches to teaching
    - contribute to the design and provision of an engaging curriculum within the relevant subject area(s)
  - 5 Adapt teaching to respond to the strengths and needs of all pupils
    - demonstrate an awareness of the physical, social and intellectual development of children, and know how to adapt teaching to support pupils' education at different stages of development
    - have a clear understanding of the needs of all pupils, including those with special educational needs; those of high ability; those with English as an additional language; those with disabilities; and be able to use and evaluate distinctive teaching approaches to engage and support them
  - 8 Fulfil wider professional responsibilities
    - take responsibility for improving teaching through appropriate professional development, responding to advice and feedback from colleagues
    - communicate effectively with parents with regard to pupils' achievements and wellbeing
- 

## 12.1 INTRODUCTION

Mental wellbeing is becoming an increasingly prevalent challenge to people of all ages. The pace of daily life is so fast nowadays that keeping up with it is difficult, to

say the least. Individuals require skills, strategies and understanding of themselves in order to cope with the pressures they face, and these skills, strategies and underlying understanding are usually developed over the lifespan. But is the pace of life too fast for this development to be effective? Do we need to acquire a skill-set far earlier in life nowadays, compared to 50 years ago? Indeed, what chances are there for our young people to acquire the necessary skill-set from the outset, during childhood, so that they are prepared for adulthood and are able to meet the demands of primary, secondary and tertiary education? Are our young people more or less able to cope in today's societies and what can we do as educators to assist them during these difficult, formative years? This chapter offers an insight into the psychological issues that lie within a clinical spectrum or classification system. Practitioners working in this area subscribe to the view that proactive early intervention is preferable to reactive treatment and also that an element of education in self-help facilitates progress by engendering a sense of personal control. Teachers would welcome such an approach, but may also need to consider the role that they must play in this process.

## 12.2 NHS CHILD AND ADOLESCENT MENTAL HEALTH SERVICES (CAMHS)

Mental health provision, administered by the National Health Service (NHS), must be diverse in its reach, available to all, from birth to old age and across all walks of life. As a result of this wide remit, it may be sub-categorised into the following distinct, yet interrelated services: child and adolescent services; learning disability services; adult services; older adult services; substance misuse services; forensic services. For the purposes of this chapter, however, we will focus on Child and Adolescent Mental Health Services (CAMHS) in relation to child and adolescent services (perhaps with an element of overlap with learning disability services and substance misuse services). Nevertheless, since we are dealing with education as a process beyond childhood and adolescence, we also consider elements of mental health in university students (which of course all teachers will have been, before embarking on their teaching positions) and we would also urge the reader to consider the material presented here in relation to MWB for teaching and support staff, who are equally an important part of the equation.

In respect of child and adolescent services, CAMHS is an umbrella term covering the various services who work with young people and children experiencing emotional or behavioural issues that are impacting on their MWB. This service also extends to parents and carers in order to provide appropriate support where it is needed most. Beyond generic support offered by local authorities, NHS Trusts or schools, for example, there is provision for specialist support through a network of multidisciplinary teams, comprising psychologists and psychological therapists, such as family therapists and play therapists,

occupational therapists, psychiatrists, nurses, social workers and specialists in substance misuse. The website for NHS England offers a springboard for further exploration, and having an awareness of it in the first instance provides a useful resource, should it be needed ([www.nhs.uk/NHSEngland/AboutNHSservices/mental-health-services-explained](http://www.nhs.uk/NHSEngland/AboutNHSservices/mental-health-services-explained)).

Access to support would normally be from a GP referral, although it may come from a school headteacher acting on behalf of concerned staff. Although a referral is the usual route to mental health services support, there are situations involving alcohol and drug issues where support can be gained without being referred by one's GP. The NHS website provides further links for those wishing to pursue them. The fact that there are a number of 'parties' involved, such as child, school, GP and social worker, ensures that the issue remains within focus and the child is not simply left without support. It is worth pointing out, however, that with the current trend towards economic cuts, the NHS is no different. As a result of government cuts, funding in CAMHS has experienced a net loss in excess of £50 standard million in England. It is perhaps little coincidence that CAMHS do not have the capacity to provide support for the approximately one in four children and young people referred to them.

If this resource does indeed act as a springboard for further exploration, the CAMHS link to the Youth Mental Health Hub is also worth exploring ([www.nhs.uk/Livewell/youth-mental-health/Pages/Youth-mental-health-help.aspx](http://www.nhs.uk/Livewell/youth-mental-health/Pages/Youth-mental-health-help.aspx)). Written for young people, it offers self-help guidance on issues such as depression, anxiety, stress (including exam stress), eating disorders, bullying (including cyber-bullying), panic attacks, low self-esteem, addiction, bereavement, relationship abuse and drugs, alongside other issues faced by young people nowadays.

## 12.3 DEFINING MENTAL WELLBEING

In providing a definition of mental wellbeing, we have explored some of the prominent organisations, whose aims are to promote mental wellbeing within society. The World Health Organization (WHO) provides the following definition, with a *caveat* that debate remains regarding all possible elements: 'Concepts of mental health include subjective wellbeing, perceived self-efficacy, autonomy, competence, inter-generational dependence and recognition of the ability to realize one's intellectual and emotional potential' (World Health Organization, 2003: 7). It has also been defined as a state of wellbeing whereby individuals:

recognize their abilities, are able to cope with the normal stresses of life, work productively and fruitfully, and make a contribution to their communities. (World Health Organization, 2009: 10)

In wider Western society, MWB has become a prominent feature of daily life. Indeed, the World Health Organization (Europe) acknowledges this as a major public health challenge affecting more than 30 per cent of the population and requiring an appropriate



action plan to improve health and wellbeing across the European region (World Health Organization, 2013), in line with and contributing towards 'Health 2020', the European policy frame for health and wellbeing. The WHO lists a variety of psychosocial factors that adversely influence MWB, which are worth mentioning here, since they have implications for teachers, trainee teachers and children alike: income, unemployment, substance misuse, crime and educational achievement are important and it is highlighted that often these form in clusters rather than existing in isolation (World Health Organization, 2013). For the purpose of this chapter, we will not explore these in detail, as they would draw attention away from our remit. Nevertheless, as teachers, we have a pastoral role to play and this role is more effective when available data is accessible and our awareness of the signs is heightened. We will return to this in Section 12.4 below. It is worth pointing out here that the WHO do propose a set of actions across the lifespan, taking into account the needs of children, adults and the elderly alike. Within the remit of this chapter, one of the WHO action points refers to 'best start', which promotes support for appropriate family life and parenting, encouraging parents to emphasise the importance of the home as a suitable learning environment and reducing detrimental childhood experiences. In order to do this, there is an increased emphasis on promoting mental health in schools, awareness of identifying emotional issues, along with actions targeting bullying inside or outside of schools (World Health Organization, 2013). This is an excellent, chronologically 'bottom up' strategy that aims to equip children with the necessary resilience skills required to enter adulthood and lead a successful life, in MWB terms.

Of course, this leads us nicely on to the notion of 'society'. In this section, we are discussing Western society; however, this is extremely broad and highlights that the educational system is itself a society. Indeed, primary, secondary and tertiary education are distinct 'societies' within the educational society, and in operational terms, each school, college or university is equally a distinct society. It is important to acknowledge this notion, because MWB has no boundaries and is not, or indeed should not be, perceived as being irrelevant within whichever 'educational society' the reader chooses to operate. We all have a certain responsibility to promote MWB in the domains within which we operate. It is important that we communicate with other like-minded professionals, who perhaps operate outside of our 'societies' but who share an element of overlap, or whose expertise we require because there is a line that, professionally, should not be crossed. We are thinking here especially of situations where a teacher with no formal psychiatric specialism may encounter a student experiencing severe mental health difficulties. We will discuss 'referring on' elsewhere in this chapter.

