Katie Wright · Julie McLeod *Editors*

Rethinking Youth Wellbeing

Critical Perspectives

Springer

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ISBN 978-981-287-187-9 ISBN 978-981-287-188-6 (eBook)
DOI 10.1007/978-981-287-188-6
Springer Singapore Heidelberg New York Dordrecht London

Library of Congress Control Number: 2014954095

Printed on acid-free paper

Springer is part of Springer Science+Business Media (www.springer.com)

Acknowledgements

There are many people who have made the production of this book possible. First, we thank the contributors for their engaging and provocative chapters, and for their patience and collegiality throughout the peer review process. We are most grateful for the generosity of the anonymous referees for each of these chapters, and we thank them for providing timely feedback and helpful suggestion. We also thank Amy McKernan for valuable research and administrative support and the team at Springer, especially Nick Melchior, Kanako Tanaka, Harmen van Paradijs, Jolanda Voogd and Rathika Ramkumar for their assistance at all stages of the project.

The development of this volume emerged from joint and individual research projects and we acknowledge the numerous sources of funding which have supported our work: Educating the adolescent: An historical study of curriculum, counselling and citizenship, Australian Research Council Discovery Project (J. McLeod & K. Wright, DP0987299); Wellbeing in secondary schools, Melbourne University Fellowship (K. Wright); Youth identify and educational change in Australia since 1950: Digital archiving, re-using qualitative data and histories of the present, Australian Research Council Future Fellowship (J. McLeod, FT110100646); and Childhood maltreatment and late modernity: Public inquiries, social justice and education, Australian Research Council Discovery Early Career Researcher Award (K. Wright, DE140100060).

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Chapter 1
Inventing Youth Wellbeing

Julie McLeod and Katie Wright

Abstract Calls to address wellbeing are now so commonplace and widespread that they can mean both everything and nothing. Across policy and popular discourses, improving wellbeing is offered as a solution to the myriad issues facing young people today. This chapter explores the invention of youth wellbeing as a concept and a category of concern, noting its ambiguity and changing applications. It introduces a case for defamilarizing the status and truth claims of the construct of youth wellbeing, by exploring its invention as well as its movements and productive effects. Two sets of conceptual resources are outlined for developing this analysis: the first is informed by Somers' approach to developing an historical sociology of concept formation, and the second is Bacchi's account of the construction of policy problems. The chapter concludes with an overview of the papers in this volume which, in drawing on a range of approaches and intellectual traditions, take a step back from taken-for-granted assumptions about youth wellbeing and provide provocations to think anew about this category, the problems it addresses and the promises it makes.

Keywords Defamilarization • Historical sociology • Policy • Problematization • Youth wellbeing

Wellbeing has become a keyword in contemporary social life. Its register cuts across policy discourses, everyday discussions and specialist programs and it has acquired particular currency and potency in the fields of education and youth studies. The construct of wellbeing has an aspirational quality, reflecting an ideal state of being. It also functions as a diagnosis of a perceived problem – lack of wellbeing – and holds the promise of its amelioration. Promoting wellbeing increasingly informs policy objectives aimed at improving the lives of young people, and expansively encompasses their physical, social, mental and emotional health. A central idea underpinning much commentary on this topic is that we are facing major social

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K. Wright, J. McLeod (eds.), *Rethinking Youth Wellbeing*,
DOI 10.1007/978-981-287-188-6_1

problems at macro-structural, interpersonal and individual levels; these are manifest, for example, in moral, ecological, health and economic crises, and there are concomitant concerns that in this period of rapid social change and uncertainty, wellbeing is increasingly precarious. These discussions are commonly framed by a sense of alarm and grave concerns about how young people are faring, with an associated and pervasive policy logic that action should be taken to improve outcomes on a range of social, economic, health and education measures. Yet calls to address wellbeing are so commonplace and widespread that they can mean both everything and nothing. It is precisely such paradoxes that provoked the idea for this volume, seeding its aims to understand the invention, movement and effects of the notion of youth wellbeing.

The contemporary focus on youth wellbeing in the policy arena and beyond reflects a broader embrace of wellbeing as a measure of the quality of life of populations. This is evident, for example, in the launch in 2011 of the *OECD Better Life Initiative*, which now publishes regular reports of wellbeing in OECD countries and other major economies (OECD 2013). Measurement of wellbeing and the ranking of countries according to wellbeing indicators are now common practices, at both a population level and for particular groups, including young people. The US-based Center for Strategic and International Studies (CSIS), in collaboration with the International Youth Foundation (IYF), recently published a report entitled, *The Global Youth Wellbeing Index* (Goldin et al. 2014), which provides an international ranking of youth wellbeing. UNICEF similarly publishes league tables on child wellbeing in some of the world's advanced economies "to encourage the monitoring of children's well-being, to permit country comparisons, and to stimulate debate and the development of policies to improve children's lives" (UNICEF 2013). Such large-scale global comparative ranking exercises combine a range of child and youth wellbeing indicators. There is generally an emphasis on objective measures, such as per capita GDP and expenditure on and access to health and education, but subjective measures that provide insights into the experiences and perceptions of young people themselves are often also included. In national social, health and education policy contexts, by contrast, the emphasis is typically placed upon social and emotional dimensions of wellbeing, with mental health and psychological distress commonly identified as key problems.

Discussion about wellbeing abounds, with considerable efforts now directed towards enhancing the wellbeing of target populations, particularly young people. There remains, however, considerable ambiguity in how the concept itself is understood in official and lay discourses, and even in how it is defined and operationalized in policy and practice. As a non-technical concept, its meaning is seemingly self-evident. The *Oxford English Dictionary* defines wellbeing as "the state of being or doing well in life" a "happy, healthy, or prosperous condition" and as "moral or physical welfare (of a person or community)". As such, wellbeing encompasses physical, emotional, social, psychological and material dimensions. Broadly speaking, it is understood as a measure of the quality of people's lives, which may be assessed objectively and/or subjectively.

Significant definitional and conceptual difficulties arise when moving beyond a commonsense understanding of the concept of wellbeing and its everyday use. At this point, it becomes strangely difficult to define. While research into wellbeing has been increasing at a rapid pace, there remains little consensus in the scholarly literature on how it should be conceptualized (Dodge et al. 2012). It is, as Morrow and Mayall (2009, p. 221) argue, pervasive but "conceptually muddy", a term that effectively acts, according to Ereaut and Whiting (2008), "like a cultural mirage: it looks like a solid construct, but when we approach it, it fragments or disappears" (p. 5). Wellbeing is different to – although may encompass – overlapping states such as happiness, satisfaction, contentment, self-actualization, and personal safety. But it is possible to experience wellbeing in the absence of any of these things, and it is also possible to experience wellbeing at the same time as experiencing states of sadness or loss or ill health (Manderson 2005).

Commonly, wellbeing is associated with physical and mental health. It featured in the Constitution of the World Health Organization (WHO), which defined health in the late 1940s as "a state of complete physical, psychological and social wellbeing" (WHO 1948, p. 1). There is, as Manderson (2005) notes, some circularity in this notion of health as wellbeing, and wellbeing as health. But perhaps more troubling is that even though wellbeing is an elusive term and a fluid concept (Ereaut and Whiting 2008; Watson et al. 2012), it is nevertheless asserted confidently in any number of policy statements and program rationales.

Both the ambiguity of the term and its elasticity mean that wellbeing is a notion that may be put to use in different ways for different purposes. One striking example of this is the changing focus and objects of wellbeing during the late twentieth century. Eeva Sointu's (2005) work is highly instructive in this regard. Her study of British newspapers reveals that during the 1980s the term was not widely used in everyday discourse. When it was discussed, it tended to be in relation to national health and economic indicators. During the 1990s, however, a more personal, individualized, psychological and therapeutic notion of wellbeing emerged. Her analysis points to a shift in the concept from one associated with "the wellbeing of a citizen in a traditional nation state – produced and conceptualized through institutionalized strategies of national governance" to "an increasing emphasis on wellbeing that is actively produced by the choosing consumer" (pp. 255–256) and an accompanying focus on wellbeing pertaining to individual health. In short, she characterizes a shift in wellbeing discourses from broadly concerned with "the body politic" to an overriding emphasis on "the body personal" (Sointu 2005, p. 259). A preliminary search of digitized Australian newspapers reveals a similar shift (NLA 2014). In the immediate post-war period, wellbeing is linked mostly to questions of national stability and economic prosperity, yet shifting to a more personalized quality attached to individuals by the latter decades of the twentieth century.

It is not only that dominant understandings of wellbeing have changed in recent decades. Alongside this there has been an overall increase in the use of the term. This is vividly captured with the aid of a statistical tool like Google Ngram, which maps word frequencies in books. Prior to the 1970s, usage of the term in published books

Fig. 1.1 Frequency of the word "wellbeing" in the Google corpus of English books from the years 1930 to 2008. The graph was made with the Google Books Ngram Viewer with a smoothing of 3

remained fairly constant. However, as the graph here illustrates, there has been a steady increase in use since that time, with a rather dramatic increase evident from the early to mid-1990s. While the raw number of instances in the word "wellbeing" varies according to spelling (that is, whether it is expressed as a compound or hyphenated word), the general trend of increased frequency of the term remains consistent (Fig. 1.1).

This rapid rise in wellbeing, as reflected by the analysis of its incidence in published books, corresponds to the embrace of the concept in social, health and educational policy in many countries during the latter twentieth century. Indeed the invention of wellbeing as a compound word in itself demonstrates its normalization and widespread acceptance (Ereaut and Whiting 2008), operating as a self-evident thing, a noun and an adjective with cross-over referents in everyday and specialist discourses. The sharp spike in the use of wellbeing also points to accelerated changes in wider cultural norms, hinting at intensified processes of individualization, or perhaps more accurately, personalization, as well as the colliding effects of therapeutic culture and neoliberalism (measuring the performance of wellbeing and mental health), and the flow of so-called private and personal feelings – optimism, feeling positive and even happy – into public life. Moreover, wellbeing has been so frequently affixed to young people that the phrase "youth wellbeing" is rapidly becoming its own new construct.

Youth, as a prefix, gives a particular meaning, focus and urgency to wellbeing – an unassailable warrant to enhance the lives of not only young people but also of future generations. In the developmental logic underpinning much educational and youth policy, intervening early to promote wellbeing is seen as vital. Additionally, adolescence remains positioned as a volatile and vulnerable stage in the life-course, making the youth wellbeing fix all the more relevant and pressing. The changing and unstable emphases in the understandings of the term, its dramatic increase in use, and its condensation of myriad social meanings and promises make "youth wellbeing" ripe for rethinking.

To consider the invention of youth wellbeing is to engage in a task of defamiliarization. The rationale for this volume of essays is framed by the

Foucauldian genealogical project to make the present strange, with an overall strategy of "problematization". As Foucault (1996) asserts: "Problematization doesn't mean the representation of a pre-existent object, nor the creation through discourse of an object that doesn't exist. It's the set of discursive or nondiscursive practices that make something enter into the play of the true and false, and constitutes it as an object for thought" (pp. 456–457). In grappling with youth wellbeing as an object for thought, the concern of this volume is not only with wellbeing as a socially constructed term, as a phrase that is invented in different times and places for different purposes – though this remains an important element in historicizing youth wellbeing. The overall purpose in bringing together this volume of papers is also to follow the movement and effects of wellbeing, not simply to observe that it is socially or discursively constructed but to understand what it has produced, and continues to do so, what it does, where it goes, what it opens up and shuts down, and what it makes possible and impossible to think and to do.

In developing such an approach to the invention of youth wellbeing, we identify here two sets of conceptual resources which we have found useful to think with. The first draws from the field of historical sociology and is guided by Margaret Somers' (1999, 2008) approach to developing an historical sociology of concept formation. She describes this as a research program designed "to analyze how we think and why we seem obliged to think in certain ways" (Somers 1999, p. 132) and consequently it seeks to expose "the historicity of thinking and reasoning practices" (Somers 2008, p. 173). Somers further proposes that this method for conducting social research is "based on the principle that all of our knowledge, our logics, our theories, indeed our very reasoning, are marked indelibly (although often obscurely) with the signature of time, normativity, and institution building" (2008, p. 173). This trio offers a helpful anchor in analyzing the invention of youth wellbeing as a concept that distils particular and shifting systems of reason about young people. In unpacking the procedural aspects of this approach, Somers identifies three key components. *Reflexivity*: "the categories with which we analyze the world are not self-evident and need themselves to be objects of study" (Somers 1999, p. 132); *Relationality*: what appear to be "autonomous concepts defined by a constellation of attributes are better conceived as shifting patterns of relationships that are contingently stabilized in sites" (1999, p. 133); and *Historicity of knowledge cultures*: "concepts are historical objects"; "successful truth claims are products of their time and this changes accordingly" (1999, p. 134). Somers' account thus offers valuable signposts for historicizing key concepts and for attending to their situated, contingent and relational effects.

Continuing in this vein, but looking more specifically at the organizing and normalizing ideas of policy discourses, Carol Bacchi's (2009) account of the construction of policy problems is also helpful. Policy, she argues, gives particular shape to social problems and in this sense is itself fundamental to the very constitution of what we understand to be problematic and in need of "fixing". A disarmingly simple but especially useful framework for our project is offered in her "what's the problem represented to be?" (WPR) approach (Bacchi 2009).

WPR is a conceptual framework that "starts from the premise that what one proposes to do about something reveals what one thinks is problematic (needs to change). Following this thinking, policies contain *implicit* representations of what is considered to be the problem ('problem representations')" (Bacchi 2012, p. 21). The first task, therefore, is to make implicit policy assumptions explicit. In relation to the focus of this volume, improving youth wellbeing – the desired outcome – implicitly represents wellbeing as problematic, with policy initiatives designed to address an apparent lack of wellbeing. This is an important first step. However, this approach also requires interrogation of assumptions that underpin representation of the problem, attention to how such representation arose, consideration of what is left unproblematic and how the problem may be thought about differently. It also invites analysis of how representations of a problem are produced, disseminated and defended (Bacchi 2012).

While drawing on a range of approaches and intellectual traditions, and exploring different dimensions of and questions about youth wellbeing, the chapters in this volume offer the kinds of interrogations called for by Bacchi (2009). And in the spirit of Somers' (1999) historical sociology of concept formation, they each in various ways seek to take a step back from taken-for-granted assumptions about youth wellbeing and defamiliarize normativities and self-evident reasoning. In so doing they provide provocations to think anew about this category and its subject (or object) of address. The focus of analysis is wide-ranging, including the social determinants of wellbeing, mental health and pathologizing practices, pedagogical approaches to health promotion, cross cultural and historical contexts, social-emotional learning, sexuality, practices of the self and changing educational ideas. The chapters variously explore how notions of wellbeing have been mobilized across time and space, in and out of school contexts, and the diverse inflections and effects of wellbeing discourses.

The issue of psychopathologization is the focus of the following chapter, in which Linda Graham examines the increasing use of medications for young people diagnosed with mental health disorders. She raises serious questions about what it means to be "well" and identifies a number of dangers that flow from this for children categorized as "unwell". Graham suggests that normative understandings of psychological wellbeing individualize important social influences that affect mental health. Drawing on interviews with young people enrolled in "behaviour schools", the chapter identifies pressing concerns in relation to the ways in which mental health diagnoses are internalized, possibilities for the development of agency within this context, and consequences of this for young people in terms of their wellbeing.

The social context and determinants of wellbeing are taken up in the next two chapters, in which Kathryn Ecclestone considers questions of vulnerability and social justice and Johanna Wyn, Hernan Cuervo and Evelina Landstedt explore the social, political and economic parameters that shape wellbeing. Ecclestone raises critical questions about what constitutes empowering and progressive education by drawing on C. Wright Mills' call to examine what seemingly "private troubles" might reveal about "public issues", in this case, those that stem from

wider structures of class, economics, culture and politics. Ecclestone argues that there is currently a deep pessimism about declining emotional and psychological wellbeing. Within this context, she suggests that issues of social justice are refracted through concerns about vulnerability, which mask the reality of economic exclusion. Attention to emotional vulnerability, she suggests, reflects new forms of neoliberal responsiblilization and pathologization of social problems and, in doing so, deflects attention from the structural conditions that adversely affect youth wellbeing.

Drawing on data emerging from a longitudinal and cross-generational study of young Australians, Wyn, Cuervo and Landstedt develop a related argument that illuminates the inherently social dimensions of wellbeing. They explore the tensions that arise for young people today in relation to the imperative of wellbeing as an individual responsibility, and the reality that being "well" is inextricably linked to social, political and economic parameters that are not of young people's own making and are most often beyond their control. Wyn, Cuervo and Landstedt suggest that indicators of the poor mental health of young people may be attributed to social factors that include uncertainty in relation to employment, economic hardship and fragmentation of time with significant others. They argue that the conditions that jeopardize the mental health of young people are cumulative and exacerbated by the strategies demanded of individuals to manage the manifold stresses of contemporary social conditions by making personal adjustments.

Themes of individualization are further explicated in the following chapter, in which Kellie Burns and Cristyn Davies examine how "health-as-wellbeing" is operationalized as a modality of neoliberal government. Focusing on young women, and taking the human papilloma virus (HPV) vaccination program in Australia as a case study, they consider how the management of youth subjectivities involves pedagogical and consumption practices which position young people as free-choosing agents and managers of the self. Their analysis of public health programs aimed at preventing HPV and HPV related cancers in young women illustrates broader social processes pertaining to norms of healthy and gendered citizenship. In particular, they explore how the right to "know" may be compromised by the obligation to "choose" healthy behaviours, lifestyles and products.

Extending the focus on gender and the policy contexts in which young people's health is regulated, Ester McGeeney explores the complexity of youth sexual wellbeing. Drawing on a UK study that examined experiences of sexual pleasure and notions of "good sex", she employs a critical culturally-informed approach to understanding young people's lives and in doing so complicates debates about policy approaches in the realm of sexual health. Of particular interest to McGeeney is the mismatch between young people's sexual cultures and their accounts of pleasure on the one hand, and contemporary policy frameworks aimed at promoting sexual wellbeing on the other. Informed by narrative accounts of young people's experiences, she argues for rethinking policy agendas and educational practices in the area of youth sexual health. Of critical importance in this regard, she suggests, is the need to ground policy and educational approaches in the reality of young people's experiences. This includes embracing holistic and complex understandings

of young people and their sexual practices, rather than foregrounding policy frameworks with alarmist accounts of young people's vulnerability and risk-taking behaviours.

Difficult questions about youth wellbeing are further explored in the following chapter, in which Kathryn Daley examines young women's self-injury. Daley challenges the established and, she argues, presumptive notion that "cutting" is inherently harmful, and offers an alternative viewpoint. Drawing on narratives of young women accessing drug treatment services, she develops a conceptualization of self-injury that moves beyond a psychiatric paradigm, shifting the focus from the behaviour as itself inherently problematic to a standpoint in which it is understood as a symptom of distress. Most importantly, she argues, rather than viewing self-injury as compromising wellbeing, it may be better understood as a mechanism by which some young people try to protect their wellbeing. Daley's alternative conceptualization is a provocation to think anew about this troubling practice, opening new ways of thinking about the relationship between wellbeing, embodiment and practices of the self.

Moving from research conducted in a treatment setting to reflections on pedagogical approaches aimed at promoting health and wellbeing, Helen Cahill continues the task of challenging dominant understandings, albeit of a different kind. Engaging with examples from her own practice in the area of sexuality and gender rights education, the focus of Cahill's analysis is the use of stories and role-play to disrupt unexamined assumptions and in doing so, enhance wellbeing. She ultilizes the concept of "trojan stories" to illustrate how entrenched narratives may unwittingly be reproduced in the classroom, thus undermining the very objectives educators set out to achieve. Cahill offers valuable guidelines for educators for rethinking conventional health education practices and developing more innovative strategies. This includes critical and creative exercises for thinking afresh about educational approaches, which, she argues, have the potential to open up and move towards a pedagogy of possibility.

Philosophical questions, prompted by the embrace of wellbeing as an educational aim, are examined in the following chapter. Amy Chapman turns her attention to the big question of the purposes of schooling, asking how wellbeing might align or compete with other educational goals. Her analysis seeks to make explicit the normative dimensions of wellbeing in schools by focusing on the diverse range of educational objectives that the promotion of wellbeing seeks to address. These include well-established aims such as overcoming barriers to and providing support for learning, and tackling the problem of mental health disorders in young people. Yet she also shows how wellbeing is marshalled as part of broader socialization processes and indeed even how fostering wellbeing is understood in an educational context to contribute to happiness. Reflecting on the implications of the take up of wellbeing in schools as well as the normative dimensions that buttress the focus on wellbeing, Chapman argues that there are pressing philosophical questions at stake which go to the very heart of what we understand to be the purposes of education.

Moving from philosophical questions to those concerning culture and schooling, Wan Har Chong and Boon Ooi Lee examine the promotion of wellbeing in an Asian

context. The focus of their analysis is the adoption of a social-emotional learning (SEL) framework for Singapore schools, which is designed to guide school-based program initiatives aimed at fostering and strengthening young people's capacity. While acknowledging the usefulness of SEL, Chong and Lee offer a salient reflection on the take up of this model in cultural contexts that may hold different values from those dominant in Western societies. The implications of this are explored as they highlight the difficulties that may arise, for example, in understandings of competence and patterns of emotional expression and distress, which vary across cultures. They identify dominant themes of western psychotherapy and counselling present in SEL models, and consider the issues this raises for the implementation of affective programs in non-Western contexts.

The final two chapters take up the challenge of historicizing the concept of wellbeing, exploring key ways in which wellbeing and its antecedents have been operationalized in schools. Julie McLeod examines self-esteem as an important precursor to the rise of wellbeing. Her analysis situates the embrace of self-esteem and wellbeing in education – and their circulation in policies and programs – within broader cultural moves pertaining to the increasing importance of emotions in the public sphere. While self-esteem has largely been dismissed as a failed educational experiment, narrowly concerned with making people feel good and leading to an epidemic of narcissism, McLeod reminds us of the liberatory feminist projects in which self-esteem played a critical role. Her chapter offers a timely reflection on the forgotten history of this concept and its mixed and contradictory effects. In so doing, it develops new ways of thinking about the implications of wellbeing discourses in the historical present.

In the final chapter, Katie Wright examines changing educational concerns with mental health and wellbeing. Focusing on two historical periods, the early decades of the twentieth century and the late twentieth century to the present, she explores dominant ideas about psychological health and the remedial, school-based strategies developed on the basis of that knowledge. In doing so, she examines the shift from the traditionally narrow focus on targeted interventions for young people identified with problems, to the embrace of universal approaches aimed at fostering the mental health and wellbeing of entire student populations. Drawing on an analytical framework informed by critical policy studies, Wright analyzes both the preventative promise that characterizes current educational approaches and the aspirational dimensions that make the concept of wellbeing appealing for both educators and policy makers.

Each chapter in this volume responds in distinctive ways to the challenge of providing a critical rethinking of youth wellbeing. In so doing, they stand on their own in addressing particular aspects of wellbeing. In aggregate, however, the contributions tell a bigger story, illustrating diverse aspects of the movement of youth wellbeing across time and place, exploring it as an invented construct with practical, public, policy and personal effects. The book thus offers researchers as well as practitioners new perspectives on current approaches to fostering wellbeing in schools, and showcases novel and productive ways of rethinking what it means to address youth wellbeing in and beyond educational settings.

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Chapter 2
To Be Well Is to Be Not Unwell: The New Battleground Inside Our Children's Heads

Linda J. Graham

Abstract A number of factors are thought to increase the risk of serious psychiatric disorder, including a family history of mental health issues and/or childhood trauma. As a result, some mental health advocates argue for a pre-emptive approach that includes the use of powerful anti-psychotic medication with young people considered at-risk of developing bipolar disorder or psychosis. This controversial approach is enabled and, at the same time, obscured by medical discourses that speak of promoting and maintaining youth "wellbeing", however, there are inherent dangers both to the pre-emptive approach and in its positioning within the discourse of wellbeing. This chapter critically engages with these dangers by drawing on research with "at-risk" children and young people enrolled in special schools for disruptive behaviour. The stories told by these highly diagnosed and heavily medicated young people act as a cautionary tale to counter the increasingly common perception that pills and "Dr Phil's" can cure social ills.

Keywords Medicalization • Disadvantage • Behaviour • Children and young people "at-risk"

Introduction

> *Mental health is a state of emotional and social wellbeing. It influences how an individual copes with the normal stresses of life and whether he or she can achieve his or her potential. Mental health describes the capacity of individuals and groups to interact, inclusively and equitably with one another and with their environment, in ways that promote subjective wellbeing and optimize opportunities for development and use of mental abilities.* (Australian Bureau of Statistics 2001, p. 4)

Wellbeing is a relatively recent and, as yet, still amorphous concept; one that is absently defined through vague references to mental health and its more sinister shadow, mental illness. Whether subtly or otherwise, the discourse of wellbeing is underpinned by an individual disease model and, as such, is inherently medical

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K. Wright, J. McLeod (eds.), *Rethinking Youth Wellbeing*,
DOI 10.1007/978-981-287-188-6_2

in concept. As a result, what it means to be "well" comes to be defined by the absence of psychiatric symptomatology or, in other words: to be well is to be not "unwell". Although a family history of mental health issues and childhood trauma are known risk factors for developing mental disorders, the application of a medical lens to human emotional distress can lead to treatment responses that eclipse these influences and their impacts. In the race to develop treatments that can reach more patients and methods to identify untreated sufferers, natural human reactions to loss, disappointment, disrespect and even abuse have become symptoms of individual pathology, as opposed to indicators of disadvantage or injustice (Levine 1997).

A number of dangers present as a result. One danger is that children and young people are constructed as "unwell" when they may not be, and another is that they are subjected to individualized treatments when the real problem may well reside within their social context (Isaacs 2006). These are familiar dangers. Few would be unaware of the controversy surrounding Attention Deficit Hyperactivity Disorder (ADHD); a controversy that stems from the same two concerns (Graham 2010). One criticism of ADHD is that the diagnostic criteria are so broad that we risk medicalizing ordinary child behaviour (danger 1). Another is that behaviours stemming from hunger, abuse, neglect, tiredness, poor diet, inappropriate curriculum, inconsistent parenting and/or poor teaching may be misdiagnosed as neurological dysfunction and treated pharmacologically (danger 2). Although these are familiar issues, the dangers involved with mental health diagnosis and treatment have increased in recent years with the ascendance of biopsychiatry (Rose 2007), and an associated upwards trend in the use of psychopharmacological agents in the treatment of behavioural problems (Frances 2013).

This trend has a long history marked by at least two epochal turns. The first was the discovery of "hyperkinetic reaction of childhood" – one of at least five precursor categories to what is now called ADHD – and the rapid rise in the prescription of stimulants to difficult and disruptive children (Smith 2008). The second turn is related but less well known. It began in the 1990s when the self-proclaimed "god" of ADHD clinical research (Healy 2006), Professor Joseph Biederman, estimated that some 50 % of the children participating in his treatment studies had symptoms of what he believed was juvenile bipolar disorder. At the time the medical fraternity was shocked; prevailing opinion was that bipolar disorder arose in adolescence or adulthood (Healy 2006) and that the main symptoms – mania and depression – were *episodic*, not chronic (as per the symptoms of ADHD). Biederman and his colleagues, however, argued that childhood-onset BPD was different to adult BPD, in that it "appears to present with an atypical picture characterized by predominantly irritable mood, mania mixed with symptoms of major depression, and chronic as opposed to euphoric, biphasic, and episodic course" (Wozniak et al. 1995, p. 459).

Biederman (1998) further suggested that the core symptoms of ADHD – inattention, impulsivity and hyperactivity – were *predictive* of BPD which could be prevented with "prophylactic pharmacotherapy" (Biederman 1995, p. 229) that involved the pre-emptive use of highly restricted mood-stabilizers, such as lithium, or anti-psychotics, like Risperdal, in young children. By 2001, "more than

100,000 children were being medicated for BPD" in the United States, with "the percentage of children being clinically diagnosed more than doubling" by 2008 (Youngstrom et al. 2008 p. 2). Three years later Biederman was investigated and found to have violated the conflict of interest policies of both Harvard University and Massachusetts General Hospital by failing to report $1.6 million in income earned from pharmaceutical companies (Kaplan 2011). Meanwhile, Johnson & Johnson has paid out billions to class action plaintiffs affected by Risperdal; the efficacy of which Biederman is alleged to have guaranteed to his funders prior to commencing clinical trials (Harris 2009).

Although the concept of childhood-onset bipolar disorder has since been displaced – and some might say, discredited – by the instantiation of a new diagnostic category, Disruptive Mood Dysregulation Disorder (DMDD) in the latest Diagnostic and Statistical Manual of Mental Disorders (DSM-5), the idea that treatment of "pre-symptoms" (that may signal the risk of future psychiatric illness in early adolescence or childhood) has spread. Take, for example, the recent and much criticized push for "pre-psychosis" intervention where young people "manifesting precursor signs and symptoms who have not yet met full criteria for diagnosis" (Mrazek and Haggerty 1994, p. 154) are treated pharmacologically with anti-psychotics, such as Seroquel and Risperdal, to "delay or even prevent onset of psychosis" (Jung and McGorry 2007, n.d.). Proponents pushed hard for the inclusion of "pre-psychosis risk syndrome" in the DSM-5, however, "given the expected high false positive rate and the unfavorable risk-benefit ratio" (Corcoran et al. 2010, p. 10), others urged caution.

While pre-psychosis risk syndrome did not make it into the final DSM-5, which was released in 2013, pre-psychosis treatment is still actively promoted and it still occurs. In Australia, for example, treatment with anti-psychotics for young people considered at-risk of developing psychosis has been advocated by *Orygen Youth Health* and the *Early Psychosis Prevention and Intervention Centre* (EPPIC) which was founded by Professor Patrick McGorry, the world's leading proponent of pre-psychosis intervention. McGorry is associated with a number of networks and centres – including headspace, the Young and Well Cooperative Research Centre, and even the Centre for Music, Mind & Wellbeing – all of which refer to youth mental health and wellbeing as a core focus. Given the positioning of the pre-emptive approach within an otherwise benign and universal discourse that constructs "wellbeing" as a tenuous state of "being (not un)well", there is a very real danger that children and young people who are living under difficult circumstances may be too quickly diagnosed and medicated for disorders that they do not yet (and may never actually) have.

As mental health diagnoses carry significant stigma and psychoactive medications can be neurotoxic, these dangers are serious enough. A third danger, however, and one that receives much less focus than it should, is that young people who face difficult circumstances may come to view themselves as mentally disordered; believing that their "illness" is both immutable and organic to them, not something that can be changed or addressed by way of improvement in other spheres of their

life. In this way, what currently *is* cements into what will always *be*: an intrinsic part of life for "someone like *me*". A lack of belief in one's ability to change one's own behaviour and life circumstances is, fundamentally, to lack agency. As described by Albert Bandura (2006, p. 164):

> [t]o be an agent is to influence intentionally one's functioning and life circumstances. In this view, personal influence is part of the causal structure. People are self-organizing, proactive, self-regulating, and self-reflecting. They are not simply onlookers of their behaviour. They are contributors to their life circumstances, not just products of them.

Importantly, a sense of agency has been identified as one of three key elements to children's wellbeing, in addition to a positive sense of self and feelings of security (Fattore et al. 2009; Foley et al. 2012). It is my contention, however, that all three of these elements – positive sense of self, feelings of security and a sense of agency – are eroded when young people are diagnosed, medicated and excluded from school, indicating an element of hypocrisy in the discursive co-option of the "wellbeing" discourse by proponents of pharmacological intervention.

Researchers considering the inclusion of psychosis risk syndrome in the DSM-5 came to the conclusion that this was a significant danger, arguing that being "labeled with severe mental illness has the potential to permeate one's social identity and threaten a sense of normalcy" (Yang et al. 2010, p. 45). Further, given the developmental age of the young people in question, Yang and colleagues warned of two other implications for identity formation: first, "mental illness 'labeling' may interfere with the acquisition of 'personal assets' or competencies needed for successful passage to adulthood" (Yang et al. 2010, p. 45), and second, there is a risk that a young person's self-concept will be "transformed via a process whereby illness roles become central to an individual's identity and valued social roles diminish until only a 'chronically ill' role remains" (Yang et al. 2010, p. 45).

The self-fulfilling prophecy effects of mental health diagnoses have been raised in the critical literature with a number of researchers drawing on poststructural theories of discourse and power to consider the role of labelling in the production of mentally disordered subjectivities (see, for example, Harwood 2006). While I am sympathetic to such analyses and have used them previously to examine how fidgety, distractible children are constructed as behaviourally disordered (Graham 2008), here I am concerned with the effect of school exclusion, diagnosis and medication on young people's sense of purpose and control over their own lives. Previously I have argued with respect to ADHD, that the fundamental difference between the medical and psychological models can be found in their respective theorization of agency, reason and control:

> The medical model appears to accept "disordered" children as having little or no control over their actions. The psychological model, on the other hand, is dependent for its very existence on the assertion that the child *can* exert or *learn* self-control. (Graham 2008, p. 21)

In my earlier work, I argued that ADHD had effectively brokered an alliance between psychology and medicine because psychological interventions had so far failed to show superior effect over medication treatment when each were

taken alone.[1] This has led to a reciprocal relationship between the two fields – despite fundamental differences in perspective – with psychology forced to subordinate to the medical model in order to remain relevant in the treatment of difficult and disruptive children (Graham 2008). This uneasy alliance is epitomized in the "reach before you can teach" mantra which is used to justify the use of medication as a first-line response. Multi-modal treatment plans that have Cognitive Behavioural Therapy (CBT) following hard on the heels of medication are supposed to be the gold standard; the rationale being that medication will address deficits in executive function that lead to poor self-regulation (the "reach"), making it possible for children to then learn CBT strategies and to put them into place (the "teach"). The paradox however is that young people need agency to both want and to be able to achieve this but their capacity for agentive action is precisely what is at stake when they come to believe that they are in the grip of something that is more powerful than themselves; whether that be mental illness, medication, the adults in their lives, or the source of the problems they face.

These are the dangers of positioning mental (ill)health within a generic discourse of youth wellbeing. The first danger is that we risk medicalizing the reactions of young people living in distressing social circumstances. The second danger is that these young people may then be subjected to treatments that further individualize those issues, effacing broader social influences and their impacts. The third danger is that young people may come to know themselves as "disordered", which can rob them of both the voice and agency they need to overcome the difficult circumstances they face. This chapter aims to critically engage with each of these dangers by analyzing data from a series of interviews with 25 children and young people who have been identified as behaviourally disordered and enrolled in special "behaviour" schools. These data suggest that children and young people who are living in distressed social circumstances *can* and *do* internalize medical diagnoses; believing both that there is something organically wrong with them and that there is little they can do to change their situation. While some may resist the construction of their self as "unwell", overall their narratives suggest that the process of being diagnosed, medicated and enrolled in a special school is disabling for many.

The Study

New South Wales (NSW) is Australia's largest state comprising one third of the national population. The government school sector educates 66 % of the K-12 schooling population with over 2,200 schools and 744,392 students (Australian Bureau of Statistics 2011). The NSW government school sector also has the largest parallel special education system in Australia with over 2,000 support classes and

[1]The MTA Longitudinal Treatment Study has since found that medication has no additive benefit over time – at 36 months all four groups performed equally (see discussion in Graham 2010).

113 special schools. These schools, termed "Schools for Specific Purposes" (SSPs), form the most restrictive placement option. Over the last two decades there has been a significant increase in their use, mainly due to growth in enrolments under the categories of emotional disturbance and behaviour disorder (Graham and Sweller 2011). Recent research has found that this increase coincided with the establishment of a series of separate "behaviour" schools (Graham et al. 2010), which now account for more than one third of all special schools in the NSW government schooling sector (Graham 2012). The overwhelming majority of these schools are located in disadvantaged communities. However, there is a lack of quality research to indicate what effect enrolment in a behaviour school has on the children involved or what contribution is made to their future educational success. Despite this gap in the research knowledge, the use of special schools and classes for students who engage in disruptive behaviour is growing, while the average age of the students who attend is decreasing (Graham et al. 2010). The aims of the study on which this chapter draws were to document how such interventions take form and the ways in which these are perceived by students and school personnel; trace student memories of their prior schooling experience and what connection, if any, these students make between these experiences and where they are now; track changes in student attitudes, beliefs and behaviour during and after their enrolment in special schools; and observe and analyze student re-integration to regular schooling to understand what events lead to positive and negative experiences (Graham et al. 2011).

To engage with these aims, the study utilized a cross-sectional mixed-method longitudinal research design (Creswell 2003; Takkashori and Teddlie 1998) with 96 participants aged between 9 and 16 years. The research participants were recruited in three groups from both mainstream and separate special educational settings; including 33 students currently enrolled in behaviour schools (the longitudinal group), 21 students with a history of severely disruptive behaviour still enrolled in mainstream schools, and 42 students enrolled in mainstream schools with no history of disruptive behaviour. The project was designed to progress in three phases. In Phase 1, each student participated in a semi-structured interview that was designed to tap into students' perspectives on schooling, teachers and teaching; their self-perception and peer-relationships; experiences of change and dislocation; future aspirations; knowledge of diagnosis and medication; and memories of current and past schooling experiences. Phases 2 and 3 were scheduled at 6 monthly intervals to longitudinally follow-up with the 33 students in the behaviour school group and to gauge whether their perceptions or experiences changed over the ensuing 12 months.

The behaviour school group was recruited first from five participating case-study behaviour schools located in the greater Sydney metropolitan region. Three of the five schools were located in severely disadvantaged communities, one school in an area that would be considered disadvantaged and one from an economically advantaged area. This is reflected in each school's score on the Index of Community Socio-Educational Advantage (ICSEA). However, as geographic information or single ICSEA scores could reveal the identity of the schools, only ICSEA ranges

Table 2.1 Socio-educational background of participating behaviour schools

ICSEA range	Number of schools
1,100–1,200	0
1,001–1,099	1
Mean = 1,000	
900–999	1
800–899	3

have been provided here.[2] As shown in Table 2.1 above, two case-study behaviour schools received scores 2 standard deviations (SD) below the ICSEA mean, one was 1 SD below and one school was 1 SD above.

This chapter focuses on the interview responses of students in the behaviour school group who confirmed that they were currently taking medication or had taken medication in the past. Individual responses to structured questions such as "What is that medication for?" "Does it help?" "Do you experience any side-effects?" "How do you feel about taking medication?" were coded using inductive content analysis (Berg 2001) and are presented below using simple descriptive statistics. Open-ended prompts were issued to encourage participants to voice their perspectives and to further examine issues that were raised by the participants themselves. Examples are presented later in the chapter through two case studies developed from student, parent and school principal interviews, as well as ethnographic data obtained during the overall data collection process. These young people's stories suggest a disturbing lack of consultation between medical practitioners, school practitioners and parents/caregivers at one end and young people on the other. The impacts of diagnosis and forced medication for young people's agency and ability to pursue their own conception of "wellbeing" are discussed.