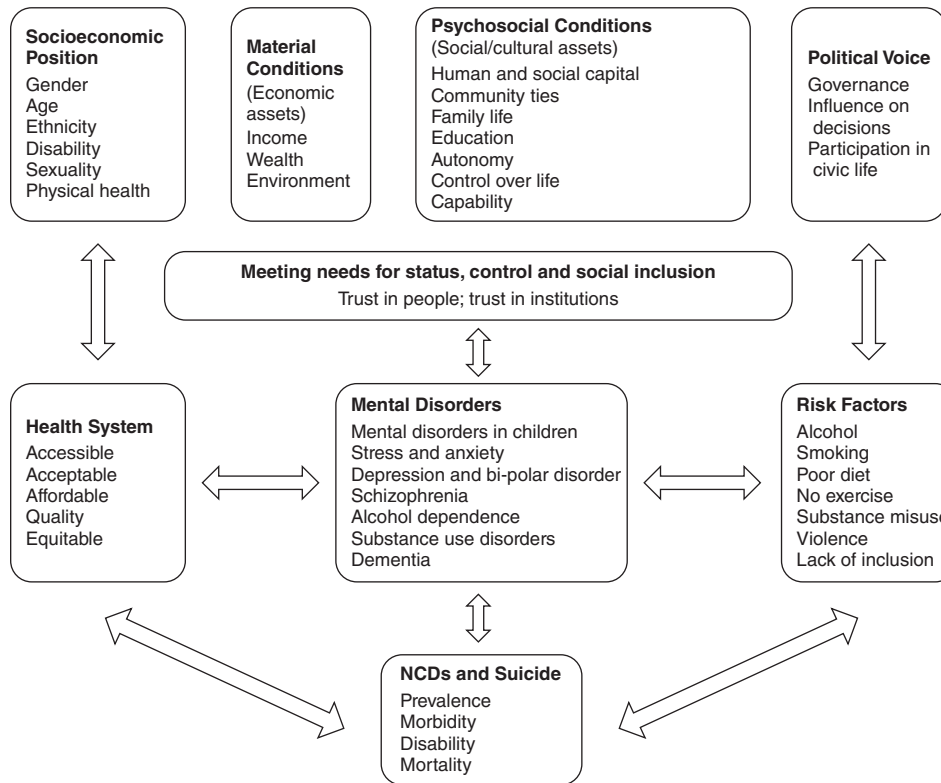
Within the higher education context, where aspiring undergraduates train to become teachers, there is an increasing level of concern in terms of the number of students who may be experiencing issues of mental wellbeing. The Royal College of Psychiatrists has acknowledged the heightened risk, such that 'Student service managers, counsellors and mental health advisors report increasing numbers of clients and an increase in the severity of the problems that trouble them' (Royal College of Psychiatrists,

2011: 20). This has been complemented by Universities UK, who produced a Student Mental Wellbeing in Higher Education (MWBHE) good practice guide (Universities UK, 2015), aimed at facilitating the integration and embedding of student mental wellbeing within higher education institutions, in line with review and potential revision of internal policies and procedures. It has been estimated by the chair of the MWBHE working group that there are approximately 115,000 students currently in higher education who have reported MWB issues. Elements of training in terms of mental health awareness and reporting protocols are recommended within this report, which has been widely adopted across the higher education sector. The 'Healthy Universities' initiative, established by the University of Central Lancashire (UCLAN) in 2006, was set up with the intention of offering a facilitative and supportive environment for the development of a whole university approach to health and wellbeing. As of 2017 it has attracted 87 affiliated UK higher education institutions ([www.healthyuniversities.ac.uk](http://www.healthyuniversities.ac.uk)). Internally, higher education institutions have further developed their existing structures and protocols for dealing with these challenges. We say 'challenges' because one might argue that such institutions are not 'specialist mental health services' and therefore it is not within their remit to provide such support. Nevertheless, higher education institutions are communities and, in some respects, they are self-contained, which makes it important for some element of MWB provision. Historically, this has been the domain of university counselling services, although more recently some of the lower-level non-counselling (yet pastoral) issues that personal academic tutors now have to deal with mean that an element of awareness of MWB issues is available to academic staff. Indeed, some institutions, such as the University of Worcester, are beginning to address the increasing number of students entering higher education with MWB issues (see Musiat et al., 2014).

## 12.4 WITHIN SCHOOLS

The World Health Organization report that approximately 50 per cent of mental disorders emerge before 14 years of age (WHO, 2013). The cycle of mental wellbeing model (World Health Organization, 2013: 18) incorporates socioeconomic, psychosocial and political elements that influence and are influenced by mental disorders, risk factors and available health provision. It is a useful source of reference, perhaps to print off and pin on the school noticeboard, as it provides a succinct, effective reminder of the complex issues that surround mental wellbeing. While one might initially consider it to be a model for the adult world, children are still subject to its elements. Although it is not always a good thing to compartmentalise children or adults into 'boxes', we live in a society that operates on the basis of classification systems. Indeed, this is evident specifically in terms of the clinical classification of mental disorders, using *DSM-5* and *ICD-11* mentioned elsewhere in this chapter. Children are classified in terms of stages of development, Key Stages and SATS results among many other forms of classification.

The model is shown in Figure 12.1. Our advice would be to examine the model in two ways: firstly, ‘from the outside inwards’, i.e., look at each box and consider how it relates to other boxes, how it relates to the systems in place within schools; and secondly, by starting with the signs presented by a child in school and then use the boxes in the model to make associations. This can be seen in the case study that follows.



**Figure 12.1** Adaptation of the cycle of wellbeing model (adapted from World Health Organization, 2013)

### CASE STUDY James

James is a 7-yearold from a single-parent family, living in a high-rise tower-block in an inner city. His father was imprisoned just before James was born, after being convicted of an offence involving firearms; now out of prison, he is not

*(Continued)*

permitted to have contact with his wife as a result of long-term violence issues towards her. This means that James does not have any contact with his father.

His 25-year-old mother is a drug addict, currently undergoing a heroin rehabilitation programme. She receives unemployment benefit and has not worked since leaving school without any qualifications at 16, although she appears to have funded her drug habit through prostitution.

### Comments

In looking at the cycle of wellbeing model again (Figure 12.1), it becomes more apparent where the model is applicable to anyone helping James.

Factors from the model that should stand out to the reader are:

- *Socioeconomic position*: gender, age, physical health.
- *Material conditions*: income, wealth (lack of), environment.
- *Psychosocial conditions*: human and social capital, family life, education (hampered), autonomy (lack of), control over life (lack of), capability.
- *Risk factors*: poor diet, no exercise, potential for future substance misuse, potential for future violence.
- *Mental disorders*: potential for stress, anxiety, depression, alcohol dependence, substance use.

Of course, it must be stressed that we cannot be certain that James will experience poor MWB issues at all. That is not the point. Rather, teachers and students alike should be made aware of the potential mediating factors, the risk factors and the relationships between them. On this basis, the model helps to direct attention.

### ACTIVITY

In taking the case study of James a step further, we would suggest that you perhaps visualise different scenarios of what James would look like and the ways in which he may behave in school, if you manipulate the mix of factors in the model. This will help you to establish some patterns of physical appearance and behaviour, i.e., the signs to look out for in the classroom and the playground (see Section 12.6 below).

It should not be difficult to write a series of 5–10 case studies of your own. Indeed, this might be an excellent group activity for all staff to participate in during a training session, so that a wider series of examples can be produced. A loose structure might be:

- Brief background information on the child.
- Brief outline of signs and symptoms displayed.
- Brief outline of the course of action that you might recommend, including other parties who should be informed.

In effect, there should be a protocol in place in school already that you report to the Head or Head of Department. We are suggesting that you have an awareness of the role played by GPs, educational psychologists and clinical psychologists as part of your own continuing professional development. This will also enable you to direct your own pastoral care in a manner that we would hope leads in to and complements the help of other agencies at a later date.

## 12.5 OBSERVING AND IDENTIFYING 'SIGNS AND SYMPTOMS'

In no particular order of priority, here is a list of possible indicators of a change in a student's personal circumstances outside of school that may impact on activities, performance and behaviour within school:

- A change in previous cleanliness or tidiness of school uniform beyond the accepted 'norm'.
- A change in apparent hygiene, i.e., unkempt hair and a 'ripe odour' emanating from the student.
- Appearance of dark rings or bags under the eyes indicating lack of sleep, along with falling asleep in lessons.
- Difficulties in concentration and focus on tasks during lessons.
- Increased lateness for registration.
- Stealing of or begging for food from peers during the school day, indicating a change in diet and nutrition at home.
- Increased agitation or aggressive behaviour, towards either teaching staff or peers.

Criticism has been levelled at attempts to define wellbeing in terms of the culmination of constituent parts, rather than in terms of generic themes (Dodge et al., 2012). These authors propose the existence of a wellbeing 'set point' or fulcrum reflecting a state of homeostasis, which is influenced by fluctuating resources and challenges. For them, wellbeing is defined as 'the balance point between an individual's resource pool and the challenges faced' (2012: 230). They go on to say that stability or homeostasis occurs 'when individuals have the psychological, social and physical resources they need to meet a particular psychological, social or physical challenge. When individuals have more challenges than resources, the see-saw dips, along with wellbeing, and vice versa' (2012: 230).