The Twenty Five

A total of 33 students enrolled in behaviour schools participated in interviews designed to track their school experiences. During the interview students were asked if they were taking any medication that they knew of. Nineteen responded that they were currently taking medication and six replied that they used to but had now discontinued. Each of these 25 students was then asked what type of medication they were or had been taking and if they knew what it was for. Five did not know the brand but some were able to describe the medication and/or indicate what it was

[2]The Australian government has allocated every school in Australia with a score on the Index of Community Socio-educational Advantage based on parent occupation, educational level and achievement, and school characteristics including remoteness and percentage of Indigenous students. ICSEA has a mean of 1,000 and a standard deviation of 100.

for. While some simply referred to "ADHD" or "sleeping" tablets, the remaining 16 students were able to identify the brand and some even noted the milligrams; e.g., Ritalin 10 or Ritalin 40 (see Table 2.2 below).

Not surprisingly, stimulants were the highest prescribed medication type (15 students), followed by anti-depressants (5), anti-coagulants (2) and lastly, anti-psychotics (2). More than one third of these young people either was or had been taking more than one medication concurrently, with one student taking five highly restricted medications daily.

When describing what the medication was for only nine students referred to a diagnosed condition. Attention Deficit Hyperactivity Disorder (ADHD) was the primary diagnosis offered by these nine students, three of whom also nominated Oppositional Defiance Disorder (ODD). However, there was considerable confusion in relation to diagnosis. One student, for example, named "ADHD, ODD, ADOD . . . (pause) and something else" (Cameron, age 13). Another student differentiated between his mental health diagnoses by saying that one of his medications was to treat "ADD and ODD" and the other was to treat "ADHD or something" (Adam, age 14). The remaining students referred to personal, emotional and behavioural characteristics, such as "attitude" (Oliver, age 13) and "anger" (Andy, 12) to explain why they were taking medication with a number then referring to school:

> To try and make me act better at school. (Harry, 11)
> So I'm not bad at school. (Jack, 11)

Follow-up prompts were issued to gauge whether these young people experienced any medication side effects, whether they felt that medication was helpful to them, and how they felt about taking it. Appetite suppression, weight loss and sleep deprivation were the most common. Despite students in the behaviour school registering expressive vocabulary scores that averaged one standard deviation below the mean, these young people were very articulate when it came to describing medication side effects, particularly on the issue of depleted energy and physical strength:

> At the start it makes you feel sick. Like you got a headache and a stomach ache and that. And then it makes you just, like, it makes you feel like you got a lot of energy but when you start runnin' around, it's like you got no energy. (John, 13)

> I don't feel hungry. I'm weak, so if someone – if I get into a fight or something, they're going to beat me because I'm weak. (Cameron, 13)

> I don't feel hunger. I only feel the pain of not eating. There is no such thing as . . . there is NO hunger. There is only like I can put food in to stop the pain but it'll probably either get thrown back up or make it worse. I'll go through a whole day and at the end of the day I'll go oh what the fuck is this and I'll be like oh my God I haven't eaten today. (Ethan, 13)

When asked if the medication helped, responses were mixed. Just over one third stated that their tablets *did* help, five either didn't respond or said "dunno", while almost half said the medication did not help.

Table 2.2 Number and types of medications reported

Pseudonym	Age	Taking/ discontinued?	Type? "dunno"	Stimulant	Anti-psychotic	Anti-depressant	Anti-coagulant	Other
Zack	12	Yes		Concerta	Risperdal			
Ethan	13	Yes		Concerta (Dex & Ritalin, discontinued)				
Oliver	9			Ritalin				
Andy	12	Yes	X					
Ziggy	13	Yes						Melatonin
John	13	Discontinued	X					
Cameron	13	Yes	X					
Max	13	Yes		Ritalin	Seroquel	Endep	Catapres	Sodium valproate
Tom	12	Yes						Sleeping tablets
Grant	12	Discontinued		Ritalin				
Nathan	13	Discontinued						ADHD tablets
Cooper	16	Yes				"Anti-depressants"		
Darrin	12	Yes		Concerta				
Quade	16	Discontinued						A white one & a purple one
Owen	12	Discontinued		Dex-amphetamine				
George	15	Yes		Ritalin & concerta				
Harry	11	Yes		Ritalin (discontinued)		Endep		
Liam	13	Discontinued	X					
Jack	11	Yes		Ritalin 40				
James	11	Yes		Ritalin 40				

(continued)

Table 2.2 (continued)

Pseudonym	Age	Taking/ discontinued?	Type? "dunno"	Stimulant	Anti-psychotic	Anti-depressant	Anti-coagulant	Other
Reuben	12	Yes		Concerta		Lovan		
Michael	14	Yes					Catapres	"... and something else to sleep"
Rory	13	Yes		Concerta 36 & Ritalin				
Adam	14	Yes		Concerta		Lovan		
Patrick	10	Yes		Ritalin 10				
25 students	**Avg. age: 12.6**	**19 currently**	**16 %**	**60 %**	**8 %**	**25 %**	**14 %**	**14 %**
		6 discontinued						

> It calms me down. And I'm very quiet when I have it. [If I didn't take it] I would get all agitated and say some funny things, or I wouldn't do my work. I'd get bored of this [the interview]. (Patrick, age 10)

> Yeah, it does. It helps me with me work. It helps settle me down. Doesn't make me so, um . . . crazy. Making people laugh and just being silly. (Darrin, age 12)

> It made me 10 times worse . . . Mum chucked it down the toilet. (Grant, age 12)

> It was not doin' nothin' but making me feel shit. (Quade, age 16)

Importantly, even though 9 of the 25 said that the tablets *did* help, only three out of those nine were positive when asked how they felt about taking medication. The rest expressed a desire to stop:

> I don't want to take tablets. I want to be like a normal kid. (Jack, age 11)

> I don't like it because I don't talk to no-one or anything. I'm like in zombie mode so I just don't have it. (Adam, age 14)

> I didn't want to because it makes me really skinny. It stops me eating. I used to look like a junkie. (Owen, age 12)

One common theme among the students who had been prescribed medication was a perceived lack of voice in decision-making with a number saying that they would "chuck it in the bin" (Zack, age 12) or find other ways to avoid taking them without their parent's or school's knowledge. These themes were investigated in more detail in the second round of interviews with questions designed to probe the diagnostic process, including whose suggestion it was to seek medical advice. Their stories reveal little consultation at point of diagnosis and/or prescription and, in some cases students noted that their school had barred attendance unless they were medicated:

> The principal at [my old school suggested]. They said if he's not put on medication by next week, because I got a week's suspension, I wasn't allowed to go back to school. They were going to expel me, so they [the doctor and my mum] put me on it. (Cameron, age 13)

> If I could stop I would but I wouldn't get any schoolwork done. They're not going to let me stay at this school unless I do take my meds. That's actually a contract that I signed on; that I won't come to school unless I'm on some of my meds. (Ethan, 13)

> . . . the school suggested [to] my mum that I should take medication for my subjects, to see if I've got ADHD . . . One tablet would put me to sleep – which they – the school wanted my mum to keep taking – giving me them ones, because it's good for them when I went to sleep at school . . . They were happy with that. My mum wasn't because she wanted me to get help. [*Why were they happy that you were asleep*?] Because I wasn't annoying anyone or I wasn't having bad behaviour. I was just sleeping all day. (Owen, 12)

By the time we returned to conduct the second interview 6 months later, 6 of the 25 had either aged out of school or were impossible to track down due to chronic absenteeism. When asked what would make them happy in life, 3 of the remaining 19 behaviour school participants answered "dunno" or "nothin". The last 16 expressed fairly simple wishes that revolved around four main themes: (1) friends,

family and love, (2) gainful and satisfying employment, (3) security, and importantly, (4) personal autonomy:

> Just doin' things *I* like to do. (Zack, 12)
>
> Having a wife and kids and doing my own thing. (Nathan, 13)
>
> Get all the stuff *I* want. Have, like, two magic fairies, I don't know, so whenever I say "I wish" it comes true or something. [*What would you wish for*?] Get out of school! (Grant, 12)

This last theme is an important consideration given the lack of autonomy experienced by these young people, particularly given that their lack of voice in decision-making was not restricted to medication. Most students were unsure of how long they would be in the behaviour school or what they had to do to be able to return to regular schooling. However, as discussed in the introduction to this chapter, lack of voice and personal autonomy in decision-making about one's own life is not conducive to producing the conditions of possibility required for the development of agency; an ability that is necessary for young people to successfully negotiate and overcome difficult circumstances.

In the following section, I present two case-studies drawn from interview and ethnographic data collected over an 18 month period to illustrate how experiences of diagnosis, medication and exclusion manifest in young people's beliefs about themselves and their ability to positively affect and direct their own lives. It is important to note that the experiences described here were not limited to the young people that have been selected for discussion, nor were they limited to students enrolled in behaviour schools. Indeed, as noted by one of the principals of the participating behaviour schools, "there is not a crack of daylight between who gets into our school and who is 15th in line" (School 3). Similar stories were relayed by other students with a history of disruptive behaviour, including those enrolled in mainstream schools, the only real exception being students from schools in highly-advantaged areas whose parents were more able to act as advocates for them and students whose parents actively resisted any pathologization of their child.

Catch-22

Zack's was the first participant consent form to arrive in the mail. Included with the consent form was the Achenbach Child Behaviour Check List – Parent Report Form, which had been completed by his grandmother. Zack had been in her care since he was 2 years old after suffering abuse at the hands of his mother and her then boyfriend who was unrelated to Zack. His father's occupation had been listed as "jail and drugs" and his mother's as "smoking pot and stealing shop". He was 12 when I first met him.

Zack moved slowly into the interview room. He was overweight for his age and wore glasses. The behaviour school principal had mentioned that he was one of

a number of "refugees from the mainstream" who had been sent to the behaviour school not because they were violent thugs but because they were small and "odd" and thus the target of school bullies. Due to the culture in some of the mainstream schools from which we drew our participants, Zack had learned, as reported by many of the behaviour school kids: "to bash or be bashed". Typically though, he would come off second best. Because he couldn't outrun and he couldn't fight back, all he had at his disposal was tough talk and public acts of rebellion for which he was now paying the price.

Twelve year old Zack reported that he had been taking Risperdal (an anti-psychotic) and Concerta (a long-acting stimulant) for about 6 years but "I don't know what they are. I don't know what I take them for." When asked if they helped, he said "Nup". In our second interview, he confirmed that he was still taking Concerta and Risperdal and that he was taking them for "behaviour and depression" but "I dunno *why*". Later when he was asked if the medication helped, he said "Nuh. Don't even – not even depressed!" He argued that the medication made no difference because "I used to never take it; I used to chuck it in the bin." One of the side effects he noted was that the Risperdal made him eat a lot.[3]

Zack reported that these two medications had been prescribed by two different doctors, one of whom believed the Risperdal – an S4 restricted drug requiring Australian federal government authority to prescribe – was not helping.

> She wants to take me off it. She has to ring up the other paediatrician that gave it to me. She told me I have to get off it and she'll try and get me off it if she can.

Zack had no idea how or when this would happen but he said that when he had told his grandmother and the other paediatrician that he wanted to stop medication, they had told him he had to "prove himself" before he would be allowed to discontinue. Earlier in the interview, Zack used the same term when talking about getting a "second chance" through the behaviour school and how that related to re-integration to mainstream:

> You'd be good here for a while and then they start thinking about sending you to a different school for like a day or something . . . a day each week. Prove yourself. If you prove yourself, you go there full time.

Zack's words "they start thinking" betray his lack of voice and agency. Rather than describe a plan for action – *change your behaviour here and then you will be able to return to mainstream through partial re-integration* – he is told to prove himself first and "then *they'll* think about it". When asked if he had ever attempted partial re-integration, Zack said he had but that he had been "stopped from going" – an interesting choice of words in itself – because he had not gone to class on the 1 day a week that he was allowed to attend a mainstream high school. His reason for avoiding class was that he couldn't engage with the level of work nor could he navigate a foreign high school campus; something that had been noted as a

[3] Significant weight gain is a known side effect of Respirdal (Parikh et al. 2008).

common problem affecting re-integration by all five participating behaviour school principals:

> . . . high schools have 75 or 80 minute periods. They have an A week and a B week. So in this week if a kid goes back on a Thursday, he hits English, Maths, Science, Art. He goes back the next Thursday, he hits four different subjects. Then it's a fortnight in between . . . at the same time everybody else in the class is hitting that lesson three other times. So our kid is expected to be up-to-date. Teachers have 200 kids to teach – are they supposed to remember that student actually wasn't there the last three classes and cut him a break? They don't. (Principal, School 2)

Now 14, Zack is resigned to remaining in the behaviour school, where he now prefers to be anyway. His reason for not attempting to reintegrate after 3 years in the behaviour school is that he has "spent too much time here" and that he "won't mix well at another school". He reasons that with only another year and a half of school to go before he can leave to train at TAFE to achieve his dream of becoming a reptile handler, there is no point in trying.

Paradoxically, however, Zack is still being told to "prove himself" before he is allowed to stop taking anti-psychotic and long-acting stimulant medication from which he suffers side-effects and that he and one of his doctors do not believe is helpful. The only way that he can prove himself is to successfully return part-time to an unyielding and unresponsive secondary school system that has proven unable or unwilling to support the integration of students from behaviour schools. Zack is therefore caught in a proverbial Catch-22, constructed as unwell when he believes he is not but without any way of proving himself otherwise. While Zack has thus far been able to resist fully internalizing this construction, others have not fared so well.

Boy Interrupted

Max was a 13 year old "school refuser" whose mother called to request that we see him at home where she felt that he would feel safer talking about his school experiences. He lived in a public housing estate in a disadvantaged area of Sydney and, while Max had been referred to a behaviour school for violence, the school advised that this was mainly directed at school bullies and that it should be safe for adults to visit him at home. As university research safety policy requires that two researchers attend home visits to potentially dangerous locations, my research assistant and I met at the address provided. When we walked up the drive to the entrance of the little semi-detached villa, someone darted from one of the chairs outside the door and into the neighbouring villa. The pungent aroma of marijuana greeted us at the doorway.

Undaunted, we rang the bell and Max's mum opened the door. She was bubbly, friendly and completely lucid. She welcomed us into a small living room and called Max. It was dark inside the house with blinds covering the windows and it took some time for our eyes to adjust. The only light was emanating from a computer

screen tucked away in the corner of the room. Hunched in front of it was a pale skinned, blonde haired boy who seemed oblivious to our presence. His mum asked if we would like a cup of tea while we set ourselves up on the dining table. She seemed anxious to talk and grateful that someone was interested in learning more about her child. Max continued to ignore us.

Eventually his mother managed to coax him away from the computer and Max approached the table. He was surprisingly tall once he uncurled himself from the little computer chair and very lean but well-built and strong looking. We cheerfully introduced ourselves, explained the research, asked if he consented to participate, and showed him the Peabody Picture Vocabulary Test (PPVT) as an example of what we were going to do in the session. Max nodded and signed the consent form but seemed barely conscious. When he did look at us, he did so by leaning his head back, so that he could see through half-open eyes. His speech was slow and slurred, which prompted his mother to explain that she'd "upped" his medication in anticipation of our visit.

In all four of our meetings and all three interviews, Max was guarded. He would consider questions deeply before answering them and, if they were what *he* considered personal or potentially straying near a topic he did not want to talk about, he would politely decline to answer. For example, the first time he encountered the State/Trait Anxiety Inventory, he declined to participate as he deemed questions about emotions too personal. Max also had an issue with the same interview questions being asked of all participants as he believed he was "different" and he did not see how structured questions could capture *his* story. In response to questions about medication, he replied:

> See, the problem is one person asked me half of these questions once and then my mum got really angry at them because they were asking personal questions about me and they had no right to know before I went to their school . . . I just don't know any more if anyone's allowed to be asking these questions at all . . . I don't really want to answer anything about the tablets. (Max, age 13)

As we also had ethics clearance to speak to parents, I invited Max's mother, Julia, to participate in an interview to provide us with some background knowledge of Max.[4] She was very happy to participate and to discuss diagnosis and medication.

During her interview, Julia revealed that Max was on five concurrent medications: Seroquel (an anti-psychotic), Endep (a tricyclic anti-depressant often used with children diagnosed with ADHD), Ritalin (a stimulant), Catapres (an anti-coagulant typically used to treat hypertension but also used off-label to treat ADHD), and sodium valproate (an anti-convulsant typically used to treat epilepsy but also used off-label for children with autism). Seroquel, she explained, had been added when Max was admitted to the Child and Adolescent Psychiatric Unit at the Children's Hospital (aged 11) but that he had been on a variety of medications since he was diagnosed with ADHD in preschool.

[4]Funding for parent and principal interviews was provided by Macquarie University's Concentrations of Research Excellence (CoRE) program.

In the years following preschool, Max acquired three more diagnoses, including Oppositional Defiance Disorder, anxiety and Asperger's Syndrome. Both his mother and the head of the support unit he was now attending noted that the autism diagnosis was a means to find a placement. Julia explained that she'd had to learn to "work the system", even going so far as to move to Sydney and relinquish care to the Department of Community Services (DoCS) to get the support she needed:

> The amount of guilt and crap I went through, it was just unbelievable. But he managed, after that . . . 'coz from Redbank they were trying to get him a place at Hall Ward, which is a children's lock down mental health unit at Westmead Children's and they said no beds, no beds, but the day I put him into DoCS care there was a bed.

The head of the support unit Max was attending was of the view that he was emotionally disturbed but not autistic and that the Autism Spectrum Disorder (ASD) diagnosis had been signed off to ensure a place in a support setting. According to this teacher, Max and his mother had issues with co-dependency and much of the school's effort was focused on helping Max make it through a full day without requesting to be picked up by his mother. Julia herself acknowledged that this was an issue and attributed it to their being a single-mother/only-child dyad. However, her story indicates that there were contributing factors beyond their relationship.

Julia explained that while she had now turned her life around and was studying at university, Max's early life had been extremely traumatic with his parents splitting up when he was a toddler:

> I found out [Max's father] been smoking heroin and was doing break and enters to support his habit, and then he finally got caught with a couple of friends, breaking into a Retrovision store. Went to jail for 12 months. I waited, I did the weekend visits and the money in the account, and I worked a night time job to support him and us and wrote letters every day, and made sure I was there for phone calls and all the rest of it. Then he came out and then two months later I found dirty needles in my garage. So I call the police and . . . he spent the next two years in and out of jail, and . . . well, when I went for custody, he was actually incarcerated. Had the option to come to the courthouse but decided he wasn't going to come because he wouldn't have won anyway.

Julia reported that neither she nor Max had received counselling in those critical early years despite the presence of acknowledged "risk-factors". Max began acting out in preschool and was soon diagnosed and medicated for ADHD. By Year 3, he began moving from school to school and Julia said that for the first 5 years of his schooling life, Max would have been lucky to spend more than two hours a day at school before they would call her to tell her to come and pick him up for misbehaviour. After he was diagnosed with Asperger's Syndrome and placed in a support unit in country New South Wales, it was a little easier to keep him at school; however, Max's anger then began to be directed towards her:

> Then we got to a stage where Max was actually beating the crap out of me. It was really bad for about 12 months. I started drinking and just not wanting to deal with him at all. I didn't even want to look at him. Didn't want to speak to him. I just . . . I'd had enough.

And so, Julia relinquished care to DoCs and Max was placed on Seroquel in addition to the four other medications he had already been prescribed. In his words, he is in the special class:

> . . . because I have autism and showed bad signs when I was little . . . No-one likes me, everyone hates me. After a while you can't just take it all up and move all the time, so I just decided to punch my way out of it . . . It's working now. Everyone that doesn't want to get hit leaves me the hell alone. (Max, age 13)

Max is a quirky individual and there are hints of ASD characteristics, such as obsessive interests (medieval history, chess and Xbox Live) and preference for rules, however, in my view it would still be a stretch to diagnose him with autism. Max makes eye contact, does not engage in self-stimulatory behaviour, does not speak in monotone and is oppositional in the face of something he would prefer not to do, rather than hysterical. While his seclusion at home and in separate settings may have accentuated his eccentricities, Max is functionally capable and could – with consistency in support and guidance – draw on his intellect to make his way in the world. This appears an unlikely prospect now, however, as Max is convinced otherwise. While he states that the purpose of school – or at least the schools that he knows – is to help him develop something resembling a sense of agency and a sense of autonomy, he does not appear to believe that this is possible for someone like him.

Interviewer:	What do you think school is for?
Max:	To learn how to do things right for when you grow up, so you can handle yourself.
Interviewer:	I see, yep, and is that important to you?
Max:	No.
Interviewer:	Why not?
Max:	Cause you know I'm screwed.
Interviewer:	Yeah?
Max:	I've had a shit amount of time at school, I'm bad at everything, no, yeah, so I don't really care anymore.

Max was not the only 1 of the 25 to have internalized his diagnosis or difference as an immutable part of his self. The majority either attributed their being sent to the behaviour school or their difficulty at school to something that was "wrong" with them, even if they weren't sure what that was. This was best expressed by 12 year old Darrin when he sought to explain why he was taking Concerta:

Interviewer:	Do you take any medication that you know of?
Darrin:	Yeah!
Interviewer:	Yeah? Do you know what that is?
Darrin:	Yeah. Concerta.
Interviewer:	Concerta. Do you know what it's for?
Darrin:	Oh, it's to help me with me. This thing that I have. Don't know what it's called . . .

Interestingly, while these students said little to demonstrate a positive sense of self, in response to the question "Is there anything you would change about yourself if you could?" only seven (just under one third) said that there was:

> Stop being bad. (Oliver, aged 9)
> Just misbehavin' that much. (John, aged 13)
> My ADHD, my learnin' . . . readin' and all that. 'Coz I'm dyslexic. (Cameron, 13)

> My anger. Because it's the main problem with me. (Tom, aged 12)
> Clumsy. Because I get into trouble. (Darrin, aged 12)
> Be polite. (James, aged 11)
> Just stop being naughty. (Adam, aged 14).

One student, who was removed by DoCS from his alcohol and drug-dependent mother (whom he still sees and clearly loves) when he was just 4 years old, replied that he would like to change his *situation*:

> I wish that I could go back live with my mum and everything went back, so we didn't have any trouble. Just have a fresh start. (Nathan, aged 13)

The remaining 17 students (two thirds of the 25) said no to the question of whether there was anything that they would like to change about themselves. The basis for such a refusal is complex but it indicates that even though these young people have experienced failure and rejection for most of their young lives, they understand that to change they must somehow reject who they currently are. But this would be the ultimate rejection, one that would validate all the negative things that have ever been said about them. When a person lives with constant rejection from almost every person with whom they interact, not rejecting *oneself* may be a form of self-protection that keeps these kids functioning, however imperfectly (see Graham 2009).

Being Well

As explained in the opening quotation to this chapter, mental health is considered to influence how an individual copes with the normal stresses of life, as well as their ability to reach their potential, each of which can affect a young person's subjective wellbeing and development. Yet, the potential for medical intervention to also interfere with these developmental processes does not feature large in the discourse that surrounds mental health and wellbeing. Of great concern to me, however, as a researcher working with disruptive children and young people who have been diagnosed, medicated and excluded from school, is the individualizing effect that such responses have and how this works to reinforce the perception that both the problem and the solution lie inside the child's head, despite considerable evidence to the contrary.

Neither Zack nor Max would discuss their home lives but it was clear from the way they responded to some of my interview questions that each had experienced unspeakable pain resulting in/from family dysfunction and break-up. While Max would state upfront what he would and would not discuss (as we saw earlier in his response to the question on medication), Zack was quite open about some aspects of his life but not about others. This was ethically challenging as the majority of the interviews were conducted by research assistants who were reading from interview scripts. However, each interviewer was instructed to veer sharply off topic if any of

the participants appeared uncomfortable or declined to answer. The sudden silence of these two boys, who were both generous and patient in their three interviews with us, indicated that the experiences they have faced in their relatively short lives have left deep emotional scars. While Max was noticeably guarded from the very beginning of each interview, Zack openly volunteered information that was not directly related to the questions being asked, for example, noting that he lived with his Nan and Pop but that his older brothers were in group homes. When Zack did decline to answer at times, it was very clear that he had suffered significant trauma, indicating that his problems stemmed from something much deeper than the "normal stresses of life":

Interviewer:	If you were making a movie of your life and it had to be real. What would be the three most important things to tell about you and your life so far?
Zack:	My Nan stopped me from going into foster care and that.
Interviewer:	(softly) Yeah . . . Can you tell me a bit more about that?
Zack:	No.
Interviewer:	Is that because you don't know? Or because . . .
Zack:	No, I know exactly what happened.
Interviewer:	No, that's all right. So just to confirm your Nan stopped you from going into foster care?
Zack:	Mmm hmm.
Interviewer:	Yeah, okay . . .
Zack:	Yeah.
Interviewer:	. . . but you don't want to talk about it.
Zack:	No.

Mental (ill)health is determined by the presence or absence of adaptive behaviours, which are types of behaviours used to adjust to and overcome life situations. A person who experiences workplace bullying, for example, might change their usual response to an antagonist by researching passive-aggressive behaviour and adopting strategies to counteract it. This would be considered adaptive behaviour. Maladaptive behaviour is a type of behaviour that is often used to reduce anxiety but the result can be counterproductive. For example, working from home to avoid the workplace bully and drinking heavily while doing so may help to reduce anxiety, but it will not alleviate the actual problem and may make it worse in the long term. Maladaptive behaviour patterns form the basis of behavioural profiles, which can be interpreted as symptomatic of disorders listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM). A fidgety, distractible child that leaves his seat to walk about the class disrupting others, for example, may be considered to exhibit behaviours that are consistent with the diagnostic criteria for Attention Deficit Hyperactivity Disorder (ADHD).

Depending on the severity of their behavioural "symptoms" children can also be diagnosed with Oppositional Defiance Disorder (ODD), Disruptive Mood Dysregulation Disorder (DMDD), and/or Conduct Disorder (CD). The prognosis worsens with each diagnosis with some researchers now considering behaviours in this family of disruptive behaviour disorders – including "verbal aggression, physical aggression, swearing, defiance towards authority figures, hyperactive behaviour,

impulsive behaviour, inattention, stealing, lack of guilt over misbehaviour, absence of empathy toward others, and violation of school rules" – predictive of future psychopathy, even referring to the children who exhibit them as "fledgling psychopaths" (Gresham et al. 2000, p. 88).

Data from classroom observations and interviews with principals confirmed that the behaviours of the students in our behaviour school group fit those described above but, while present, these behaviours did not encapsulate any 1 of the 25 in toto. Like all children, Max and Zack had no choice in the hand they were dealt, and rather than receive support in the formative early years both experienced parental, school and peer rejection and both have learned to use physical aggression to protect themselves from others. Neither believes that medication helps. This is not surprising given that medication cannot change their social circumstances. Disturbingly however, neither boy has a clear idea of what they can do to make those changes themselves, even if they do know what would make them happy in life, whether that be "just hanging out with friends" (Zack) or knowing love:

Interviewer:	Okay, right. Now, next question. What do you think will make you happy in life?
Max:	Hmm. A pony – nah, I'm kidding. Hmm. Being immortal.
Interviewer:	Why would you like to be immortal?
Max:	Actually no. Probably never going to hell.
Interviewer:	Yeah.
Max:	Or knowing what actual true love is.
Interviewer:	Hmm . . .
Max:	That's what would probably make me happy; actually knowing when to know what true love is.

Conclusion

The concept of "wellbeing" has become popular in many contemporary Western societies, yet it is difficult to uniformly define and measure. Rather than to refer to anything definitive, the term is commonly used as a positive frame of reference through which to promote and discuss mental ill/health. In this way, what it means to be "well" comes to be defined by the absence of psychiatric symptomatology. As discussed, there are a number of dangers that flow from this.

Firstly, normative conceptions of what it means to be *well* are at risk of imposing judgments upon young people who, while dealing with difficult issues, do not necessarily view *themselves* as unwell. Secondly, such young people may be subjected to psychological and/or medical treatments that further individualize those issues, denying broader social influences and their impacts, including the roles and responsibilities of parents, schools, communities and governments. Thirdly, young people may come to know themselves as "disordered", which can rob them of both the voice and agency they need to overcome their circumstances. Finally, this

construction invites a preventative focus resulting in the development of treatments to prevent particular young people from "becoming" unwell, however, the potential for false-positive diagnosis and treatment presents yet another risk that must be balanced against all the others.

Whilst each of the above dangers is evident in both the clinical and critical research literature, they are typically considered individually and weighed against the risk of doing nothing. Seldom are these dangers considered collectively, even though they often operate in unison or in a sequence. When considered individually, each of these dangers pale in significance to what "might" happen to a young person from distressed social circumstances and, as a result, tend to be dismissed. In this chapter, however, each of these dangers is considered and weighed against the progress and perspectives of the individuals most affected. Ultimately, the medical model is found wanting.

The research presented in this chapter indicates that children and young people *can* and *do* internalize medical diagnoses; believing both that there is something organically wrong with them and that there is little they can do to change their situation. Interestingly, very few actually want to change *themselves*. However, by individualizing and pathologizing young people's reactions to the conditions in which they live, dominant treatment responses can reinforce the perception that both the problem and the solution lie inside the child's head, none of which is conducive to producing the conditions of possibility required for the development of agency and, ironically, the realization of wellbeing. For this reason, greater conceptual clarity around what it means to be "well" is urgently needed, as well as objective point-in-time analyses of young people's own beliefs and self-characterizations by the practitioners involved in assessing youth mental health and wellbeing.

Acknowledgements This research was supported under the Australian Research Council's *Discovery Projects* funding scheme (DP110103093) and a Macquarie University Concentration of Research Excellence (CoRE) grant. The views expressed herein are those of the author and are not necessarily those of the Australian Research Council. Ethics approval was obtained from the Macquarie University Ethics Committee (Final Approval No. 5201000654) and the NSW Department of Education and Communities (SERAP No. 2011027).

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Chapter 3
Vulnerability and Wellbeing in Educational Settings: The Implications of a Therapeutic Approach to Social Justice

Kathryn Ecclestone

Abstract Contemporary discourses of social justice in educational settings are refracted increasingly through three intertwined trends: (i) concerns about psycho-emotional and psychological vulnerabilities created by socio-economic exclusion and alienation; (ii) the rise of universal interventions to develop "emotional well-being"; and (iii) the legitimization of therapeutic ideas and practices in everyday and institutional life. In this context, new conceptualizations of social justice privilege the recognition of psycho-emotional vulnerabilities. These conceptualizations extend older forms of the psychologization of politics and society into a powerful popularized therapeutic version. This "therapization" of social justice elevates vulnerability in a particular way, both in educational settings and more broadly. This chapter explores the implications of these developments for ideas about what counts as "wellbeing" and empowering and progressive education.

Keywords Social justice • Vulnerability • Therapization • Empowering education

Introduction

In the crises of late capitalism that beset numerous countries, ideas about social justice are cohering around profound political and public pessimism, in particular about declining emotional and psychological wellbeing and rising levels of disengagement and poor motivation amongst growing numbers of groups and individuals deemed to be "at risk" (e.g. Coleman 2009; Dahlstedt et al. 2011; Sharples 2007; Sodha and Guglemi 2009). Although the traditions and commitments that generate these concerns are diverse, there is general agreement about the desirability of three inter-related goals: that educational settings are key sites for interventions that foster a virtuous circle of engagement, inclusion, participation and emotional

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K. Wright, J. McLeod (eds.), *Rethinking Youth Wellbeing*,
DOI 10.1007/978-981-287-188-6_3

wellbeing; that these interventions are crucial for overcoming cyclical problems with aspirations, achievement and employability (and therefore as important as traditional educational outcomes); and that barriers to education and subsequent educational needs are primarily psycho-emotional (see Ecclestone 2013a, b).

Between 1998 and 2010 – in all four countries of the United Kingdom – these goals led to government sponsorship of a large increase in targeted and universal initiatives to build the attributes and competences of emotional wellbeing in the present whilst also preventing problems in the future. Formal schooling, youth and family work, youth educational programs, transition and rehabilitation projects, adult and community learning have all promoted a range of approaches that aim, in different ways, to develop the attributes associated with emotional wellbeing, such as resilience, optimism, emotional literacy, self-esteem, confidence and stoicism (e.g. DfES 2005; Ecclestone and Hayes 2009; Humphrey 2013; Sharples 2007; Watson et al. 2012; Weare 2004).

Although the British Conservative-led coalition government withdrew formal sponsorship of centralized programs such the Social and Emotional Aspects of Learning (SEAL) Strategy for primary and secondary schools in 2011, there is little sign of declining enthusiasm for interventions to enhance emotional wellbeing. Nor has there been any abating of the concerns that underpin them. These concerns are multifaceted and not necessarily coherent: they include perceived declining levels of mental health, general disengagement from and demotivation in formal schooling, disaffection amongst many educators with curricula and assessment regimes, and a rise in behavioural problems (see Ecclestone 2013a, b; Humphrey 2013, for discussion). Outside compulsory schooling, there is growing enthusiasm in mainstream adult and community education programs for incorporating the goal of "mutual recovery" and support for those with mental health problems, as well as promoting emotional wellbeing more generally (Lewis 2012; Lewis et al. 2013).

Policies, practices and underlying imperatives for these developments are not homogenous or coherent, with disagreement amongst advocates and critics about the efficacy, ethics and appropriateness of different approaches (e.g. Lowenthal and House 2009). Nevertheless, wellbeing in educational policy and practice is now associated primarily with *emotional* wellbeing and mental health, while debates about wellbeing focus on which form of psychological intervention is most appropriate to promote it. Nevertheless, for the purposes of discussion in this chapter, it is important to note at the outset that direct interventions and programs are only part of the policy and practice context. The impact of "therapeutic culture" – namely the popularization of therapeutic claims, ideas and practices and new forms of lay therapeutic expertise – on everyday educational discourses and practices around wellbeing remains overlooked in current debates.

Drawing on policy, associated research and some examples of practice in the British educational system, this chapter explores the relationship between conceptualizations of social justice that privilege "vulnerability" and the shift from older cultural manifestations of "psychologization" to more powerful and pervasive forms of "therapization". It argues that this relationship narrows educational ideas about what constitutes wellbeing and shifts associated discourses and practices

towards various forms of therapeutic intervention. The analysis and arguments here also have implications for other countries where similar concerns and responses are evident, including Australia and Finland amongst others.

In grappling with these developments, I have revisited some influential ideas of American sociologist, C. Wright Mills. Writing in 1959, Mills urged social scientists to use what he called a sociological imagination, combining history, psychology and sociology in order to help people see that the troubles they experience as private individual troubles are really public issues that stem from wider structures of class, culture, economics and politics. Certainly, different historical periods influence what we see as private troubles and public issues. Yet Mills (1959) also asked a deeper question: how should we understand the varieties of men and women that seem to prevail in this society and in this period? What kinds of human nature are revealed in the conduct and character we observe in this society, in this period? I suggest that the rise of vulnerability as a public issue, its appropriation in notions of social justice and its manifestation as part of therapeutic culture have important implications for the "varieties of men and women" that come to prevail, and how educators regard and respond to their wellbeing.

I begin by summarizing how "vulnerability" has become prominent in official policy definitions and the challenges this poses to understandings of inequality and social justice. I then go on to chart the shift from older forms of "psychologization" in society, politics, social policy and education to a more popular, powerful and pervasive therapeutic manifestation as part of what some sociologists refer to as the "therapeutic society" or "therapeutic culture" (e.g. Furedi 2004; Nolan 1998; Wright 2011). In the third section, I draw on a small body of empirical work that has explored the consequences of therapeutically informed interventions for young people's agency and subjectivity. I conclude by highlighting implications of my analysis for the ways in which educators conceptualize "wellbeing" and the types of responses they deem to be empowering.

The Rise of "Vulnerability" in Concerns About Inequality

Educators have long been concerned about social and educational prospects for young people at the margins of education and employment, especially at key milestones in transition through the education system (e.g. Ecclestone et al. 2010; Hayes 2012; Lumby 2012). As Jacky Lumby (2012) observes, those responsible for ensuring young people's safe development to adulthood worry about their vulnerability, especially for those seen to be disadvantaged by their socio-economic or family status:

> ... From Willis's (1977) seminal study of the educational roots of inequality to more recent explorations of the burgeoning mental health and behavioural issues among adolescents, or the effects of globalisation on at-risk youth ... their fragility and degree of exposure has made many apprehensive. Education is depicted as a structural aspect of a risky

> environment, presenting perils which some young people fail to navigate successfully, with lasting detriment to their lives (p. 261).

The intertwining of concern about vulnerability, risk and fragility and the idea of building resilience amongst communities, individuals, institutions and government agencies is embedded in the areas of public health, security, social policy generally and educational policy specifically (see Durodie 2009; Ecclestone and Lewis 2014; Furedi 2008). Contemporary understandings of vulnerability blur notions of emergency, risk and crisis to encompass diverse fears, ranging from serious civil unrest, terrorist attacks and pandemics to everyday educational difficulties and dealing with social relationships (e.g. Furedi 2008; Durodie 2009). In part, a widening spectrum of risk and vulnerability is rooted in a formal redefining of vulnerability and the criteria to assess it. Under the previous Labour government, for example, the Law Commission's 1997 definition of vulnerability suggested that it applied to someone "who is or may be in need of community care services by reason of mental or other disability, of age or illness and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation". However, a much wider definition of vulnerability is reflected soon after in the Care Standards Act of 2000. This drew in those for "whom prescribed services are provided by an independent hospital, independent clinic, independent agency or National Health Service body", encompassing anyone in counselling or palliative care alongside other forms of prescribed support (see Brown 2012, 2014; McLaughlin 2011 for discussion, also Eves 2006).

The overall effect at the level of policy is to widen significantly those depicted by professionals, policy makers and the targets of social policy themselves as "vulnerable". These diffused and malleable criteria reflect changing rationales with diverse preoccupations and preferences. In her review of Labour and Coalition British governments' approaches to vulnerability between 1998 and 2010, Kate Brown (2014) argues that government appropriation of vulnerability serves various purposes: enhancements of state and professional power through therapeutic and disciplinary interventions, a necessary part of building citizenship, and justifications for strategies designed to justify new anti-social behaviour mechanisms and to reduce welfare provision (Brown 2014).

At the levels of everyday educational practice, it has become commonplace to hear teachers, support workers and other professionals refer informally to whole groups as "vulnerable" (see Ecclestone and Lewis 2014). This is reinforced by interventions designed to build young children's resilience as part of emotional wellbeing, such as Promoting Alternative Thinking Strategies (PAThS) program, which defines risks and vulnerabilities that require children to develop positive responses through alternative ways of thinking very widely, as feelings or experiences that make them "uncomfortable" (ibid). In some institutions, whole groups, such as adults following English for Speakers of Other Languages programs are categorized formally as vulnerable. In many educational settings, the overall effect of loosening meanings of vulnerability is to create a wide spectrum of risk encompassing serious structural problems and associated labels. This spectrum includes

the effects of divorce, bad educational experiences, witnessing or experiencing physical, sexual or emotional abuse, being bullied, failing examinations, being alienated or disaffected from formal learning or having a vulnerable or fragile learning identity (see Gillies 2011; Ecclestone and Lewis 2014; McLaughlin 2011; Procter 2013a, b).

In response to official categories of vulnerability, some researchers aim to counter the blaming of individuals for social problems. This recasts vulnerability as a progressive attribute of an understanding, empathetic citizenship, integral to the "fragile and contingent nature of personhood" where we are all "potentially vulnerable" and where vulnerability is a "universal" dimension of human experience and identity (Beckett quoted by McLeod 2012, p. 22). In this scenario, acceptance of universal vulnerability enables everyone to claim their right to "be protected from the effects of potential vulnerabilities [whilst] defending the rights of others to receive support in the light of their actual vulnerability" (Beckett ibid.).

In the area of social policy, however, other researchers argue against generalized notions and for the context-specific nature of vulnerability and protective effects (e.g. Luthar and Cicchetti 2000). This requires more focused attention from social, welfare and education professionals to understanding and developing people's resilience as a response to vulnerability and "attention . . . to empirically derived knowledge about vulnerability and protective mechanisms . . . salient within, and possibly unique to, particular risk conditions" (Luthar and Cicchetti 2000, p. 861). Subsequent interventions, they argue, need to be rooted in theory and research on the group being targeted and therefore sensitive to gender, class and cultural sensitivity (e.g. Gerwitz and Edleson 2007; Burchardt and Huerta 2008).

Some social researchers go further, arguing that it is possible to view both universal and specific vulnerabilities as sources of political resistance that illuminate structural inequalities and the deflection of social responsibility for them. From the field of mental health, Helen Spandler (2013) argues for seeing "illness" as embodying both negative and positive possibilities, as something to marshal in order to illuminate enduring oppressions of capitalism. In the broader context of concern about wellbeing, radical accounts of illness aim to offer wider hopes by de-stigmatizing vulnerability through collective narratives of suffering and placing lay expertise at the heart of de-centring professional definitions and diagnoses (ibid). Rejecting the normalizing and unrealistic aspirations of capitalist materialism for growing numbers of people, Judith Butler's account of "precarity" offers a fruitful way of analyzing vulnerability. As she argues:

> precariousess [is] a function of our social vulnerability and exposure that is always given some political form, and precarity as differentially distributed [is] one important dimension of the unequal distribution of conditions required for continued life . . . precaritization as an ongoing process [avoids reducing] the power of precarious to single acts or events. Precaritization allows us to think about the slow death that happens to targeted or neglected populations over time and space. And it is surely a form of power without a subject, which is to say that there is no one centre that propels its direction and destruction. (Butler, in Puar 2012, p. 169)

Whilst recognizing that universal depictions seem to offer an expanded, humane and socially just account of vulnerability, Julie McLeod (2012) argues that they risk overlooking profound structural differences and real vulnerabilities that lead to more powerful, damaging and unequal exclusions than others. Other critics go further, rejecting any progressive possibilities from intertwining vulnerability, risk and resilience. From this standpoint, Frank Furedi (2004) argues that popular and political sensibilities that see vulnerability as a universal human condition and a cultural norm leads to social policies that respond, not by aiming to solve problems but to support disempowered clients to face diverse vulnerabilities. Pervasive and pessimistic notions of vulnerability are, he argues, encouraged by policy experts who promote "risk analysis" underpinned by "vulnerability analysis" of the various forms of psychological, physical, economic, social and cultural "harms to which individuals and modern societies might be susceptible" (Furedi 2004, p. 651). In the light of these trends, Furedi argues that discourses of empowerment and resistance reflect lack of faith in the public's ability to be resilient and a defeatist pessimism amongst academics, policy makers and many social policy professionals about the future and how to deal with it (ibid.; see also McLaughlin 2011).

Such criticisms do not counter the growing tendency to see vulnerability as a progressive or radical/critical possibility for ideas about wellbeing and resistance (see Ecclestone and Goodley 2014). Emerging from long-running debates in critical and social psychology, sociology and cultural studies that seek to harness the cultural and political influence of psychological ideas and practices in progressive ways, the contemporary appeal of vulnerability shifts psychologization to a much more pervasive and popular therapeutic form. I explore this shift below, and the manifestations of vulnerability in everyday educational discourses that have emerged.

Psychologization, Therapeutic Culture and Therapization

Since the late 1950s, psychologists in both professional practice and academic study, together with sociologists, historians and cultural analysts, have engaged critically with the ways in which "psychological vocabularies and explanatory schemes enter fields which are not supposed to belong to traditional theoretical and practical terrains of psychology" (de Vos 2012, p. 1; see also Illouz 2008; Ingleby 1987; McLaughlin 2011; Parker 1995; Rose 1999; Thompson 2006; Wright 2011). This work evaluates critically an increasingly global and cross-cultural phenomenon where psychologizing discourses have spread across and into schools and families, and more widely into everyday life. In different ways, the critical accounts cited here aim to resist both the pathologizing of social problems as individual psychological deficiencies and the behavioural interventions that result, and to offer more emancipatory, lay-based and democratic approaches.

Some studies within this wider body of work explore the ways in which changing psychological fashions influence the understanding and subsequent assessment

and labelling of human character amongst educationalists, bureaucrats, health professionals, parents and young people, and the resulting psychological categories, diagnoses and practices that extend into politics, everyday and family life (see Myers 2010; Thompson 2006). Epitomized by the growing reification of official texts such as the Diagnostic and Statistical Manual of Mental Disorders (DSM), which is increasingly influential in British schools and other areas of psychological practice, some researchers have evaluated the roots, arenas of influence and consequences of medicalizing a growing range of behaviours, category disorders and syndromes (e.g. Harwood and Allan 2014; Lau 2012).

The popularity of DSM and wider interest in Cognitive Behavioural Therapy (CBT) and positive psychology in education settings in countries such as America, Britain, Australia, Finland and Sweden are high profile manifestations of psychologization (e.g. Dahlstedt et al. 2011; Kristjánsson 2012). There is also growing political interest in Britain and Australia in what might be called radical behavioural psychology. Here the world-leading work of the British government's Behavioural Insight Team is the first official initiative to draw directly on new combinations of neuroscience, emotional science, sociology, behavioural and cognitive psychology in order to generate overt behaviour change strategies (see Ecclestone 2013a, b; John et al. 2011; Jones et al. 2013). In response to this initiative, some researchers and activists in areas such as community politics and social policy more broadly hope that radical behavioural psychology will enable governments to address the psycho-social dimensions of inequalities and to democratize behaviour change (e.g. Brooks 2011; John et al. 2011).

From Psychologization to Therapization

Over the past 10 years or so, sociological analysis has extended earlier seminal accounts of therapeutic culture by Philip Rieff (1966) and Christopher Lasch (1978) to explore the mechanisms through which ideas, practices and assumptions from diverse branches of therapy that have come to permeate the social policy, legal and overseas aid systems of growing numbers of countries and evaluate their progressive or regressive consequences (Furedi 2004; Nolan 1998; Wright 2011; see also Durodie 2009; Moon 2009; Pupavac 2001). My own contribution has charted the roots, mechanisms and consequences of therapeutic culture in the British education system (Ecclestone and Hayes 2009). In Finland, Kristiina Brunila (2011, 2012a, b, c) has explored the effects of what she and I refer to as "therapization", namely the ways in which therapeutically informed programs for marginalized "at risk" youth change participants' perceptions of themselves, the causes of their profound structural problems and the solutions that therapeutic programs offer them.

There is not space here to do justice to the epistemological and political alliances, complexities and disagreements reflected in the growing body of work on therapeutic culture (see Wright 2011 for discussion). However, in the light of

discussion in this chapter so far, it is useful to summarize briefly the key features of therapization in educational contexts as two inextricably linked trends. The first is the very large growth of targeted or specialist interventions within social policy settings in numerous countries, alongside the rise of universal approaches derived from these. Their psychological roots are very diverse, ad hoc and eclectic, drawing on CBT, positive psychology, different strands of counselling, self-help, psychotherapy and psychology. For example, the British Social and Emotional Learning Strategy for schools fuses elements of person-centred counselling, emotional intelligence and CBT, while government-funded parenting support programs in Flanders must use one designated CBT techniques (DfES 2005; de Vos 2012).

Yet the shift in educational settings from specialist targeted methods for those deemed to have certain emotional, social and behavioural needs, to universal inclusive and preventative approaches is merely the most obvious manifestation of therapeutic ideas and practices. The second and equally important trend is more amorphous. Widely seen as the cornerstone of a progressive, empowering curriculum, therapeutic ideas and strategies also permeate older calls for pedagogies that aim to foster collaboration, empathy, confidence, self-esteem, resilience and a positive learning identity (e.g. Ecclestone 2013a, b; Priestley and Biesta 2013).

The intertwining of these characteristics of therapization parallels the growing popularity of self-sought therapy outside education settings and the powerful diffusion of therapeutic ideas, practices and assumptions throughout culture, politics and everyday life. Taken together, the manifestations of therapization provide a cultural sensibility or mindset that helps us make sense of ourselves, our problems and reactions to life events and those of others close to us, but also those of colleagues, public figures and celebrities (e.g. Furedi 2004; Nolan 1998; Wright 2011). Through a compelling set of commonplace orthodoxies, therapization opens up and popularizes claims and strategies derived from formal psychological and therapeutic practices. These claims and associated practical strategies portray an expanding range of experiences and life events as creating fragile identities or worse forms of lasting emotional damage that need to be explored and addressed through certain ways of thinking and other techniques.

In educational settings, policy discourses of vulnerability outlined above resonate powerfully with broader therapeutic orthodoxies about lasting legacies of emotional damage, emotional barriers to life and learning, emotional "baggage", being in denial or repressed, dysfunctional or manifesting "disavowal". As I observed above, expanding definitions of vulnerability generates professional, parental and student references to a very wide spectrum of vulnerability and risk. This spectrum combines with therapeutic orthodoxies to produce non-specialist attributions of motives and roots of behaviour for certain "types" of students or individuals (see for e.g. Brunila 2012a, b, c; Gillies 2011; Procter forthcoming). Reductionist derivations of psychoanalysis are also sometimes used to explain unpalatable political opinions or to "expose" unspoken or repressed reactionary attitudes behind expressed argument (e.g. Leathwood and Hey 2009; McLaughlin 2011).

As new manifestations of psychologization, popular therapeutic orthodoxies legitimize tight and prescriptive behavioural interventions such as PAThS as well as looser approaches such as SEAL. Therapization also encompasses very different political and educational commitments. In this context, vulnerability is not a general instance of therapization. Rather, therapization means that vulnerability is now manifest in a particular kind of way. This explains that while individual commentators, such as Judith Butler cited above, might resist behavioural psychology's appropriation of vulnerability, they are drawn into the sometimes useful and emancipatory insights that give therapization its appeal (e.g. Wright 2011).

Resonating also with critical accounts of mental health and vulnerability that seek to democratize professional expertise, therapization legitimizes lay experts in the form of lifecoaches, wellbeing trainers, consultants, mentors, personal development advisers, youth workers. In programs such as SEAL, the Penn Resiliency Program and Promoting Alternative Thinking Strategies (PAThS), decentering expertise enables children and young people to be trained to help peers develop therapeutic strategies (e.g. Humphrey et al. 2009; Procter 2013a). Although some experts may be trained in specific techniques, most offer popularized, eclectic combinations of them. Policy makers, other professionals or participants in interventions or mainstream students are therefore unlikely to regard them as "therapy people". By diluting therapeutic specialism, lay experts working inside the state and, increasingly, through publicly-funded private providers, expand state-sponsored therapeutic pedagogies and assessments. These features make therapization a cornerstone in debates about psycho-emotional dimensions of inequality and social justice.

The Therapization of Social Justice: Psycho-emotional Aspects of Inequality

In recent educational debates about social justice, there is a noticeable shift from the redistribution of material resources to the redistribution of relational justice in the form of social responsibilities, obligations and duties and through expanded notions of social and cultural capital that take account of emotional and identity capital (e.g. Gerwitz 1998; Griffiths 2012; Hayes 2012; Hyland 2009; Leathwood and Hey 2009; Lewis 2012; Reay 2012). Acknowledging power as integral to recognition, and *vice versa*, and asking how we can promote ethical ways of treating each other on a day to day basis, these conceptions of social justice raise questions at the macro level about how those who have structural forms of power treat us by drawing in what Nancy Fraser calls the "politics of recognition" and what Iris Young calls an "openness to unassimilated otherness" (Gerwitz 1998, p. 475).

My summary here cannot do justice to the nuances of meaning and disagreement in these debates. Nevertheless, a relational view of social justice moves universalist notions of justice towards an "ethics of otherness" and acknowledgment of cultural

identity on the terms of specific groups claiming recognition (Gerwitz 1998; see also McLaughlin 2011). This encourages welfare professionals and educators to adopt practices that foreground the need to listen to the pain of cultural loss amongst oppressed groups as they "co-author . . . joint narratives about problems, needs and claims" (Leonard, quoted by Gerwitz 1998, p. 476). Here an "ethics of otherness" and a "politics of recognition" are "important in so far as they provide an ethical and practical basis for relations marked by a celebration and respect of difference and mutuality" (ibid., 477). According to Ken McLaughlin (2011), radical social movements and identity groups seeking redress for cultural domination, non-recognition and disrespect place most emphasis on the demand for recognition.

More widely, advocates of the social justice possibilities of a therapeutic culture, argue that sociology has failed to attend to the problem of suffering, thereby offering a partial and diminished account of human experience (Wright 2008, p. 326; see also 2011). Acknowledging the tendency towards individualistic self-indulgent preoccupation with personal fulfillment, Katie Wright argues that, nevertheless, the cultural diffusion of therapeutic ideas and practices "has facilitated the assertion of individual rights to bodily autonomy, emotional wellbeing and personal safety" (2011, p. 48). Following this argument, both the rise of self-sought therapy in response to growing levels of anxiety and distress and government responses to the exposure of abuse and suffering within institutions, including the family, enable gendered, raced and classed experiences of suffering to be a springboard for personal and political action.

The progressive aspects of therapeutic culture she identifies challenge other accounts that lament the erosion of public and private spheres, the rise of emotional exposure and openness and narcissism and interest in the self (Wright 2011). Rather, the moral dimension of the multidimensionality of therapeutic culture is evident in the "valuing of the self, which entails recognition of suffering . . ." (Wright 2008, p. 333). Furthermore, she argues that critiques of therapeutic forms of state governance and de-politicization are overly deterministic and therefore overlook the emancipatory possibilities for personal and collective understandings of oppression and suffering (Wright 2011).

Whilst not relating their analysis directly to the manifestations of therapeutic culture, certain radical accounts of educational inequalities regard recognition as central to social justice. For example, Lydia Lewis argues that educational forms of recognition in adult communication redress cultural, symbolic and status injustices, and the emotional and psychological harms caused by "*non-recognition*, *the rendering of invisibility as a result of dominant cultural forms*; *misrecognition*, *being seen as lacking value and as inferior*; *and disrespect*, *being maligned or disparaged in everyday interactions or representations*" (Lewis 2009, p. 259). Here recognition affords a universalist understanding of shared humanity, where struggles for justice are linked inextricably to identity, the shaping of people's subjectivities, or senses of self in relation to the social world (Lewis 2012).

In educational settings, feminist debates depict exposure of, and attention to, the psycho-social effects and causes of inequality as a key source of recognition,

both as a precondition for social justice and an end in itself (see Leathwood and Hey 2009). In a similar vein, Diane Reay (2005) argues that understanding and exploring the psyche offers powerful political insights into the shaping of class, raced and gendered identities. She suggests that "the generative dynamic between thinking, feeling and practices" can illuminate "the psychic landscape of social class", where everyday and structural inequalities are framed and lived emotionally and psychologically (Reay 2005, p. 912). From this standpoint, there is a related shift towards knowledge of the personal, local and affective and the valorizing of the knowledges of oppressed groups as central to social justice. This acts simultaneously as a counter to alienating and target driven systems, a condition for educational success and a lynchpin in political consciousness (e.g. Reay 2012).

Resistance to forms of schooling and wider social conditions that create disaffection and disadvantage lead to an overt focus in both theory and pedagogic practices on the affective and relational dimensions of inequality, or on more general emotional and psychological barriers to learning as affordances for voicing inequality and oppression (e.g. Cramp et al. 2012; Hyland 2009, Leathwood and Hey 2009). For Leathwood and Hey, a feminist ethics of care requires attention to "the investments, feelings, fears, pains, pleasures and contradictory emotions entangled within the world of education". This ethic is not merely for students from oppressed and disadvantaged groups but also for educators working in new regimes of accountability and performativity whilst supporting increased demands to be available emotionally for their students in a mass higher education system (2009, p. 431).

Seen in the light of these arguments about social justice, a combination of vulnerability and therapization offers a politically and morally-informed way of developing "complex understandings of social reproduction and social privilege" as integral to "the cultivation and growing of dispositions of openness and positive recognition of the other ..." (Reay 2008, 1085; see also Wright 2011). In terms of everyday educational practice, communally rather than individually focused therapization encourages educational consciousness that leads to achievement, participation and confidence. For example, the creation of "learning communities" should privilege attention to the emotional stresses and highs that assessment creates for non-traditional students, and encourage them to collaborate in developing strategies for emotional survival (Cramp et al. 2012).

Informed by feminism, socially-progressive forms of therapization have the potential to challenge instrumental forms of emotional training for "employability", the separation of learning from support and the male, elitist construction of education as rational, reasoned and in pursuit of truth (e.g. Leathwood and Hey 2009). Indeed, challenging critiques of vulnerability as invariably defeatist and diminished, Leathwood and Hey argue that the "turn towards the emotional cannot be reduced to the claim of it being merely about showcasing 'damaged' subjects but is rather a way to re-theorize what is at stake when we deal in social difference" (ibid, p. 436).

In part, the emphasis on recognition, capabilities and the psycho-social dimensions of inequality synchronizes with attempts to depatholgize those at risk of

serious structural inequalities, summarized above. Recasting vulnerability as a universal dimension of human experience and identity and therefore a focus for resistance aims to destigmatize vulnerability as a springboard for political and social consciousness.

Of course, not all the educators cited here invoke therapeutic orthodoxies about the conditions that necessitate emotionally-focused pedagogy, assessment and knowledge as sources of recognition and justice. Nor do they advocate overtly therapeutic responses. Nevertheless, although some theorists of social justice, including Fraser, argue that recognition should not displace calls for economic redistribution, McLaughlin argues that emphasis is placed increasingly on removing what Fraser sees as barriers to "participatory parity" and, in a therapeutic culture, these barriers are cast predominantly as psycho-emotional (McLaughlin 2011).

Implications for Educational Practices

My analysis so far raises theoretical and empirical questions about the consequences of therapization for everyday educational discourses and practices. This requires critical scrutiny of the ways in which supportive or critical standpoints on therapization are often attributed in determinist ways to particular ideological perspectives. This makes it important to explore the forms of subjectivity and agency that emerge, not only from interventions that can be characterized as therapeutic but also from the wider diffusion and lay adoption of therapeutic ideas about social justice. Drawing on a small body of empirical studies of therapeutic interventions in educational settings, I turn here to consider forms of subjectivity and agency that are promoted by therapization, before indicating some empirical questions that further study needs to address.

In an earlier paper, Brunila and I argued for understandings which illuminate how forms of circulating power in programs that are underpinned by therapeutic assumptions and practices teach individuals not only to reproduce what is expected from them in the form of insights about their situation and compulsory participation in certain practices, but also how to use those insights and practices (Ecclestone and Brunila 2014). This approach rejects the idea that a person would or should fulfill the role offered by founders of particular discourses in a passive way. This means that we cannot regard therapeutic pedagogies and forms of knowledge simplistically as repressive or emancipatory, confining or empowering, humane or manipulative, elitist or democratic, masculinist or feminist (see also Wright 2011). Rather, forms of subjectivity and agency that emerge from therapization are not only in flux, changeable and unstable but also avoid evaluations of whether therapization is "good" or "bad", progressive or reactionary.

Studies cited below offer some insights into the ways in which therapization becomes embodied in the aspirations, mindsets, pedagogies and assessments of programs that adopt therapeutic ideas and practices with varying degrees of expertise and theoretical rigour. These studies also reveal some of the ways in which

ongoing negotiations and consequences might involve resistance, instrumental compliance, enthusiastic adoption, confusion or indifference among participants and implementers performing wellbeing "targets" in such programs.

For example, studies of school-based therapeutic programs for young children and young adults that have been trialed or adopted in British primary and secondary schools, such as SEAL, PAThS and the Penn Resiliency Program, hint at the ways in which participants and teachers enthusiastically internalize the therapeutic assumptions, discourses and subjectivities offered to them. Yet these studies also show that others resist in small and idiosyncratic ways, or are, variously, indifferent, compliant, confused and bemused (see Challen et al. 2011; Gillies 2011; Humphrey et al. 2009; Procter 2013a, b). More specifically, while some participants and implementers regard such programs as very helpful and positive, they can lead both parties to adopt learned techniques in order to manipulate others' emotions. For example, learning mindsets and behaviours associated with emotional literacy enable some children to deploy them strategically to get their way with parents (see Challen et al. 2011). Conversely, the supposedly transferable mindset and thinking strategies advocated for "resilience" can be dangerous for children when they try to use them in situations such as being caught up in parental violence (ibid.). Sometimes benefits and drawbacks in discourses and practices of emotional learning or emotional wellbeing are intertwined. For example, programs such as SEAL can offer an acceptable identity and helpful strategies to children who experience emotional and behavioural problems. Yet these can then generate normalizing judgments about that identity and the strategies that children are made to deploy from peers and teachers, thereby creating new forms of peer power and new essentializing labels (e.g. Procter forthcoming).

Brunila's study of compulsory programs in Finland that require young men experiencing unemployment, prison and educational failure to take part in therapeutic diagnoses and psychometric assessments followed by individual and group explorations, illuminates the subtle negotiations, responses, and their consequences (Brunila 2012a, b, c, 2013). She argues that these activities circumscribe agency through individualizing forms of speaking and being heard that involve confessing and then attending to psycho-emotional mistakes, legacies and vulnerabilities located in the self rather than society. Here therapization elicits and frames individuals' problems through expected and appropriate modes of being and knowing. Yet, when participants remain unable to enter educational or working life, this "failure" is cast as an individual deficit (see also Dahlstedt et al. 2011; Fejes 2008). In a similar vein, a study by Val Gillies of children in the Behavioural Referral Unit of a British urban school in a disadvantaged urban area showed the ways in which highly regulated, normalizing strategies to manage emotions that SEAL offers actually sidestep some of the challenges that arise from intractable poverty, racism and class oppression. For other young people, such strategies are useless in helping them manage the conflicting emotions these problems create (Gillies 2011).

Stephen Ball argues that we do not just speak a discourse, it speaks us (Ball 2013). Seen in this light, these studies illuminate how therapization speaks through language and social relations whilst also allowing us to think about how we are

"reformed" by therapization, how we learn to act in the power relations that such programs offer, as well as how to utilize them. These studies also show how alternatives and critical voices might appear through overt resistance to therapeutic approaches, or rejection of their usefulness and related questions about the absence of more meaningful educational experiences and outcomes in the face of unemployment and poor. It is therefore crucial to acknowledge critical voices within contemporary forms of therapization as resistance.

Nevertheless, discursive understandings require skepticism about discerning possibilities for resistance in therapization. In his study of the relationship between radical political movements, subjectivity and the distinction between public and private spheres of action, James Panton argues that political and social preoccupation with "absorbing the self in the world and reflecting the world in the self" diminishes individuals' capacity for, and interest in, action in the world. Rather, "collective or community life is understood as held together not by common experience or activity, but through the ability of individuals to 'disclose' themselves to each other" (Panton 2012, pp. 167–168).

This argument challenges accounts that argue the opposite, namely that therapeutic erosion of these boundaries are emancipatory and that attempts to defend those boundaries are invariably gendered and classed (e.g. Giddens 1992; Wright 2011). Instead, Panton argues that even when attempts to theorize outwards from therapeutic understandings and practices as a springboard for political understanding and action are highly sophisticated, they will fail because "the process of interpreting experience involves an explanation of experience in terms of something other than its own content" (Panton 2005, p. 21). Drawing on Sennett and Arendt, Panton argues that a sense of collective being has become confined to the orthodoxy that "*if there is no psychological openness*, *there is no social bond*" (ibid). Following this argument, therapization gains further legitimacy by blurring of boundaries between private and public life, where our professional and public relationships are increasingly expected to be modeled on intimate ones, through notions of emotional empathy and emotional disclosure, and mutual recognition of suffering. For Panton, then, therapization exacerbates a diminished individuality by prioritizing feeling over agency in the public sphere (Panton 2005; see also Sennett 1976).

Implications for Empowering Approaches to Wellbeing

I have argued in this chapter that new ideas about social justice emerge from a relationship between shifts towards a wide spectrum of psycho-emotional vulnerabilities that encompass risks created by structural inequalities, particular individual and social crises and everyday life and educational experiences, and therapization as pervasive, popular and powerful manifestation of psychologization. I have aimed to show that debates about social justice advocate a commitment to redistribution of social, relational and psycho-emotional resources, rather than a commitment to the redistribution of material goods per se. Within this context, I have argued

that therapization intensifies and extends older forms of psychologization by popularizing compelling orthodoxies and narratives about our own and others' experiences. It also generates new forms of expertise that respond to our increasing sense of psycho-emotional vulnerability in the face of structural conditions we no longer believe we can do anything about.

Despite my scepticism about these developments, it is important to assert here that I am not suggesting that people are not experiencing rising levels of stress, distress and anxieties, or that I am indifferent to feelings of vulnerability, or that I do not see connections between concern about vulnerability and social justice. Nevertheless, it is not yet clear how accounts of social justice rooted in these preoccupations translate into everyday educational practice, particularly in relation to the ways in which therapization responds to and creates certain subjectivities and notions of agency and, in turn, the ideas about empowering and progressive education that emerge. In-depth, comparative analysis of therapization in different contexts is therefore much needed. Here I indicate some implications both for practice and associated images of wellbeing.

These developments change how we understand wellbeing. As a result of expanding policy definitions of vulnerability and public and political concern about declining levels of emotional wellbeing and mental health, wellbeing is predominantly a psycho-emotional condition. As I've argued, formal behavioural programs depict it as a set of psychological capabilities, skills and dispositions. Seemingly more radical understandings rooted in commitments to social justice might reject crude behavioural explanations but end up, nevertheless, with a predominantly psychological view, albeit one augmented with broader social, relational and structural factors. For the former, different interpretations of therapization amongst promoters of behavioural interventions and critical educators lead for the former to learning about proper feelings and a healthy mental state as integral to a proper way of being. For the latter, therapization is a form of radical resistance to normalizing and invidualizing notions of a "proper" way of being and feeling.

On a prosaic level, the elevation of universal psycho-emotional vulnerability resonates with a powerful unifying therapeutic orthodoxy, namely that behind our confident facades, we "all have issues" with vulnerability, and that mutual recognition of this facilitates empathy. In his analysis of respect in crisis-ridden capitalist societies, Richard Sennett (2005) argues that public service and welfare professionals' guilt about their own relative privilege and their inability to address structural inequality leads them to "cross the boundaries of inequality" by privileging the promotion of clients' self-worth and showing empathy with their emotional and psychological experiences (see also Procter 2013a, b). Arguably, this is especially tempting in education where profound fears about growing pressures on those most marginalized and at risk of educational failure have eroded radical hopes for socially progressive mechanisms for equality, thereby creating the education system itself as simultaneously a main culprit in social injustice and an increasingly high stakes source of remedy (e.g. Hayes 2012). In both behavioural and radical/critical psychological depictions of wellbeing, much broader, older spiritual, philosophical and educational understandings are silent.

Conclusions

In different ways, both the governance of emotionally vulnerable subjects and resistance to it both respond to C. Wright-Mills' injunction to "make private troubles public issues" (1959/1979). In a contemporary version of Mills' argument, the therapeutic orthodoxy that we all "have issues" combines with "we are all vulnerable" to turn private issues into public troubles for educational settings to remedy.

In response to arguments that vulnerability is a form of resistance that speaks powerfully to uncertainties and anxieties in fearful times, it is important to scrutinize the effects of contemporary ideas about social justice on ideas about subjectivity and agency in formal interventions as well as in broader therapeutic discourses and practices. It is also important to extend ideas about children and young people's wellbeing beyond narrow psycho-emotional depictions. In addition, although I have not had space here to explore statistics and claims about levels of psycho-emotional wellbeing, it is important to challenge these and the widening and increasingly diffused meanings of stress, anxiety, depression and vulnerability that underpin them.

Accounts of the possibilities of therapization suggest that therapization in practice is not monolithic or coercive: instead, it holds conditions for its own challenge. Nevertheless, studies of therapeutic programs cited in this chapter also point to a need to scrutinize claims for emancipation and empowerment. From both standpoints, Brunila argues that we need to take account of Gil Deleuze's warning that this kind of power analysis might not be enough in the face of "control societies" and forms of power that permeate even further into mind and the personality, not only by grasping the body but also by shaping the "right" kind of mindset (Brunila 2012c).

The chapter also raises questions about whether these developments reflect the "neo-liberal" responsibilization of the psychologically and structurally independent individual citizen (e.g. Leathwood and Hey 2009; Spander 2013). I would argue that the state is not rolling back as part of a laissez-faire abandonment or abdication of psycho-emotionally vulnerable citizens. Instead, therapization enables the state to sponsor new pedagogies offered by lay and professional experts as an omnipresent source of authority for managing everyday emotional vulnerability whilst avoiding attention to the underlying structural conditions that create it.

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Chapter 4
The Limits of Wellbeing

Johanna Wyn, Hernan Cuervo, and Evelina Landstedt

Abstract This chapter addresses the complex interrelationship between wellbeing as a personal responsibility and individual experience and the reality that the parameters of wellbeing across populations are social, political and economic. It focuses on the issue of mental health, which is recognized as one of the most significant challenges to young people's health in developed countries. The nexus between social determinants of wellbeing and individual experience of being well is at the heart of the project of rethinking youth wellbeing. Drawing on longitudinal data from the Life Patterns research program about generation X and Y Australians, this chapter explores the relationship between contemporary social conditions – such as the increased time spent in formal education; the rise of precarious work; the fragmentation of time with significant others; and the tendency to combine study and work – and the deterioration of mental health rates. Data from the Life Patterns program suggests that young people experience wellbeing as yet another dimension of life in which they must perform to normative standards, and for which they are responsible. Rethinking youth wellbeing to acknowledge the social processes that shape emotional and social health leads to the conclusion that governments, institutions and workplaces bear responsibility for the mental health of young people.

Keywords Youth • Generations • Wellbeing • Mental health • Stress • Longitudinal study

Introduction

In Australia, young people are the healthiest age group in the population (AIHW 2007, 2011; APS 2011; Slade et al. 2009). The country's relative economic prosperity and the overall high levels of educational participation by young people are

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K. Wright, J. McLeod (eds.), *Rethinking Youth Wellbeing*,
DOI 10.1007/978-981-287-188-6_4

elements that are traditionally associated with high and improving levels of health and wellbeing (OECD 2011; UNICEF 2011). Yet in Australia, overall economic prosperity and increasing levels of educational participation have been associated with increases in some health problems, in particular, mental health problems, which represent the greatest burden of health amongst the young population (especially depression and anxiety disorders) (AIHW 2007).

Against this background, this chapter explores the relationship between youth and mental health through a consideration of the experiences of young Australians in Generations X and Y. It explores the relationships between youth and wellbeing by analyzing how social conditions circumscribe the possibilities of being well. Rethinking this issue has become an ever important task in late modernity, as wellbeing becomes an increasingly significant dimension of youth's lives through processes of responsibilization, and as a social issue. Young people's wellbeing is "a social concern and a personal quest, a public preoccupation and a private responsibility" (Wyn 2009a, p. xi). While acknowledging that both youth and mental wellbeing are more than social processes, this chapter focuses on youth as a social category and process, and on mental wellbeing as a social phenomenon. The chapter focuses specifically on mental health, our analysis draws on a two-decade old longitudinal study, the Life Patterns research program (Andres and Wyn 2010), to analyze the ways young people have navigated their lives through the social conditions of the early 1990s and beyond (for a cohort that corresponds with Gen X) and the mid-2000s (for a cohort that corresponds with Gen Y). We use a concept of "social generation", drawing on a sociological tradition that links back to Mannheim (1952), foregrounding the social dynamics of youthhood. We argue that just as the quality and nature of youth is historically distinctive, so too is the quality and nature of being "well". Wellbeing and particularly mental health is a crucial element of generational experiences and subjectivities and therefore opportunities for being well are both made possible and limited by the environment in which young people are living.

To illustrate this, we draw on data from the longitudinal study that shows a decrease in self-reported mental health for young people in both the Gen X and Gen Y cohorts. Various aspects of mental health in high school-aged youth, including a negative trend regarding psychological distress, have gained increased attention over the past decades (see Collishaw et al. 2010; West and Sweeting 2003). However, there has been less of a focus on young adults. The latest Australian National Survey of Mental Health and Wellbeing in 2007 showed that a quarter of young people aged 16–24 years had suffered from a mental disorder during the previous 12 months (ABS 2007). Evidence of an increase in major depression and perceived stress in young adults has also been identified by New Zealand and Australian research (Bell and Lee 2003; Fergusson et al. 2007). American and Canadian studies suggest poor mental health (depression and anxiety) increases over time but seems to level off at age 24 (Ge et al. 2006; Leadbeater et al. 2012). In the following sections we offer an analysis that makes an association with the conditions of life and the nature of youth in late modernity, and their social and emotional wellbeing.

This chapter contributes to an understanding of the interrelatedness of the concepts of youth and mental wellbeing. A central element in rethinking youth wellbeing is the recognition that both are social processes – social conditions shape how youth is experienced, and how "well" young people are able to be. Hence, the quality and nature of young people's wellbeing, in this case mental health, is an indication of the quality of social, political and economic conditions that surround them. Given that mental health problems are the largest contributor to years of life lost due to premature death, and years of healthy life lost due to disease, disability and injury (Slade et al. 2009), it is especially important to understand the relationship between social conditions and mental health.

Conceptualizing Youth Wellbeing and Mental Health

Wellbeing and mental health are broad terms that are used to encapsulate quality of life, happiness and satisfaction. Wellbeing is underpinned by conditions such as economic security, safety, connection to others, having a sense of meaning in life, having control over decisions in life and having positive personal relationships (Marmot and Wilkinson 2006; Wyn 2009a). We agree with the Australian Institute of Health and Welfare (AIHW) that mental wellbeing "is often difficult to define" and that "health is more than just the presence or absence of disease" (AIHW 2011, p. 14). As Wyn (2009a, p. 107) asserts, wellbeing is often used as "an umbrella term" that can encapsulate different "tensions and contradictions as well as overlapping dimensions". Further, Wyn argues that conceptual approaches to wellbeing are often dichotomized between "categorical" and "relational" frameworks. The distinction between categorical and relational approaches to wellbeing is summarized in this way:

> Categorical approaches define wellbeing as a property, outcome or *product* that can be measured at one point in time. Relational approaches define wellbeing as a *process* that is not fixed in time and that is a function of the relationships between individuals and groups and of social practices. Wellbeing as a category, something that can be enumerated and delineated in a universal way, locates wellbeing within individuals – it is something that they "have" more or less of, an individual property, skill or capacity that they can build, be given or have taken away. A relational approach locates wellbeing in the nature of the social processes and the social practices that inform their lives. From this approach, an individual's sense of wellbeing is *experienced* individually but is a reflection of their social relationships, including institutional practices (for example "health promoting schools") and personal relationships (for example, positive relations within families and at work). (Wyn 2009a, p. 107)

If wellbeing is a general term, mental health indicates a focus on specific aspects of wellbeing (Tengland 2007). The list of definitions of mental health is endless, although it is likely that most scholars would agree that mental health refers to an individual's emotional and psychological wellbeing as well as the presence or absence of a mental disorder (AIHW 2011). In contrast to a biomedical perspective focusing on biological markers and functional normality, we draw on a holistic

conception of mental health. This can be illustrated by the definition framed by The World Health Organization (WHO): "Mental health is a state of wellbeing in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community" (WHO 2004). In line with this approach, we use the concepts mental health and mental wellbeing interchangeably. Furthermore, a holistic view of mental health constitutes the foundation of the *relational* approach to both mental wellbeing and youth that we address in his chapter.

Experience of stress is central in this view of mental wellbeing. We follow Aneshensel's (1992) understanding of stress as a product of the discrepancy between limits on achievement imposed by external conditions and the needs, values, perceptions, resources and skills of individuals to achieve their goals. We draw on an established literature that documents the links between prolonged experiences of stress and poor mental health (Aneshensel 1992). In this chapter we report on survey-based self-reported ratings of mental health, as well as subjective experiences of stress, anxiety, worry and depressive symptoms as expressed by the participants in open-ended survey comments regarding their health to explore the relationship between young people's mental wellbeing and the conditions under which they are living. The focus is therefore on young people's subjective experience of mental health, not on psychiatrically defined symptoms or disorders. Self-report rating of health is a recognized valid indicator to measure health status (AIHW 2008). Further, we support the Australian Institute of Health and Welfare's (AIHW) claim that a "broader and holistic view of health" is needed and that "a person's perception of their own health has been shown to be a powerful, independent predictor of their future health and survival" (2008, p. 14). While in this chapter we do not have space to engage in a discussion of the distinction between discourses of mental health and the incidence of mental health in historical perspective, we note however that the idea of mental health has become part of everyday language and concern (see Sointu 2005), which complicates how mental health is measured and reported.

Conceptualizing Youth

The concept of youth does not refer to something real or innate – it is a signifier; it endows meaning to (arbitrary) age divisions and norms and relations as many youth researchers, including Jones (2009), Talbut and Lesko (2012), and White and Wyn (2013), have argued. For example, previous analyses of the data in the Life Patterns research program have explored the way in which the social conditions of the 1990s became framed by a "youth-as-transition" approach, popularizing the idea that the period of youth had become a new "extended" period of the life course (White and Wyn 2013; Wyn 2009b; Wyn et al. 2012), reflected in the label "emerging adulthood" (Arnett 2004).

The 1990s in Australia (and in many Western countries) saw the emergence of youth transitions (from school to work) as a problem. This had an economic

basis in the shift from economies based on industrial production and primary industry to economies based in knowledge and services (OECD 2007), and in the implementation of monetarist economic policies drawing on neoliberal ideas (Mizen 2004; Pusey 2010). For young people, this meant that youth labour markets collapsed; employment became precarious, even for graduates (through the deregulation of the labour market amongst other things); credentialism escalated, with educational credentials increasingly required for even the most menial jobs; and bridging education and employment became a long process requiring active navigation for a majority of young people (Andres and Wyn 2010). Since the early 1990s the challenge of "transitioning" into a conventional and secure adulthood has led youth researchers to seek to understand how young people negotiate these challenges (Furlong and Cartmel 2007; Leccardi and Ruspini 2006; Thomson et al. 2004). What is less well understood is how these challenges impact on young people's wellbeing.