Others would argue perhaps that this state of equilibrium equates to the term 'flourishing' (Ramachandram, 2016; Seligman, 2011), referring to 'the experience of life going well' (Huppert and So, 2013: 838). Huppert and So refer to research suggesting that flourishing, which they argue is synonymous with wellbeing, is linked to enhanced learning, increases in both productivity and creativity, effective relationships and increases in pro-social behaviour, improved health and extended life expectancies (Huppert and So, 2013: 838). The aim of Huppert and So's research was to examine the symptoms of depression and anxiety, in accordance with international classification (see Section 12.7 on classification below), and identify the mirror opposites of their symptoms. Ten features reflecting hedonic (H) and eudemonic (E) dimensions, i.e., positive feelings and positive functioning, were established: competence, emotional stability, engagement, meaning, optimism, positive emotion, positive relationship, resilience, self-esteem and vitality. Ranking of each of these elements in relation to three European regions and 22 European countries can be found in Huppert and So (2013) and is well worth examining. It shows, for example that those living in Denmark are ranked 1st for positive emotion, positive relationships, resilience and emotional stability, whereas those living in the UK are ranked 10th, 3rd, 6th and 19th respectively on the same features. Indeed, the UK does not rank 1st on any of these features.

## 12.6 MENTAL WELLBEING ORGANISATIONS

Society loves to classify, code and compartmentalise objects, ideas, concepts and phenomena, in order to provide a suitable and standardised understanding of them (as we will see in Section 12.8 below). With the extreme variation in quality of information available electronically these days, through a wide range of social media and internet sources, it is important to establish the suitability of material. For example, if we choose to set up a wiki page, stating that the world is flat, with slightly curled up edges to stop boats and people falling over the edge, there is nothing to stop us doing it and inevitably there will be people who access the material and believe us entirely because we are 'qualified' and are 'experts'. While such naivety may be slightly alarming, there is a grey area when one examines the available resources on MWB. With this in mind, the resources we have selected in this chapter (and indeed throughout the book in general) have been deemed to be of an appropriate standard. Professional bodies, such as the British Psychological Society (BPS) or the Royal College of Psychiatrists (RCP), are governed by professional and ethical principles and are therefore deemed to be 'safe'. Equally, the websites chosen below have, wherever possible, been selected because they have been certified by NHS England and have achieved the status of satisfying the 'Information Standard', which is committed to raising the quality of health and care information that is accessible by the public, patients and practitioners in the health and care professions ([www.england.nhs.uk/tis/about/the-info-standard](http://www.england.nhs.uk/tis/about/the-info-standard)).

The Health and Care Professions Council is another quality provider that governs various health and care professions. Registered practitioners practise under its auspices and are governed by its rules, regulations and disciplinary procedures, and so members of the public using its services receive an appropriate level of protection, commensurate with the expectations of the professions within its remit. Often, practitioner psychologists will be chartered members of the British Psychological Society as well as members of the Health and Care Professions Council. Psychiatrists will have trained in medicine and specialised in psychiatry and it is the medical training that distinguishes them from clinical psychologists. For the purposes of this chapter we would not wish to exclude the Royal College of Psychiatry as an important source of information, with a considerable element of overlap with psychology in terms of MWB.

Another organisation that sits under the certification of the Information Standard is Mind ([mind.org.uk](http://mind.org.uk)), a registered charity whose aim is to provide advice and support to empower people experiencing mental health difficulties. Since the production of their 2012 strategy document, Mind acknowledge the amelioration in public perception towards mental health, which has led to their producing a new strategy for 2016–2021, 'Building on Change' (Mind, 2016). In this document, six fundamental challenges remain: one in four people will experience a mental health issue in any year; approximately 25 per cent of people experiencing mental health issues receive support in a given year; 57 million prescriptions for antidepressants have been prescribed, equating to a 46 per cent increase since 2012; a reduction in funding for mental health services in England alone by 8.25 per cent has been seen during the last parliament; 50 per cent of people have to wait over three months before starting 'talking therapies' and in excess of 105,000 people were hospitalised as a result of their mental health; there has been an increase in suicide in England and Wales in 2013, compared to 2012, with approximately 5,140 people taking their own lives.

Other examples include the Mental Health Foundation and the Charlie Waller Memorial Trust, which are charities set up along similar lines to address mental health, providing support for children and adults alike. The Mental Health Foundation ([www.mentalhealth.org.uk](http://www.mentalhealth.org.uk)) has been conducting pioneering research in this field over the past 60 years and has recently, for example, explored the concept of 'digital mental health' or 'e-mental health' as a platform for providing assistance to a society that spends large amounts of time online in both adults (Musiat et al., 2014) and children (Stallard et al., 2010). Although e-therapies are increasing, both studies represent and reflect the caution its users perceive towards it, a situation certainly highlighted in Stallard et al.'s paper, in which 49 per cent of 8–17-year-old participants reportedly preferred face-to-face contact, as opposed to e-support. Capp (2015) calls for a mental health 'presence' to be integrated into school communities, rather than being 'accessed off-site', suggesting again the preference for face-to-face contact. We will, however, consider digital mental health in more detail elsewhere in this chapter.

The Charlie Waller Memorial Trust aims to offer support for young people relating to mental wellbeing and specifically the signs of depression. An e-learning package

consisting of six 20-minute sessions has been designed for those people working with students; it is available online, free of charge ([www.learning.cwmt.org.uk](http://www.learning.cwmt.org.uk)), and allows users to work through it at their own pace. Guidance is provided on: key principles in supporting students in order to provide effective support within the realms of one's professional role; awareness of the signs of deterioration in mental health and what to do in such instances; the skill-set required in order to support a student who presents in a distressed state, or who becomes increasingly distressed during a period of support; transitional issues from home to university, in the case of students entering higher education; support in crisis-intervention where students are taking risks, either with their own mental health or that of others; integrating skills from sessions 1–5 into a key summary for helping students, along with an example of good practice. In each of these sessions, there is a useful set of case-study-type scenarios and a self-test element to check the viewers' understanding. An associated Charlie Waller Memorial Trust project has facilitated the creation of 'Students Against Depression', a website that offers clinically validated information, strategies and resources for students facing issues such as low mood, depression and suicidal thoughts ([www.studentsagainstdepression.org](http://www.studentsagainstdepression.org)). Significantly, it offers stories from students who have experienced these issues and how these challenges were overcome. Depression is seen as something requiring a campaign against it and the aim is to kickstart the campaign against depression. Cleverly and in keeping with student-relevant terminology, the organisers provide a set of ten modules for students to work through on their campaign. Each module has a downloadable workbook for recording notes, providing evidence and a sense of what is being focused on, along with their acting as a monitoring and reflection tool. There is certainly a benefit in being able to look back on one's journey and see how far one has come. The module series is structured as per Table 12.1 below.

**Table 12.1 Summary of steps in a student's personal campaign against depression**

1	Creating a safety plan
2	Establishing a support network
3	Taking those difficult first steps
4	Establishing a healthier daily routine
5	Increasing one's understanding of depression
6	Changing thinking patterns
7	Developing skills for living well
8	Viewing depression from a different perspective
9	Making efforts to continue working on overcoming depression
10	Writing a personal reflective account of winning the campaign to overcome depression

*Source:* adapted from [www.studentsagainstdepression.org/take-action/take-action-in-your-own-life/](http://www.studentsagainstdepression.org/take-action/take-action-in-your-own-life/)



Although aimed primarily at undergraduate-level students, much of the material can be easily transferred to secondary school and college-level students, along with post-graduate students, all of whom are equally susceptible to depression at some point in their student lives (and beyond). The key element that must be adhered to is that progress builds on solid foundations, so with this in mind, we propose that it is useful to see Table 12.1 in terms of a series of incremental and related steps. Modules 1–3 are concerned with the immediacy of the situation, and on this basis they sit together nicely. This is rather like planning ahead for the short-term future (also, see Prochaska and DiClemente's stages of change model in Chapter 14) (Prochaska and DiClemente, 1982). Modules 4–6 focus on increasing understanding of depression and the ways in which one might change one's thinking about it, while also beginning to make changes. This is rather like working on it in the present: it concerns action rather than planning and focuses the person on actively changing their patterns of activity. Module 7 starts with the present and then, in combination with Modules 8 and 9, begins to adopt a longer-term, future approach to living well, recognising and acknowledging one's emotions, how these should be expressed, what society expects and how to remain true to one's own (and probably newly restructured) perspectives on mental health. This is rather like the transition to the 'next level' of the campaign. Again, we can draw appropriate parallels with the stages of change model here. Finally, Module 10 requires reflection on the past, the campaign and the level of success achieved.