Many analyses of youth transitions emphasize the active role that young people play in navigating complex social and economic environments, and the work that they do to form and hold the dispositions and forge the kinds of identities that enable them to gain a foothold in precarious labour markets and establish "adult" lives. For example, Stokes (2012) analyzed the work that young school-aged people do to forge "worker identities". Kelly (2001, 2006) has argued that young people in late modernity are almost compelled to develop an entrepreneurial, reflexive subjectivity that signals their acceptance of responsibility for navigating the risks created by social change. Drawing on the work of Foucault (1991) and Rose (1989; see also Miller and Rose 2008) these arguments explore the processes whereby individuals take personal responsibility for governing themselves in ways that are compatible with dominant political ideas. This process has also been analyzed as the project of the self, which involves an orientation towards constant self-management and self-surveillance against the "codes of success" that institutions provide (Beck and Beck-Gernsheim 2002, p. 140).

A Relational Approach to Mental Health and Youth

Although mental health is *experienced* by individuals (e.g. "I am well"), it is also a product of the *relationship* between young people and their social and physical environment. Seen this way, young people's mental wellbeing is a reflection of the quality of their social and economic relationships. Moreover, health, whether physical or mental, is central to the processes that constitute youth. Being well, against a backdrop of complex social and economic circumstances that they have little control over, is one of the dimensions of life that young people must navigate. As Rose (1999) argues, in late modernity individuals feel they have autonomy and freedom (to choose to be healthy) but are in fact obliged to make particular choices and to achieve particular outcomes. In this context, Beck and Beck-Gernsheim point out that maintaining health has become one of the most significant "projects of the

self" in which the body is seen as an outcome of conscious choices and actions, and health has come to take on a "transcendental meaning – a kind of secular salvation" (Beck and Beck-Gernsheim 2002, p. 141).

Despite the relevance of wellbeing to young people's navigation of their environment, research that draws on a transitions approach to understand young people's lives tends to relegate wellbeing to the sidelines (see Wyn 2009a). We argue that this is not just a result of a lack of attention, but an inevitable outcome of conceptual approaches to youth and to wellbeing, particularly mental health, that fail to sufficiently acknowledge the social and relational aspects of both. This, and the individualizing and universalizing elements of traditional approaches to youth and to mental health, compels us to "rethink" both.

As we explore in the following sections of this chapter, these conceptual issues are central to the framing of problems and solutions in relation to young people's wellbeing. We have drawn attention to the dichotomy between categorical and relational approaches to both youth and wellbeing because, as we argue below, it is timely to strengthen our understanding of young people and their wellbeing as social processes. The next sections explore in more detail how the social conditions that young people encounter both shape their experience of youth and limit the possibilities of mental health in very particular ways.

Challenges to Mental Health

The Life Patterns research program is a longitudinal study using a mixed-method approach, which involves two research techniques: surveys and interviews that generate quantitative and qualitative data. The combination of both methods allows us to check both pieces of data against each other, avoiding falling into over-simplifications or over-stating anomalies as a finding of research significance (Tyler et al. 2011). The interaction between both techniques and the longitudinal character of the study has assisted us to better comprehend participants' decisions and choices over these two decades and to understand how some decisions in one area of life affect another.

With regard to assessing mental health, participants in both cohorts were asked to rate their mental health on a scale from "very unhealthy" to "very healthy" in surveys. Self-reporting of health is "often used as an indicator of health status" (AIHW 2011, p. 14). Cohort 1 (Gen X, born in 1973) was asked during their late 20s and early 30s and cohort 2 (Gen Y, born in 1988–1989) was asked during their early 20s. Figure 4.1 describes a decline in self-report assessments of mental health over time for both groups, reflecting the changing nature of challenges over time. A comparison between cohorts is not within the scope of this chapter and has thus not been undertaken.

The most significant drop in mental health occurs with cohort 2 (Gen Y), between the age of 19 and 22, predominately during their tertiary education years (at least 85 % of participants in cohort 2 stated that they have done some study after leaving

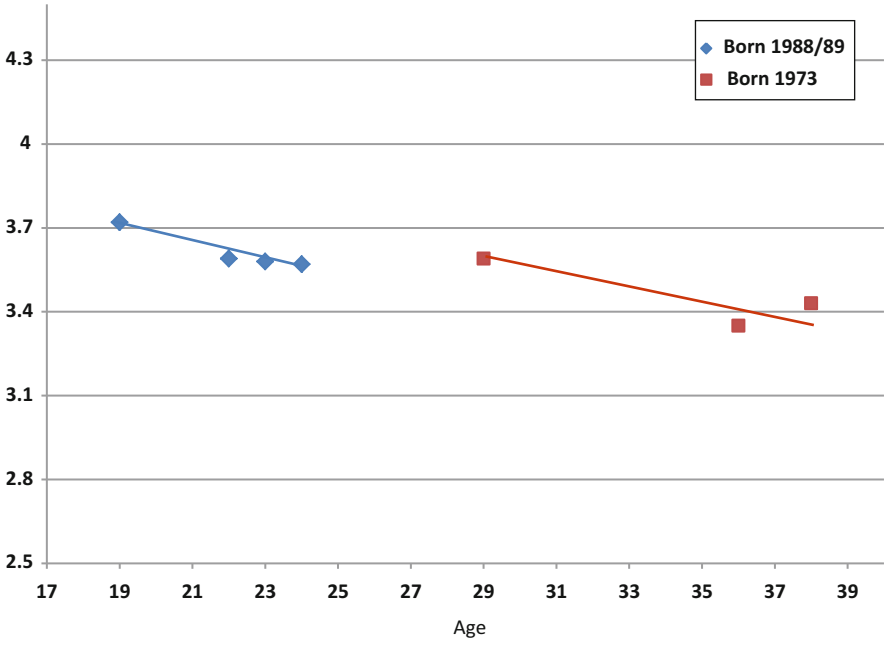

Fig. 4.1 Mean scores of self-rated mental health (range 1–5, very unhealthy – very healthy) over time for participants of Generation X (born in 1973) and Generation Y (born in 1988/1989)

secondary school). The mean of rated mental health for cohort 1 (Gen X), decreased from 3.59 at the age of 29 to 3.35 at 36 years of age. Time will tell whether cohort 2, as they get older, will also experience worsening mental health in their late 20s and early 30s. However, what we can conclude from these figures at this stage is that different sets of circumstances combine to "limit" the possibilities of mental health over time, and we can conjecture that for individuals the effects may be cumulative. Finally, perceived stress was not measured in the surveys on which this chapter is based. However, the recently finalized 2013 data collection for Generation Y shows a strong correlation ($r = 0.65$) between perceived stress and mental health. In the surveys, participants had the opportunity to write reflections and comments about their health. Both groups describe their experience of poor mental health as "stress", "fatigue", "depression" and "anxiety". As will be outlined below, they also linked their mental wellbeing to circumstances in their daily life. Our data suggests that a number of social conditions are contributing to the reported rates of poor mental health for both groups. For Generation X, the drop in mental health between 29 and 36 years of age corresponds to the establishment of employment and the difficulties to balance work, family and personal life.

In the following discussion we discuss four key issues that are evident in the responses of our respondents: performing health, life as a project, the problematic nexus between education and work and managing complexity.

Performing Health

Drawing on participant comments from open ended survey questions given by both cohorts, it became clear that young people experience significant pressure to perform well across various spheres of their lives: studies, work, career, parenthood and personal relationships. At different stages in their lives, participants expressed stress and anxiety deriving from the difficulties to keep up with their peers or conform to societal expectations of "progress"; particularly in relation to achieving a career path. For instance, this female participant from cohort 1, at 33 years of age, commented:

> There is too much pressure on young people today to have figured out by 16 years what they want to do for the rest of their lives.

In the 2011 survey, a male participant from cohort 2 in his early 20s said:

> I don't like the pressure applied by family and society that says I need to have a career. I'm not saying that I like being lazy, but I find it depressing, if you don't have a career you are nobody. I am feeling a bit trapped/lost at the moment and I associate it with the concept of having a career.

Their comments capture the acute awareness of social expectations by young people. They also allude to the paradox, highlighted by Rose (1989) and Miller and Rose (2008), of the (supposedly) autonomous, free and rational individual is that it is governed or steered from afar, by others. In health, as in education and other dimensions of life, this steering from a distance is consistent with neoliberal policy technologies that place the emphasis on performativity and accountability, and the marketization of any dimension of life (Cuervo 2012; Wyn 2009b).

The power of the "external gaze" is amplified by unpredictability and insecurity. This is because, as the participants in the research program have frequently explained, uncertainty provokes a need to keep options open. "I am keeping my options open" became a mantra of these generations, creating a *problem of choice*. As Melucci (1998, p. 181, italics in original) argues, "the paradox of uncertainty is that it is *impossible not to choose*". In this scenario, the responsible individual became not just an "autonomous individual" surrounded by supposedly multiple options but someone "obliged to be free" and actively choose a path "as if it were an outcome of choice" (Miller and Rose 2008, p. 18). Many of the stories of the people in this study reflect this tension: on the one hand, they expressed excitement about how they could shape their own lives through their involvement in education; and on the other hand, how choice and expectations created uncertainty and, as a consequence, stress.

For example, when Gen X participants were asked to reflect on their pathway into adult life, the *problem of choice* featured strongly in many of their comments:

> The most difficult thing I find is that my generation is probably one of the first to have all the options available to it. This is a problem as it makes you combine career, personal relationships, children, clubs/organizations etc. in one, so that somehow you end up feeling that you haven't done the best job in any of them. (Female participant, age 27)

> Too many opportunities/choice creates a new kind of stress. Today is moving so fast that I feel too many of us don't take time out and this is a concern. It may be a contributing factor to our suicide rates. Society gives higher expectations today than 50 years ago. (Female participant, age 27)

These comments reveal the challenges that "the pace of change, the plurality of memberships, [and] the abundance of possibilities" thrust upon young people, changing the goalposts that held firm for some decades for previous generations (Melucci 1998, p. 184).

Life as a Project

An awareness of the project of actively building their lives was central in the comments provided by both generations, crucial components of which were: certainty of goals, hard work and ability to conform. Working for a successful career was perceived as exciting yet demanding and comes with a price mentally and physically, as described by this female student from cohort 2, aged 22, in 2011:

> I have overloaded myself with university, part-time work and work placement. I feel tired all the time and fall asleep on the tram and in class. I feel like I get sick more often because of this but there's not a lot I can do if I actually want to turn my university studies into a career . . . I know I brought this on myself but it seems this is the only way for Gen Y to function and have a "successful" career and a "successful" life. The pressures for people my age to have successful careers whilst still maintaining an active social and family life as well as partaking in leisure activities, social work, personal relationships and physical activity put a lot of strain on our health and ability to do everything we need to do to the best of our ability. Most of my friends are working just as hard as or harder than me and I still haven't worked out whether these pressures are self-imposed or society-imposed. My parents certainly don't want me working this hard but I feel I need to. I support myself entirely.

This comment illustrates the complex nature of the relationship between young people and the institutions and social practices. This complex relationship between individuals and institutions is informed by the acceptance of responsibility for risks that are created by institutional arrangements and labour markets. As many researchers, including Ball (2001), Kelly (2006), Walkerdine et al. (2001) have explored, individuals are encouraged to add value to themselves, to be entrepreneurial and productive – carrying with them high (self) expectations that might lead to disappointment and a feeling of guilt and underachievement. Participants in this research program have been no different. Regardless of age or their structural location, they have consistently reflected on their progress, including feelings of disappointment and dissatisfaction of where they were in life. Like many of the voices above, what seems to come out of the burden of having to choose among multiple options and the responsibility to keep all options active and open is an unavoidable sense of disappointment and loss (Melucci 1998). Most importantly, Melucci (1998, p. 180) alerts us to the proliferation of social roles and times (i.e. inner and social times), to which adapting these to "our inner world" is always

a challenge and where the "gap is too large to be filled, we experience unease, suffering and, in the most serious circumstances, illness".

In response to the increasing uncertainty in everyday life, participants revealed a high level of individual responsibility for fulfilling the moral imperative of staying healthy (see Wyn 2009a). Reflecting on two decades of work, Miller and Rose (2008, pp. 5–8) argue that in this risk society the "the administration of the self" responds to practices of subjectification, "a mode of action on actions", an approach that views human subjects as autonomous and rational individuals not only capable but needing and willing to constantly choose, be self-reflective, master and improve themselves (and their health). This "administration of the self" encourages and demands the "engineering of conduct and the normalizing of behaviour" (p. 5). Most pervasively, they show the incorporation of "rationalities and technologies of markets" (p. 15) advancing into social areas like health and education. It is clear from participants' comments a sense of moral obligation to stay healthy.

Young people also face the difficult project of achieving financial stability, and this is a central condition shaping the lives of students and non-students. In the case of students, a recent report from Universities Australia shows increased levels of financial distress between 2008 and 2012 (see Bexley et al. 2013). Patterns of social and economic inequality are also having an impact on youth mental health. There is an indication of a widening gap in the levels of distress experienced by students in a stable financial position compared with those in disadvantaged situations (for example regarding housing and financial support from family (Cassells et al. 2012). As the time spent in formal education is increasing, so the time spent in adverse circumstances of financial stress increases for the disadvantaged.

The extended time spent in financial stress in turn increases the risk of subsequent stressful episodes and poor mental health (Turner and Turner 2005). As a result, adverse circumstances are likely to generate cumulative negative effects on mental wellbeing. Given that Generation X went through similar social and economic conditions as Generation Y in their early 20s, it is possible that the relatively poor mental health reported by Generation X at age 29 might be a result of the cumulative effects of adverse circumstances, adding to the challenges some experience in securing a full-time position in the labour market and forming a family.

The Precarious Nexus Between Education and Work

Participants' comments from both generations also reveal the increasing precariousness of the relationship between the fields of education and work, as they experience the reality that tertiary education degrees do not guarantee a safe and smooth passage from student to worker (Ball 2006; Brown et al. 2011; White and Wyn 2013). A comparative analysis of the life of Generation X in Australia and Canada reveals the challenges confronted by the former in achieving a "secure, well paid job" that could provide financial and emotional stability (Andres and Wyn 2010). According to the authors of that study, it took the Australian cohort more than a decade to achieve

this goal. This has been a source of stress and disappointment for this generation, particularly, as indicated from earlier surveys results, they predicted they would arrive to that position earlier than they did. The comments of these 31 year old male and female, respectively, illustrates concerns about the limited opportunity to gain full-time permanent positions and how this contributes to insecurity, uncertainty and financial stress.

> I was told that university degrees were vital in getting a job and having a future. This seems to be true for teaching, nursing and accounting graduates. Job security seems to be very scarce now – lots of short term contracts but no full time jobs.

> I'm finding it very hard to find any full time work as most jobs tend to be part time or casual. House prices are so high, you need to either have a partner to help financially or have a very secure job with a high salary.

Data from the 2011 survey with the second cohort reveal that Gen Y are less optimistic than their counterparts in the Gen X cohort about the possibility of achieving a "secure, well paid job" by their late 20s. Although they have an awareness of the tenuous relationship between the institutions of education and work, they are more likely than the previous generation to believe that additional investment in tertiary education will result in a meaningful position in the labour market (in 2012, a quarter of participants who already held a tertiary education degree believed they needed a second degree to secure a position in the job market). Despite this awareness, the difficulty of finding a job in the industry for which they had been trained is already having an impact on their mental health. The comments of these male and female participants at the age of 22 and 24, respectively, illustrate this point:

> Mentally I am not feeling as positive as I usually am because of the uncertainty of my future after completing my degree this year. I don't know if I will get a job in the career I was looking for or even if I will find full time employment.

> I have felt depressed as a result of not finding employment after university and experiencing a change and lack of routine due to the completion of my university studies.

The weakening relationship between education and work, that has contributed to create an environment of uncertainty that permeates the comments of these two generations of young people, has been identified by youth researchers as a source of stress (Furlong and Cartmel 2007). What is also clear from participants' perspectives is that in the last two decades young people have experienced a proliferation of guidelines, options, pathways, routes, and a call to make the most of these opportunities by actively shaping their future (Woodman 2011). This process has occurred at the same time that the Australian labour market has been defining itself as one of the most precarious in the world (Stokes and Cuervo 2009). The need to play an active role in managing the risks derived from complex social and economic scenarios – including acquiring the necessary dispositions to succeed in them – is identified in their own words as producing pressure and stress.

Managing Complexity

The proliferation of social roles and time schedules during the "student years" and beyond contributes to the challenge of managing complexity. In 2010, 85 % of the Gen Y participants who were studying combined it with part time work – a situation that was frequently expressed as stressful and mentally draining. By the age of 23, 41 % of students reported they needed to both work and study but found it difficult combining them. The driving force behind mixing work and study was in most cases financial and many students expressed concerns about their financial situation and how it influenced their lives in terms of dependency, lack of stability, stress and poor mental health. The following quote by a male participant from cohort 2, age 23, illustrates a generational concern:

> I need part-time work to supplement my youth allowance while at university. Lack of money for basic essentials and rent is hard. Youth allowance does not cover the high rents and the living expenses – food, petrol, car costs. Financial pressures affect me mentally and this flows on into my study, affecting my clarity of thought in study, assignments and exams.

Work and study were not the only commitments identified by young adults in both cohorts. Managing the balance between study and work commitments, family and social relationships and staying healthy have been key aspects of both generations' lives. A strong issue that has been pointed out by members of both cohorts over the years is that they feel "time poor" and they have reported that this has a significant impact on their mental wellbeing. For example, this female participant from cohort 1, in her late 30s, commented:

> I have suffered anxiety attacks and depression in recent times. Likely as a result of too many pressures and stress in my life – children, working 2 part time jobs and maintaining a house.

This generational peer, 10 years ago in her late 20s, had to say:

> I'm finding it very difficult to maintain a healthy work/life balance at the moment. There is so much pressure from work to work long hours (65 hour weeks). By the time the weekend rolls around, I'm exhausted, and find it very difficult to find energy and time to find a partner/person I'd consider for a personal relationship. This is not what I want for my life.

The experiences of cohort 1 reveal that securing a job and achieving a career creates its own stresses. Participants in cohort 1 reported that the demands of work, in combination with long working hours and unpaid overtime left them worried, stressed and exhausted. According to 2011 survey data, 30 % of cohort 1 reported that they feared the amount of stress in their work was going to make them ill. In this same survey, this female participant commented:

> High levels of stress caused by long hours and heavy workloads have had an extremely negative impact on both my mental and physical health. This has been to the extent that I will be resigning from my current position and taking some time off from work.

Gen X made it clear that working long hours was expected at early stages of their career: "in order to get somewhere you need to put in long hours to show your commitment." This was also understood by participants in cohort 2; including a strong awareness of the precarious nature of the labour market (Cuervo and

Wyn 2011). Despite this awareness of the structural conditions of employment, many participants in cohort 2, like this male (age 24), showed stress in relation to their work conditions, opportunities and future:

> The nature of the work (including volunteer work) that I do creates a lot of stress and pressure which impacts my physical and mental health. I am so time poor and weary after work.

The data presented here describe a situation where the feeling of being under pressure, concerns about under-achieving and experiences of stress are chronic (e.g. during university exams, mixing study and work, seeking a secure job). This is associated with social, economic, cultural and political conditions that both Generations X and Y are compelled to contend with. Dominated by a youth-as-transition approach, much youth research has overlooked the social and emotional elements of social generations (see for example FYA 2013), and has thus contributed to an individualizing of mental health problems that hides from view the ways in which normative patterns of life for successive generations limit the possibilities of wellbeing.

Concluding Remarks

Our analysis of two generations of young Australians provides insights into the interrelatedness of youth and mental wellbeing as social processes. This contribution to the conceptual task of "rethinking youth wellbeing" invites a consideration of the ways in which social conditions in Australia for Generations X and Y have framed (and limit) the possibilities for being well. We have drawn on a framework of social generation to understand the distinctive nature of youth in Australia over the last quarter of a century. The analysis has highlighted the multiple ways in which young people take personal responsibility for risks, uncertainties and challenges that are not their making. We have argued that poor mental health amongst Australia's young population are attributable to distinctive sets of conditions (employment uncertainty, fragmentation of time with significant others and financial hardship) that are heightened during the "student years" (when they are aged between 19 and 24). These conditions jeopardize the mental health of a significant proportion of young people, who experience damaging levels of stress. Our evidence suggests that over the "student years" elements that contribute to poor mental health are cumulative. Based on the analysis of participants aged in their late thirties, we suggest that although the specific conditions that contribute to poor mental health during the "student years" become less significant over time, new sets of conditions including managing the work-family balance, as well as a continuation of conditions experienced in earlier years (such as precarious work), influence mental health.

Making personal adjustment in their lives has been one of the most challenging issues for both generations; this, in turn, has had a significant impact on their mental wellbeing. For both generations, spending more time with their family and

friends has been a top priority in their lives – but this has become increasingly difficult for those with fewer resources and in need to constantly study and/or work. While a majority of the young people in the Life Patterns study have managed the pressures of juggling complexity well, we identify a significant minority who do not. Acknowledging the challenge of identifying a causal link between specific social conditions, the experience of stress and of poor mental health, our analysis highlights the limits that stressful social conditions place on mental health. The patterns of self-reported mental health by Life Patterns participants resonates with the sociological distinction by C. W. Mills (1959) between personal hardship that is part of one's personal milieu and public issues that are matters of social structure, involving the interpenetration of social institutions that impact on many individuals. Although personal troubles in the form of poor mental health can be addressed at an individual level, when patterns of poor mental health are an outcome of social systems and institutions, their solutions lie in addressing the social determinants of health.

The challenge, in rethinking young people and wellbeing, is to acknowledge that chronic levels of poor mental health require new solutions. Educational institutions and workplaces can be healthier places for young people. We have already identified how traditional assumptions about health emphasize the responsibility of young people to make themselves healthier – and have demonstrated that young people hear this message. It is timely to consider the responsibility that governments, educational institutions and workplaces have for the mental health of their young people.

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Chapter 5
Constructions of Young Women's Health and Wellbeing in Neoliberal Times: A Case Study of the HPV Vaccination Program in Australia

Kellie Burns and Cristyn Davies

Abstract This chapter explores how the concept of wellbeing is operationalized in policy and practice, constituted as health's more flexible and well-rounded counterpart. Drawing on Foucault's (1991) analytics of governmentality, we argue that "health-as-wellbeing" is mobilized as a modality of neoliberal government. Taking the Australian Human Papillomavirus (HPV) vaccination program as a case study, we explore how discourses of healthy citizenship, HPV and HPV vaccination are produced and consumed through conjoining discourses of health and wellbeing. We analyze the initial televisual and online promotional materials that targeted girls and young women alongside data from a qualitative research study about the school-based HPV vaccination program. We argue that the shift from health to health-as-wellbeing produces and manages contemporary subjectivities through a range of pedagogies and consumptive practices that position individuals as free-choosing agents and managers-of-the-self. We illustrate how the discourse of health-as-wellbeing is employed to mediate knowledge about HPV and HPV related cancer, and to construct the norms of healthy and gendered citizenship.

Keywords Human Papillomavirus • Neoliberalism • Sexual health • Vaccination • Youth wellbeing

Introduction

In recent years, wellbeing has been operationalized in policy and practice as health's more flexible and well-rounded counterpart. The concept of wellbeing has enabled an extension of approaches to health that move beyond the biomedical to consider

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K. Wright, J. McLeod (eds.), *Rethinking Youth Wellbeing*,
DOI 10.1007/978-981-287-188-6_5

the psychosocial, economic and even spiritual determinants of health. Drawing on Foucault's (1991) analytics of governmentality, we examine how "health-as-wellbeing" has come to operate as a modality of neoliberal government. We argue that the shift from a fairly narrow definition of health towards a broader conceptualization of health-as-wellbeing produces and manages contemporary subjectivities through a range of neoliberal pedagogies and consumptive practices that emphasize self-responsibility and proactive agency as necessary and normative ideals. Under the conditions of neoliberalism, individual citizens are positioned to take up these ideals in producing themselves as healthy, responsible and empowered citizen-subjects.

To explore the ways in which health knowledge is produced and consumed through discourses of health and wellbeing, this chapter takes as a case study the Australian Human Papillomavirus (HPV) vaccination program. We analyze the vaccination program's initial televisual and online campaign materials that promoted the program to girls and young women, alongside data from a qualitative research study about the HPV school vaccination program in the Australian state of New South Wales (NSW) that initially targeted girls in early high school.[1] We illustrate how neoliberal technologies associated with health-as-wellbeing – personal responsibility, choice, agency and risk-management – mediate knowledge about HPV and HPV related cancer, constitute girls and young women as a target audience for the vaccine, and uphold the norms of healthy citizenship. We argue that while the campaign promotes discourses and practices associated with health-as-wellbeing, the erasure of knowledge about HPV and its associated disease risks means that young women and girls are generally not aware that they have *not* been taught fundamental information regarding their sexual health.

In relation to HPV vaccination at the time of this study, we argue that health-as-wellbeing discourses served to elide key sexual health knowledge that may be controversial or contentious, given that HPV is a sexually transmitted infection. There is an expectation that girls and young women will choose to get vaccinated as an investment in their future health and wellbeing without having access to user-friendly, accessible, relevant information about HPV. Girls and young women are a vulnerable population in this context because their healthy citizenship is *in the making*.[2] School-aged girls are particularly vulnerable, especially when

[1]The national rollout began in 2007 across Australian states and territories. In NSW, Year 10, 11 and 12 girls were vaccinated in May, 2007. In 2008, girls in years 7, 8, 9 and 10 were vaccinated. These 2 years were part of the "catch up program" which ensure maximum coverage across year groups. From 2009, all year 7 girls entering high school were offered the HPV vaccine as part of the broader NSW school-based vaccination schedule.

[2]In Australia, young people can apply for a Medicare card from the age of 15 years. An Australian Medicare Card is issued to individuals or families (permanent residents of Australia except those residing on Norfolk Island or those deemed not to be residing in Australia) who are eligible to receive a rebate of medical expenses under the Australian Medicare system when a doctor treats them privately with a provider number. A Medicare card is required for claiming a Medicare benefit, visiting a doctor who bulk bills, seeking treatment as a

schools and parents/guardians do not involve young people in decisions about their health or provide them with accurate, evidence-based information about HPV and HPV vaccination (Cooper Robbins et al. 2010a, b). While discourses of health-as-wellbeing position girls and young women to take responsibility for their health, within the school-based vaccination program, our research indicates that the target audience were not provided with adequate, relevant sexual health information to understand just what this responsibility entailed. Similarly, parents/guardians whose legal responsibility it is to make health choices for young people in their care also did not feel adequately informed (Burns and Davies under review).

This chapter begins with an analysis of health-as-wellbeing as a modality of neoliberal government, followed by overviews of HPV and the Australian HPV school vaccination program. The research methodology employed is then outlined and the tenets of our theoretical approach elaborated. We then turn to analysis of data collected on the HPV vaccination program and discuss key themes that emerged, namely in relation to personal responsibility and choice, and risk reduction and knowledge production. In offering this critical reading of HPV-related knowledge it is important to establish that our critique is not aligned with anti-vaccination rhetoric and we acknowledge the significant impact HPV vaccination has had on HPV-related cancer presentation rates (Szarewski et al. 2012). Our focus is on understanding emergent discourses of health and wellbeing within a neoliberal era in Australia, and specifically, the ways in which girls and young women are positioned in the knowledge cultures of public health campaigns, programs and pedagogies.

Health-as-Wellbeing and the Production of Healthy Citizenship

The term wellbeing offers a holistic and multidimensional view of health beyond traditional definitions that focus merely on the absence of disease or infirmity. Extending understandings of health towards the notion of wellbeing broadens perceptions of health causes, dimensions and treatments to include the social, economic and political determinants of health and takes into account behavioural and attitudinal factors that impact morbidity rates and disease burden (O'Brien 1995). Martin O'Brien analyzes the social and political implications of an extended view of health that incorporates the tenets of wellbeing. He maintains that it is not only the range of health beliefs and modes of health knowledge that have broadened through the conceptualization of health-as-wellbeing, but also the modes of health intervention and surveillance. Health-as-wellbeing, he argues, produces a "systemic

public patient in a public hospital or having a Pharmaceutical Benefits Scheme prescription filled. Before the age of 15 years, parents/guardians are legally entitled to make health decisions for their children. See: <http://www.humanservices.gov.au/customer/subjects/young-people-becoming-independent#a5>, accessed 12th December 2013.

surveillance process" (O'Brien 1995, p. 195) in which there is continual monitoring of health practice, lifestyle, behaviour patterns and even modes of thought about what defines healthy living. In other words, an expansion of what constitutes health results in concern for a broader range of health matters. Michael Kelly and Bruce Charlton (1995) contend that health "has expanded out of control. Cut loose from disease-based definitions of science and medicine, it has become a commodity and like all commodities is available in the marketplace" (p. 83).

The notion of wellbeing has grown in use and popularity in Western cultures, with a broad focus on lifestyle, happiness, body-mind balance, mental stability and hygiene (Jack and Brewis 2005; Sointu 2005, 2006). Discourses of wellbeing and wellness now proliferate across a range of government sectors and public institutions, and buoy a range of traditional and emergent markets: education and training, therapy and counselling, alternative and complementary medicines, food, fitness, beauty and cosmetics, fashion and the media. Getting or keeping "well" is mediated through the marketplace and citizens are positioned as agentic consumers of healthy living with a broad scope of consumptive freedoms and choices. In her analysis of British newspaper references to wellbeing from 1985 to 2003, Eeva Sointu (2005) notes a significant shift in the dominant tropes of wellbeing over the mid-1980s to the latter part of the decade and into the 1990s. She maintains that wellbeing in the mid-1980s was a term used to refer to the "body politic"; the wellbeing of a citizen was produced and conceptualized through institutionalized strategies of national governance. From the late 1980s, however, wellbeing was mobilized more in the context of the "body personal", placing a greater emphasis on the active and choosing consumer-citizen who is responsible for his/her own achievement of wellbeing. Self-responsibility not only became a norm, but a means of governing individuals who would come to see themselves as autonomous and free-choosing in their wellness pursuits.

Inequities arise in broadening health beyond its scientific and biomedical origins towards an idea of wellbeing that is produced and managed in large part through the marketplace. Those who are better resourced have a greater number of opportunities to achieve whole-health than those who are under-resourced (O'Brien 1995). Broadening health to include a wider range of variables and risk factors means that individual citizens are not only asked to consider and be responsible for a greater number of health promoting behaviours, they are also expected to be accountable for a greater number of health deficiencies - bad health choices, an unhealthy lifestyle, failure to consume healthy products or options, and so on.

Like Sointu, we understand wellbeing as a project of the self and, following Nikolas Rose (1999), we theorize the expansion of health discourses to incorporate the tenets of wellbeing against the current neoliberal governmental context in which traditional modes of governance have been replaced by an array of technologies of self-management and self-work. We position O'Brien's (1995) notion of health-as-wellbeing as a neoliberal governmental technology that produces and manages contemporary subjectivities through a range of pedagogies and consumptive practices that position individuals as free-choosing agents and managers-of-the-self. Within this context, as we have noted, wellbeing operates as health's more flexible

and well-rounded counterpart, extending health knowledge and approaches beyond the biomedical and functional body to accommodate the psychosocial and spiritual dimensions (i.e. body *and* mind) of personal and community health.

Health-as-wellbeing promises new modes of subjectivity that value freedom, choice and self-responsibility. Pedagogies and commodities of wellbeing offer individuals new ways to "narrativize their lives, new ethics and techniques for living which do not set self-gratification and civility in oppositions . . . but align them in a virtuous liaison of happiness and profit" (Rose 1999, p. 86). Individuals thus uphold the order of the citizenry by taking responsibility for themselves and fashioning a particular (healthy) lifestyle through acts of choice and consumption. Maintaining health remains the political objective, but state bureaucracies are not required to monitor the choices and behaviours of the citizenry (Rose 1999). Instead, "in the new modes of regulating health, individuals are addressed on the assumption that they *want to be healthy*, and enjoined to freely seek out the ways of living most likely to promote their own health. Experts instruct us as to how to be healthy, advertisers picture the appropriate actions and fulfilments and entrepreneurs develop this market for health" (Rose 1999, pp. 86–87). The healthy citizen-subject works towards his or her state of "wellness" by incorporating expert advice and making the right consumer choices within the marketplace. Citizens are thus "expected to avail themselves of 'expert' assistance that is ideologically embedded within the prevailing neo-liberal order" (Fisher 2008, p. 585).

Paradoxically, constructing oneself as healthy in the current neoliberal context is mediated through hegemonic notions of healthy citizenship, which are at odds with the promise of an authentic and personal health journey engendered in contemporary understandings of wellbeing. While individuals are positioned as freely choosing products and practices that will optimize health and wellbeing, the ideal of informed choice is mitigated by normative ideals about what constitutes good practice (thus rendering choice something of a non-choice?), and by a lack of available information that makes it difficult for consumers to actually be knowledgeable about the choices they are making.

In the sections that follow, we explore this in relation to vaccination, focusing specifically on HPV and HPV vaccination within the Australian school-based vaccination program. We also examine the associated national promotional campaign, which while not targeted specifically at school-aged girls, was prominent in establishing public discourses about cervical cancer and the vaccine.

HPV, HPV Vaccination and the National Vaccination Promotional Campaign

HPV is a sexually transmitted infection linked to 70 % of cervical cancer cases globally (Frazer 2010). There are more than 40 types of HPV, some of which can cause genital warts, and some of which can cause cervical, vulva, vaginal, penile, anal, and tongue and throat cancers. In Australia, cervical cancer affects more than

700 women annually, while just under 70 men are affected by penile cancer each year. More than 300 women and men are affected by anal cancer and more than 500 are affected with throat cancer (Australian Institute of Health and Welfare [AIHW] 2005). The HPV vaccine currently available in Australia is called Gardasil®, which is a prophylactic, quadrivalent vaccination against four HPV genotypes: 16, 18, 6 and 11. HPV-16 and HPV-18 are associated with the majority of cervical cancers (70 % internationally; 80 % in Australia) and HPV-6 and HPV-11 cause anogenital warts. The HPV vaccine protects those who have never been exposed to these HPV genotypes, therefore the vaccine is most effective if administered before any sexual activity with another person begins, and before exposure to the virus (Davies and Burns 2013; Tabrizi et al. 2012).

In November 2006, the Australian Federal Government announced funding for Gardasil®, under the National HPV Vaccination Program. Australian women aged 18–26 had access to the HPV vaccine subsidized by the Australian Government from 1 July 2007 to 30 June 2009 through their General Practitioner (GP). The vaccine was also included in the school-based National Immunisation Program in April 2007 for girls in either late primary school, or early high school depending on jurisdiction.[3] From January 2013, the vaccine was also offered nationally to boys as part of the school-based vaccination schedule. Within the school-based program, the HPV vaccine is free for 12–13 year old girls and boys.[4]

With the vaccine free to women aged 18–26 from 1 July 2007 to 30 June 2009, Commonwealth Serum Laboratories (CSL) Biotherapies, the pharmaceutical company responsible for the production and distribution of the Gardasil® vaccine in Australia, engaged Edelman, a public relations firm, to develop a media campaign to raise awareness of the HPV Program.[5] This campaign encouraged women in this age group to seek information and vaccination from their GP. Edelman designed an unbranded HPV vaccination awareness campaign titled "I-did" that informed the public about a free cervical cancer vaccine under the National Immunisation Program. The campaign consisted of a television and online advertisement about the vaccine and a succession of posters that were displayed on public billboards and in doctors' offices. Various "I-did" ambassadors and their personal vaccination stories were a core feature in campaign media and functioned as an endorsement of the vaccine. The campaign had a number of objectives. Primarily, it aimed to generate awareness of and support for the launch of the vaccination program to women aged 18–26 and encourage them to see their GP to get vaccinated, thereby creating

[3] In Tasmania, the school-based HPV program commenced in May 2007. The recommended target groups for 2007 were Grades 6 (primary aged students) or 7, and 10–12. In 2008, the target group will be Grades 6 or 7, 8 and 9, and 11 and 12. HPV vaccinations were co-administered with hepatitis B and varicella vaccines in Grade 6 and 7 and dTpa in Grade 10.

[4] A catch-up program is also available for boys aged 14–15 years of age at school.

[5] CSL Biotherapies is a subsidiary of CSL Limited, a global, specialty biopharmaceutical company that researches, develops, manufactures and markets products to treat and prevent serious medical conditions.

rapid uptake of the vaccine. It also sought to leverage relationships with the "I-did" ambassadors and spokespeople to ensure involvement in the media campaign; and to ensure the launch of the campaign was compliant with the Medicines Australia Code of Conduct (Golden Target Awards 2008).

Research Methodology and Theoretical Approach

This chapter combines analysis of promotional materials for the national vaccination campaign roll out and data collected for a qualitative pilot study undertaken in 2010 about HPV and vaccination knowledge in Australian secondary schools. The main aims of the research were to provide a deeper understanding of the instrumental role that school policy and health curricula play in shaping the *kinds* of knowledge young people, their parents/guardians and their teachers have about HPV, HPV vaccination and adolescent sexual and reproductive health more broadly. Given the very recent inclusion of boys as part of the HPV school-based vaccination program, our analysis in this chapter focuses solely on the knowledge and attitudes of girls and young women and considers how they are positioned within discourses about vaccination to be healthy and "well" citizens, responsible for their future health.

Qualitative research methods were employed to allow participants' experiences, beliefs, attitudes, perceptions and knowledge to emerge (Richie and Lewis 2008). Semi-structured interviews and focus groups were conducted at two independent secondary schools in metropolitan New South Wales, Australia. Vice principals involved in the roll out of the vaccination program (n = 2), Personal Development, Health and Physical Education (PDHPE) teachers[6] (n = 5), one school nurse (n = 1), and parents/guardians (n = 2) were interviewed, and four focus groups were held with female students (n = 20). Two of these focus groups were with year 10 students (n = 12) aged approximately 14–15 years, and the other two were undertaken with then current year 7 students (n = 8), aged around 12 or 13 years.

National HPV promotional campaign materials were collected and annotated to identify key themes. Interview and focus group data was also coded and key themes were identified. Both data sets were analyzed through a poststructuralist framework, drawing specifically on feminist poststructural theory and Foucault's (1991) analytics of governmentality. Poststructuralist analyses focus on discourse, and discursive and regulatory practices (Gannon and Davies 2006). Feminist post-structuralism identifies the construction of gendered and sexualized subjects, and provides a lens through which to analyze language, discourse, power, knowledge and subjectivities (Davies 1989, 1994, 2012, 2013; Davies and Robinson 2010, 2013; Gannon and Davies 2006; Robinson and Jones Diaz 2006; St Pierre 2000). In our research, feminist poststructuralism is central in foregrounding analyses of

[6]In the state of NSW PDHPE is the key learning area that covers health and physical education related content.

gender and sexuality as they are produced and consumed throughout the school-based HPV vaccination program, in vaccination promotional materials and in broader health discourses.