There are two things to notice here. Firstly, beginning the sentence with 'Finally' is not really appropriate. It is not 'final'. It is the start of the rest of one's life and as with stages of change, is in need of constant monitoring and adaptation as necessary. This, however, is not a burden, but rather is satisfying, motivating and self-confidence building. It is in effect a 'campaign for life', with depression entering the campaign as a part of the richness of that life. Secondly, by embarking on a package such as this, or indeed any similarly structured package of mental health support, it would be nigh on (if not) impossible to be at the same point at the end as the starting point. Obtaining appropriate guidance, creating a support network and working through the challenge foster a sense of control, which by its very nature would appear to be the inverse of that experienced by someone with depression.

Since there are numerous other organisations we could have included here, there comes a point at which one needs to finish off, so we will do so with two additional charities: Young Minds and Heads Together. We have not excluded others on any basis other than restricted space in the pages of this chapter, but what we have attempted to do is provide an 'e-journey' or 'paper-trail'. You will notice that among the collective resources here, there is a synergy between many of these links.

Young Minds ([www.youngminds.org.uk](http://www.youngminds.org.uk)) is a leading charity, established in 1993, aimed at improving the health and wellbeing of children and young people, with a specific early-intervention approach. Heads Together ([www.headstogether.org.uk](http://www.headstogether.org.uk)) is a campaign established by their Royal Highnesses the Duke and Duchess of Cambridge along with Prince Henry of Wales (Prince Harry), and in synergy with partners such

as Young Minds, serves to raise awareness of and reduce the stigma associated with underlying, unresolved mental health issues that are creating significant difficulties to individuals and the societies within which they live.

## 12.7 A COLLECTIVE FOCUS?

Collectively, two common themes emerge from these sources. Firstly, the stigma that has been inappropriately linked with mental ill-health has been challenged in recent years and continues to diminish (e.g., Murman et al., 2014; Yau et al., 2011). There is still progress to be made; however, young people appear to be far more at ease and open with discussing issues that would have remained hidden 30 years ago. Fostering this de-stigmatisation through the agencies outlined here, along with the countless others which we have not been able to mention but which share this collective focus, is vital in perpetuating the momentum that exists. Secondly, early awareness is a key element in helping people to overcome their mental health challenges. In the context of this book, this is especially the case for children, which is why there has been an increasing emergence of MWB-related programmes introduced into schools, both in the UK and abroad. An extremely short article in the *Education Journal* (2017) highlights how this is being tackled in Wales, since 2012, through the use of 'young champions', although there is no other information available. Early awareness by staff is a vital element in ensuring the MWB of children in the education system. Naturally, additional training is always a favoured approach and this is no exception in terms of MWB in schools. Of course, we are not advocating that you train to become a professional counsellor (unless you have a desire to change your profession at this point). There are, however, important and extremely beneficial courses that can be taken, with a little investment of time from you, which you can take back into school and share with colleagues, where you are the 'named member of staff'. One such course operating currently is Mental Health First Aid (MHFA), which was originally developed in Australia in 2000; it is internationally recognised in 23 countries and was implemented in the UK in 2007, by the Department of Health's National Institute of Mental Health in England (NIMHE) as one element of a national approach to improving public mental health. MHFA is aimed at a wide variety of people and professions, particularly where contact with the public is a primary feature. It is certainly of benefit to teachers, especially those working in secondary education, where mental health issues are frequently seen, and has been evaluated favourably, in terms of using educational psychologists to deliver the MHFA-YP (young people) programme through NHS Scotland (Currie and Davidson, 2015). This has been echoed in the MHFA country of origin, with similar favourable results in Australia (Hart et al., 2016), and in relation to the Wellbeing in Secondary Education (WISE) study in the UK, which examines MHFA for wellbeing in students and teachers alike (Kidger et al., 2016).

MHFA aims to provide support in the first instance, using principles applicable to physical first aid. Participants on the course are taught to recognise the warning signs associated with diminishing mental health. Training is also given on how to talk directly with someone who is expressing an issue, what might help them, how to remain or become calm and what not to say or do, depending on the presenting signs and symptoms. A toolkit, entitled ‘Take 10 Together’ and developed for World Mental Health Day 2016 has been adapted by MHFA England for year-round use (<https://mhfaengland.org/mhfa-centre/resources/take-10-together>). There is also a school

**Table 12.2 Adaptation of MHFA infographic ‘Take 10 Together’**

Provide a ‘safe’ space	<ul style="list-style-type: none"> <li>• The classroom may be intimidating, so use a neutral area outside of the classroom, such as a pastoral support room.</li> <li>• Ensure that you sit down, which will foster a more relaxed approach to the conversation.</li> <li>• Allow plenty of time. You are not restricted to 10 minutes.</li> </ul>
How to ask questions	<ul style="list-style-type: none"> <li>• Use a non-confrontational style and body language.</li> <li>• Keep them positive and encouraging.</li> <li>• Show empathy and take the questions (and their answers) seriously.</li> <li>• Avoid irrelevant advice, such as ‘Cheer up’.</li> <li>• Make eye-contact while being mindful of potential cultural differences.</li> </ul>
Types of question to ask	<ul style="list-style-type: none"> <li>• ‘How are you feeling at the moment?’</li> <li>• ‘How long have you felt like this? Is it an ongoing issue?’</li> <li>• ‘Who do you feel you can go to for support?’</li> <li>• ‘What kind of support do you think might help you?’</li> <li>• ‘Are there any factors outside of school or the classroom that are contributing to the way you are feeling?’</li> <li>• ‘How can I help you?’</li> </ul>
How to listen	<ul style="list-style-type: none"> <li>• Pay full attention without interrupting or being distracted while the student speaks. Focus on their choice of words, their tone of voice and any signs of body language for cues.</li> <li>• Respect the student’s attitudes, values, beliefs and feeling as important, even if they differ from your own.</li> <li>• Show genuine concern by avoiding making any moral judgement or criticism of what they say.</li> <li>• Establish a rapport by placing yourself in their position, displaying empathy for what they are saying.</li> </ul>
What to do next	<ul style="list-style-type: none"> <li>• Ensure that the conversation continues until you feel that you have both determined the next course of action.</li> <li>• Make a note to follow up within a period of time (this may be an hour, a day or a few days, depending on the severity of the issue).</li> <li>• Provide reassurances regarding your support along with the support of other staff (subject to confidentiality and your assessment of any risk). Ensure that the student is aware of the school counselling service, the school nurse and their family GP.</li> <li>• Report through usual school protocols as appropriate.</li> </ul>

Source: adapted from MHFA (2017) ‘Take 10 Together at School’

version for use with young people and it is this version that we will discuss here, although we would direct teachers to the adult version for their own MWB. Readers will be aware of the day-to-day pressures surrounding modern school life, such as bullying, academic pressures and increasingly challenging concerns based on social media technologies, along with those issues of daily life experienced outside of school, so it is not surprising that MWB issues are increasing in young people. These issues are perhaps an inescapable element of modern Western societies, and young people will only benefit from resolving issues if they are provided with adequate support. As inferred by the title of the toolkit, the starting point for this may be as simple as taking ten minutes with a student, in a non-confrontational way, to explore their mental health. 'Back in the day' we would have called this 'a chat', which of course, it still is. The difference is the underlying purpose, which structures the questions one might ask and the way in which those questions probe specific mental health issues. There is a downloadable infographic on the MHFA England site for use in the staff room, although the information has been adapted for inclusion in Table 12.2 (which we believe is less attractive but succinctly condensed as a quick reference).

## 12.8 MENTAL WELLBEING IN A CLINICAL CONTEXT

Classification enables us to assess something against an agreed set of criteria and, in this sense, ensures accuracy and replication, subject to the suitability of the criteria of course. While mental wellbeing issues are perhaps less tangible than concrete, physical items, there are still elements of consistency that enable us to classify human behaviour in a way that provides insight and facilitates appropriate interventions. Of course, from a philosophical perspective, there is an argument against the classification of mental health in this way. Such classification may be seen as trying to fit behaviour into a specific category, purely because the category and its associated label exists. There will inevitably be elements of confusion in which a child with something non-clinical, such as a behaviour-management problem, is categorised into something more serious because a classification exists. For the purpose of this chapter, we adopt the former position and use classification in a positive light. Regardless of any standpoint against classification, classification exists, is in use and will continue to be used. No doubt refinements will be made over time, in line with cutting-edge thinking, and this provides an element of protection for all. Two major classification systems exist: *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)*, written on behalf of the American Psychiatric Association; and the *International Classification of Mental and Behavioural Disorders (ICD-11)*, written on behalf of the World Health Organization and used across Europe. Chapter 7, entitled 'Mental and Behavioural Disorders', has received 310 proposed revisions, of which 286 have been successfully actioned as of February 2016.