An analytics of governmentality is closely linked to the project of feminist poststructuralism as both frameworks attend to the ways in which certain bodies of knowledge gain the authority to determine normative and viable subject positions. Governmentality studies trace the modalities of government that produce, govern and constrain individuals and populations. Unlike sovereign and disciplinary formulations of power where order is secured through repression or violence, governmentality studies trace the diffuse power effects that define contemporary political and economic imperatives. Emphasis is placed on how individuals mobilize a variety of technologies of self-management and self-regulation to become intelligible citizen-subjects under particular governmental regimes. Technologies of government refer to the mechanisms and instruments through which governing takes place including ways of collecting, storing and assembling information in order to shape conduct using performance criteria. Within the domain of vaccination, an example of a technology employed by the Australian government includes rewarding families who immunize their children with monetary tax benefits. Families whose children receive all the recommended vaccinations are eligible for a Family Tax Benefit Part A Supplement, which is $726 per child who is fully immunized.[7] This governmental approach aims to strongly encourage and reward families who immunize their children in an effort to achieve broader public health goals. Another example includes the Australian government's subsidization of selected vaccinations offered through the school-based immunization program, which includes HPV vaccination.

The analysis in this chapter focuses specifically on neoliberalism as mode of government. Although in no way a unitary governmental strategy, neoliberalism is a mode of government that emphasizes the value of an "open market" where all existing constraints on market activity are lifted (Cheshire and Lawrence 2005). Neoliberalism is characterized by the government's disengagement with social welfare programs set up to assist the marginalized and otherwise socially disenfranchised. Governmental authorities adopt a hands-off approach in the belief that a more effective state is one in which power is decentralized. Globally there has been a turn toward neoliberalism in political and economic policy, practices, discourse and knowledge cultures since the 1970s. Key shifts in political regimes are often associated with the neoliberal turn, and are marked by compelling political platforms based on the ideals of freedom, choice and self-enterprise and the championing of entrepreneurialism, self-advancement and competitive economic principles (Cheshire and Lawrence 2005; Larner 2000; Rose 1999). The adoption of neoliberal governmentality globally has taken place through differing and complex technologies and practices, including the use of force, but more commonly through dominant discourses circulating through corporations, the media and key socio-

[7] See <http://immunise.health.gov.au/internet/immunise/publishing.nsf/Content/faq-related-payments> accessed 23rd December 2013.

political institutions. Within the Australian context, both the Australian Labor Party and the Liberal National Party have adopted neoliberal economic policies since the 1980s. This has included privatizing government corporations, floating the Australian dollar, reducing trade protection and deregulating markets.

Health and wellbeing have been reconceptualized through neoliberal discourses and practices that prioritize individualism and self-responsibility. This is characterized, for example, by the devolution of responsibility for health care and social services from the state to individuals and communities (Petersen and Lupton 1996a, b). Neoliberal policy agendas are also evident in public health promotion campaigns, including the one associated with the introduction of the HPV vaccine.

Theme I: Personal Responsibility and Choice in a Postfeminist Era

One of the key themes emerging from the cervical cancer media campaign was that of personal responsibility and choice. However, as we explore below, this was markedly lacking in the experiences shared by female school students eligible for the vaccine. Discourses of responsibility and choice in the promotional campaign for the Australian vaccination program reflect a shift towards a health-as-wellbeing imperative that positions individual citizens as agentic and free-choosing consumers of health and wellbeing. Being "healthy" is not simply about the presence or absence of disease in the present, it also entails consideration and proactive management of future health risks.

Getting the HPV vaccine was positioned as a wise choice, not only because the initial catch-up programs were government subsidized, but also because the vaccine was constructed as a smart investment in women's immediate and long term health. The idea of *choice* is bound to neoliberal ideals of freedom and the virtues of free market enterprise where increased choice is primarily defined by a greater number of consumer choices (Rose 1999). As Peter Bansel (2007) notes, discourses of choice and freedom are conflated within a market economy as *freedom of choice*. Having *freedom of choice* in the current neoliberal context, assumes an autonomous rational economic agent who makes choices between competing goods and services based on price and value, cost and benefit (Bansel 2007).

The campaign encouraged its target audience to become the *first generation* of young women to protect themselves against cervical cancer. Female empowerment and choice, once the cornerstones of second wave feminism, were reproduced through postfeminism alongside discourses of personal responsibility for future health and wellbeing. Choice and responsibility in the campaign were mediated through a postfeminist discursive lens in which young women were positioned as active agents capable of making an informed choice to be healthy – that is to choose to get the HPV vaccine Gardasil® – thus ensuring their long-term wellbeing. Choice, responsibility and postfeminist rhetoric, when conjoined with the ideals of health

and wellbeing, construct women as autonomous agents no longer constrained by power inequalities or imbalances. Instead young women were produced through discourses that imply that practices are freely chosen (Davies and Burns 2013).

The choice to be vaccinated was also mediated as a *right to choose*. Girls and young women were positioned to make a responsible choice in order to constitute themselves as empowered female citizen-subjects and as agentic health consumers (Burns and Davies 2013; Burns and Russell 2012; Davies and Burns 2013). The advertising slogan "I did" was affirmation of girls' and young women's "good" decision-making and their commitment to life-long health and wellness. The "I did" tagline implied that vaccination against HPV is not simply a "health" choice, but also a choice that young women make to gain agency and control over their bodies. Constructing girls and young women as empowered subjects responsible for their own health and wellbeing incites them to value and participate in the priorities established by the state and its corporate partners, which ultimately lessens costs associated with the potential disease burden on the state (Davies and Burns 2013).

To effectively address their target audience, CSL commissioned market research with young women, which indicated that young women are more responsive to "real" and "ordinary" Australians in campaigns of this kind, and that they believed a smile was essential (Golden Target Awards 2008). In addition, they suggested that the choice of ambassadors for the vaccination campaign would be critical to the campaign's effectiveness, suggesting that celebrities could undermine its credibility (Golden Target Awards 2008). Informed by this research, the core elements of the campaign communication strategy were: the generation of dialogue about the HPV vaccine by a group of "I did" ambassadors and making the ambassadors available to participate in media events and advertising; creating awareness about the availability of the free, government-funded vaccine for young women aged 18–26 in order to mobilize this target group to ask their GP for the vaccine; and, to alert healthcare professionals that Gardasil® was to be funded for the target audience from July 1, 2007 until June 2009 (Golden Target Awards 2008).

One part of the campaign was a short television commercial featuring Australian Olympic Swimmer Libby Trickett who explained that she has, "joined more than a million Australian girls aged 12–26 in the fight against cervical cancer". As she offered important information about the three required doses to complete the vaccine, and the subsidized funding program, a series of "I did" ambassadors were profiled in black and white close up shots. The only colour in the commercial was the red of the "I did" Band-Aids (sticking plasters, or adhesive bandages) adhered to each ambassador's arm which they proudly displayed as they declared "*I* did". The camera panned then out to reveal that, like the others, Trickett was an HPV vaccination program ambassador, donning three colourful "I did" Band-Aids, signalling that she had completed her three required doses of the vaccine. In the advertisement's closing shot, Trickett pronounced "I did" and in an act of encouragement asked her audience, "so, what are you waiting for?"

The complementary poster campaign featured the same "I did" ambassadors but here the models in the campaign were named and their careers listed. Potential consumers of the vaccine were introduced to "everyday" Australian women:

Felicity the university student, Simone the public servant, Victoria the waitress, Candice the nurse, Emma the chef, Jessica the music journalist, and Kate the client administrator. The women's credentials were set against the poster campaign caption, "Join the Fight Against Cervical Cancer". The ambassadors' names and occupations personalized their narrative of responsibility and positioned them as free-choosing agents of their health. Joining these "everyday" ambassadors in their fight against cervical cancer were a series of famous female Australians: Tania Major, 2007 Young Australian of the Year; Laura Andon, professional surfer; and Giaan Rooney, 2004 Australian Olympic relay swimming gold medallist. In contrast to the unknown faces, these women functioned as public role models whose bodies and lifestyles were positioned as healthy (Burns and Russell 2012).

Collectively, the ambassadors were constructed as healthy female citizens, committed to the ongoing project of "health-as-wellbeing", a broadening of health that allows women to make active choices about their bodies and sexual health and to act as wise consumers of state-subsidized health care. The testimonial-style iteration of the "I did" tagline positioned the ambassadors as free-choosing, responsible citizens and as empowered young women. The campaign's target audience, young women, were encouraged to take personal responsibility for their health and wellbeing and to produce their own journey narrative towards wellbeing. Journey narratives function as testament to the self-responsible individual who values a holistic view of health. Health and wellness opportunities and products serve as validation for healthy citizenship and render viable the self-reflective, entrepreneurial and self-managing citizen-subject (O'Brien 1995; Sointu 2005). The assumptions around free choice that the ambassadors in the "I did" campaign represented, constitute the postfeminist sensibility of the current era. Increasingly, privatized and personalized postfeminist sensibilities counter earlier feminist approaches such as naming systemic and cultural inequalities and making the personal political. Girls and young women are expected to manage the uncertain conditions of contemporary living by investing in a range of entrepreneurial and self-managing strategies in order to become "responsible self-made citizens" (Harris 2006, p. 268). However, as argued elsewhere, responsibility and personal direction are produced to ensure girls' and young women's economic independence from the state, rather than necessarily repositioning them as more active or equal citizen-subjects (Burns 2008).

Even though the mediated HPV promotional campaign was directed primarily at young women aged 18–26, many school-aged girls and young women who were able to access the school-based vaccination program also viewed this campaign. In the television and online advertisement, Trickett stated that she is joining women aged 12–26 in the "fight" against cervical cancer, interpolating school-aged girls to become aware of the program. A familiarity with the campaign was reflected in the responses of year 7 (aged 12–13 years) and year 10 (aged 14–15 years) participants in the research study focus groups. For instance, Selena, a student in year 10 commented: "when I went into the doctors with another girl I saw something about it, a girl with a Band-Aid saying 'I did'". Elaine, another year 10 student remembers advertisements in magazines, commenting, "*Cosmo* and *Cleo* had it, the one with the girl and the Band-Aids saying 'I did'". While Elaine couldn't remember

who featured in the ads, she commented: "wasn't there a celebrity who got it? Wasn't someone on Oprah talking about it?", suggesting that some school-aged girls thought the vaccine was being promoted by celebrities. This demonstrates that school-aged girls were consuming advertising for the vaccine, which was marketed as the "cervical cancer vaccine", rather than as Gardasil®, its trade name or as the HPV vaccine. In addition, school-aged girls not only imagined themselves as being addressed by the "I did" campaign, but they were also aware of celebrity involvement (Oprah) in the global media promotion of the vaccine more broadly. Curiously, none of the younger students could remember some of the well-known Australian sporting celebrities, but they did have some awareness and felt addressed by the "I did" campaign. Leanna, aged 13 commented: "Yes I saw [the posters] in the elevators. My friend did say that after you have had your third injection you get one of those band aids, and we didn't get one!" Disappointed that she didn't get what the advertisement promised, evidence of inoculation in the form of an "I did" Band-Aid, Leanna positions herself as a consumer of choice who expected to receive material proof of her healthy decision-making.

Schools were not positioned as sites of knowledge production about HPV or the HPV vaccination program. Elaine, a year 10 student, observed that "there was no advertisement at school" about the vaccine, which suggests that girls consumed information about the vaccination program through the media and popular culture, rather than within the school environment. Alison, a 16 year-old student remembered seeing advertisements in "the newspaper, about, like, schools getting a free vaccine". It was through this newspaper advertisement that Alison first learned about the vaccine being subsidized for female students at school.

Unlike the empowered and agentic young female ambassadors from the "I did" promotional campaign, the girls in this research did not report being active in decision-making about whether to get vaccinated or not. Furthermore, girls in this study had very limited or no knowledge about HPV or the vaccine. Selena, a 15 year-old student recounts her vaccination experience: "I just remember the school giving us this thing saying you are getting this done!" Rather than being integral to the decision-making process, Selena felt that she was commanded to get the vaccine. Similarly, Joanne, a 14 year-old student, commented that the school she attended "didn't really talk about it, like the information and stuff". As a boarder at the school, she commented that her "Mum signed it . . . and then it went to the school but no one really went through it". Joanne didn't have an informed understanding of why she was being vaccinated, and nor was she part of the decision-making process. Like Selena, Joanne didn't really understand what she was being vaccinated against and why. Joanne had thought that "the school would say something at assembly to all the kids . . . because it was sent home to everyone", but an information session never took place.

These experiences demonstrate the critical role that schooling could play in providing information, and equipping students with the knowledge and skills for them to develop an understanding about HPV vaccination and sexual health more broadly, given that schools in Australia are key vaccination sites. Alison, a 15 year old student who boards at the school reported a similar experience to other girls in

the study: "Since I got mine [consent form] given to me at the school I just gave it to [the year coordinator] and she signed it and I just got told on the day, 'Oh you're having a vaccine'". The experiences from girls receiving the vaccine in the school-based program demonstrate that in the earlier years of the vaccination roll-out, they were a vulnerable population who were largely not educated or consulted about this vaccination program.

Rather than understanding vulnerability through discourses of risk (i.e. vulnerability to HPV related cancer), we employ the term vulnerability in the context of girls and young women having access to the HPV vaccine without access to a coordinated, comprehensive and systematic HPV vaccination education program to inform them about the vaccine. The neoliberal discourse of health-as-wellbeing relies on having some knowledge and understanding about one's own health (in this case, HPV vaccination) and being part of the decision-making process such that one appears to have *freedom of choice*. Girls and young women were encouraged through the initial media promotion for the Australian HPV vaccination campaign to take control of and responsibility for their sexual and reproductive wellbeing, aspects of their health from which they have been historically detached (Burns and Russell 2012; Davies and Burns 2013), and to make a wise health choice. Young girls at school, however, were not able to take up this subject position and thus be constituted as empowered female citizens due to a lack of pedagogy directly related to HPV or the vaccine itself and/or models for healthy and informed decision-making.

Theme II: Risk Reduction and the Production of "Knowledge"

A second key theme that emerged across the data concerned the management of risk. Risk-management is central to "new public health" discourse, which Alan Petersen and Deborah Lupton (1996b) maintain represents a modality of neoliberal government that produces new bodies of "expert" knowledge, individual and institutional| practices that facilitate "healthy" living and countless discursive effects that constrain the parameters of "healthy" citizenship. Individual citizens are positioned within this discourse to take responsibility for managing their health and wellbeing, and minimizing future risks though preventative lifestyle behaviours and consumptive practices.

Managing the risks associated with cervical cancer was implicit in the "I did" advertising campaign, but the health-related burden of disease associated with HPV and/or cervical cancer was not fully disclosed. The campaign did not provide any information about what cervical cancer is and failed to outline rates of morbidity or overall burden of disease. While there was a strong call to "join the fight against cervical cancer", it was not clear how or why women are impacted by cervical cancer. More significantly perhaps, HPV was completely omitted from the promotional materials. As such, how HPV is contracted as a sexually transmitted infection was not addressed, HPV was not identified as the precursor virus to

cervical cancer, and there was no mention at all of anal and oropharyngeal cancers, many of which are also caused by HPV. Likewise, the campaign overlooked the link between HPV and ano-genital warts and/or the vaccine's defence against HPV genotypes 6 and 11, which are among the HPV genotypes designated as "low risk" for cancer, but are associated with 90 % of genital warts (Australian Government 2008).[8] While the campaign did reinforce the message about regular Pap smears, these tests were not explained, and the links between HPV, Pap smears and cervical cancer remained opaque.

Young women were thus offered a sanitized understanding of the virus and its risk effects, and the ambassadors used throughout the campaign were constructed as healthy female citizens associated with notions of self-care, prevention and good health rather than with sexually transmitted infections. The vaccine's promotion as a preventive measure against cervical cancer and the erasure of HPV also served to circumvent debate and resistance of the kind raised in the United States when the HPV vaccine first came onto the market; there was significant parental concern that the vaccine would encourage girls to experiment with sex and encourage promiscuity (Freed et al. 2010). Rather than jeopardize campaign imperatives by potentially alienating consumers (i.e. parents and guardians), a depiction of healthy female citizenship characterized by self-care and self-management under the guise of empowerment was offered. Despite not being agents of sexual health knowledge, the campaign ambassadors and target consumers were positioned as agentic healthy young women who were making empowered choices to reduce health risks and ensure a healthy future.

Where HPV-related cancers are concerned, positioning young women as managers and agents of health risk at the exclusion of young men reinstated the norms of gendered and sexual citizenship. Tamara Kubba (2008) points out that historically, gender-specific immunization programs have been demonstrably less effective than gender-neutral immunization programs, and refers to the success of the rubella vaccination program when boys, as well as girls, were included later in the program. Excluding boys and young men from the initial roll out and campaign upheld the idea that women are responsible in large part for minimizing risks related to sexual health, in this case HPV transmission. Although in some countries like Australia, boys and young men are now being included in HPV vaccination programs (from January 2013), their erasure in the initial phases of advertising is significant. For one, vaccinating boys against HPV will complement the girls' vaccination program by increasing herd immunity and thus providing indirect protection to an estimated 28 % of girls who have not been vaccinated (Australian Department of Health 2011). For another, the vaccine, specifically HPV genotype 16, protects against 90 % of all HPV attributable cancers in males, including anal cancer. As such, men who have sex with men are likely to have the greatest benefit from the vaccine, and it could decrease risks associated with other sexually transmitted infections (Australian Department of Health 2011). For instance, HIV infection is strongly

[8]HPV 6 and 11 also cause 100 % of recurrent respiratory papillomatosis (RRP) cases, which are warty growths in the upper airway that can cause significant airway obstruction or voice change (Australian Government 2008).

linked with persistent HPV infection, and the re-activation of latent HPV infection (Kubba 2008). The assumed heteronormativity of the original target audience for the national vaccination campaign in Australia, that is, young women, overlooked the diverse sexual practices of this population (who are presumed not to have futures that include anal sexual practices), and excluded boys and men who may engage in anal sex.

Reducing risk factors was also a theme in the data collected with participants in the school-based study. Robert Castel (1991) maintains that the risks associated with contemporary living are often not associated with concrete or specific dangers, but are instead characterized by a series of abstract factors that pose *possible* dangers or threats. This shift from concrete risks to abstract risk factors, extends risk's regulatory effect and therefore the possibilities for intervention and self-management. In one of the focus groups with girls aged 12–13 years of age, the issue of risk emerged. Eleanor focused on the vaccine's value to her: "[the vaccine is] not like completely bullet proof, is it? But just to know that you have some sort of protection to lower the risk". Paige commented that " . . . I felt like it was something to do to prevent something else". When asked if getting the vaccine made them feel different in terms of their health, Leanna commented that she "didn't know enough about it to feel that . . . maybe safer, but not healthier". For Leanna feeling safer is not necessarily linked to knowledge in the same way feeling "healthy" is.

While risk reduction was addressed, both the younger and older girls in the focus groups knew very little about HPV or how the vaccine operated in the body to reduce their risk of cervical cancer. Reducing risk, therefore, was not dependent upon having adequate knowledge to make an informed choice. Instead, reducing risk entailed simply being vaccinated and accepting that this was a healthy and wise short- and long-term decision. As we have suggested, getting the vaccine was a decision that by and large was made by the participants' parents/guardians and there was little to no discussion about the vaccine or the program at home or at school, including on vaccination day. As such, the girls did not know much about HPV, cervical cancer or how the vaccine worked to reduce "risk". When asked what they knew about the vaccine, Victoria, aged 12 years of age, explained:

> Like with the cervical cancer, obviously it's a cancer because it's called cervical cancer, the needle, but I still don't know anything, like, I still don't know anything about the cervical part of it. I don't know what it does in the body or anything . . . everyone said "oh at least you can get it done and over with", but you don't actually know what you'd get if you didn't have it.

In the other year 7 (aged 12–13 years of age) focus group, Lydia and Eleanor made similar comments, Lydia confessed that she "didn't know there was a cervix" and Eleanor added that she "kind of did and thought that HPV was linked to cervical cancer, but didn't know how . . . ". Continuing to piece together what they knew about cervical cancer, HPV and the vaccine, Eleanor's query resulted in the following discussion:

Eleanor:	Well aren't vaccines all a part of a strand of the disease and then it helps by getting the disease put into you?
Sam:	So that when you do get it you are used to it and can fight it off.
Researcher:	Ok and so what disease do you think the vaccine is putting into you?

Lydia: The, I don't know, I guess the cervical, the cancer.
Sam: I think it was like this thing that was overlooked, that you just got it and didn't really know about it. No-one seemed to worry about what it was for.

Participants also spoke about the various rumours that circulated about the vaccine and the vaccination procedures and these served to confuse the year 10 girls (aged 14–15 years) and raise some problems with medical disclosure:

Elisa: There was just the most random things coming up, like if we had [the vaccine] than like, I don't know … like, it was just really weird we had no idea. There were just so many rumors going around.
Researcher: Was that the same for all of you?
Serena: I remember that apparently the vaccine wouldn't work if you were already sexually active.
Emma: Yeah.
Serena: People who were sexually active were too scared to tell people that they were, because they thought it wouldn't work and stuff.

…

Sarah: Yeah, I could remember people saying that the vaccine could backfire on you and you could have like while getting the needle, you could actually get the disease, like the cancer.
Jenny: Because people were like, when you get the needle, you get a little bit of it or something in you or something.

In order to ascertain a basic understanding about these areas of knowledge, school-aged girls would be reliant on learning about the vaccine at school, or from their parents/guardians, and/or undertaking their own research. We understand forms of knowledge as a broad set of discourses that are socially and culturally produced and which function as technologies that govern the limits of human subjectivities (Burns 2013). Like Kerry Robinson (2013), we believe that bodies of knowledge pertaining to such issues as sexuality and sexual health have been socio-culturally and politically constructed as "difficult", which has resulted in censoring this information from the education of young people. "Difficult knowledge" is frequently determined by adults, even if this knowledge has a direct impact on the lives of young people (Davies and Robinson 2010, 2013; Robinson 2013). The students in this study did not have an understanding of cervical cancer, HPV, how HPV is contracted (i.e. as a sexually transmitted infection), other HPV related cancers, and only had a basic understanding about vaccination. Students did not understand why they received three doses of the vaccine, why it is most advantageous to get the vaccine at an early age before any sexual activity, the implications of getting the vaccine if they were already sexually active, and how immunity functions. That the vaccine would reduce risk was something many of the participants accepted without question, but having adequate knowledge to understand how and why risk is reduced by the vaccine was not necessary to "decision-making". Interestingly, most girls in this study did feel that they had adequate knowledge about HPV and HPV vaccination. Our findings relating to girls'

lack of knowledge about HPV and HPV vaccination, and their lack of involvement in the decision-making process vaccination are consistent with other Australian studies in this area (see also Cooper Robbins et al. 2010a).

Conclusion

We have illustrated throughout this chapter how discourses of HPV vaccination are produced and consumed within a shifting governmental climate where health-as-wellbeing operates as a neoliberal modality of government that constructs the norms and ideals of healthy citizenship. Mobilized in policy and practice as health's more flexible and well-rounded counterpart, health-as-wellbeing pedagogies and consumptive practices position individuals as free-choosing agents and managers-of-the-self who are responsible for reducing health-related risks. We have argued that the Australian media campaign designed to promote the Australian Human Papillomavirus (HPV) vaccination program during its initial rollout (2007–2009), positioned young women as agentic citizens and health consumers who were well positioned to take responsibility for managing their health and ensuring their future immunity to "cervical cancer". Curiously, the data from focus groups with school-aged girls took up some of these tropes around choice, responsibility and risk reduction as reasons to "get vaccinated", however these narratives were at odds with participants' obvious lack of knowledge and understanding about HPV and the HPV vaccine.

The experiences of girls who were part of the school-based vaccination program directly contrast to the images produced of agentic, empowered young women taking control of their health and wellbeing in the "I did" marketing campaign. In the first few years of the school-based vaccination rollout, the data from this research demonstrates that many girls did not have an informed understanding of why they were being vaccinated, what they were being vaccinated against and they were not involved in the decision-making process to have the vaccine. Even though school-aged girls viewed the "I did" campaign on free to air television, their experiences of the HPV vaccine revealed that they were a vulnerable population who were not educated about the vaccine, had no choice in the decision making, and were certainly not empowered.

In the current neoliberal era where conceptions of health have been broadened towards notions of health-as-wellbeing and are mediated in large part within the marketplace, there is a potential for the right to knowledge about health to be "traded-in" for the obligation to "choose" healthy behaviours, lifestyles and products. Given schools' administrative role in various health initiatives of this kind, there is an important balance to strike between schools' clinical role in facilitating healthy living and its role in providing young people with the knowledge and skills to make informed health decisions. This encompasses, we would argue, the capacity to critically reflect on how they are constituted through discourses of health *and* wellbeing.

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Chapter 6
Young People, Sexual Pleasure and Sexual Health Services: What Happens When "Good Sex" Is Bad for Your Health?

Ester McGeeney

Abstract Drawing on data from a recent study of young people's (16–25) understandings and experiences of "good sex" and sexual pleasure, this chapter critically examines the concept of "sexual wellbeing" in the UK context. The chapter begins by outlining how concepts of "sexual wellbeing" have been taken up in English and UK health and education policies and explores some of the benefits and limitations of current policy approaches. The chapter then examines how research findings from the study complicate debates around health and education policy and raise questions about how to operationalize concepts of sexual wellbeing and "good sex" in youth, education and health institutional settings. The research suggests that there is a range of sexual experiences that young people consider to be "good" that may not necessarily enhance their "wellbeing" or promote safer sexual practices. This raises questions about how practitioners working with young people can manage the sometimes uncomfortable mismatch between young people's understandings of "good sex" and a policy agenda for promoting sexual wellbeing.

Keywords Sexual pleasure • Sexual health • Youth policy • Youth wellbeing

Introduction

> Sexual health is (or should be) an affirmative concept, a state of wellbeing imbued with positive qualities, not merely the absence of those that are undesired. (Aggleton and Campbell 2000, p. 285)

The concept of children and young people's wellbeing has attracted growing interest from policy makers and commentators in recent years (e.g. Ipsos MORI and Nairn 2011; Rees et al. 2012). In the UK, these debates are frequently framed

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K. Wright, J. McLeod (eds.), *Rethinking Youth Wellbeing*,
DOI 10.1007/978-981-287-188-6_6

by a sense of alarm and concern, with media reports evoking the image of the unfit, risk-taking, anxious or anti-social teenager (Robb 2007), or the vulnerable, socially disadvantaged and marginalized child (Atkinson 2012). In relation to young people's sexual health and wellbeing, public commentary has focused on concerns about the high rates of teenage pregnancy in the UK relative to other European countries, the rising rates of Sexually Transmitted Infection (STI) in young people under 25 and most recently, on young people's use of mobile and digital technologies to access and produce sexual images and "sexualized" media content (e.g. Bailey 2011; Papadopoulos 2010).

As several commentators have noted, young people's lives are frequently held up as a "social barometer" for wider social changes (Jones and Wallace 1992). Rather than offering a productive or supportive framework for understanding young people's sexual experiences, these debates often reflect wider anxieties about a rapidly changing media and technological landscape and the increasing liberalization and secularization of sexual values in the UK as a result of a series of wide ranging social transformations (Attwood and Smith 2011; Robb 2007; Weeks 2007). Whilst some recent accounts have highlighted the importance of positioning children as "co-constructors" in solutions to health inequalities (Atkinson 2013, p. 3), others prioritize the view of parents (Bailey 2011), with limited attempts to ground policy and practice recommendations in empirically-based understandings of young people's lives and sexual cultures.

This chapter draws on an empirical study of young people's sexual cultures and a body of research/activism calling for more critical frameworks for understanding young people's sexual lives (Aggleton and Campbell 2000; Carmody 2009; Hirst 2008). My aim is to critically engage with debates about young people's sexual health and wellbeing and consider the implications of these debates for the provision of sexual health and education services in the UK. My approach draws on research conducted by scholars from various disciplines who have argued for a culturally-informed approach to wellbeing (Robb 2007), suggesting that this enables understanding of the ways in which social contexts and structural inequalities shape young people's individual decision-making, health, education and employment outcomes (Henderson et al. 2007; MacDonald and Shildrick 2013). This framework is offered as a critique of traditional approaches to health research and policy that tend to focus on individual behaviours and health outcomes, and as an alternative to popular psychological approaches to understanding and promoting youth wellbeing (Carlisle et al. 2009).

In the first section of this chapter I provide an overview of the current sexual health and education policy arena in England and consider the ways in which the concept of sexual wellbeing is framed in this context. In the second section of the chapter I provide an overview of the study, which explored young people's understandings and experiences of "good sex". I use this study as an example of the critical, holistic approach to sexual wellbeing that I advocate in this chapter, working with focus group and interview data to foreground the diversity and complexity of young people's sexual values and experiences. I highlight the "gap" (Allen 2001) between "official" discourses of sexuality and young people's sexual

values and practices, to raise questions about how practitioners working with young people can manage the sometimes uncomfortable mismatch between young people's understandings of "good sex" and a policy agenda aimed at promoting youth sexual wellbeing.

The Policy Context in England

In this section I provide an overview of the policy arena currently governing the provision of youth sexual health and education services in England,[1] outlining a move towards a more holistic and comprehensive approach to young people's sexual health and wellbeing that remains limited by ongoing political tensions (Moore 2012; Monk 2001; Thomson 1994). Until the general election in May 2010, youth sexual health and sex education policy agendas in England were framed by the former Labour Government's teenage pregnancy and social exclusion agenda and an accompanying shift towards more comprehensive sexuality education. In 1999 the former government's Social Exclusion Unit published its *Teenage Pregnancy* report (SEU 1999), which identified Britain as having the highest rates of teenage pregnancy in Western Europe and set out the need to reduce these rates through addressing issues such as education, housing and self-esteem, as well as through the provision of sexual health services and information. The report has been criticized for the ways in which it, perhaps unintentionally, pathologized teenage mothers and focused on the provision of sex education and career pathways for young mothers, whilst failing to address the correlation between teenage birth rates and socio-economic inequalities (Arai 2003). Despite these criticisms and the failure to meet the ambitious targets set out in the *Teenage Pregnancy Strategy* (TPS) published shortly after the report, the rate of under 18 conception rates did decline by 13.3 % between 1998 and 2008 and the TPS included a significant increase in funding for sexual health services, sex education and support for teenage mothers in and out of school (DfCSF 2010).

In 2000 the Labour government published new guidance on delivering Sex and Relationship Education (SRE) for primary and secondary schools in England and Wales (DfEE 2000) aimed at children and young people aged 4–16 years. Although non-statutory, the new guidance for schools was comprehensive and its location of SRE within the Personal, Social, Health, Economic (PSHE) curriculum marked an attempt to move beyond reductionist and biological frameworks for delivering sex education (Monk 2001). As several critics have noted, the conceptual framework that underpins the guidance is contradictory, with protectionist concerns about childhood sexuality and a morally informed public health agenda limiting

[1]The current guidance governing the provision of sex education in schools also applies to Wales. For summary of the legislation in England, Scotland and Wales see FPA 2011 and in Northern Ireland see FPA 2012.

its potential to realize the broader aims of SRE (Monk 2001; Spencer et al. 2008). Whilst the guidance may allude to a discourse of empowerment and young people's rights to make "informed choices", it also makes clear what the "right choices" should be – avoiding pregnancy and STIs and delaying sexual intercourse – ultimately prioritizing a state-led, public health agenda as opposed to a social justice agenda that acknowledges young people as autonomous sexual subjects (Allen 2005; Spencer et al. 2008). Further, although the former Labour government expressed a commitment to making SRE statutory as part of a new Children, Schools and Families Bill (Knight 2008), this clause was removed amid disputes about the rights of parents to withdraw their children from compulsory sex education classes and the rights of faith schools to abstain from delivering SRE.

Research on young people's views of sex education in England and the UK consistently shows that young people are not satisfied with the quality or the quantity of sex education that they receive, which is frequently characterized as "too little, too late and too biological" (Alldred and David 2007; SEF 2008; UKYP 2007). Reports by Ofsted, the official government body for inspecting schools, supports these findings, suggesting that sex education provision continues to be patchy and inconsistent, with significant variation in the quality of teaching and resources used across schools (see for example, Ofsted 2013).

Since coming to power in 2010, the Conservative-Liberal Coalition Government in the UK has expressed a commitment to providing "comprehensive SRE" (Teather 2011) but not to making this provision compulsory or to updating the SRE Guidance published in 2000 (DfEE 2000). As part of a series of radical health reforms, however, the English Department of Health has launched a new public health strategy (DoH 2010a), sexual health policy (DoH 2013a) and best practice guidance for local authorities (DoH 2013b). Whereas the rhetoric of "wellbeing" is entirely absent from the education guidance published over a decade ago, it is central to the current government's new public health policy and vision of a healthy society (DoH 2010a, b, 2013a, b).

Under the new commissioning arrangements each local authority in England is required to establish a *Health and Wellbeing Board* and to develop a *Joint Health and Wellbeing Strategy* in collaboration with partner organizations. The new sexual health policy (DoH 2013a) sets out a holistic approach to sexual health and wellbeing, instructing local Health and Wellbeing Boards to address the wider determinants of sexual health and take account of the different factors that can influence relationships and safer sex; these include "social norms; peer pressure; religious beliefs; culture; confidence and self esteem; misuse of drugs and alcohol; and coercion and abuse" (DoH 2013a, p. 8). The policy specifically addresses the needs of young people up to age 16 and those aged 16–24 (DoH 2013a, b, p. 12–18), advocating a "positive approach" that aims to focus on young people's "assets" and "resilience", rather than on "deficit" factors such as "growing up in a single-parent family or living in a deprived area" (DoH 2013a, p. 16). The policy aim is to build young people's "resilience" in order to enable them to "enjoy life, survive challenges, and maintain positive wellbeing and self-esteem" (DoH 2013a, p. 16).

This approach to young people's sexual health and wellbeing can be understood as part of a broader shift in UK policy making, away from welfarist models of health, in which responsibility rests with society to provide the conditions that promote wellbeing, towards a neoliberal policy agenda that emphasizes individual responsibility and personal choice (Brown et al. 2013; Robb 2007). In this neoliberal policy climate, individual factors, such as "self-esteem", are seen as key to improving health outcomes, despite the lack of evidence that self-esteem interventions will be successful in enhancing young people's health and wellbeing in the context of ongoing social and economic inequalities (Emler 2001; Goodson et al. 2005; Hargreaves et al. 2013). As several critiques have highlighted, such approaches function to individualize social problems, promoting individual solutions to structural inequalities, often in highly gendered ways (Aapola et al. 2005; Shoveller and Johnson 2006).

Study Outline: Young People's Understandings of "Good Sex"

I turn now to a study of young people's sexual cultures that I conducted in London, England between 2009 and 2013. The study had two key aims; firstly to explore young people's understandings and experiences of "good sex" and secondly to examine the methodological possibilities for researching the largely "unspoken" and under-researched topic of young people and sexual pleasure (Marston and King 2006; Tolman and Szalacha 1999). Using multiple research methods, the study examined the biographical and cultural resources that young people were using to negotiate competing understandings of "good sex" and sexual pleasure. Further it reflexively examined the effectiveness of different methods for creating "safe spaces" (Fine 1988) within which to engage young people in conversations about sex, pleasure and desire. In this way, the research set out both to document the sexual lives and values of a small sample of young people in one location and to use reflexive insights from the research to contribute to debates about the potential inclusion of sexual pleasure in sexual health and sexuality education services (e.g. Allen 2005; Fine 1988; Philpott et al. 2006).

The study used an incremental, reflexive research design consisting of an initial stage of exploratory and pilot work followed by a survey of 278 young people aged 16–25, 4 focus groups and 16 individual interviews all with young people aged 16–22. The primary aim of the survey was to recruit young people for the qualitative stages of the research and to gain a broad understanding of participants' views on sex and relationships. Participants were asked to complete a questionnaire that contained questions relating to their demographic characteristics, use of sexual health services and level of sexual experience, followed by a series of open-ended questions asking for their views on "good" and "bad" sex, and on sexual relationships more broadly. These written responses were analyzed using a combination of open coding, word frequency searches and content analysis methods to identify key themes and patterns in participants' responses.

In focus groups participants were given a series of cards, each containing a quote about "good sex" or sexual pleasure and asked for their views on what counts as "good" and "bad" sex. Each group interaction was analyzed separately, with a focus on the patterns of interaction, story telling and affective practice (Wetherell 2012) at play within each situated group encounter. At the final stage of the research, participants took part in individual interviews and were asked to talk about themselves, their lives and their experiences of sexuality, pleasure, sex and desire. The research adopted a reflexive, situated analytic approach, drawing on frameworks such as Sara McClelland and Michelle Fine's theory of "thick desire" that locates sexual desire within structural contexts, and encourages researchers to "thread the sexual experiences and wants of young people to the ideologies, policies, power relations, institutions, families, and schools in which they live and develop" (McClelland and Fine 2008, p. 244). In line with this approach, interview narratives were used to explore the ways in which young people's sexual experiences and values and "sexual stories" (Plummer 1995) were embedded within their broader unfolding biographical narratives (Thomson 2011).

The research was part-funded by Brook, a UK based young people's sexual health charity, who facilitated access to both educational institutions and sexual health clinics as well as to groups of "hard-to-reach" young people, such as a group of young men who were not in education, employment or training and were involved in criminal activity in their local area. These recruitment practices generated a research sample that was diverse in terms of participant's gender, sexuality, ethnicity, religion and place of birth. Whilst not intending to be representative of the wider "youth" or London population, the characteristics of the sample seem to confirm what is known about the high volumes of migration in and out of London (ONS 2011) and the fluidity of urban youth and student populations in an increasingly "super diverse" Britain (Fanshawe and Sriskandarajah 2010; Vertovec 2006). For example half (51 %) of survey participants were born outside London and a third (33 %) were born outside the UK. Whilst some young people were recruited from training providers and community projects aimed at "hard-to-reach" or vulnerable young people, other participants were college and university students or young people who were employed in the local area.

The sample also included young people with a wide range of sex and relationship experiences. Jessica and James[2] for example were two interview participants of similar age who attended the same local college where they were trained as sexual health peer educators. While James reported having sex with 17 male and female partners and described the "*thrill*" of experimenting with having sex in public places, Jessica stated that she had not had any "sexual" experiences since kissing a boy in the second year of secondary school. In her interview Jessica told me that although she experienced feelings of desire and attraction towards men, she wanted to wait until she was "*at least twenty*" before starting a sexual relationship.

[2]All names are pseudonyms chosen by participants.

As I explain below, diversity was a key feature of both the cohort and the data generated at each stage of the research. The research suggests that young people have access to a range of competing discourses and cultural resources for describing sexual experience and making sense of their sexual values. The study also suggests that access to these resources is uneven, shaped by participant's social locations and evolving sexual histories and relationship experiences. Some of the sexual values and experiences documented in the research fit closely with accounts of "good sex" framed in sexual health and education policy – love, reciprocity, intimacy, delay. Others, such as the pleasure of anonymous sex and the pleasure of sex in violent and non-consensual relationships may be more challenging or impossible to explore in the "official" spaces of schools, clinics and other institutional environments (Allen 2005; Fine 1988; Kehily 2002).

This "gap" (Allen 2001) between young people's sexual cultures and the official discourses of sexuality constructed in policy documents and the sex education curriculum has been well-documented and is identified as a key barrier to the provision of good, comprehensive sexuality education (Alldred and David 2007; Allen 2005; Fine 1988; Kehily 2002). It has been suggested by a number of scholars internationally that one way of addressing this gap is to include and prioritize sexual pleasure in the delivery of sexual health and education services (Allen 2005; Beasley 2008; Fine 1988; Holland et al. 1998; Ingham 2005). The argument follows that this would create opportunities for young people to access more diverse, realistic and critical accounts of "good sex" than those offered through the current sex education curriculum and through mainstream popular media and pornography.

The research discussed in this chapter broadly supports these arguments, suggesting that creating spaces for young people to talk about "good sex" and sexual pleasure provides opportunities for young people to articulate and explore a range of good, bad and ambivalent experiences of sexual desire and sexual relationships. However, the research also suggests that creating spaces for young people to talk about "good sex" and sexual pleasure will not necessarily produce insights or accounts that policy makers or critical researchers may judge as being "good" for the wellbeing of the young people involved.

Although evidence of a discrepancy between young people's accounts and the aspirations of policy makers and critical researchers/educators is not surprising, it raises questions about the function of sexual health and education work with young people. Is it to challenge young people's accounts of "good sex" and offer more critical, "health-promoting" (UNESCO 2007) or gender equitable alternatives? Or is it to create spaces, as I did as a researcher, to give voice to a range of sexual meanings and experiences and allow young people, as one focus group participant suggested, to "*find their own way*" (Jessica, focus group 2) – even if we believe that "their own way" may be harmful or detrimental to their wellbeing?

In the following section I draw largely on focus group and interview data to explore these questions further, focusing my discussion on the theme of casual vis-à-vis "stable" relationships. This emerged from the data as key criteria for making distinctions between "good" and "bad" sex, particularly in group discussions. Further, it is identified in English health and education policy documents as a key area to be addressed in the delivery of sexual health and education services for young people.

Good Relationship = Good Sex?: Bridging the Gaps Between Research, Policy and Practice

The recently published sexual health policy for England states that education and health services should support children under 16 to learn "the benefits of loving, healthy relationships and delaying sex" (DoH 2013a, p. 13) and young people aged 16–24 to understand "the benefits of stable relationships" (DoH 2013a, p. 17). At each stage of the research, participants emphasized the "benefits" of long-term, intimate partner relationships and suggested that this was the ideal, or perhaps the only context, in which it is possible to experience "good sex". When asked to define "good sex", 19 % of survey respondents mentioned love or loving relationships and when asked what they were looking forward to in their future sex and relationship experience, 13 % said falling or being in love. Twenty one percent of respondents said that they were looking forward to being in a "good" or long term relationship and 24 % said they were looking forward to experimenting sexually or becoming more sexually experienced or skilled.

For most interview and focus group participants, however, it was not love that was identified as making sex more enjoyable or fulfilling, but the feelings of comfort, familiarity and emotional connection that could be developed in a relationship over time. As one young woman, who was in a 4 year relationship stated, "*if you have been with someone for long*, *then yeah obviously it's going to be better* '*cos you know each other and you know each other*'*s body*" (Vinnie, focus group 1).

In other focus groups, participants commented on the importance of having sex within a stable relationship as a way of ensuring respect and respectability among peers. In these discussions, participants expressed concern, confusion, and disgust towards young people – in particular young women – who "*rushed*" into having sex with new partners. In this familiar gendered moral landscape, the "*quick*", casual sexual encounter was rarely recognized as pleasurable for young women, who were judged more harshly than young men for having sex in brief or casual encounters.

This was particularly apparent in a focus group conducted with a group of "hard-to-reach" young men who had been participating in a series of six outreach sexual health sessions with their local youth worker and an outreach sexual health worker. Throughout this particular group the young men used jokes, banter, vivid storytelling and the playful use of metaphor to construct an account of "good sex" based on the pursuit of male sexual pleasure in brief, casual and often anonymous sexual encounters, frequently referred to as "*a quick beat*". The young men in this group drew on a range of discursive resources to offer accounts of "good sex", but the dominant affective pattern was one of ridicule and disgust. Consequently, opportunities to explore alternative notions of pleasure and desire to that of the "*quick beat*" in the park with the "*slag*", were frequently blocked. The sexual health worker who participated in this discussion attempted to provide the young men with alternative accounts of "good sex". For example, he challenged the young men's assertion that sex with the same partner over time would inevitably become

"*boring*", suggesting instead that long term relationships could provide greater opportunities for sexual experimentation.

> If you are able to communicate with that person, what happens is those things that you wanna try out, or that person wants to try out, you can do that with that same person because they're comfortable talking to you, they're comfortable trying new things. (Graham, sexual health worker, focus group 3)

In other focus groups, participants endorsed this account of "good sex", emphasizing the importance of "*feeling comfortable*" (Jessica, focus group 2) with a partner and talking to your partner about "*what you like*" (Indiah, focus group 4). In this group context, however, Whiley – the most prolific story teller and dominant group member – challenged the perspective offered by the sexual health worker by telling his own story of "*what happened last week*, *the last time I left here* [*the sexual health session*]".

> **Whiley**: The slag was over there and I asked her what happened. And before I know . . .
>
> Noise and laughter
>
> **Steven** (youth worker): You are joking?
>
> **Whiley**: No, obviously. I went to [the park] innit? But man never had to speech it or do nuttin' you get me? But, I could have done whatever I wanted . . . It's the first time I met her in my life!

Whiley's story of "*what happened last week*" celebrates the pleasure of immediate gratification and the brief, anonymous "zipless fuck" (Jong 1974). It presents a direct challenge to the sexual health worker's account of the benefits of a couple relationship and partner communication for sexual experimentation and pleasure. We cannot know from the focus group data whether this, or Whiley's other stories, are true but the performative mode of competitive banter and joking suggests that it would be unwise to use these stories as a tool for information gathering on young people's sexual practices (Holland et al. 1993, p. 13). Rather we can understand these story telling practices as part of a competitive performance of hegemonic (Connell 1987) or hyper-masculinity (Kehily and Nayak 1997), in which the young men tell familiar "sexual stories" to their peers (and to observing researchers) in order to consolidate a particular set of gender and sexual values. In telling this story, Whiley establishes his sexual prowess and status within the context of this competitive hypermasculine group performance (Kehily and Nayak 1997). In doing so, he is also seeking to establish the authority of his own sexual experience as a more credible form of knowledge to the "official" account provided by the sexual health worker (Kitzinger 1995; Kehily 2001).

In interviews the "stable" couple relationship was frequently identified as the ideal context for experiencing "good sex", but this did not necessarily mean that sex within casual relationships was unsatisfying or fulfilling. Nineteen year old James, for example, talked in his interview about the overwhelming "*wow*" feeling of being in love and "*finishing off each others sentences*". Yet he also described the pleasure of experimenting sexually with "*fuck-buddies*" and the "*thrill*" of having sex with new partners in public places. When asked to describe a particular

sexual experience that he found pleasurable, James talked about a serendipitous experience one night with friends where they all ended up "*drinking*, *having drugs and having sex*, *like in the same room as each other*" leading to a "*complete loss of inhibition*". Like James, 20 year old interview participant, Chanelle, described experimenting sexually with men and women, but maintained a desire to be in a long-term heterosexual relationships. Unlike James however, heteronormative ideals of marriage and female virginity were powerfully endorsed at Chanelle's local church and within her extended family. These norms were held in an often painful tension with her identity as a "*pansexual*" and her participation at a local LGBT group and in the London LGB social "*scene*".

Five of the 16 interview participants were in long-term relationships at the time of the interview. These interviews generated rich, complex accounts of the benefits and challenges of being in a "stable" relationship and negotiating sex in this particular relationship context. All of these young people had been through difficult life experiences, such as being excluded from education or rejected by their families. Four of these participants were heterosexual, and had all previously experienced pregnancy and/or abortion. The narratives of these five young people in particular highlight the importance of the partner relationship for providing a safe space for sexual experimentation and learning, as well as a key source of friendship, emotional and practical support. Seventeen year old Oscar's interview account is perhaps the clearest example of this. Oscar describes his first sexual experience within a casual sexual relationship as "*proper bad*" stating that he felt "*worried*" and "*uncomfortable*" – "*Like I felt like I was all getting itchy and like I was thinking*, *oh*, *what do I do*? *How do I do this and that*?" For Oscar, this experience "*ended up tragic*" as he didn't use a condom and his partner became pregnant. In contrast to this brief, early sexual encounter, Oscar is overwhelmingly positive about his current sexual relationship with the girl he is going to be with "*for the rest of my life*." Oscar described the way he and his girlfriend have gradually experimented and learnt how to pleasure each other so that he knows that his girlfriend is happy by the "*look on her face*". Oscar claims that he doesn't want to "*slip in and get out*", like other boys his age, but rather to make time to ensure that sex is "*meaningful*", that "*she's happy*" and that there is time for the "*little things*" like "*being stupid*" or having "*a giggling fit*". Unlike in the all-male focus group discussion which embraced the pleasure of the "*quick beat*", Oscar's account privileges the duration of time spent in a relationship and in a sexual encounter. For Oscar, "*taking my time*" was a way of according a value, meaning and durability that travels beyond the boundaries of the "fleeting" erotic moment (Bauman 1998).

Nineteen year old Kat also described her partner as her "*best friend*", "*role model*" and key source of inspiration and support. Unlike Oscar's account, however, Kat's description of her sexual relationships unsettles any easy equation between "good sex" and "good relationships". With her first boyfriend, Kat reported really enjoying the "*rough*", "*angry*" sex that she stated was the basis of their otherwise dysfunctional and at times violent relationship. Kat emphasized the embodied and emotional pleasure she experienced, stating that although she did not like her partner

kissing or touching her, the sex "*felt good*" in her vagina and she liked "*all the roughness*" and being able to act out her "*proper rage*" and "*frustration*" through sex. "*Rough sex*", she told me, is when "*you just want to beat them up*, *but instead of beating them up you have sex*".

In her second sexual relationship, Kat reported not wanting to have sex with her partner when he initially "*popped it in*" whilst they were lying in bed together. Despite her initial frustration, Kat revealed that sex in this relationship was "*surprisingly*" good. Unlike her first boyfriend, this partner "*had a really small penis*" and "*just wanted to come quick – which he did*", leaving Kat "*shocked*" when "*he gave me my first orgasm*". Kat describes sex with her current boyfriend however as "*not that good*" due to her boyfriend's lack of sexual experience:

> He just doesn't know what to do! (*laughs*) When a boy – I have to basically put it in, and then he does the rest but, – I like when they know what they are doing. He doesn't know what he is doing and so it's quite annoying when you have to *always* do it. It's like, get, get it now. Shit. What's wrong with you?

In her current relationship, the traditional gendered hierarchy of heteronormative sexual experience (Lees 1986) has been reversed, creating a role for Kat as the more sexually experienced partner with greater levels of control, but also with greater levels of responsibility for the "*work*" and "*doing*" of sex. This is new territory for Kat. Although she initially thought, "*Oh my God yes*" when she realized she would have more control in her sexual relationship, she increasingly finds it "*annoying*" stating – "*I want you to do it now. I can't keep doing this. I feel like a man*!" Unlike other young women I interviewed who described the pleasure of being "*in charge*" and performing an apparently unusual powerful female role, Kat expressed anger and frustration in always having to perform the apparently "unfeminine" labour of sex. For Kat, at least at this stage in her life, being in a emotionally connected long-term relationship in which she has a greater sense of sexual agency and control, prohibits rather than enables the experience of "good sex" and a positive sense of sexual wellbeing. Like other young women in the study, Kat described the challenges of negotiating sexual pleasure within the context of a long-term heterosexual relationship. These accounts demonstrate, as has been documented in previous research (i.e. Holland et al. 1998; Allen 2005), the limitations of heteronormative frameworks for understanding the variety and complexity of embodied, gendered practices involved in negotiating sexual pleasure.

Kat's interview narrative provides a rich account of the range of emotional and embodied sexual experiences that can be experienced by one young woman in a 3-year period; roughness, aggression, surprise, frustration, hard work, sensations of orgasm, ecstasy and disgust. Her interview account, like others in the sample, suggests that what counts as "good sex" to a young person is dynamic and shifting, contingent on relationship context, on challenging negotiations between partners and on both partners' evolving levels of sexual experience and sexual desire.

Analysis of the interview data suggests that the couple relationship is an important space within which young people can experiment sexually and learn

about sexual pleasure. Yet, particularly for young women, it can also be a space of inertia, where sexual desires and the fragile ideals of reciprocity and mutuality can become compromised and restrained (Braun et al. 2003). These findings suggest that whilst there may be advantages for young people in exploring the "benefits" and pleasures of longer-term, supportive relationships – as recommended in English policy documents – such an approach fails to engage with the messy and complex realities of some young people's sexual experiences. Further, the imperative to promote the "benefits" of "stable relationships" (DoH 2013a, b, p. 17) may fail to provide young people with a critical account of the ways in which gendered power dynamics continue to shape possibilities for pleasure. As the focus group data in particular suggest, notions of delay, timeliness and relationship "stability" can all too easily get taken up in group discussions to reinforce the moral authority of the sexual double standard.

An alternative approach to supporting young people's sexual health and wellbeing would be to create opportunities within sexual health and education services for young people to explore the different possibilities and barriers to pleasure within different casual and longer-term relationship contexts. Such an approach could encourage young people to think critically about different gender roles and expectations and to explore the range of moral values and emotional experiences that may shape understandings of "good" and "bad" sex (Alldred and David 2007; Allen 2005; Carmody 2009; Fine 1988; Thomson 1994).

Conclusion: Safe Spaces and Institutional Contexts

> Rather than having to create a safe space for and by ourselves, each week we found ourselves being pushed by adults to re-evaluate our comfort zones, be them [sic] political, social, or poetic. I felt that by the end of the year long *Echoes* project, there were no barriers among us. (Youth Researcher Kendra Urdang in Torre et al. 2008, p. 26)

This chapter has critically examined the sexual experiences and values of a sample of young people in London, England, focusing on how young people respond to questions of "good sex" and "sexual pleasure". Drawing on an international body of literature that advocates the inclusion of pleasure in sexual health and education frameworks, the chapter argues that placing questions of pleasure at the centre of research/practice on young people's sexual wellbeing can create spaces to explore some of the contested, emotional and moral aspects of sexual experience that frequently remain unspoken in sexual education and health service interventions and in wider cultural domains. The research indicates, however, that engaging young people in this critical research/practice will not necessarily have the transformative effects or political value that both policy makers and critical researchers may hope for (Allen and Carmody 2012). It follows, then, as others have argued (Alldred and David 2007), that work aimed at promoting young people's sexual wellbeing involves engaging with the messy, and sometimes uncomfortable, realities of young people's sexual lives and values.

The research suggests that creating spaces to explore questions of sexual pleasure and desire presents opportunities for young people and researcher/practitioners to explore this contested terrain of conflicting moral values and to work through experiences of difference, inequality, loss, desire, exclusion, fear, pleasure and, as one focus group participant suggested, the "emotional garbage" of sex (Wallay, focus group 1). Reflexive analysis of the focus group data suggests that it is possible for researcher/practitioners to set up group spaces with young people in order to explore what counts as "good sex" or a "good" or "healthy" relationship. Such accounts also suggest that these meanings are contested and contradictory, provoking lively and emotive responses from participants – and in one group – from the sexual health worker and youth worker participating in the discussion. Differences between individual and group accounts indicate that this work is unpredictable; what it is possible to say and to hear in any given encounter will depend on the power relationships at play in different local, institutional and wider social contexts (Phoenix 2008). For researcher/practitioners this suggests that critical work on youth sexual wellbeing and pleasure can be productive yet challenging, requiring the practitioner to be open and ready for the unpredictable nature of these encounters and the potential for resistance, disruption, humour and play (Gillies and Robinson 2010).

Perhaps the ideal space for engaging in this work would be the kind of "safe spaces" described by youth researcher Kendra Urdang (Torre et al. 2008, p. 26, see above), who participated in the year long participatory *Echoes* project in New York. As Maria Elena Torre and colleagues describe, this project aimed to address issues of inequality and difference through co-creating safe spaces over time in which young people felt able to re-evaluate their "comfort zones, be them [sic] political, social, or poetic" (Torre et al. 2008, p. 26). It seems unlikely, however, that this kind of creative and longitudinal work would be possible within already squeezed PSHE curricula and the "cerebral" space of the school classroom (Alldred and David 2007). Possibilities for creating these kinds of "safe spaces" will depend on locally available resources, institutional and policy contexts. Practitioners working in schools, for example, may find that possibilities for exploring the diversity of sexual meanings, values and experiences with young people are limited by policy imperatives that assert the moral value of stable and loving relationships or by individual school SRE policies. Arguably, there may be more potential for this work in sites that are peripatetic to schools, such as those created through collaborative research projects (e.g. Gilies and Robinson 2010; Torre et al. 2008).

The work of voluntary sector organizations, which in England are frequently commissioned to deliver outreach sexual health and education sessions in a range of informal community and youth worker settings, may offer another site of possibility. As the outreach worker who participated in focus group 3 observed, in the context of a 6 week outreach program at a local youth centre he had been able to deliver a number of sessions on sexual pleasure at the young men's request, but he would not advise, or think it possible, to conduct this work and the focus group activity that we co-facilitated in a school environment. This suggests that in order to engage young people in conversation about the holistic, political and emotional dimensions

of "good sex" and sexual wellbeing in different institutional settings, intervention is required at the level of socio-political campaigning as well as at the level of professional practice. In the UK, in the current climate of "austerity", cuts to youth services, increased pressures on the secondary education system and the rise in conservative agendas around abortion and sex education, it seems increasingly important to both offer an alternative proactive and positive agenda around youth sexuality education and to consider how limited resources can be used and "scaled up" (Askins and Paine 2011) most effectively in order to deliver this work.

This chapter began by acknowledging that the concept of youth wellbeing has attracted growing popular, political and policy interest in recent years. Yet this is frequently framed by a sense of alarm or concern about young people's vulnerability, marginalization or risk-taking behaviours. Using research that has adopted a critical and culturally informed approach to young people's sexual lives, this chapter has argued that researchers, practitioners and policy-makers need to ground understandings of youth sexual wellbeing in empirically based accounts of young people's sexual experiences and values. Such an approach views young people as "co-constructors" in understanding wellbeing, highlighting the ways in which young people's accounts speak to – but are distinct from – policy accounts that foreground particular moral agendas and/or individualized solutions to health and wellbeing promotion.

The analysis presented here highlights the kinds of insights made possible through adopting this approach, which encompasses: a broad and holistic perspective on young people's sexual lives that moves beyond a concern with sexual behaviour and health outcomes; an appreciation of the diversity of young people's sexual values and experiences and the ways in which these are shaped by different relationship, community and wider social contexts; and an understanding of the moral and emotional dimensions of young people's sexual lives that surface when young people start to explore the unequal distribution of pleasure, risk and power in their relationships and communities.

To understand the experiences of a young woman such as Kat, for example, requires recognition of the ways in which sexual health and wellbeing are shaped by personal and relationship histories, as well as the wider social contexts within which those histories develop and evolve. At the time of the interview Kat expressed anger, frustration and resentment towards her boyfriend, not just for his sexual inexperience and failure to embody the traditional male sexual role that she desires, but also for his part in the decision to have an abortion when Kat became pregnant early in their relationship. This decision was shaped both by Kat's boyfriend and his family's aspirations that he should go to university and her own desire to not "*walk into my mum's shoes*" – that is to not become pregnant at a young age, receive a low level of education and work in low-paid, unskilled jobs. In order to develop a nuanced understanding of Kat's sexual health and wellbeing, what is required is not an individualized account of the factors of risk and resilience at play, but an explanation of the ways in which Kat's class, gender and racial identities and aspirations – together with her embodied experiences of loss, pleasure and desire – shape her sexual experiences and broader sense of wellbeing. Such an account

demands a rich and complex approach to youth wellbeing. One that can attend to the social, physiological, emotional and moral dimensions of wellbeing and that uses a social justice agenda to ensure that inequalities of sexual health and wellbeing are understood within the broader social and community contexts.

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Chapter 7
"I'd Just Cut Myself to Kill the Pain": Seeing Sense in Young Women's Self-Injury

Kathryn Daley

Abstract Self-injury is a complex and stigmatized phenomenon, most commonly associated with young women and generally assumed to be damaging to wellbeing. This chapter challenges the assumption that self-injury is a threat to wellbeing by arguing that it is a defence mechanism some young women draw on to cope with immense emotional pain. When understandings of self-injury begin from the assumption that the behaviour is "harmful" ("self-harm") and counter to one's wellbeing, they are unable to capture its nuanced function. To presume self-injury compromises wellbeing is to presuppose that the effects of cutting are worse than the effects of *not* cutting. Drawing on narratives of young women accessing drug treatment services who also had a history of self-injury, the complex correlations between self-injury and childhood trauma – specifically, sexual abuse and experiences of abandonment – are highlighted. These traumas appear to lead to a ruptured sense of embodiment and emotional dissociation. The accounts of these young women suggest that rather than an indicator of psychopathology, self-injury may be better understood as a logical response to trauma. The young woman is not seeking to compromise her wellbeing; rather, she is trying to ensure it.

Keywords Self-injury • Sexual abuse • Abandonment • Dissociation • Childhood trauma

Introduction

Self-injury refers to the purposeful, non-suicidal, injury of oneself. The most common form of self-injury is cutting. Other types of self-injury include: burning, bruising, pinching, or wound interference. The severity of self-injury varies. It is often mild with superficial wounds not requiring medical treatment but self-injury can sometimes be so severe that it is life-threatening (Adler and Adler 2011; Levenkron 1998). Self-injury is sometimes referred to as "self-harm" or "self-mutilation", but these terms are problematic as they presuppose that the behaviour

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K. Wright, J. McLeod (eds.), *Rethinking Youth Wellbeing*,
DOI 10.1007/978-981-287-188-6_7

is negative without exploring why people engage in it. Focusing on the behaviour rather than its function frames self-injury as an individual's problem and responsibility rather than a consequence of an interplay of structures and experiences in which an individual is embedded. Moreover, and importantly for the concerns of this chapter, self-injury is widely assumed to be damaging to one's wellbeing.

Beginning from a sociological viewpoint, this chapter provides a description of the function of self-injury among a group of young women who were involved in drug-treatment services. Self-injury is a behaviour associated with women, but as little is known about the demography of the self-injuring population, it is difficult to know how representative any sample is. Studies drawn from psychiatrists' case studies portray the typical "cutter" as a middle-class white schoolgirl (i.e.: Favazza 1996; Levenkron 1998). Other research has also presented self-injury as exclusive to women, though recognizing that the practice is not limited to the teenage years (Strong 1998). Importantly, some recent studies have actively sought to recruit men. Chandler (2012b), for example, interviewed 12 people aged 12–37 years and she sampled purposively to gain a gender balance (seven female, five male). Adler and Adler (2011), whose study involved 135 in-depth interviews, also included men, although 85 % of the sample was female and most were Caucasian. In Australia, a large cross-sectional telephone survey of 12,006 people drawn from a representative sample found that self-injury was most common among young women aged 20–24, with 24 % reporting having ever self-injured, compared with 18 % of men the same age (Martin et al. 2010). While a number of studies suggest self-injury to be more common among young women, other research has found no significant gender difference (Tyler et al. 2003).

The current study was undertaken with young people accessing drug treatment services. Through life-history interviews, 20 of 26 women disclosed a history of self-injury compared with only 3 of the 35 young men. This chapter seeks to explain the gendered nature of self-injury among young women experiencing problematic substance use. The chapter begins with a discussion of the literature on self-injury and an outline of the methods of the current study. It then presents the accounts of the young women who were interviewed and these accounts suggest that there is a connection between childhood sexual abuse, abandonment, and "dissociation". The research findings challenge the assumption that self-injury is a threat to young women's wellbeing; rather, it suggests that self-injury may be a rational and logical response to compounding traumatic life experiences. This alternative way of thinking about self-injury provokes new and challenging ways of understanding the relationship between wellbeing, embodiment and practices of the self.

Conceptualizing Self-Injury

The intentional injury of oneself is highly disconcerting, and this discomfort is exacerbated when the injury involves perforating one's flesh. The sight of blood is confronting as the breaking of the body's boundaries is a powerful symbolic gesture

which is deeply embedded within the social imaginary as something deviant and/or pathological. Hodgson (2004) has suggested that attempts to classify self-injury as a mental illness is a consequence of society's need to explain the "deviant". Self-injury is a feature of several formal psychiatric diagnoses; however, it was only in the recently released fifth edition of the Diagnostic and Statistical Manual of Mental Disorders that "Non-Suicidal Self-Injury (NSSI)" was listed as a "Section Three" disorder. Section Three disorders are those that may not be covered by health insurance as they are "disorders which require further research" (American Psychiatric Association 2013).

Prior to NSSI having its own diagnostic criteria, it was still a deeply pathologized behaviour and closely associated with Borderline Personality Disorder (Cameron et al. 2012; NIHM n.d.). Even where a person qualified for such a diagnosis, this did not explain self-injury, as many people with Borderline Personality Disorder do not self-injure; and most people who self-injure do not have Borderline Personality Disorder. Nonetheless, the focus on the behaviour as a symptom of disorder has perpetuated the need to diagnose the individual. The need to assess and treat those who self-injure begins from the basis that there is something inherently wrong with the behaviour. Attempts to understand self-injury's function have been constrained by the heavy psychiatric lens through which it is typically framed (Adler and Adler 2011; Chandler et al. 2011; Hodgson 2004). Psychiatrist Armando Favazza (1996) has written extensively on self-injury. He calls for "cultural psychiatry" to be adopted as a way for the profession to gather a better understanding of all that self-injury entails. Cultural psychiatry adopts a more holistic understanding of people's psychopathologies by assessing the role and place of culture in their lives; yet, cultural psychiatry still views the individual as a patient and symptoms as a sign of pathology.

There is a small but emerging body of work which questions the assumption that self-injury is indicative of psychopathology. Claes and Vandereycken (2007) argue that there are multiple theoretical explanations. The first is the traditional structuralist approach which sees self-injury as an irrational behaviour of the individual and thus a symptom of illness. The second is the functionalist perspective which understands self-injury as a coping mechanism and/or a sign of distress. These perspectives suggest that rather than accepting that self-injury is an implicitly pathological issue, it may actually be a meaningful behaviour. Likewise, Chandler (2012a) suggests that sociological explanations are needed as the psychiatric paradigm problematizes the individual rather than understanding the context which contributes to the urge to self-injure. Harris (2000) undertook a "correspondence study" where she exchanged letters with women who self-injured to learn about the contexts in which they cut themselves and found that there was a "situated logic" to young women's cutting. Many of her participants explained that the intention of their self-injury was to "cut out the bad". Rather than focusing on the "bad" being intrinsic to the individual, Harris was curious to understand how the "bad" ever "got in". She began from the viewpoint that the negative emotions which instigated self-injury were not manifestations of an individual's pathology but a consequence of an individual's experiences.

Harris (2000) suggests that the oft-held view that self-injury is irrational is a consequence of Western society's privileging of dispassionate knowledges. When looking at self-injury in isolation from the individual's experience, the logic of the behaviour is impossible to see. This apparent absence has helped to reinforce the view that self-injury is a psychiatric issue. However, seeking to separate emotions and experiences from understandings of an inherently embodied phenomenon such as self-injury fails to capture a full understanding of the function it services for the person who engages in it (Chandler 2012a; Harris 2000; Horne and Csipke 2009). Notwithstanding, self-injury is a deeply individual practice and psychology offers useful frameworks for understanding some of the individual processes at play.

Recent sociological discussions have demonstrated that when self-injury is explained with attention to the emotions the individual feels, self-injury can be seen as a coping behaviour. So while it may be "unconventional", self-injury is not irrational (Alexander and Clare 2004; Crouch and Wright 2004; Harris 2000). Although literature on self-injury is dominated by psychiatry, there have been some very useful sociological studies which offer an alternative and complementary angle. These explore the motivations for self-injury and contexts in which it takes place in order to understand the phenomenon at a broader level. Hodgson (2004) conducted an exploratory study which sought to understand how cutting is learned, as well as how people who cut manage the stigma with which it is associated. Adler and Adler (2007) note that Hodgson's study is an exception to the overall absence of systematic sociological inquiry. This absence prompted Adler and Adler to undertake a large, longitudinal qualitative study, published as a book in 2011, and from which I draw upon throughout this chapter. Similarly, Chandler's small empirical study (2011, 2012a, b) sought to extend the sociological literature as well as give voice to those who self-injure and who are not involved in psychiatric care.

Method

This chapter draws on 20 life history interviews with young women aged between 15 and 24 (mean age, 19). The interviews were conducted as part of a larger study exploring young people's pathways into problematic substance use. That study had a total sample of 61 young people (57 % male) recruited from across various services in the Australian state of Victoria. Prior to conducting this research, I had been employed as a youth alcohol and other drug outreach worker and was therefore familiar with the sector and the staff of a number of service providers. This afforded me "insider" access to services as the staff felt that they could trust me adequately to be left to collect data and spend time with the young people without staff needing to supervise me. Guiding this research was the sociological concept of "situated choice" (Shiner 2009), which I adopted to understand how young people negotiated the structural barriers they faced.

The young people in my study faced multiple and marked indicators of disadvantage. Only 7 of the 61 had completed secondary school and 86 % of the young men

and 95 % of the women had been homeless. Contact with state care and protection systems was common, with 69 % of young women and 39 % of young men reporting involvement with child protection services. Mental health issues were pervasive: 30 of the 35 young men disclosed a mental health issue with depression, anxiety and psychosis most common. Among the young women, 23 of the 26 reported a mental health condition. The young women fared worse on all indicators of vulnerability except criminal justice involvement and this finding supports that of 2013 Statewide Youth Needs Census of young people accessing drug treatment services in Victoria, which found women were faring particularly badly (Daley and Kutin 2013; Kutin et al. 2014).

The central aim of the broader study was to answer the question of how some young people came to experience problematic substance use and thus the young women were not recruited because of their self-injurious behaviour. Participants were recruited in residential withdrawal units ("detoxes") and day centres for youth with substance abuse issues. To build rapport and get to know the young people, I spent my days "hanging out" in these places, sitting in a lounge area or outside on a basketball court, with them. This preparatory fieldwork enabled the young people to get to know me in an environment in which they had some ownership.

There were almost always several young people hanging about together, which tended to generate a greater degree of comfort and forthrightness in these informal discussions. These discussions gave young people an opportunity to get a sense of me before deciding on whether or not they would like to participate in an interview. Bourdieu (1996) has rightly noted that providing people with time – an absence of which in everyday settings constrains the search for depth in communication – is central to the interviewer setting up necessary conditions for life-history interviews. As a way of fostering a sense of calm, I ensured that my time "in the field" was spent without a sense of urgency. This was a practice I used in my former life as an alcohol and other drug outreach worker – where I made the conscious decision to not wear a watch. The intention of this was to demonstrate that time was not a limiting factor. The young people could take their time in getting to know me and tell me their story when and if they were ready.

I endeavoured to provide participants with a space to feel comfortable to share the intimate parts of their lives. Doing this provided them with the opportunity to talk about their lives, free from the constraints of a formal interview schedule. There was an interview schedule that was used as a guide to ensure the same themes were canvassed among each participant. However, I explained to my participants that they were the experts and I was the learner, "tell me what is important to you", I would emphasize. Very early on in the data-collection, it became obvious that a key commonality among the women was a past history of self-injury – a topic I had not initially intended to explore. Although self-injury was not exclusive to women, it was far more prevalent. Among the young women, 77 % disclosed a history of self-injury compared with only 9 % of men. All of the young women used cutting as their method of injury.

The following discussion focuses on the 20 young women who disclosed a history of self-injury. These women were experiencing considerable adversity.

Housing was precarious and educational attainment was poor. Only 4 of the 20 had completed their final year of secondary school (Year 12). Eight young women had left the education system completely by the age of 14. Four young women had completed Year 9 and four left at the end of Year 10, aged 15–16 years. Comparatively, across the state of Victoria, 92 % of female students in schools complete Year 12 (DEECD 2013). The interviews revealed that school disengagement and homelessness were often consequences of family breakdown and childhood trauma.

The young people in this study shared with me the most intimate parts of their lives. Some young people were practised at telling their story and others were telling it for the first time. There were, of course, many ethical considerations in a study such as this and I have written in more detail about this elsewhere (see Daley 2009, 2012, 2013). A major issue for me was how to protect young people as they shared their stories without going so far as to preclude, and thus silence, them. There were also ethical considerations in ensuring that I did not experience vicarious trauma hearing these heavy stories of abuse and neglect. In the coming section, I quote the young women heavily with little analysis or comment interspersed. This is partly because I feel that these young women spoke with more eloquence than I could offer them; but most significantly, I wanted their voices to permeate this account of their lives. Christensen and Prout (2002) have rightly articulated that, "The task of the social scientist is to work for the right of people to have a voice and be heard" (p. 483), and it is in this spirit that, wherever possible, I aim for the young women's voices to "speak for themselves". At times, this is very confronting.

Bourgois (2002) discussed his own dilemma about wanting to soften the sometimes ugly aspects of his field data drawn from the years he spent living in East Harlem undertaking an ethnography on the street-based crack trade. He decided against it for much the same reason as I: as a researcher, our job is to report the worlds we are seeking to understand. Therefore, the darker our subject, the darker our writing. To add light where they may be none is a disservice to participants and research integrity. Attempting to soften our readers experiences privileges the reader over the participant. The researcher's duty is to tell the story, irrespective of how disconcerting it may be.

Childhood Trauma: The Body's Boundaries

Physical abuse, neglect, and involvement in the state care and protection system were common among the young women in this study. Childhood sexual abuse was not a scheduled topic for the interview; nonetheless, 16 of the 20 young women disclosed that it had been a part of their lives. As well as the high prevalence of sexual abuse, a shared sentiment among the young women was the experience of feeling abandoned – both literally and figuratively – by their mothers. In total, 13 of the 20 reported that they had been abandoned.

Sexual Abuse

The topic of sexual abuse presented itself in a variety of ways within the participant's broader narrative. As noted, I did not specifically ask young people about this, but if they did disclose it I would offer them the space to discuss it provided I felt that this was in their best interest.[1] My background as a clinician informed much of my ethical negotiations, as well as Noddings' (2003) theory of relational ethics which suggests that caring for people, and ensuring they feel cared for, will guide ethical reasoning. With care, I listened as these young women spoke, often tearfully.

Ebony had a biography that was typical among participants. When I asked her if as a teenager she had stayed at home much, she revealed:

> Nup, never. I just … I'd rather live at my friends' houses … [where] I'd never get bashed or hurt in other ways. I'd always try to prevent going to my parents.
>
> KD: Was there abuse at home?
>
> Yeah, yeah. I got, er, ah … by my so-called stepdad … I was staying there, in the living room, in the fold-down bed, and he raped me. I was only 15 … He bashed our family … Yeah, we've bled a lot over him.

Lisa was also sexually abused. Like Ebony, Lisa was raised in a home of family violence and neglectful parenting; but, Lisa's case differs from Ebony's in that her mother did not know about the abuse and the perpetrator was not a family member. Lisa had spent 3 years sleeping on the streets in her early teen years and when I asked if her safety had ever been compromised during this time, she explained that it had not been while she was on the streets, but it had earlier:

> When I was in primary school, Dad wasn't there, because Mum had to go … what it feels for me … I am just trying to get the words – I am not very good with words, sorry …
>
> KD: No, take your time …
>
> … what made me, when I first was young, what started everything, being angry and sort of wanting to, I don't know, knick off somewhere or just drink, was because … it was when Mum put me in after-school care and like, I feel that's what caused me to go off the rails a bit. Because, like, what happened … it was one of the ladies' sons or something … I couldn't tell my mum what he was doing, because, well [*starts crying*], I felt like I was going to get in trouble or something. Yeah, he just kept … I had to go there every day. Mum sent me. Mum asked him to babysit me … he just kept making me do shit with him [*sobbing*] … I can still remember it.

Riley had also been sexually abused. For her, it was in the place she had sought refuge:

> I was in Year Eight … it was one of my friends who I was staying with when my mum kicked me out – her dad sexually assaulted me. He always sexually assaulted my other friends when they stayed over too.

[1] For a detailed discussion of assessing the risks of over-disclosure, see Daley 2012.

Not long after this, Riley had moved interstate to a boarding school, which an estranged – albeit caring – extended family member financed. However, her personal issues eventually led to a separation from school and her tenuous housing arrangements contributed to an escalation in her drug use. At one point, Riley was able to find accommodation in a share house and she attempted to return to the local public school for Year 11. However, with the complexities in her life this was not sustainable. Throughout all of this, there was no contact with her mother. When asked if she missed her, she replied, "She really hurt me. She really, really hurt me". The young women often had many unresolved issues and were attempting to "move on" from these while simultaneously trying to build a new future.

Abandonment

Sexual abuse was not the only common experience among these young women. Always, there were several other factors which prevented recovery from the abuse. Parental mental illness and/or substance abuse, disconnection from school, housing instability, family violence and involvement in child protection systems were all frequent. Yet, the most common and the most devastating factor appears to have been the experience of being abandoned. For the purposes of this chapter, abandonment refers to the young women's primary carer's ejection of the child from both the family and the home. In my study, this was always maternal abandonment; however, it should be noted that at the time of the abandonment, these young women's biological fathers were mostly disengaged from their life. The lasting and troubling effects of abandonment among these young women is consistent with Alexander and Clare's (2004) research, which found that environments where young people were undermined and their feelings invalidated were a key factor in the lives of people who self-injured. Like Riley, a sense of home or security was never part of Ebony's life. Ebony's mother kicked her out of home when she was 13: "Mum sent me up to Melbourne, she just didn't want me anymore".

When asked how that made her feel, she replied, "I cry, I cry every day. Every day I cry".

Ebony's sadness about being kicked out was compounded by the reasons she was excluded from the family. Ebony's stepfather had been sexually abusing her and she felt that her mother was envious that her daughter was receiving his sexual attention:

> Yeah, she knew [about the abuse], but she loved him. I'd ask her, "If you put us first, why didn't you leave him?", and she'd say, "I didn't have anywhere else to go", and I'd say, "Well going anywhere is better than going back there", and she goes, "Yeah, well I loved him and I didn't want to break his heart" … I asked her again down the track and she said, "When you've been with someone, you just become attached and you know, the sex just becomes, well you know, you just really love it and you need it". That just really hurt me.