We refer to the *ICD-11* as a clinical source of reference, in guiding the reader through clinical descriptions and diagnostic guidelines. It is important to bear in mind that this source is used in primary health care settings and general medical practice, but nevertheless it is important for us, our colleagues and you, the reader, to have an understanding of these descriptions and guidelines in order to inform our own courses of action, when needs arise. The *caveat* that we must impress on you is the issue of where to draw the line in terms of the support you are able to offer students without overstepping the professional boundaries requiring counselling or clinical qualifications. This is a grey area, so if in doubt, do not go beyond areas of pastoral support that you would be expected to provide as a teacher. For more guidance, it is worth looking at webpages of the British Association for Counselling & Psychotherapy ([www.bacp.co.uk](http://www.bacp.co.uk), [www.itsgoodtotalk.org.uk](http://www.itsgoodtotalk.org.uk)), the British Psychological Society's Division of Clinical Psychology ([www.bps.org.uk/networks-and-communities/member-microsite/division-clinical-psychology](http://www.bps.org.uk/networks-and-communities/member-microsite/division-clinical-psychology)) and the Royal College of Psychiatrists ([www.rcpsych.ac.uk/](http://www.rcpsych.ac.uk/)). Each of these contains a diverse array of resources that may guide your intuitive thinking and help you to balance the issue of providing support with that of duty of care.

The UK National Health Service (NHS) offers five generic steps to aid mental wellbeing: connect, be active, keep learning, give to others, be mindful (NHS Choices – [www.nhs.uk/Conditions/stress-anxiety-depression/Pages/improve-mental-wellbeing.aspx](http://www.nhs.uk/Conditions/stress-anxiety-depression/Pages/improve-mental-wellbeing.aspx)). Each of these are based on sound underpinning research literature and indeed apply to children and adults alike. Connecting with people – building and developing relationships with colleagues, peers, family and friends – helps to provide a support network (Ponce-Garcia et al., 2015). Finding a form of physical activity that is personally enjoyable provides physical and psychological benefits that are well documented and multifaceted (e.g., Christie and Cole, 2017; McNaughton and Meldrum, 2017; Thum et al., 2017). Learning new skills or developing knowledge in new areas provides motivation, confidence and a sense of achievement. Giving to others can be as simple as smiling at someone, or holding a door open for them, or be more structured as in the example of volunteering. Regardless of what it entails, this is an element of altruistic behaviour that provides personal satisfaction and a good feeling for the altruist. Mindfulness, or spending time in the present, rather than pondering on the past or thinking about the future all of the time, enables people to take stock or 'stop the merry-go-round' for a while and is linked to states of relaxation (e.g., Zeidan et al., 2014). There is of course an element of overlap between these steps. For example, learning new skills through participation in a sporting or exercise activity increases physical fitness, but more than likely involves other like-minded participants and hence increases connectedness and enhances support networks. It may be that one offers a lift to a fellow participant and thus is an act of giving. While participating, the future or past are of little significance and hence a sense of mindfulness is fostered. Readers who walk, run or cycle as a preferred form of physical activity will perhaps readily identify with this final point (we will return to mindfulness in Chapter 17)

## 12.9 MEASURING MENTAL WELLBEING

As we discussed above, MWB can be measured in adults using the 14-item Warwick-Edinburgh Mental Well-Being Scale (WEMWBS) (Tennant et al. 2007). This has strong construct validity against the Positive and Negative Affect Scale (PANAS) (Watson et al., 1988) and the Scale of Psychological Well-Being (SPWB) (Ryff and Keyes, 1995), against which it was compared. Where depression may be suspected as an underlying issue during a visit to one's GP, MWB can be measured using the nine-item Patient Health Questionnaire-9 (PHQ-9) (Kroenke et al., 2001), which is widely available to health professionals and acts as a quick and efficient screening tool for depression along with potential suicide risk.

Difficulties associated with any questionnaire that should be borne in mind are validity and reliability. Validity refers to whether the questionnaire measures what it purports to measure, i.e., whether it is accurate and precise. It also refers to the appropriateness of the data generated and whether it has been measured correctly. Reliability refers to the repeatability of data generated, i.e., is the measure consistent in producing similar results over multiple occurrences (Denscombe, 2010)? To use an analogy, a tin of baked beans labelled 'baked beans' should contain baked beans. If it contains baked beans it shows strong validity, but if it contains peas it shows poor validity! If one opens ten tins of baked beans and each one contains baked beans, it shows a high level of reliability, but if seven of those tins (this is simply a subjective choice of number here) contain peas it shows poor levels of reliability (see Chapter 19 on validity and reliability).

The questionnaires outlined above have been peer-reviewed, which acts as a quality assurance mark concerning their validity and reliability. As with many questionnaires, refinements tend to be made over time: new ways of thinking promote new (and one would hope better) questionnaires. We would like to think that avid readers are beginning to anticipate a serious potential difficulty in respect of the questionnaires highlighted. They are all aimed at an adult population and as a result may be neither valid nor reliable for use with children. In real terms, this raises the question not of when to use them, but rather how far down the chronological age scale one is able to go before the questionnaire becomes inappropriate. Is it 16? Is it 14? Is it 12? And so forth. Equally, there is an issue regarding the type of language used in questionnaires that may give an indication about whether it is suitable for children of a particular age. Of course, as a teacher, you should have become adept at assessing the level at which pieces of prose, instructions, guidelines, rules, etc. need to be 'pitched' for your specific audience, whether it is a class of 8-year-olds or a class of 14-year-olds. Some language may render the information prohibitive and one's judgement is a good indicator of appropriateness. However, this is not enough. Do not simply assume that a questionnaire is inappropriate for children if it has been designed for use with adults. A quick search engine query usually establishes this, and some follow-up research using a

**Table 12.3 Example 'search' query form**

Search Engine	Search Term	Sample result and our comments
Google	Can the PHQ-9 be administered to children?	<p>Severity Measure for Depression, Child Age 11 to 17:  <a href="http://www.psychiatry.org/psychiatrists/practice/dsm/educational-resources/assessment-measures">www.psychiatry.org/psychiatrists/practice/dsm/educational-resources/assessment-measures</a>.                      Click on 'Disorder-Specific Severity Measures' and then 'Severity Measure for Depression, Child Age 11 to 17 (PHQ-9 modified for Adolescents [PHQ-A], Adapted)'</p> <p><i>Used to monitor progress through the treatment. Administered at initial session and then as a monitoring tool. Further background information provided in DSM-5. Adapted from PHQ-9 A (Johnson et al., 2002), which can be used with children aged 11–17.</i></p> <p><i>Subtle differences in phrasing, more specific to 'school' rather than 'work'.</i></p> <p><i>Original PHQ-9 can be used with clients aged 13 years and above.</i></p> <p><i>As PHQ-9 A also examines suicide risk, a 'Life Satisfaction' measure may be appropriate, such as the Students' Life Satisfaction Scale (SLSS) (Huebner, 1991a, 1991b, 1991c), a 7-item self-report scale, which assesses overall life satisfaction for students aged 8–18. (cf. Proctor et al., 2009)</i></p>
Google	Strengths and Difficulties Questionnaire	<p>The Strengths and Difficulties Questionnaire (SDQ):  <a href="http://www.sdqinfo.com/a0.html">www.sdqinfo.com/a0.html</a></p> <p><i>A 25-item behavioural screening questionnaire about 3–16-year-olds. There are numerous versions in different languages and for different age groups. To be completed by a child, teacher and/or a parent, on the basis of observed behaviours (see discussion below on triangulation).</i></p> <p><i>An 'early years' version exists for 3–4-year-olds, which is completed only by parents and/or teachers. We are certain that it is not necessary that we explain the reason for this here!</i></p>

variety of journal articles can be used to provide academic support for one's findings. The examples below highlight how efficient this process can be.