While Lisa was aware that her mother did not know of her years of abuse at the after-school care program, she still felt a deep sense of hurt and abandonment that

her mother had left her in this program to be "cared" for. Later, Lisa's feeling of betrayal was cemented when she was literally abandoned:

> ... one night my mum kicked me out basically, and I went down to my best friend's house, and into the city ... we both went into the city on a train and ended up staying in this squat with these old guys. ... sometimes I would go back home, because they'd put a warrant out or something, and then I would go back and stay a couple of nights and we would have a fight or something and I would just go again. So yeah, I don't know, she got a bit sick of me being, just, um, just having a daughter, I guess.

In addition to this abandonment, there were other issues in Lisa's past which made living at home untenable. Lisa's stepfather was abusive and this was not an issue addressed by her mother. As Lisa shared this, her voice both lowered in volume and began to tremble in tone. The pain associated with this trauma was clearly still raw. It was apparent that her mother's inaction caused just as much – if not more – distress than the assault itself. The absence of her mother's protection affected Lisa not only physically but also psychologically as she felt that she had been neglected by the person who should have kept her safe.

A feeling of abandonment was echoed by Riley:

> I was always having problems with Mum ever since I was a little kid. Always the little things: I was sporty, but she wanted me to do music. It was always a lot of hate with each other. Even though I was only so small ... it got to the point where she just didn't want me anymore.

Pining for a mother's love was a common narrative. Lisa spent some time in the care of the state, an experience which she found mostly positive because it was the one place where she had both food and safety. Nonetheless, she eloquently captured the feeling of being without a parent's love: "If you don't have the affection from a parent and everything like that, you are an outcast in the world".

For 16 year old Jessica, a volatile and problematic home environment increased the insurmountable pain she experienced after being abandoned:

> She kicked me out and told me that us kids stole the best years of her life and she wished she never had us, that we were all spoilt little brats ...
>
> KD: Do you miss Mum?
>
> Yes. I hate her so much that sometimes I think I could actually kill her, but ... [*starts crying*] ... she doesn't deserve fucking anything. She's an arsehole and that's the truth.

Jessica, like all of these young women, experienced a tension between feeling hurt and angry at her mother; and a desperate want for her mother's love. We can see that these young women's trauma was not isolated to their experiences of sexual abuse. The abuse the young women in this study experienced was compounded by the absence of support and safety. Not only were they frequently being abused by a trusted male in their lives, but their mothers ignored or dismissed their cries for help and not uncommonly, abandoned them entirely. In my study there were four young women who had not been sexually abused and seven who had not been abandoned; however, these young women also had backgrounds that included other experiences of trauma. For example, Jess had been physically abused so severely

that she was removed from her parents' care and raised in the care of the state. Jessy (distinct from both Jessica and Jess) was also raised in Out of Home Care because of inadequate safety at home. Katte was not removed from her parents' care, but perhaps should have been as her home life was characterized by violence. Mary had not been sexually abused, but had been abandoned by her parents who were separated: first by her mother, and then her father.

Abusive and/or ruptured family relations typically inhibit a child's capacity to develop positive coping strategies (Strong 1998). This also eliminates the key place in which one typically addresses personal or psychological issues: home. For the young women in this study, being kicked out of home, and later experiences of homelessness, meant that there was no safe place in which to recover from their trauma. Feeling abandoned by their mothers exacerbated their pain immeasurably.[2] A consequence of such experience is that the individual learns to internalize their pain (Strong 1998). The dominant theme in the narratives of these young women is the mother's omnipotence, reflecting an underpinning assumption that overlooks any role or responsibility of a male caregiver. This is probably because most had absent or abusive fathers. Yet, common among all of the young women was the absence of a nurturing caregiver of either gender. Therefore, what can be seen from these extracts is the complex interplay of multiple traumas that went without support. These young women did not have the supports of their immediate or extended families and typically did not come to the attention of authorities for any other interventions or assistance. Rather than receiving the nurturing that we take for granted as a part of childhood, they were often simply trying to survive. The intense emotional pain that these 20 young women felt, combined with a lack of physical safety, contributed to many experiencing what appeared to be a sense of emotional dissociation.

Dissociation and Self-Injury

A woman's relationship with her body after sexual assault can be highly troubled as her sense of embodiment is violated. Adler and Adler (2011) highlight that women learn early that their body is a commodity. After rape, the body can be seen as the enemy and in turn, this perception can lead to a separation of the body from the mind. Psychologists refer to this separation as dissociation. Although dissociated states are strongly connected with self-injury, it is important to recognize that

[2] "Mother blame" stems from the notion that a "good mother" is all-knowing and is dutifully able to care and protect her children in all ways at all times. It is deeply implicated in the patriarchal notion that men cannot be held responsible for their actions as it was a woman who created an environment for the action to be possible. Most of the women in my study were sexually abused and all of the perpetrators were men. It is curious that the shocking part of the narrative is not that men abused these women, but that their mothers did not stop it. See Liebman Jacobs (1990) for discussion of mother blame within the context of father-daughter incest.

they serve a positive psychological purpose. How one learns to dissociate, and the psychological function it serves, is described well by Strong (1998, p. 38):

> Dissociation in its more serious forms is a psychological defense mechanism that keeps traumatic memories, sensations, and feelings out of conscious awareness. It is a key defense used by abused children. In the face of overwhelming danger from which there is no physical escape, it is an ingenious bit of mental gymnastics … Mind and body separate. Pain is anaesthetized. The individual feels depersonalized: numb, unreal, outside oneself, a dispassionate observer rather than an anguished participant … She can't remove her body from danger, but she can leave it emotionally.

Strong also explains that the ways in which children learn to cope can help to explain why some people will go on to cut themselves in times of intense stress. When understanding various "maladaptive" coping mechanisms, a distinction is often made between people who externalize their stress and those who internalize it. Those who externalize are likely to attribute responsibility for their stress to an external source and demonstrate their anger in ways that are outwardly demonstrable, for example: yelling, punching a wall, or blaming others. In contrast, the person who internalizes their stress tends to take too much responsibility for the situation and become intensely angry, disappointed, or frustrated in themself. The anger is often unnoticed by others as it is directed inward. The self-injurer is an internalizer (Adler and Adler 2007; Alexander and Clare 2004; Strong 1998). It is the tendency to internalize pain, combined with states of dissociation that typically precipitate self-injury.

As a defence mechanism, separating the psychological self from the physical self is likely to bring its own problems. Shutting off the mind from the body has led many of the young women in the current study to express that they no longer feel alive. Yet an accompanying desire to feel alive was constrained by a deep sense of self-loathing that often came from viewing their body as the source for their troubles. Consequently, we can see how young women's desire to "feel alive" was restricted by the depression and self-loathing which they experienced so severely. It seemed that when they did feel emotions, their pain was intolerable to the point that they actively sought to escape it and cutting was the method they used to do this.

There is a duality in explaining the relationship between self-injury and dissociation. The neat conceptual understanding that the young woman is emotionally dissociated and cuts to feel alive[3] is not an adequate account – a one-size-fits-all explanation is insufficient. Suyemoto (1998) has suggested that self-injury may serve multiple functions and both Tyler et al. (2003) and Chandler (2012b) discuss the competing explanations of the function of self-injury. Suyemoto (1998) agrees that self-injury's function may be to disrupt dissociation – the urge to feel "alive". However, she also suggests that for some, the purpose of self-injury is to *elicit* dissociation – the urge to stop feeling. Both of these explanations were offered by the participants in the current study. While it may seem that these explanations of the role of dissociation in self-injury is paradoxical, Horne and Csipke (2009)

[3]It is suggested that either the release of endorphins or the sight of the blood trigger this.

suggest that regardless of whether the intent is to bring on dissociation by stopping overwhelming emotions, or to end a period of dissociation by eliciting emotions, the function of self-injury is the same – to suspend an intolerable emotional state. Of the 20 young women who had self-injured, a common theme was that all felt a tension between wanting to feel and wanting to cut out the pain. This duality was integral to these young women's explanations for their self-injury.

Both in my research and in other studies, there appears to be a strong relationship between childhood abuse and self-injury. Among 50 self-injurers interviewed, Strong (1998) found that nearly all had experienced some form of abuse and/or neglect in their childhoods. The violation of the physical body can lead to a problematic relationship with it. Yet the body, the site of the trauma, is physically inescapable. It is also possible that the victim views their body as "seductress" and in turn, the body might be blamed for attracting unwanted attention (as is so often the case in mainstream conjecture about whether "she asked for it"). Harris contends that biblical references such as "If your hand is your undoing; cut it off" (Mark 9:43 in Harris 2000, p. 166) encourage the notion that the individual's body must suffer where it is more likely to be the source of the problem. Using a more secular framework, Strong (1998) explains the relationship between sexual abuse and one's sense of embodiment:

> Sexual abuse is the most obvious, and perhaps the most devastating, attack on body image. The body is never wholly one's own again. In fact, the victim's own body is used as a weapon against her. It is controlled by others and can be made to respond—the ultimate betrayal—against the owner's will. Its boundaries are violated and intruded upon, creating a lingering confusion between inner and outer ... An abused child may come to feel totally divorced from her physical self. (p. 122)

Strong suggests three possible explanations for the link between sexual abuse and self-injury. The first is that self-injury may have been used as a way for these women to regain some control over their bodies. The notion of control – that cutting releases pain in a way that the individual has control – is inherent within many explanations of self-injury (Chandler 2012a; Harris 2000). Like dissociation, control is a theme which abounds the literature on self-injury (Adler and Adler 2011; Favazza 1998; Tyler et al. 2003). Strong's first explanation is focused on the young woman's desire for control of her body.

Strong's second explanation is that self-injury focuses on the control of pain. She asserts that cutting may "allow the tortured individual to play out the roles of victim, perpetrator, and finally, loving caretaker soothing self-inflicted wounds and watching them heal" (p. xviii). These explanations are supported by the work of both Suyemoto (1998) and Chandler (2012b) who found that for some self-injurers, having control of their body's injury, as well as being able to care tenderly for their wounds, was the purpose of this behaviour.

Strong's third explanation suggests that the visibility of the blood disrupts the young woman's dissociated state and provides evidence that despite their emotional numbness, they are in fact alive. This explanation is again about the woman's search for control – this is for control over her emotions. While none of the young women in

this study spoke explicitly of self-injury as a form of self-care, Strong's explanations of control of body and control of emotions were dominant.

Thus far I have outlined some of the childhood traumas of these young women and their common experience of abandonment. I have also shown how this led to what can be characterized as a sense of dissociation, and that this, combined with a pattern of internalizing their feelings, appeared to be the common formula for self-injury. I suspect the tendency to push emotions inwards was forced upon these young women through the absence of a viable external outlet such as a secure relationship with a positive adult or a home where they were safe and cared for. Others have also found that people who self-injure lack the opportunity to outwardly express emotion, and/or the ability to do so (Inckle 2011; Strong 1998). Next I provide first-hand accounts of why the vast majority of the women in this study used self-injury as a strategy to deal with the dilemmas that I have suggested are a consequence of dissociation. We see how the young women in this study wanted to reassert control of their body, their pain, and their emotions.

In Search of Control

When asked what she liked about self-injury, Stevie replied: "It made me feel like I was alive". In fact, when asked about the function or purpose of self-injury, the descriptive language participants' adopted was profoundly similar. The frequency that "feeling alive" was used to describe self-injury was what initially highlighted that there was a common phenomenological pattern emerging. Like Stevie, Lizzie also explained, "I just felt like I deserved it … so that I knew that I was alive", as did Katte, who stated that, "It was the only thing that made me feel alive".

Slicing one's flesh with a blade as means of feeling "alive" seems counter-intuitive; but deeper than the wounds lay the overwhelming emotional states that these young women were living with. To need to do something to feel "alive" implied that they were previously feeling in a way which was not alive; not dead, but numb, which is consistent with the previous discussion of dissociation. Adler and Adler (2011) explain two motivations for self-injury common among their participants. The first was to manage overwhelming emotions such as stress, anger, frustration, and the need for a release. The other motivation was to provide a rationale for self-injury. These included the drive to demonstrate their internal feelings externally; seeking control over something in their life; to punish or hurt oneself; or to manage an "emotional blockage" (such as a dissociated state).

The need to release overwhelming emotions was cited consistently among the young women in this study. The visual of blood itself seemed to be therapeutic in that it was a symbolic release of these emotions. When asked what she liked about self-injury, Alex replied:

> I don't know. It was like a release. After I'd seen the blood, it was like a release of anger or some sort of release. I can't really explain the feeling, but it was just a release.

"Releasing" pain in a way that the woman is able to control is a theme also found by other researchers (Chandler 2012b; Harris 2000; Horne and Csipke 2009). Alex's feelings were in similar sentiment to Riley, whose deep sense of self-loathing and overflow of heavy emotions was the catalyst for her self-injury:

> I'd hate myself so much, and I'd just feel so much pain, and just feeling … I don't know how to put it … just seeing myself hurting, I don't know … It's because you hate yourself. You hate yourself. I don't know – seeing the pain when I did it—it helped.

Riley's description of "*seeing* the pain", as opposed to "*feeling* the pain" illuminates that for these young women, the pain associated with self-injury was emotional, rather than physical. Chandler (2012a, b) has noted how society's privileging of physical pain over emotional pain is reflected in the behaviour of people who self-injure. People use self-injury as a way of turning emotional pain into physical pain as physical pain is seen as more valid (Harris 2000; Horne and Cspike 2009).

For the participants in my study, emotional anguish was pervasive. Stevie was engulfed with a deep sense of sadness. Self-injury helped her to "feel things other than hate and negativity and depression". Finding ways of experiencing emotions other than depression was also a common theme. Mary, for instance, pointed out, "It's the only thing that makes you feel some other way than what you are feeling". For these women, self-injury was an attempt at "cutting out the pain". Although this may initially seem a bizarre way of dealing with emotions, Amanda, a participant in Hodgson's (2004) study into self-injury, points out that it may not be as unusual as it first appears:

> Cutting, even at 11, is not REALLY such a foreign idea. We cut the brown part off our apple when we eat it, we cut the dead leaves off house plants, we cut the grass when it no longer looks neat and tidy, heck, we even cut out body parts when they no longer work right. Even small children want you to cut the part they don't like off [like the crust off bread]. Everybody cuts the bad out. (p. 176, Original emphasis)

Amanda's quote highlights that it is a learned human characteristic to remove the intolerable. For these young women, cutting serves to remove their pain and gives them some control. While injuring oneself as a way of controlling emotional turmoil seems paradoxical and counter to one's wellbeing, it needs to be understood in parallel to the fact that these young women are also seeking control of their physical bodies, which have been ravaged by others. Suyemoto explains that "Self-mutilation serves to define the boundaries of the self, as the skin is the most basic boundary between self and other" (1998, p. 546). Wanting to remove emotional pain, as well as define and enforce the parameters of her own body makes self-injury multi-functional. Sixteen year old Jessica explained, "I liked feeling like I could control things—I liked hurting myself". Similarly, Christina found relief in punishing herself:

> It just made me feel better. I felt like I was punishing myself – I felt like it was my fault that he was doing it … I don't know, it got out pain, if you will.

It seemed that having control over the pain inflicted upon their bodies was part of the function of self-injury. Given the common experience of childhood abuse where their bodies were assaulted and their control was stripped, it is easy to understand why having this control of the body's boundaries is so desirable. While violating the body further as a way of releasing pain and garnering control seems nonsensical, it is pertinent to remember that many of these women loathed their bodies for "attracting" the sexual abuse. For these young women, the need to be punished was a part of their everyday experience. Jazmine explained that while her cutting was not pleasurable, it was functional: "Sometimes I felt like I deserved it". Understood in this light, self-injury is not a sign of pathology; self-injury is a method of coping.

Conclusion

The very high prevalence of self-injury among the young women in this study was an "accidental" discovery. The behaviour itself is very confronting and could be perceived as indicative of a broader psychopathology. When asked the function of her self-injury, Ebony replied, "I'd just cut myself to kill the pain". On first hearing, this seems like a paradox – how can cutting oneself be pain *relieving*? But when contextualized with her background of abuse and abandonment and with an understanding of why cutting is attractive (want for control over emotions and body), Ebony seems less irrational. In fact her behaviour seems somewhat logical. Framing self-injury as a logical behaviour may at first appear to be an ill-informed suggestion. This is because focus is almost always on the behaviour rather than its function. The narratives of the young women in this study illustrated that self-injury was a way of managing deep emotional pain and of exercising some control over their body – something most of them had not had in their childhoods. None of the 20 women were raised in homes where they were safe, secure, nurtured and loved; or in another words, in an environment that fostered their emotional wellbeing. Rather, their early years were characterized by abuse, neglect and insecurity.

This chapter began with an outline of what self-injury is, it then offered an explanation as to why some young women partake in it and in doing this, I argued that it is not an indicator of pathology. Coping with internal pain was central to all of these young women's narratives. Sixteen of the twenty young women disclosed a history of childhood sexual abuse and not one had received appropriate support, safety and care following this abuse. The effect that sexual abuse had on women's emotional wellbeing and development was considerably exacerbated by it having not being addressed at the time. The sexual abuse often continued despite adults being aware of what was happening. Ongoing abuse and an absence of safety from those tasked with their protection, created further issues. Over time, the pain of these events, compounded by other traumas – particularly abandonment – took their toll. Unable to carry the heavy emotional burden and the absence of a physical space in which they could be nurtured and safe, these young women seemed to create their own psychic sanctuary. They created a mental space in which they were free

from the trauma; thus, they dissociated their minds from their body. For some, these states of dissociation seemed permanent and cutting sought to end them; for others, disassociated states appeared to be sought out, and cutting enabled them to elicit them.

Almost all of these young women had experienced a trauma against their body which had not been attended to and they lacked the safety and security of a home environment. I suggest that consequently, the trauma these young women had experienced was internalized because there was no other way of reconciling this pain. Their painful feelings were overwhelming and appeared to lead to what I have analyzed as a dissociation of body and mind. Their relationship with their body was frequently impaired: their discomfort in their own skin was associated with their body having been sexually objectified and commodified. The emotional pain was manifested into a loathing of oneself and a desire for control. Because this pain is inside of these young women, to cut themselves and bleed was to let it, quite literally, pour out. Cutting sought to "suspend" an intolerable state.

The findings of my study and the arguments presented here challenge us to rethink assumptions about the effects of self-injury on young women's wellbeing. The narratives of these women invite us to understand self-injury as a sign of coping rather than a sign of mental impairment. To see self-injury as simply a threat to these young women's wellbeing fails to understand the backgrounds which led to their cutting. Certainly, the wellbeing of these women had been compromised; however, this was *prior* to their self-injury. Childhood abuse and an absence of care and safety – typically total abandonment – left these young women with few options to cope with their considerable pain. Young women had no supports as those tasked with their care and protection – their parents – were most commonly the source of their pain. Disconnection from school and high rates of homelessness meant that these women had few, if any, positive relationships with other adults in their lives. The absence of support and care, combined with a loathing of themselves and their own bodies, made damaging their flesh an effective way of reconciling the overwhelming emotional states which they experienced. For young women with substance abuse issues, cutting had served a purpose, a function. This function is not suicide or a symptom of disorder; rather it is something more complex—cutting helps these women manage their emotions. When she cuts she is not seeking to damage her wellbeing; she is trying to protect it.

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Chapter 8
Rethinking Role-Play for Health and Wellbeing: Creating a Pedagogy of Possibility

Helen Cahill

Abstract This chapter explores the use of narrative and poststructuralist theory to re-think the effectiveness of role-play within health education programs for young people. It draws on examples from the author's practice in sexuality and gender rights education to demonstrate how theory can be drawn upon to drive pedagogical innovation. The discussion illustrates the potential for "trojan stories" to re-inscribe negative social norms and subvert the objectives of the health education program. Applied examples highlight the way in which genre shifts within role-play exercises can help to dislodge a dominant story and provide a more elastic space within which to assemble new possibilities for "playing the self". This approach can assist young people to deconstruct entrenched health-related beliefs, creating a pedagogy of possibilities within which counter-stories can be created and new options imagined and played out, which in turn holds the possibility of enhancing their wellbeing.

Keywords Health education • Role-play • Poststructural theory • Youth wellbeing

> ***The sting in the tale***
> *Once upon a time there was a compelling story that was told so often that everyone came to believe it was true. It became a very dangerous story. It worked its way into people's heads and then pretended it wasn't there. It was a Trojan story. Once inside the head it hatched all sorts of conclusions that came to dominate people's minds. Every so often people would become disturbed and scratch away to see if they could detect what was making them unhappy. But the source story was hard to find. It hid behind other stories. It covered its tracks. It would remain invulnerable – so long as no one noticed that its sting was in its tail.*

Introduction

Schools provide an important setting for the promotion of wellbeing. The evolving discipline of prevention science has informed the development of an evidence-base pertaining to the contribution school-based prevention programs can make to

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K. Wright, J. McLeod (eds.), *Rethinking Youth Wellbeing*,
DOI 10.1007/978-981-287-188-6_8

enhancing positive health outcomes in a range of areas (Catalano et al. 2012). The last three decades have seen the development of a growing evidence-base about the difference that can be made via drug education programs (McBride 2003; Soole et al. 2008; Tobler et al. 2000); social and emotional learning (Durlak et al. 2011; Seligman et al. 2009); sexuality and reproductive health education (Kirby et al. 2007; Paul-Ebhohimhen et al. 2008); and body image education (O'Dea and Maloney 2000).

This prevention science literature usefully establishes the contribution that can be made via school-based programs. However, the results papers tend not to discuss the underpinning pedagogical approaches that inform these programs, nor to entertain the possibility that an interdisciplinary approach might enhance pedagogical design and efficacy. Within the discipline of health science, program goals are usually framed within either the psychological or the public health tradition of understanding development and wellness. Program goals emphasize the importance of reducing risk factors or of enhancing protective factors. There has been little recognition that the sociological tradition might also offer useful tools for educators. Yet an interdisciplinary approach that draws both from the arts and from the traditions of narrative and poststructural theory can potentially inspire improvements in pedagogical design and contribute to enhanced learning outcomes (Cahill 2011b).

Given that social norms are understood to influence health-related beliefs and actions, it makes sense to call upon the theoretical work done within the sociological tradition wherein philosophers and educators have paid explicit attention to the social construction of desire. Poststructural theory can make a particular contribution to the work of health educators seeking ways to empower students to challenge and change the social norms that influence risky health practices.

In the following discussion, I explore ways in which engagement with narrative and poststructuralist theory has assisted me to critique and to evolve my classroom practice. I focus on the use of the storied medium of role-play. It is of particular interest to health educators because it provides an applied form of learning in which students can actually "rehearse for life" whilst still in the classroom.

Role-play is commonly used to provide students with opportunities to develop the negotiation, problem-solving and help-seeking skills they will need in order to transact healthy choices within their everyday lives. The conventional use of role-play in health education has students practicing the skills they will need in their everyday worlds and inventing the strategies they will need to overcome various forms of resistance in situations of unequal power relations (Cahill 2013). This type of dramatized play works within the naturalistic tradition of "rehearsal for life". Augusto Boal's "forum theatre" work has been very influential in advocating the use of improvised theatre as a mode through which to address various forms of internal and external oppression (Boal 1985). His forum theatre technique entails re-playing a given scenario with the express intent of changing its direction through use of strategies to overcome the external or internal "oppressor". This technique of play and re-play has met the need health educators have for a pragmatic approach to rehearsal of health-related skills.

Naturalism tends to be the performance genre used within this tradition of role-play in health education settings. Students seek to trial their interventions through scenes that represent their reality. However, I have found within my own practice that there are some limitations and possible iatrogenic effects that can arise from the dependence on naturalistic modes of role-play. I use this chapter to discuss some of these limitations and to illustrate the way in which alternative surrealist approaches can be used to assist students to work more critically with narratives in the health classroom.

The chapter begins by first considering the way in which stories work to transmit cultural discourses related to wellbeing. Health programs make use of "real life" scenarios as the focus for problem-solving and role-play exercises. However, whilst the content of a story may be pertinent, the meta-messages it transmits may work against the educational goals of the program. Drawing on examples from my professional practice as a health educator, I develop the idea of "trojan stories" as a way of examining this problem. The broad argument I develop is that health education programs should provide learning activities that assist people to understand the ways in which hidden but influential storylines work to shape the fears and desires that underpin health-related choices. Building again on my applied experience, I propose the use of innovative pedagogical strategies to invite alternative stories into the frame in order to create the conditions within which students might be able to imagine and enact the possibility of playing themselves differently. The following discussion illustrates how narrative and poststructural theory can help drive a re-thinking of conventional health education practices, pointing to the need for inclusion of critical and creative thinking exercises within the pedagogical canon.

Trojan Stories

Stories teach. They contain overt messages. These are usually carried in the narrative line or emphasized in the coda. However, stories also contain covert messages. These meta-messages are hard to manage. They slip under the radar of our attention. Yet they transmit the very storylines which work to perpetuate the norms, expectations and practices which shape the way in which we come to understand ourselves and thus may actually limit the effectiveness of engaging with narrative and role-play for educative purposes.

If teachers are to help young people to critically engage with the structural and social conditions that influence their health-related behaviour, then they need strategies that will assist their students to deconstruct dominant discourses. They will need to be able to detect the influence of "trojan stories". I define a "trojan story" as one that the educator presumes to be attractive and useful, and subsequently harnesses as the centrepiece of a lesson. However, the story is revealed to be "trojan" when it is discovered that despite its engaging nature, it hosts health-corroding messages that work against the teacher's pedagogical intent. Just as the Trojan horse

concealed an army of attackers to be released after gaining entry to the city, the "trojan story" carries a bellyful of negative scripts about why things happen the way they do and what possibility there is for things to be done differently. The health-corroding messages may be codas that transmit individualized blaming and shaming scripts: "If you failed to use a condom, and acquired an STI, *you must be stupid*, *irresponsible*, *bad or careless*"; "If you gained too much weight, *it was because you were greedy or lazy*." Individualized blaming codas such as these can readily creep out of a story, generating a legacy of anxiety, shame, low self-esteem and self-blame in relation to one's health status.

The implicit message of the story may work against the health educator's intent to use it as a tool through which to promote pro-health attitudes. This is because individualized storylines that implicitly blame and shame can foster desires and anxieties, which in turn can lead to risky health practices such as smoking or excessive drinking or dieting. They can also foster the belief amongst young people that it is by consuming "fix-it" products, for example, that they will be able to help themselves look better, feel better, or be better liked by their peers.

Health educators wishing to understand and address this problem can benefit from the insights provided by narrative theorists. For example, Elliott (2005) draws attention to the way in which the structure of a story influences the meaning that is derived from it. She outlines the way in which the recounting of events in a sequence suggests a causal relationship between them, even when the storyteller does not specifically state causality. The choice of beginning works to identify what will be meaningful within the story, and the choice of ending suggests a point of closure that retrospectively casts meaning upon the tale. The linear narrative works to implicitly "teach" the inevitability of cause and effect. If we build an example from this theory, using well-known fairy tales as the basis for our attention, we would detect that "if you *are* beautiful the prince *will* find you", or "if you *are* ugly, then you are undoubtedly bad, and will remain unloved". We may find even more insidious conclusions such as – "Bad things happen *to the mean and the unworthy*. So, if something bad happens, *it must be your fault*."

Today's young people are caught up in a conflagration of stories about who they are and who they should be. Dwyer and Wyn (2001) point to the way in which narratives about adolescents are increasingly medicalized in nature, with this leading to an increasingly individualized understanding of adolescence as a risky developmental phase (Dwyer and Wyn 2001). Kincheloe and McLaren point to the problematic portrayal of youth in the media wherein images and behaviours associated with youth are crafted for the market place. They argue that the bombardment of distorted media-created images produces a hyper-reality which becomes a pervasive benchmark against which to measure everyday experience (Kincheloe and McLaren 2003). Thus, what is understood to be normal may be learnt through the fantasies played out in the media. One effect is that young people become increasingly disconnected from the standards and experiences that pertain to everyday lives and begin to measure themselves against the standards learnt through the media. By comparison their bodies, their lives and their relationships may fail to measure up. This in turn leads to increased anxiety and despair.

The context of medicalized constructs of wellness and commercialized standards against which to measure youth development means that it is vitally important that young people develop a facility to detect and critique these storylines and find ways to create alternative stories more conducive to the promotion of a positive self-concept and wellbeing. Consequently, an underpinning argument of this chapter is that health education programs should provide opportunities for students to critically reflect on the influence that dominant social ideals and storylines have upon health-related choices. This may mean educators need to introduce additional pedagogical strategies into the classroom program, including critical and creative thinking exercises that equip students to do this work of deconstruction and re-construction.

Deconstructing Health Narratives

Davies (1993, 1994) has written extensively about her use of poststructuralist theory to guide approaches in the classroom. Her work using stories as a mode through which to engage children in deconstructing the influence of gender norms is particularly relevant here. She argues that young people themselves can be engaged in a poststructuralist analysis so as to track how dominant storylines affect the way in which they construct their sense of identity. She recommends a threefold practice for deconstruction, whereby students must first recognize the constitutive power of discourses, then catch the discourse in the act of shaping their desires and perceptions, and further, engage in a collective process of re-writing and re-positioning in order to produce the possibility of change (Davies 1993). Davies engages poststructural concepts to argue that the conditions of possibility affect the choices people make: "choice stems not so much from the individual, but from the conditions of possibility – the discourses which prescribe not only what is desirable, but what is recognizable as an acceptable form of subjectivity" (Davies et al. 2001).

Following from this argument it can be seen that it will not be sufficient for the health teacher to provide information and opportunities for skill development. They will also need to assist students to critique the social discourses that influence the very desires that underpin their health-related thinking and practices in order to create the "conditions of possibility" which might foster the viability of healthy choices. However, one of the challenges educators face in engaging students in the process of deconstruction is that dominant discourses tend to remain unnoted. Precisely because they are taken-for-granted, they are eclipsed from attention. A key role for the educator, then, is to find ways to have students detect and deconstruct the influence of shaping stories. To do this they may need to disrupt what seems natural, in order to bring it to the field of attention. Foucault (1984) refers to this as a process of "problemization". The construct of problemization can help the health educator to consider how they will stimulate and guide the process of critical thinking. They will need strategies to help make visible the ways in which hegemonic cultural stories "teach" ways to understand the "problem" and suggest "conclusions" about the possibility of taking protective or corrective action.

In the following section, I discuss my use of Davies' three-step model to critique the way in which I have used role-play within the health class. In this I focus on techniques through which to involve students themselves in detecting the discourses that underpin the stories that play out through the role-plays. In doing so, I highlight the need to re-think the way role-play can be used to incorporate the work of deconstruction and re-construction and evoke different kinds of knowledge about the self.

Capturing the Discourse at Play

My first example describes efforts to "catch the discourses at play" in the act of shaping the self. Here I discuss my work with a class of 16–17 year old students in a Health class in an Australian suburban high school. They are completing a unit of study on sexual health, and are in the midst of a series of lessons about contraception. Their task in this instance is to role-play a scene in which a young couple discusses the possible use of a condom.

Students work in pairs to prepare their own version of the scene. Some work in single-sex pairs and some are mixed. When they play the scenarios back, the conversations are awkward and indirect. The characters are uncomfortable and inarticulate. They draw lots of laughs. Many of the scenarios show the girl initiating hints about the need for a condom, usually in a circumspect manner: *Do you have something with you*? Some have the boy use the euphemism to ask: *Do we need to use protection*? None use the word "condom". Most variations of the scene presume that the girl will be the responsible agent who must set the standard about use or non-use of the condom. All of them have presumed a heterosexual couple. I draw attention to this, and they dismiss my concern. One of them mentions the scene might be harder for a gay couple as it is the fear of pregnancy that is actually motivating them to bring up the condom issue at all. *No one wants to think about infections whereas pregnancy is more a certain kind of thing*.

The class agree that the scene is difficult to play, but is also very important. They are engaged. I am engaged. Watching a number of scenes play out does not diminish their interest. Rather it seems to become more compelling to watch how other "couples" will navigate the interaction.

A thread of concern cuts into my teacherly pleasure at the engaged nature of the class. Despite using a forum theatre technique to coach the "actors" and seek an alternative iteration of the scene, we fail to make progress towards creating a conversation that directly addresses the issue. *Is it possible that our work with this story is hindering rather than augmenting the very possibility that I have strived to create* – the possibility that the couple will find a way to communicate with consideration, respect and ease? This may be so. The repetition has become a powerful form of reiteration. Not only have the scenes replicated gendered positions and excluded the possibility of same-sex relations, they have also repeatedly re-inscribed the cultural storyline that dictates that this will be an awkward scene.

The students perform themselves as those who *can't* rather than as those who *can* conduct this conversation. It is this kind of performance of the self that may be working against my educative intent. Judith Butler (2004) offers insights into this phenomenon. She argues that identity can be understood to be a form of performance (Butler 2004). People make an effort to play themselves "appropriately" to the real or imagined gaze of others, striving to fit and to belong within particular membership categories. In playing one's self as a member of a category, the ongoing performance itself becomes evidence of the naturalness of one's way of being, and in doing so contributes to the persistence of the storyline (Butler 2004). Building on Butler's thesis, I can deduce that as the students replay their awkwardness and embarrassment, they convince each other that this is a "natural" and hence an inevitable way to be.

Poststructuralist theory highlights the way in which we internalize certain desires associated with the positions available to us, moderate ourselves in relation to established norms, and self-monitor in our effort to enact the categories that pertain to ourselves and others (Davies et al. 2001). In this case, the students are embodying and re-inscribing the gendered norms at play in the scenario, and in this may be furthering their own desire to fit in these patterns. The girls are taking what is held to be an appropriate feminine position – hinting rather than asserting. The boys are adopting the nonchalant and non-verbal masculine norm. Both parties are performing an agreement (this is how things go in our world) rather than a possibility (this is how things *could* go).

In an effort to engage the students in a deconstruction of the influences that are at play within these scenarios, I asked one of the pairs to re-play their scene for the class to use as the basis for a deeper enquiry. Once the scenario had been played out, I invited some of the observers to step into the role of "hidden thoughts". It was their job to reveal what their character may have been thinking or feeling but not say aloud in this scene. I interviewed those playing the Hidden Thoughts, first asking the character representing the "Girlfriend" what that character might be thinking/feeling/fearing/hoping, but not saying out aloud as she asks her partner if he has a condom. The response went something like this:

She thinks she shouldn't have to do this – it should be the guy

She is scared he will think she just sleeps around with anyone and that's why she knows so much about condoms

She worries that this will kill the romance

She wished she was on the pill so she never had to talk about this

She is scared what she will do if he says no – will that mean he is only using her?
She is scared if she drops him she won't get another boyfriend.

She just wants to be in love and have a boyfriend because then it will be like she has a good life.

She hopes it can just go all romantic like in the movies where no one has to worry about this stuff

Then I interviewed the Hidden Thoughts player who represented the "Boyfriend": what might he be thinking/feeling/fearing/hoping, but not saying?

He just wants sex to happen
He is trying to be cool and like he knows how to handle everything

He doesn't want to get with the reality factor – he just wants it all to happen

He thinks it should be the girl to worry about pregnancy because it's not like he will have a disease or anything

He thinks just this one time can't really cause a problem

He wishes someone had explained all how to do this and when you should have this conversation

He is scared he will get all self-conscious if he has to stop and put on a condom

He never used one before so he thinks it might not feel good

He wants to be in charge but he wants her to organize it all so he doesn't feel like he is to blame if it goes wrong

He is scared she might look down on him if he doesn't know the right way to handle this situation

Within the poly-vocal "Hidden Thoughts" device, the students were readily able to articulate the way in which the characters are shaped by gendered scripts about who and how to be. The respondents articulated the yearning the characters have for their lives to match the storylines of romance and glamour absorbed from the media. They detected the way in which desires and fears pulled the character in multiple directions. Their accumulated responses worked to demonstrate the way in which the characters were driven to moderate themselves against a set of internalized standards, needs, hopes and dreams.

Through the Hidden Thoughts device it became possible for the students to articulate the complexity of underpinning discourses governing the first-told version of the tale. In this, the pedagogical device assisted the students to catch the discourses "at play" and to detect their shaping influence.

The Hidden Thoughts exercise is useful because it provides a metaphoric space within which internal and commonly silenced scripts can be spoken aloud. St Pierre (1997a) uses Deleuzian theory to describe the way in which figurations and metaphors can create deterritorialized thinking spaces within which different types of knowledge can be constructed. She uses the example of the aside, whereby the actor steps forward to address the audience outside the frame of action in the drama, and then returns to the continuing narrative. The actor is both within and outside the performance as they make this address. The structure of the aside permits a different kind of talk, one that is conscious of the constructed nature of the performance. She also uses the metaphor of the fold or pleat, to show how the internal and external might be understood to be part of the one material, rather than binary opposites. The Hidden Thoughts device provides a type of "aside" or a time out from the linear narrative. In this it functions as a figurative thinking space. The device also arranges for the internal dialogue to become the external dialogue. Metaphorically,

it functions like the "fold" that can display both the internal and the external. The original scene is held in mind, and kept in view via the presence of the original actors, whilst its "internal" or hidden life is played out across the memory of the previous scene.

Once we had worked between the original naturalistic role-plays and the subsequent non-naturalistic Hidden Thoughts exercise, I felt we had begun the work of deconstruction, without having lost the original interest in the pragmatics of how to transact oneself in such a scene. The first scenario was a compelling "trojan story", a platform for further enquiry. It provided a rich archeological site for digging up the discourses that work to influence choices within relationships. I don't know whether this work "loosened" the grip of the social scripts, but it did at least bring them into view, which enabled recognition and scrutiny. Without recognition, we cannot begin the process of critique and reconstruction, and within Davies' three-step model, the process of recognition is the first phase in deconstruction. However, it was clear that additional pedagogical work needed to be done to assist students to invent alternative possibilities for playing the self.

Shifting Genre

My second example takes place some lessons later within the same sexuality education unit. I use it to discuss the use of genre shifts to help propel the students into the work of reconstruction, or the invention of other possible ways of playing the self.

We had by this stage covered the basic facts about sexually transmitted infections, and now my intent was to explore attitudes towards medical help-seeking whilst at the same time reinforcing information about the need for timely treatment to address STIs. I had again elected to use a conventional naturalistic role-play, asking the students to play the part of a young adult aged 22, attending the health clinic to request a sexual health screening. The character was to be motivated by symptoms of painful discharge following a history of unprotected sex with multiple partners.