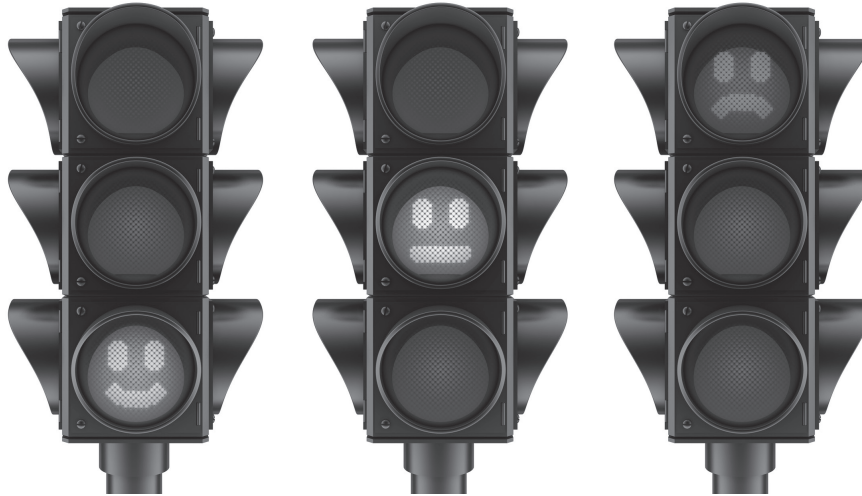
Once you have established whether a questionnaire is appropriate for your requirements, it is then important to consider who may be eligible to complete it. Of course, the child should be able to complete a self-report version if the language and terminology are adequate. This, however, only provides part of the available picture. In transferring the concept of triangulation, adopted in sport psychology, for example, the picture can be 'enhanced' (e.g., Thelwell and Maynard, 2002). In sport, there are generally three stakeholders in relation to the performer, or client: the performer themselves, family/partner/spouse, coach/trainer. By obtaining data from each of these stakeholders, it becomes clear whether an element of agreement exists regarding the data. For example, you might hold certain maladaptive beliefs about your competence that are not shared by your coach or your partner. Equally, you may hold maladaptive beliefs that you are more competent than you actually are, whereas the coach perceives your competence in a more realistic manner. The ability to triangulate the data and look for similarities or differences provides a far richer picture than without triangulation. So, in transferring this concept to the school



environment, different stakeholders exist: the child, the teacher, the parent or carer (see Handley and McAllister, 2017). Rather than looking for similarities, we would suggest that one looks for discrepancies in the triangulated data, simply because adopting a mindset where one is looking for discrepancies seems to set thinking in terms of asking the question: why would X (child/parent/teacher) think this when the other stakeholders do not?

## 12.10 A WORD ON EMOTICONS OR 'EMOJIS'

In recent years, there has been a novel emergence of the use of the emoji as a child-friendly equivalent to the widely used Likert-scale form of psychometric measurement. In this sense, communication is enhanced as a result of considering the simplicity with which it takes place (Hickson, 2013). Depending on the child's age, a standard Likert-scale version of a questionnaire may appear to be a daunting and confusing document; however, the incorporation of emojis in the form of 'smiley faces' can transform the same document. Indeed, the same principle applies to adults and is not restricted to psychometric measures, as illustrated when we were travelling towards a small village in Worcestershire recently. The mandatory 30mph speed limit sign was prominently displayed and of course we began to slow down in order to adhere to it. A car that was a little distance ahead of us did not appear to slow down sufficiently and, just after this sign, another sign suddenly illuminated with a red



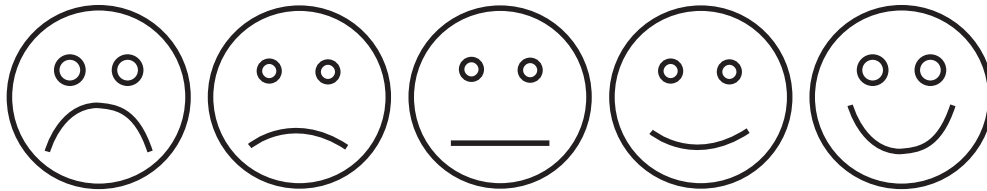
**Figure 12.2** Use of emojis in the environment

Source: [iStock.com/vladru](https://www.istock.com/vladru)



'frownie face' representing a speed in excess of 30mph. For us, the sign illuminated with a green 'smiley face' representing an appropriate speed for the village, as depicted in the example images below. Apart from this appearing to be a great success on our part, we also perceived that 'society', or at least the villagers, were 'pleased' with our commitments to road safety. The point here is that the emoji served a practical purpose, but also seemed to relate nicely to our emotional feelings associated with the activity at that point.

In terms of MWB, emojis would seem, therefore, to be powerful in the message underlying them. Look at the example 'emoji Likert scale' below and rate how you feel at this particular point in time. Can you go one step further and put a percentage to this feeling? In the true sense of Likert scales, you should choose one box only, so the scale is perhaps not very accurate. Can you identify why? As we were writing this subsection, we were feeling happy but also the topic was somewhat amusing. In this situation, one would need to consider the primary feeling, which for us was happiness. The research methods chapter (Chapter 18) will help you to avoid anomalies such as this when designing or using pre-existing emoji-based measures.



**Figure 12.3** Example emoji-based Likert scale

There is evidence in the literature regarding the psychology of emoticons/emojis and their possible underlying mechanisms. In this age of digital technology, electronic communication is often criticised for lacking emotional expression, or for expression being misinterpreted. The use of emoticons has been explored as a way of expressing emotions, reinforcing messages and in the expression of humour, and it has been argued that emoticons incorporate everyday facial expression into this form of computer-mediated communication (Derks et al., 2008). It has also been pointed out that internet users have become increasingly familiar with this type of computer-mediated communication and are adept in its use (Lo, 2008). In the nine years since this research, one would be safe in assuming that the generation of younger people who have known nothing other than this type of daily communication would feel perfectly 'at home' with emoticons as a language-form. Differences in usage between males and females exist, with more usage in females compared to males, although the sample population examined was 18+ (Fullwood et al., 2013).

As a result of a study examining brain activation in relation to a happiness emotion, it is suggested that the underlying mechanism relates to the configuration of shapes, assembled in a configuration of their well-known form (i.e., a face) rather than their constituent parts (e.g., colon + semi-parentheses) (Churches et al., 2014). This provides some neuroscientific evidence to support the plethora of examples within perception, where humans create objects, faces, etc. in relation to perceptual constancy, figure-ground, illusory contours (edge detection) and object ambiguity.

## 12.11 MENTAL WELLBEING IN A SCHOOL CONTEXT

In combination with the *ICD-11* it becomes possible to consider mental wellbeing in schools, which in essence mirror institutions and businesses in the adult world, but with a different set of members. With this in mind, one might consider the pastoral role played by teachers and dedicated support workers within the counselling side of the school care system. Each school will have a member of staff, or a team, dedicated to fulfilling this role and there will be a policy in place to guide staff through the process (Roffey, 2015). It is essential that all staff familiarise themselves with school policy as a minimum requirement, not least because, unfortunately, it is necessary in this age of litigation to protect oneself against potential disciplinary procedures. Having said this, it is also hugely rewarding to help guide a young person through some of the challenges they face and which appear insurmountable to them at the time, but which they can conquer, with your assistance. Adolescents and young adults are an 'at risk' group for problems as serious as suicide (e.g., Zanus et al., 2017), and it would appear that school is the place where serious psychological issues incubate and indeed show themselves (Onieal, 2017). It is vital, therefore, that we all consider the ways in which we can best help young people before they arrive at this 'at risk' group, or indeed, create a new, younger 'at risk' group, which is something we suspect is already beginning to emerge.

## 12.12 ANNUAL SCHOOL CYCLES: SEASONAL PATTERNS?

Humans are subject to internal biorhythms or cycles, which dictate (physiologically speaking) how we operate. Sleep-wake cycles dictate our patterns over a 24-hour period. Within sleep, 90-minute 'ultradian' rhythms dictate how deeply we are sleeping at given points throughout the night (or day); body temperature fluctuates rhythmically over a 24-hour period, as does protein synthesis, which acts to repair our bodies before, during and after the daily challenges we face. Excretion of faecal

material follows a similar pattern as indeed you already know when you need to rid yourself of a previous meal. Casting the eye further, fluctuations in MWB follow seasonal patterns. For example, seasonal affective disorder (SAD) or ‘winter depression’ is, as one may expect, more prevalent during the winter months, when light levels are low, sunshine is a rare occurrence and what would appear to be ‘50 shades of grey’ fill the skies, before darkness sets in far too early for our liking.

The academic school year is no different, containing what we would describe as shared ‘pinch points’: certain generic periods in the school year that are commonly anxiety and stress inducing. Certainly, we see this in higher education, where anxiety and stress increases around November time. The academic year starts in September, yet from an MWB perspective, it is relatively quiet for counselling staff until November, which generally tends to be synonymous with the first set of assessment deadlines. The same can be said around April/May with an increase especially in final-year students – whose final dissertation deadline looms large – requesting support from counselling services. In order to provide common ‘pinch points’ for primary, secondary and tertiary education, Table 12.4 below offers some insight into this phenomenon. We have specifically left some cells blank, which may not have ‘pinch points’, or for you to insert your own.

There will of course be variation within this table, in terms of exact timings. However, the principle remains the same and we would advise that you create a bespoke version of your own, which is appropriate to your own school, bearing in mind that there may be differences between the state sector and private or independent sector, or differences if you are teaching (or intending to teach) in a different country. The main thing is that you ask the question and establish an awareness, so that you can be alert to issues when they inevitably arise. Of course, there will also be situations that do not fit neatly into such a table, but this does not matter, since your focus towards identifying issues will now be heightened.

## A NOTE ON ‘BLUE MONDAY’

‘Blue Monday’ is a term that seems to be endearing to the media. It is the notion that the third Monday in January is the most depressing day of the year, at least in the northern hemisphere anyway. The day is short (although not the shortest); there is usually a greyness to the day; it is cold, miserable and dank; Christmas and New Year celebrations are well and truly over, with no holiday period in sight; and the bills start to arrive, signalling how much debt the festivities have cost. Little to cheer about then! Why wouldn’t this be the most depressing day of the year? Despite this accumulation of doom and gloom, there is no evidence to support the claims. The second or fourth Monday could be equally as bad. Some journalists even cite the last Monday in January as Blue Monday, as seen in a newspaper article printed in the *Times Educational Supplement* in 2008 (Frankel, 2008), in which advice is provided for teachers on how to beat the Blue Monday blues. There is just as much likelihood that

**Table 12.4** Generic 'pinch points' throughout the education system

Month	Primary Schools	Secondary Schools	Higher Education
September	New start, new class, sometimes a new school	New start, new class, sometimes a new school Beginning of 2-year GCSE subjects for Years 10 and 11	New start in a completely new environment (and possibly city), with new systems Possible feelings of social anxiety
October			
November		Mock GCSE examinations	First assignment deadlines
December	Winter Festival Productions		
January	'Blue Monday' (see note in text)	Deadline for university applications (sixth form only) 'Blue Monday' (see note in text)	'Blue Monday' (see note in text)
February	Teacher assessments Key Stage 1		Return to campus Readjustment period
March		GCSE coursework BTEC coursework	
April		GCSE coursework BTEC coursework	Final year dissertation deadline
May	SATs	Revision for examinations	Final year dissertation deadline Revision for examinations Examinations and assessments including A level students in further education
June	Report writing	Examinations, especially for GCSE students and A level students within sixth form Report writing	Examinations and assessments, including A level students in further education
July	Transition period for Year 6 students, leaving primary and moving on to secondary school	Departure of final year students	Results made available, determining future courses and beginning of career progression
August	n/a	n/a	n/a

the second day of August, the fourth of September or even Christmas day could be equally depressing. The key element is that depression does not adhere to a calendar or schedule. So, avoid adding it to your annual list of 'pinch points' and question the validity of the message by seeking out evidence to support or refute it. A quick search of academic databases using the terms 'depression' and 'Blue Monday' swiftly revealed no peer-reviewed, data-driven research articles at all. It is important, however, that we do not confuse Blue Monday with 'winter depression', or seasonal affective disorder, to give it its correct term, which is a very real phenomenon, related

to the time of year in a far wider sense and related to low levels of melatonin production as a partial consequence of lack of available daylight. A similar search of the academic databases will throw up a vast amount of peer-reviewed, data-driven research articles to support it, along with potential interventions or solutions to assist in reducing its deleterious effects.

## 12.13 THE NATIONAL CURRICULUM AND MENTAL HEALTH

In contextualising this section, the new National Curriculum was largely introduced in September 2014. English and Mathematics became operational a year later for Year 2, 6 and 10 students, while for Year 11 students this was the case from September 2016. The new curriculum for Personal, Social, Health and Economic Education (PSHE) was published in September 2013. As a non-statutory subject the publication maintains that 'Schools should seek to use PSHE education to build, where appropriate, on the statutory content already outlined in the national curriculum, the basic school curriculum and in statutory guidance on: drug education, financial education, sex and relationship education (SRE) and the importance of physical activity and diet for a healthy lifestyle (Department for Education, 2013). One might expect that MWB is embedded within this; however, while there is an underlying link, it is not made explicitly.

With this in mind, there was a call for MWB to be incorporated into the National Curriculum formally. Indeed, a petition was created online in July 2015, which aimed to introduce education in mental health into schools in order to equip children with the skills required to face the challenges that life might present to them, while reducing the stigma associated with mental ill-health at the same time (<https://petition.parliament.uk/petitions/104545>). As with all government petitions, this ran for a period of six months, closing in January 2016, and as is the norm, required 100,000 signatures in order for it to trigger a debate by members of parliament. It achieved 51,234 and thus failed to do so. While this would appear to be a missed opportunity, the Department for Education did provide funding to the PSHE Association, which provides dedicated support, resources, training and guidance for PSHE education professionals, to produce guidance on how to embed MWB into the curriculum (PSHE Association, 2015). This document provides advice on mental health and emotional wellbeing in each of the Key Stages. Table 12.5 below is an adapted representation of the four, much larger separate tables found in the original document. It appears here purely as an example and taster and we would recommend that you access the original as appropriate. You will note that what students should learn in later Key Stages is based on the premise that earlier Key Stages are used to provide stable foundations for development.

**Table 12.5 Example guidance provided in PSHE Association Teacher Guidance Document on Mental Health**

	<b>Health and wellbeing</b>	<b>Relationships</b>	<b>Living in the wider world</b>
	Students should have the opportunity to learn about:	Students should have the opportunity to learn about:	Students should have the opportunity to learn about:
Key Stage 1	Positive and negative feelings, how to describe those feelings and simple strategies for dealing with those feelings.	Communicating feelings with other people, recognising the feelings of other people and discovering appropriate ways to respond to the feelings of other people.	The needs of other people and other living things, along with the responsibilities to meet those needs by everyone.
Key Stage 2	Expanding their understanding of their feelings by increasing the vocabulary used to explain the variety and intensity of those feelings.	Identifying the constituents of positive healthy relationships, including how to develop and maintain them.	Health and wellbeing in society, by examining debates, challenges, topical issues and making recommendations about these.
Key Stage 3	The relationships between confidence, self-esteem and attitudes, personal qualities, achievements, acquired skills and how these may be interpreted by other people.	Developing and maintaining relationships by enhancing essential communication skills, such as active listening, providing and obtaining constructive feedback and assertiveness skills.	Developing an appreciation and understanding of similarities, differences and their impacts on societies, by examining sex, gender identity, culture and ethnicity, stereotyping and prejudice, discrimination and bullying.
Key Stage 4	Causes and characteristics of mental health, along with the development of effective management strategies, e.g., for anxiety, stress, depression, self-harm and suicide.	Developing an awareness of bullying, harassment and exploitation in relationships and effective strategies for responding to these, including cyber-bullying and abuse within relationships.	Approaches for evaluating personal strengths and challenges, through intervention strategies such as goal-setting.

Source: adapted from PSHE Association, (2015) : 6–10

## 12.14 WHEN TO 'REFER ON'?

When deciding whether or not to refer a student, there are two recommendations we would offer here and these are perhaps two sides of the same coin. Firstly, remain within the realms of your professional qualifications and, secondly, use what can only be described as a highly subjective, yet intuitively effective sense of your 'comfort zone'. We will discuss this latter point first, simply because it may seem controversial. Whether we use the term 'comfort zone', 'gut-feeling' or 'instinct' does not matter. What we are talking about here is whether you feel that you are acting within the realms of your (perceived) capabilities or whether you feel totally out of your depth. As a rule of thumb either of these can act as an indicator of whether you should refer on and, crucially, you should do so quickly. Let us illustrate with a case study illustrated in Table 12.6. Rather than using three different case studies, which would be rather straightforward, we have chosen to show how the referral process may operate with increasing levels of symptoms. Our student is 14 years old and has just entered the first year of GCSEs.

**Table 12.6 Considerations for referring a student presenting to staff**

Presenting Issues	Comments	Refer On
1 Difficulties with social group at school. Continually falling out over minor 'differences of opinion'. Performance on schoolwork has started to drop. No other signs or areas of concern shown.	For the student's age group is this a common adolescence issue? Is performance dropping in all subjects? Check with relevant staff. Is this a 'bullying' case? (N.B. we are presenting it as non-bullying.)	No. Provide pastoral support to student. Involve other staff only as appropriate.
2 Difficulties with social group at school. Continually falling out over minor 'differences of opinion' and X is becoming increasingly isolated from social group, peers and friends outside of school. Performance on schoolwork has shown a marked drop across all subjects, homework is not being handed in and X is absent from lessons more than one day per week.	See above and: Invite student into office for a personal tutorial to discuss any issues. Consider speaking to all members of the social group to ascertain their perspective on the situation. Invite parent(s) into school to discuss the situation.	Yes. Inform Head or Head of Department and school counsellors. Inform Educational Psychologist of concerns if necessary.
3 Completely isolated from social group at school. X is absent from lessons most days per week and, when in attendance, shows signs of self-harm on arms and legs. Tells certain teachers that 'there is no point being alive anymore' and when confiding in them is frequently in tears. Physical appearance has changed, in terms of lack of hygiene, dirty clothing, little pride in appearance. Often overheard vomiting in the toilets.	See above and: Make contact with and assemble a support team as a matter of urgency. Provide the student with contact telephone numbers, or offer to make telephone calls on their behalf.	Yes. Inform GP, Educational Psychologist, Clinical Psychologist as a matter of urgency.

It is your professional qualifications that ultimately act as your level of protection. Remaining within professional boundaries will provide this protection (assuming you have conducted yourself appropriately of course), should you need it (*Teachers' Standards*, Department for Education, 2013). In terms of continuing professional development (CPD), there are of course areas where expertise may be lacking that you can then target for development, which will naturally enable you to extend your capabilities and in turn widen your skill-set. The consequence of this would usually be that you create a wider, broader or deeper 'comfort zone'.

We like to keep a simple phrase in mind, when MWB cases emerge:

'Whatever you do, do something'

Or even just

'Act!'

This serves as an opportunity to assess the student and his or her issue, assess your pastoral support role and where it ends, assess your capabilities to deal with the issue

and finally assess 'relevant others' who may need to be made aware of the issue. There is of course an element of confidentiality here, if a student has told you something in confidence, but equally there is an element of responsibility, on your behalf, to report issues where threat of harm (to the student or others) is a possibility.

Each of these questions deals with the 'what' of what to do, but not the 'when' element. It may be that referring on to someone with the appropriate level of expertise to help has been established, but in the short term ('short term' is determined by your own judgement and on a case-by-case basis) the student may benefit from your pastoral support in helping them to take the next step of seeing someone else. It may be that you ask to be included in the process as it progresses, or where this is not possible for professional or confidentiality reasons, that you are provided with some form of updates, with whatever information can be made available to you. This is certainly the case within counselling, where you would be suggesting to a student that they sign a 'freedom to disclose information' form, which would enable the counsellor to keep you updated on progress. In our experience, we are noticing a trend for students in higher education to see no reason not to sign such a form, since there appears to be far less of a stigma attached to MWB issues than say, 20 years ago.

## 12.15 DIGITAL OR E-MENTAL HEALTH: BENEFITS, CHALLENGES AND IMPLICATIONS

As we mentioned earlier in this chapter, both adults and children are spending what appears to be increasing amounts of time on digital media, to the extent that it is now seen as commonplace. Indeed, this is evident in higher education every day of the working week. It is common for lecturing staff to stand at the lectern and be faced with a sea of laptops or tablets in the audience, almost to the point where an A4 pad and a pen are seemingly redundant as a form of note-taking. This phenomenon was unheard of even five years ago and would, previously, have been frowned upon as a distraction away from the lecture and the speaker, rather than as an aid to learning. Of course, we are aware that social media platforms are being accessed during lectures, which of course is not conducive to learning, but there is certainly an acceptance that technology cannot be removed from the learning environment. It is quite common in the classroom for adventurous teachers to make use of e-technology within sessions in order to retain focus, motivation, entertainment and to foster learning. Access to downloadable journal articles and books, specific to MWB, can be almost immediate and this certainly helps to facilitate learning. In staff meetings, the tablet is now increasingly more popular and has similar benefits in terms of efficiency-saving, information-providing resource acquisitions. Equally, in the classroom at primary and secondary level, the use of tablets has increased, to the extent where children in some regions have what we would argue is the privilege and luxury of having tablets allocated to them in the longer term,



compared to 'the good old days' (e.g., Kim et al., 2016; Korenova, 2015; Van Hove et al., 2017). As an anecdote, we recall the days when accessing journal articles not held in the university library necessitated completing an inter-library loan form, which required a signature of approval, waiting up to two weeks for it to arrive, before being able to read and work on it, along with no more than six other requests. This involved much planning ahead and frustration during the waiting period. In contrast, a search on the library databases, or even a generic search engine, usually provides a multitude of options and opportunities with great ease. There is no waiting, no forward planning and perhaps most efficiently – if the article turns out to be less relevant than originally thought, there is little time wasted.

In this respect, digital technology goes far beyond providing information at the click of a mouse. In relation to MWB, it provides materials, support platforms and *fora* (as in the plural of 'forum') almost as if it were a personal e-assistant. We highlighted evidence earlier to suggest that people are somewhat reluctant to use digital technology as a replacement for face-to-face support. There is something comforting in knowing (or perceiving that one knows) the person providing the support. A 'virtual practitioner' is just not the same. While this may be the perception of older adults (we are not specifying a particular age range here), advances in technology, through video-conferencing platforms, enable people to communicate while seeing each other face-to-face. As a learner, I (Paul Castle) take regular 'remote' French language lessons with my teacher, Olivia, who lives 360 miles away in Brussels. We both sit at our laptops in the comfort of our respective homes and finish one hour later. For me, there is nowhere to hide! Each lesson is so challenging and exhausting, yet so rewarding and confidence inspiring. Broadband speeds are efficient and the connection is predictable and usually consistent (ironically and with a little humour, 'buffering' would offer a few seconds of respite but this rarely happens). As a practitioner psychologist, i.e., with the shoe on the other foot, I have taken the knowledge acquired through using such straightforward video technology and applied it to my consultancy work. In embracing this technology, I have been able to provide support on MWB to clients far further away than without using it. The beauty is that multiple information sources can be accessed; copy and paste can be used to send material, images and worksheets directly or by email; and a transfer of completed materials can be returned, frequently even for discussion during a session. There is something satisfying about this and it fosters a sense of working in the present, while providing material for the future. In this way, both client and practitioner work on the challenge as a unit. For instance, they might work on a questionnaire, which appears on both computer screens at the same time, so that it becomes more like a conversation, rather than a questionnaire. Results are obtained immediately, along with a summary piece of prose explaining what the results mean. An example of this can be seen with a robust personality questionnaire I have completed (both in English and in French) from [www.16personalities.com](http://www.16personalities.com) (see Cattell et al., 1993), which sets the tone for further discussions on MWB with clients.

The *caveat* of course is to remember that face-to-face interaction was discussed earlier as being preferred to 'remote', e-interaction. The question is, however, whether video-conferencing is perceived by the interlocutors as 'remote'. It goes without saying that an e-mental health platform is not recommended for teachers to use with students, but rather that it is a potential tool for personal MWB.

## 12.16 CONCLUSION

We have established the importance of MWB in this chapter, through a wide variety of sources. Significant opportunities have been provided for you to explore your own MWB needs and we have suggested how you may incorporate this experiential learning into the classroom, in order that your students may develop similar strengths. In the following chapter, we explore the topics of positive coaching psychology and the development of resilience. In the absence of developing MWB strengths, resilience would be difficult in the extreme. When taken in the context of developing these strengths, resilience is more likely to emerge and this is the challenge we face in the next chapter.

## 12.17 FURTHER READING

For information on the IAPT programme currently in operation within England please visit [www.england.nhs.uk/mental-health/adults/iapt/](http://www.england.nhs.uk/mental-health/adults/iapt/) (accessed 6 October 2017). *The Psychologist*, 22 (5) contains two additional papers that are relevant to the IAPT programme and are worth reading in conjunction with the Marzillier and Hall papers (2009a and 2009b).

Roffey, S. (2015) 'Becoming an agent of change for school and student well-being', *Educational & Child Psychology*, 32 (1): 21–30.

This paper explores the role of educational psychologists and additional support in enhancing MWB in schools. It is also linked to the next chapter, on developing resilience.

NB: We would recommend that in the first instance, your reading results from accessing the web links provided. Follow the areas that interest you personally, or share the reading load with your peers in order to build up a collective knowledge-base in your school.