The students worked in pairs to try out the help-seeking conversation. When they showed their work it became quickly evident that each of them had called upon standard types of scenarios, showing an inarticulate and shame-ridden patient who struggled to speak with a moralizing or patronizing doctor. The hidden coda of each scenario was that the character deserved their suffering for they had brought their problem upon themselves. They possibly "deserved" the judgmental response of the doctor as due penance for their "crime". There was no space in these stories to construct a line of hope about the possibility or desirability of help-seeking, or any real sense of recognition that an ordinary person may at some time in their life need such medical treatment. Again, the task I had set had to some degree worked against my liberatory pedagogical intent. Another "trojan story" had emerged – carrying hidden "enemies" in the form of scripts of blame, shame and denial. Potentially

the exercise was aggravating the reluctance that young people are known to have in relation to medical help-seeking on sensitive issues (Wilson and Deane 2001).

In the hope of evoking a greater sense of possibility around help-seeking, I experimented with re-framing the doctor-patient scene. I cast one player as the Penis-with-painful-symptoms and the other as the Brain-with-multiple-demands. Penis was to attempt to enlist Brain's help to get access to medical attention in order to secure relief from the painful symptoms.

The re-framing of the scene invited a completely different sort of play. In high burlesque, Penis expressed his pain, and bewailed the Brain's choice to leave him unprotected in risky situations, pleading to be taken to the doctor to get relief from the pain. Brain defended himself, citing the multiple pressures involved in negotiating life and relationships. The captive and dependent Penis vehemently argued the breach of rights, pointing to his dependence on Brain to get access to healthcare.

This new story had a different coda: *it is cruel to leave a suffering organ without access to medical assistance*. It also depicted power differently. Rather than the struggle occurring across the divide between two persons (doctor-patient), the new story depicted an internalized struggle, with one set of desires working in conflict with another. Due to the burlesque nature of the dramatic play, the "yes" case for help-seeking became more theatrically compelling than the "no" case. Penis after all could wail with pain. The audience was also re-positioned, to sympathize with the organ in urgent need of relief from pain, and to hope that the Brain would agree to seek help.

The genre shift, from naturalism to surrealism, helped to dislodge the story from its base as a cautionary tale urging morality and safety. The new story became a tale about rights – the right to healthcare, the right to protection, and the struggle to attain these rights.

Richardson and St Pierre (2005) highlight the way in which making a shift in genre can produce a shift in the kinds of knowledge that can be constructed. Here the genre shift from naturalism to surrealism provided a different set of rules about how to play the "self". Within the genre rules of naturalism the students had to work to create a "believable" person who must by definition be a good fit with the norm or type. In the body organs scene, however, they could transgress without penalty. Indeed, to transgress was a marker of success. Additionally, when working within the body organs metaphor, it became possible for the students to openly articulate both the fear of help-seeking and the need for help – both of which had to be silenced in the naturalistic portrayal of young male patient. Both Brain and Penis could speak freely about their emotions and their "bodily" needs. In contrast, the young male patient felt that he had to hide these aspects of the self, and the doctor was so dehumanized as to be presumed to be without either.

Thus the genre shift made it possible for the students to articulate some of the underpinning desires and fears at play in the original doctor-patient scenario. The surrealist re-casting as Penis and Brain prompted an articulation of underlying fears and needs. This was particularly apparent when the Brain bewailed the factors

constraining its freedom to act, citing the pressure of embarrassment, shame, and competing demands. In this scenario the participants worked at the first stage of the Davies model. However, Penis and Brain also engaged in some explicit dialogue about the way in which these fears were defining the course of action. They also worked into the second phase, which entails catching the discourse in the act of shaping our desires and perceptions. Through this work, the students engaged in a process of "re-writing" or re-construction in that a different storyline was created. The new story became one about the struggle to attain one's right to access health service. This inverted the original story, which had been one about the undesirability of using such a service. The exercise provided an opportunity to work at what Davies describes as the third phase of deconstruction, that is, incorporating the collective re-writing of story and the creation of new possibilities.

Transgressive Talk

The contribution that a genre shift can make in providing a deterritorialized space within which to speak (St. Pierre 1997b) can also be seen at work in the following example drawn from my experience in leading a sexuality education program in a very different cultural context. I draw on this example from my work leading a group of women in Bangladesh through the "Connections" gender rights and sexuality education program. One of the aims of the Connections program is to assist women to initiate conversations about gender rights and sexuality with partners, friends and family members (Cahill 2013, 2010). An initial hurdle is that it is somewhat taboo to talk about sex and sexual development: over half the girls under 24 in Bangladesh do not find out about menstruation until after it has happened to them (Population Council 2009).

The women struggled to explain pubertal changes within a naturalistic role-play in which they are cast as mother and teenage daughter. The mother's task was to explain menstruation to a daughter who had not yet experienced this. Just putting their knowledge into words caused significant embarrassment. The participants played out self-silencing scenes and for the most part failed to give the needed information to their daughter. During reflection on this challenge, the participants pointed to a long lineage of silence reaching beyond their grandmothers. They highlighted that the problem with playing the scene was not lack of knowledge. The problem was finding release from the grip of the gender norms. Their struggle to complete the role-play revealed that talking about the grip of these norms was far easier than actually shrugging them off, particularly when locked into the mutually reinforcing intergenerational subject positions of mother-daughter. To talk about a problem is not necessarily to gain release from it. Thus use of discussion alone is not a sufficiently powerful pedagogical strategy when one is aiming to generate the belief that change is possible, or to establish some liberatory space within which to work outside the norm.

A later exercise, however, demonstrated that it was possible for the women to break the gender and cultural rules, albeit temporarily, and to speak boldly about sex. This was seen on the following day when I invited the participants to engage within an exercise in which they were to take on the role of various contraceptive devices to be interviewed within a dramatization of a TV chat show. The chat show was set up as a competition in which the various contraceptive devices would battle out which of them should be known as the most useful method of fertility control. The participants prepared first with a small support team with whom they brainstormed the points to be made. Then the TV chat show host called for the six characters of IUD, Pill, Implant, Male Condom, Female Condom, and Abstinence to battle it out on the chat show. The audience members were engaged to provide enthusiastic support.

Upon entering the chat show performance space, the women embodied themselves differently. They pranced and strutted in the play-space whilst lauding their attributes and attempting to impress their audience with their popularity. Through translation, I discovered that their talk had become quite explicit. Female Condom asserted her advantages. *She can be left inside awaiting later use*. The sexual act need not be interrupted to put her in place. The IUD hailed the advantages of invisibility – *Your partner will not even feel that I am there*! Male Condom bragged about his variety of forms. *You can choose me as vibrating*, *scented*, *flavored or ribbed*. Abstinence highlighted the advantages of independence and self-satisfaction: *you do not need rely on anyone else for your pleasure*.

As they performed themselves within the battle between the Fertility Control devices, there was no lack of language to talk explicitly about matters to do with sex. There was no squeezing of the self into a self-silencing shyness. The genre shift and employment of metaphor provided a space within which they collectively re-imagined and enacted the possibility of talking openly and cheekily on these matters.

There was a sense in the thrilled laughter that comes from the observers that a transgression was taking place. Davies points to the disruptive power of laughter:

> While its constitutive power (structure) must be recognized, the possibility that it can also be laughed out of existence, played with, disrupted, or used to manufacture new possibilities, can also be recognized. (Davies 1993, p. 198)

It became evident that the participants could play themselves differently, even if only in this permissive performance space.

Potentially it is when we play ourselves differently, that we begin to sketch the possibility of change. Butler (2004) argues that fantasy is critical in change work. She describes fantasy as the "art of the articulation of the possible", and argues that we must be able to "imagine ourselves and others otherwise" if we are to create change (Butler 2004, p. 29).

If, as Butler (2004) argues, real change occurs in response to the creation of possibility, then it may be insufficient for health educators to depend entirely on the rehearsal of resistance strategies when trying to accomplish certain changes. If part of the work is to imagine that things can be otherwise, it will be crucial

to frame the drama in such as way as to permit and invite a radical re-imagining. A mere duplication of reality, such as one often gets through a naturalistic drama, provides a restricted space for such re-imagining. Within naturalistic play, the social rules and expectations so govern the interactions that there is little room left for divergence from the norm. In contrast, construction of play within a surrealist genre *requires* that everyday rules be broken. To some degree the genre requires some sort of interruption to the order to think afresh about what ever is recognized to be "reality".

Constructing a Pedagogy of Possibility

My discussion of these three classroom examples has demonstrated the way in which "trojan stories" can colonize the learning space and re-inscribe limiting social norms. This has highlighted the need for alternative pedagogical strategies through which to engage students in the work of discourse detection. I have also demonstrated that counter-stories are not readily created within the boundaries of the problem-as-known. Indeed, it is difficult to create a new story by simply changing the moves made by various characters within the original narrative line. A new story needs a new shape, or an alternative structure.

My analysis has shown that the performance genre within which the role-play is conducted influences the paradigm or rules of reality that can be used to create the story. In this, the selection of genre influences the construction of knowledge and consequently, the creation of possibility. Naturalism has strong performance norms pertaining to credibility. This limits the conditions of possibility needed to enact the self differently. Within a surrealist genre however, it is permitted, or even expected, that certain rules of everyday reality will be broken. In the exemplars discussed, objects could come to life and comment on the way the world works, body organs could enact archetypal power struggles over rights and responsibilities, and time could be suspended so that people could step out of their hurtling relational narrative to explore the multiple and contradictory thoughts that influence their choices. These examples show that pedagogical innovations in drama-based play can help to provide alternative worlds within which to produce the possibility of knowing and playing the self differently.

I have argued that once the health educator acknowledges that human behaviour is influenced by social norms learnt within dominant discourses, they will recognize that it is not sufficient to focus solely on knowledge and skills development as is common within the conventional health education program. Rather efforts must be made to additionally engage students in identifying constraining social norms and in creating the conditions of possibility that will help them to circumvent these norms. This requires pedagogical innovation – a fashioning of new methods through which to engage students as critical readers and as active creators of new possibilities.

A number of pedagogical imperatives can be derived from the examples discussed in this chapter. Additional pedagogic practices are discussed elsewhere, see

for example (Cahill 2011a, 2012, 2013). These pointers for the health educator seeking include the following:

- Critique the "trojan stories" that captivate attention but also work to re-inscribe social norms. *Pedagogical options* include efforts to detect the meta-messages that are transmitted via the story structure and coda. Experiment with alternative beginnings and endings. Use parody or caricature to heighten awareness of key positions and patterns. Re-tell the story from alternative perspectives. Use minor characters or objects to comment on the narrative line.
- Find the invisible rules directing the desires and behaviour of the characters. *Pedagogical options* include use of allegory, figurations and metaphors to provide new spaces within which to imagine and articulate the self. Use poly-vocal techniques such as the Hidden Thoughts exercise to help participants articulate the competing and contradictory desires that influence the character.
- Create alternative worlds within which to imagine and play the self differently. *Pedagogical options* include the use of genre shifts to invite alternative modes of being. Use a surrealist genre to disrupt the regular, and regulating, rules of reality. Invent playful spaces within which to imagine and embody new possibilities in being. Fashion alternative stories to explain why things happen the way they do.

Conclusion

Health educators work with stories and through stories. When they use drama-based activities to develop skills and understanding, they add to the bank of stories that tell students who we *are* and who we *can* be. Some stories are more tempting and insidious than others. Those that contain "trojan stories" can colonize the work-space and subvert efforts to advance the conditions of possibility that will foster the adoption of health-promoting behaviour, and in turn, the wellbeing of young people. Regardless of selection, the stories that are selected as the basis for classroom enquiry can never be "innocent". Stories teach and stories preach. The characters, content, causal lines, conclusions and coda all play their part in the construction of meaning. It is crucial then that health educators find ways to engage students with the challenge of unpeeling the explanatory through-lines within the stories used, and to detect the way that they perpetuate certain patterns, positions and presumptions. Ideally this process of deconstruction generates a space for re-cognition. It hatches a pedagogy for possibility, within which young people can re-imagine who it is possible for them to be as they exert efforts to enhance and care for their own and others' wellbeing.

The rupture in the story

Once upon a time there was a story that was told so often that everyone came to believe it was a Truth. It became a very dangerous story, ruling the world with its cruel conclusions. Until one day, whilst playing a game of let's pretend, people found a way to duck past its conclusion and work backwards to interrupt its internal explanatory logic. Once the story was dissected, people could see that it was just an assemblage made credible with

repetition. The rupture in the story made room for the invention of a new possibility and the hatching of alternative stories. Transgressive and transient, the new tales left their own vapour trails. Though only a marker in the sky, they promised the possibility that things could be otherwise.

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Chapter 9
Wellbeing and Schools: Exploring the Normative Dimensions

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Abstract This chapter develops a critical analysis of wellbeing as an educational aim. While the goals of schooling have become increasingly concerned with the promotion of wellbeing, the philosophical dimensions of such a move remain largely unexplored. This chapter examines the relationship between wellbeing and schooling, drawing attention to some implicit normative dimensions. It does so through an analysis of educational aims in Australia as well as the normative claims that buttress the contemporary focus on wellbeing. This analysis prompts consideration of whether wellbeing represents an acceptable goal for schooling. Further, it questions how wellbeing might compete or align with a range of other educative and social goals and agendas. These include not only the achievement of academic outcomes, but also a variety of other important educational goals, such as equity, citizenship, economic prosperity and social cohesion. In exploring these issues, the chapter seeks to contribute to both the conceptualization of wellbeing in educational settings and longstanding debates about the purposes of formal schooling.

Keywords Educational goals • Philosophy • Schooling • Normativity • Wellbeing

Introduction

The "education world" (Symes and Preston 1997, p. 3) is complex and dynamic. It has competing goals and agendas that shape the organization of schooling. An important agenda in the current educational context is the promotion of student wellbeing. While notions of wellbeing have gained significant attention in the last decade or so, the actual meaning of wellbeing is commonly not defined and often assumed to be self-evident. In light of this, the aim of this chapter is to explore the philosophical dimensions of wellbeing as an educational goal. In particular, it seeks

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K. Wright, J. McLeod (eds.), *Rethinking Youth Wellbeing*,
DOI 10.1007/978-981-287-188-6_9

to challenge assumptions of wellbeing as a neutral concept through examination of the implied values inherent in wellbeing claims, and indeed in any claim pertaining to what social institutions, such as schools, ought to do.

In recent years, a great deal of attention has been given to the prevalence of mental health issues and improving the state of wellbeing amongst young people. However, little attention has been paid to the philosophical dimensions of this and the broader implications of incorporating wellbeing practices and programs into systems of schooling. I suggest that the notion of wellbeing implicitly draws on a variety of normative or value-laden dimensions. These include a view of schools as providing a "captive audience" for social interventions to address the problem of youth mental health, of wellbeing as a means to tackle growing concerns about academic outcomes, and of wellbeing as key to the socialization of the "whole person", whether it be in terms of important social values, self-actualization or even happiness.

This chapter offers an alternative perspective on student wellbeing and its contemporary educational focus by reconsidering long-standing ideological disputes about the goals and purposes of schooling. I argue that the current emphasis on wellbeing needs to be understood as more than simply a concern with the physical and psychological health of young people. Indeed, the adoption of wellbeing as an educational aim raises important philosophical questions regarding the purposes of formal schooling. These include the question of whether the pursuit of student wellbeing in and of itself is an acceptable goal for schooling; and if it is, how it compares and competes with other socially-valued goals, such as academic achievement, equity, citizenship, economic prosperity and social cohesion. I begin by considering wellbeing as a contemporary goal for schooling with reference to key Australian education policy documents, as well as historical debates regarding the purposes of schooling, including the promotion of mental health. I then proceed to examine the normative dimension of education goals, that is, the value-laden dimensions of claims about what schools should do. The final section develops four categories to conceptualize wellbeing in schools based on normative arguments about what schools should do. Analyzing wellbeing as a goal for schooling makes explicit some of the normative dimensions of wellbeing that often rely implicitly on moral and political values. I argue that this aspect deserves more attention.

Wellbeing and the Goals of Schooling

Renowned educational philosopher Nel Noddings states: "Until quite recently, aims-talk figured prominently in educational theory, and most education systems prefaced their curriculum documents with statements of their aims". She goes on to ask: "What functions have been served by aims-talk, and what have we lost (if anything) by ceasing to engage in it?" (Noddings 2003, p. 74). The idea of "aims-talk" is, I suggest, helpful for understanding some of the ways in which wellbeing and schooling is conceptualized. For those working in disciplines external

to the institutional field of schooling, such as health promotion, psychology and psychiatry, the following discussion seeks to draw attention to the "main game" of schooling as it is currently envisaged in government documents outlining educational goals. For those currently working in schools, this section of the chapter may offer a point of reflection on the current trajectory of contemporary schooling.

In Australia, the *Melbourne Declaration on Educational Goals for Young Australians* (Ministerial Council for Education, Employment, Training and Youth Affairs [MCEETYA] 2008) represents collaboration and joint agreement between all Australian Education ministers – the federal education minister and the eight education ministers of the states and territories – on the goals for Australian schooling. Goal One states that "Australian schooling promotes equity and excellence" and Goal Two asserts that "all young Australians become: successful learners, confident and creative individuals, and active and informed citizens" (p. 7). In its ideal form, this is what Australian schooling is currently charged with doing.

Wellbeing as a concept features throughout the document. It states: "Schools play a vital role in promoting the intellectual, physical, social, emotional, moral, spiritual and aesthetic development and wellbeing of young Australians, and in ensuring the nation's ongoing economic prosperity and social cohesion. Schools share this responsibility for wellbeing with students, parents, carers, families, the community, business and other education and training providers". Later, as a subcategory of creating "Confident and Creative Individuals", the document also states: Students gain from schooling "a sense of self-worth, self-awareness and personal identity that enables them to manage their emotional, mental, spiritual and physical wellbeing" (p. 9). It goes on to assert that the curriculum will include a strong focus on literacy and numeracy, which "will also enable students to build social and emotional intelligence, and nurture student wellbeing through health and physical education in particular" (p. 13).

Conceptions of wellbeing underpinning the goals for Australian schooling invite questions about whether wellbeing, in and of itself, represents a goal for schooling or if it is the means by which we achieve other ends, such as academic outcomes (typically measured as high school completion or in terms of national testing results). Or is wellbeing simply a proxy for the creation of "Creative and Confident students" (a version of students, not overtly measured, but one that forms the basis of the school socialization process). If wellbeing does in fact represent a worthwhile goal for schooling, an important question is whether it can compete with the importance placed on academic achievement, particularly literacy and numeracy outcomes or the plethora of other important non-academic aims mentioned in the *Melbourne Declaration*, such as equity, citizenship, economic prosperity and social cohesion. A further consideration is how it sits in relation to a host of other important goals for schools, such as democracy and environmental sustainability, which lie at the heart of some more radical goals for schools. The false-front of the all-inclusive logic in such documents belies the ambiguities and tensions at the conceptual foundations of these pluralistic goals. Questions about the priority of educational goals may involve decisions that require us to make a choice between conflicting alternative frameworks where goals and values do not sit comfortably alongside

each other. Such tensions in educational goals cannot be rhetorically glossed over in one swift sweep of the pen, and "aims-talk" (cf. Noddings 2003) has a significant contribution to make in drawing attention to tensions, inconsistencies and even occasional nonsense.

In Australia, Reid's (2009, 2010) ongoing analysis of Australian curriculum has critiqued the Australian federal government's chief focus on the economic goals of education, whereby government policies position education's key goal as preparing human capital for the labour market. Accompanied by an arrangement of policy initiatives – e.g. NAPLAN, [the National Assessment Program (Literacy and Numeracy)] and MySchool, a public website reporting data on the resources and performance of all schools – such a goal for education is aimed at economic reform and achieving higher productivity and participation in the global knowledge economy. Despite the rhetoric of the *Melbourne Declaration*, the goals for Australian schooling, Reid argues, are implicitly couched in language where the economic aims of education are given precedence amongst many other aims worthy of attention.

The emphasis on the economic value of education, in which the goals of educative activity is primarily to create future Australian economic citizens, has been used as a tactic to validate increased spending on education. In such a context, it is useful to consider some of the possible implications for wellbeing. One consequence of an education system with a key focus on economic ends may be a view of students that fails to recognize them as human beings who have interests other than economic ones. Within this frame of reference, wellbeing becomes a means of achieving the end goal, which is a schooled, literate, highly productive worker. Alternatively, we could argue for a longer-term, perhaps more sinister, notion of wellbeing as one that views the "student as a means to the end of national productivity" (Haynes 1998, p. 47). Yet in this case, the "ought" version of wellbeing in schools may be considered acceptable because of the long-term payoff offered by the advantages of later becoming an economically successful citizen, thus ensuring longer term wellbeing. In both cases there is a complex relationship between wellbeing as both means and ends. Yet, these constructions of wellbeing have little in common with a national health agenda that seeks to address concerns about the mental health of young people. Despite international recognition of the significance of mental health promotion, including derivative issues of accessible and cost effective treatment, associated programs, polices and interventions, these important matters risk remaining separate to current conceptions of the core goals of schooling.

As noted, educational "aims-talk" is not new. However, its importance may have been lost in the ongoing debates that in recent times have been preoccupied with identifying the most efficient means to deliver educational outcomes. Interestingly, mental health as an educational goal has been debated in tides since the late 1960s and 1970s, with prominent Oxford analytic philosophers of education, R. S. Peters and John Wilson, offering detailed starting points for our contemporary examinations of wellbeing. Though my purpose is not to review in detail the positions of either Peters or Wilson, my discussion of their work illustrates that many of the debates occurring under the pretext of student wellbeing reflect and

broadly mirror long-standing philosophical discussions into the very question of the goals of schooling, and these are useful for developing a more systematic contemporary analysis.

Peters argued in his paper "Mental Health as an Educational Aim" (1964) that Western society was now unable to provide a universal goal for education and in order to address such an absence, educators turned to psychology as a discipline capable of providing justification for particular educational practices and schooling goals. Peters cautions against this approach. He first warned of the dangers of confusing "man's nature" with the "normative ideals" we hold for ourselves and our children (p. 186). Deeply held ideological positions about the individual's proper relationship to society was at the heart of such a view.

Contemporaneously, John Wilson addressed the same issue in his book, *Education and the Concept of Mental Health* (1968), providing an examination of a number of important concepts frequently in use within education, such as health, moral maladjustment, organization of curriculum, social arrangements in schools, moral education and the relations between school and home. Much of Wilson's argument also consists of a conceptual analysis of the distinction between "curing" and "educating". Wilson advocated the inclusion of mental health related issues in education, yet his advocacy rests on a conceptualization of mental health in schooling that is distinct from the biomedical paradigm and that recognized what schools are about. As he asked: "Is 'mental health' the whole concern of education? If not, what aspects of the child does it cover? His mind? But presumably the usual curricular subjects which we teach cover that. His brain? But surely that's the concern of doctors and brain-surgeons. His soul? But that's something to do with religious education. His moral attitudes and behaviour? But that is different from his mental health – it's one thing to be naughty or wicked, and another to be mentally ill" (Wilson 1968, pp. 17, 18).

Even though these debates have taken place for over 50 years, contemporary discussions of youth wellbeing typically provide little to challenge an entrenched economic agenda. In considering the diverse expectations placed on schools, Ladwig reminds us to "keep in mind the question of just how much we really want schools to do?" (Ladwig 2010, p. 114). The "natural" importation of wellbeing into schooling is clearly a matter that warrants debate, not only at the level of abstract ideals or as "ends", but also in terms of the means identified for achieving such ends. However, while the normative dimensions of wellbeing in schools remain implied or "hidden", it is difficult to engage in a serious democratic debate not only about its place, but what we really want the focus on wellbeing to achieve.

Facts, Values and Implicit Normativity

Wellbeing and its close ally health promotion in schools has for some time, suffered from a lack of philosophical reflection on the notions of health, disease and their relationship to education (Laura and Chapman 2009; Seedhouse 1995, 2001;

Khushf 1997; Prilleltensky and Gonick 1996). While wellbeing, in and of itself, is often seen as a worthy and self-evidential goal for schooling, its polyamorous nature lends itself to varying explanations. The diverse range of views of wellbeing is illustrated by briefly looking at two examples of wellbeing programs in the Australian context. MindMatters is a program carried out in schools to address increasing concern over the wellbeing of young people. It draws on the principles of the World Health Organization's Global School Health Initiative to "embed promotion, prevention and early intervention activities for mental health and wellbeing" (Commonwealth Department of Health and Ageing 2010) through a whole school approach to mental health promotion. Wellbeing also features as part of the National Partnerships Program, a program designed to improve literacy and numeracy outcomes in disadvantaged schools and communities. In contrast to the mental health focus of Mindmatters, the Partnership program aims to "improve student engagement, educational attainment and wellbeing in participating schools; make inroads into entrenched disadvantage, including in Indigenous communities; contribute to broader social and economic objectives; and, improve understandings of effective intervention that can be implemented beyond the schools participating in the Agreements" (pp. 3–4).

To assist in elaborating what "wellbeing in schools" might involve, the following section draws on a framework provided by Ladwig (2010) whose discussion of non-academic outcomes is utilized to explore wellbeing not as a neutral or technocratic issue comprised of a clearly delineated set of problems to be solved, but rather as an ideological struggle based on normative arguments about what schools should do. As Ladwig states: "The normative basis of this debate is sometimes well articulated, sometimes muted or embedded within observations about reality, and sometimes forgotten (confused with claim about reality)" (2010, p. 116). Ladwig's framework goes some way toward focussing our attention on the importance of well-articulated normative claims, but also reminds us that facts and values can be easily entangled in our discussion of what schools "ought to do".

Additionally, I draw on Ramaekers and Suissa's (2012) notion of "hidden normativity", developed through their work on parenting practices as represented in the field of developmental psychology. They argue that parenting will "always reflect certain values and normative assumptions about what constitutes being human, living well, and about what the role of childrearing is in a particular society. And these assumptions are never uncontroversial and thus are open to discussion" (p. 359). Ramaekers and Suissa's analysis exposes the tendency to reduce value judgements to statements of fact, providing a model for my exploration of the implicit normative dimensions of wellbeing in the educational context. While it is not the purpose of this chapter to sail away in the direction of a long and debatable philosophical enquiry into the notion of normativity, drawing attention to the distinction between facts and values is useful for the progression of the argument.

> Normativity pervades our lives. We not merely have beliefs: we claim that we and others ought to hold certain beliefs. We not merely have desires: we claim that we and others ought

> to act on some of them, but not on others. We assume that what somebody wants believes or does may be judged reasonable or unreasonable, right or wrong, good or bad, that it is answerable to standards and norms. So far, so commonplace; but we have only to go a little further to find ourselves on the high seas of moral philosophy. (Korsgaard 1996, p. xi)

The field of moral philosophy is some distance from much of the contemporary literature that informs understandings of wellbeing. Yet distinctions between what "is" and what "ought" to be and the nature of value-based questions are vital ones for schools to consider, particularly with regard to the pursuit of their educational goals.

In summary, the following analysis of "hidden" or implicit normativity in wellbeing discourses and practices is informed by a philosophical orientation that seeks to take a closer look at the normative dimensions of any public policy or program directed toward the undertaking of particular educative goals. I attempt to untangle the tendency in discussions of wellbeing in schools to muddy the distinction between facts and values and I do so by analyzing the implied educational goals of wellbeing. These implied educational goals are not neutral; they are normative. They do not simply describe what we do, but also what education "ought" to be about. These goals make claims on us, they command our action, oblige our attention, recommend, or guide what educators do. Such an exploration is useful in that it seeks to make implicit educational goals more explicit, making them amenable to democratic discussion. If wellbeing is to be considered an appropriate goal for schooling amidst a range of other goals such as educational attainment, democracy and social justice, then it is crucial to understand its underpinning values.

Normative Dimensions of Wellbeing in Schools

To develop this analysis, I identify four broad categories of educational goals supporting wellbeing: wellbeing in the schools for (i) the National Health Agenda, (ii) educational achievement, (iii) socialization and social values and, (iv) bildung, or the "good life". Directing attention to goals for schooling exposes some of the normative dimensions of wellbeing as well as moral and political values intrinsic to educational goals. I elaborate my argument in relation to each of these below.

Wellbeing in Schools for the National Health Agenda

Schools have long been a site for health education and health promotion (see for example WHO 1951), predominantly through a focus on the Physical Education curriculum. Approaches have focused on the importance of enabling students to develop the knowledge and capacity to manage the multifaceted implications

of unhealthy lifestyles and activities, as well as wider social issues influencing their health. Guided by the Ottawa Charter for Health Promotion and the Jakarta Declaration, in recent years school health initiatives have been designed to serve as a unifying framework for all countries to work towards strengthening health promotion and education activities at the local, national, regional and global levels (Konu and Rimpelä 2002; WHO 2000, 1998).

Such developments have led to schools being perceived as capable of providing a single point of entry to wider aspects within the health agenda, such as mental health and social services. Moreover, statistics illustrating an increase in mental health problems have made schools a primary site for efforts to improve the health and wellbeing of the child population (WHO 2000, 1998). This approach to school health promotion is spawned not only by a growing burden of disease and disorder experienced by young people, but also a concern that an increasingly "complex, costly and fragmented health care system" may be unable to meet the physical and mental health needs of young people (Brindis and Sanghvi 1997). The delivery of specific services within schools has wide support, appealing to policy makers, service providers, school administrators, teachers, parents and even students, as schools are comparatively less "clinical" and threatening environments and are more accessible (socially and geographically) to students when compared with hospitals and health centres (Evans 1999; Flaherty et al. 1996; Slade 2002; Weist 1998). As noted by Adelman and Taylor (1999), commenting on the US context:

> [W]hile participation of clinical psychologists in schools is not extensive, the discipline of clinical psychology and the field of mental health have much to contribute to the success of schools. In addition, schools provide invaluable access to students and families in need of mental health services. Schools offer unique opportunities for intensive, multifaceted approaches and are essential contexts for prevention and research activity (p. 137).

The school setting is thus regarded as one of the most influential sites for the development of both current and future health knowledge and health and social attitudes and behaviours (see Atkins et al. 2010).

Literature in the field of health promotion and prevention indicates that arguments made by proponents of school-based health services are generally well founded, particularly when examining the effectiveness of services provided and the utilization rates by students (Evans 1999; Konu and Rimpelä 2002; Nystrom and Prata 2008; Testa 2012). However, some critical literature has shown that school-based mental health services in the US have resulted in concerns about confidentiality and quality of care (Evans 1999). Evans' review of mental health services in schools noted that critics of such services question the school's role in the provision of mental health services, particularly where parents regard the provision of such services as an infringement on their rights as parents (Citizens Commission on Human Rights 1995, in Evans 1999). Concerns have also been raised over the issues of consent and privacy of treatment in school-based services. Evans (1999) noted an absence of research literature documenting consent practices for service delivery in schools, which potentially reflects differences in codes of ethics for school-based service delivery compared to other settings.

Wellbeing in Schools for Educational Achievement

A positive association between health and wellbeing and educational achievement is well established (Currie and Stabile 2006; Cutler and Lleras-Muney 2006; Ross and Wu 1995). As discussed above, the development of school-based mental health and other social services has stemmed from an interest in their potential effectiveness as mechanisms to improve student health and wellbeing. The Global School Health Initiative (GSHI), developed in 1995 by the World Health Organization, led to the "health promoting school" concept and helped strengthen the expansion of school-based services. The GSHI, however, does not solely focus on health as a primary outcome, but is rather built on the premise that health and education outcomes are inextricably linked and that effective health education programs "can be one of the most cost effective investments a nation can make to simultaneously improve education and health" (WHO 2013). Interest in the provision of health services and programs in schools also follows this reasoning (see for example WHO 2005, 2006).

In supporting the WHO GSHI, Weist and Murray (2007) define mental health promotion within a school context as involving "a full continuum of mental health promotion programs and services in schools, including enhancing environments, broadly training and promoting social and emotional learning and life skills, preventing emotional and behavioural problems, identifying and intervening in these problems early on, and providing intervention for established problems" (p. 3). Such an all-encompassing definition allows for any initiative or policy that promotes a degree of support and community connection, and which also facilitates communication and encourages the development of life skills and social competencies.

Consequently, schools have become increasingly involved in the early recognition, intervention and treatment of students. Schools are now regarded as being able to recognize students who may be at risk or displaying symptoms of poor mental health, and offer them assistance. For example, by referring them to specialist professionals (whether inside or outside the school setting) from which the student can receive treatment, with a view to improving their wellbeing and, subsequently (according to the logic of this model) increase their chances of successful learning (WHO 2005).

Critics have pointed out that wellbeing must be more than the absence of disorder, and should also emphasize building on human strength through a focus on self-esteem, social skills and resilience (Compton 2005). Drawing on Seligman and Csikszentmihalyi's *Positive Psychology* (2000) this approach, termed "positive education", proposes that intervention programs that stem from "mainstream psychology's traditional focus on what goes wrong in life and how life's unhappinesses can be ameliorated" should be replaced with "an enhancement agenda, thus increasing knowledge of "what makes life worth living" and how that worth can be magnified through massive research on human happiness: positive traits, positive emotions, and positive institutions" (Kristjánsson 2012, p. 86 citing Seligman and Csikszentmihalyi 2000).

However, positive education's "pursuit of happiness" through "positive traits, positive emotions and positive institutions" has been criticized as a rather superficial approach that prioritizes education as a form of pleasure development (Smith 2008; Suissa 2008). In his critique of positive psychology and its role in education, Kristjánsson (2012) claims this approach potentially fails to recognize the value of educational activities that may be emotionally painful and disquieting. Consequently, it is seen as rendering obsolete educational processes that are designed to unsettle or challenge the student (see Smith 2008; Suissa 2008). Others suggest that it promotes particular character traits in some groups of students more than others. While approaches utilizing interventions tend to target outwardly misbehaving students, positive education has been criticized as creating an archetypal student who is an outgoing, goal-oriented and status seeking extrovert, to the point where introverted practices are seen as a potential deficit (Cain 2012; Miller 2008).

That positive education has been taken up by a number of elite schools, including Geelong Grammar School, arguably Australia's most elite private school, also draws attention to some political values. If such schools, or "positive institutions", now possess an academic edge, the claims for positive education can be hard to distinguish from the educational and social benefits deriving from socio-economic positioning and elite status. In other words, the benefits of positive education are also linked to socio-economic factors, yet this is not often acknowledged by proponents of positive education. It also risks sending the message that developing resilience through the self-monitoring of behaviour and action in the face of any given situations (including poverty), equates to putting on a happy face. As Sara Ahmed writes: "The face of happiness, at least in this description, looks rather like the face of privilege" (2010, p. 11).

Schooling and the Socialization of Wellbeing

Despite its more recent focus, it could be argued that wellbeing has long been embedded – at least implicitly – in school settings through the cultural, ethical and spiritual ethos of schools. Traits such as respect, tolerance, courage, friendship, honesty, fairness, self-esteem, work ethic and self-discipline, have a long history in discussions about values education and have gained momentum in a broader curriculum movement from values education to wellbeing as a whole school responsibility.

In Australia, approaches to socialization and the teaching of values have become more national and coordinated, with the promotion of wellbeing emerging in a range of schooling policies and practices. Wellbeing features prominently in a number of supporting educational policies, such as the *National Framework in Values Education* (2005) under the guiding principle of "Support for Students", which claims that "student health and wellbeing" (p. 7) should be addressed through values education programs. Wellbeing features in the *National Safe Schools*

Framework (2011), overarching vision: "All Australian schools are safe, supportive and respectful teaching and learning communities that promote student wellbeing" (p. 3). It is also present in the *National Framework for Protecting Australia's Children* (2009): "Australia needs to move from seeing 'protecting children' merely as a response to abuse and neglect to one of promoting the safety and wellbeing of children" (p. 7).

Within school settings, values education is in part connected to the hidden curriculum, what Hamilton and Powell (2007, cited in Halstead and Xiao 2010) define as "the unofficial rules, routines and structures of schools through which students learn behaviours, values, beliefs and attitudes" (p. 303). Similarly Giroux has drawn attention to the "... unstated norms, values, and beliefs embedded and transmitted to students through the underlying rules that structure the routines and social relationships in schools and classroom life" (Giroux 2001, p. 47), The hidden curriculum suggests that values can be learnt either formally or informally and are embedded in all that goes on in the classroom and school: from non-study activities (such as pastoral care) and classroom routines to praise and discipline, seating models and use of classroom space (Halstead 1996). In relation to this, Hill (2010) has identified a blurred "distinction between simply assisting maturation and deliberately promoting a particular view of mature adulthood" (p. 651). Mainstream Australian schooling, Thompson (2010) argues, tends to fall towards the latter, providing a narrow vision of what "good" entails "that is exclusive and repressive ... in practice if not intent" (p. 414). Notions of the "hegemonic good student" shape how student practice is understood and assessed by teachers, schools, parents, other involved agencies and, ultimately, students themselves. Hill (2010, p. 651) asks:

> On what grounds do we dare to intervene in the life-streams of other human beings? To what extent should their consent or dissent be factored in to our consideration of means? What models of the human person underlie our attempts to modify their behaviour and dispositions? What shall count as normal? What visions of human flourishing and viable community justify our interventions? And if individual and national interest conflict, on which side should we, as professionals, come down?

Raising such questions does not amount to a rejection of the notion of values teaching. Rather, it underlines the effects of norms guiding the curriculum, and invites more open discussion of them. Hill (2004) rightly notes that "schools could not remain valueneutral and still call themselves "educational" institutions" (n.p). According to Hearn et al. (2006), the Australian "approach does not set explicit values of what is right, leaving the decision as to what constitutes good values up to individual and school – an approach which is arguably more appropriate in a multi-cultural society" (p. 4). The scholarly domain of the broad field of values education has long demonstrated such debates about the nature of and issues related to educational socialization and indoctrination. Schools' fundamental role in socialization leads Barrow (1981) to write: "The only question can be whether an agency like the school should take thought for the matter or let its contribution be haphazard" (p. 54).

Wellbeing as Bildung: Schooling and the "Good Life"

Conceived by German thinker Wilhelm von Humboldt, *Bildung* is an educational concept that, although not having a direct translation, refers to notions of the development and formation of the human mind – and more precisely to some degree it refers to formative self-development through independent and autonomous thinking and actions (see EUNEC 2011; Wood 1998). Arguments for the use of a *Bildung* philosophy draw on insights from the Aristotelian eudaimonic tradition in schooling and generally stand in opposition to more functional and technical/instrumental approaches to education that focus on skill development. Central is the idea that a focus on self-development through the cultivation of knowledge, ethics and personal character provides the path to achieving eudaimonia, or the "good life". *Bildung* therefore shares some ground with contemporary discussions and research into wellbeing, especially those within positive psychology (Bauer et al. 2008; Waterman 1993; Waterman et al. 2008). However, drawing on Nodding's Aristotelian notions of happiness, Fishman and McCarthy (2013) provide a more critical assessment. As they argue:

> In contrast to current psychological research, what stands out about Aristotle's view of happiness is its evaluative dimension. That is, for Aristotle, happiness is a life of excellence or virtuous activity. At times, Aristotle stresses the exercise of practical virtues like courage, generosity, prudence, and justice, and, at others, he emphasizes the exercise of intellectual virtues like contemplation of eternal truth. (p. 511)

Eudaimonic wellbeing is more concerned with living well by realizing one's human potential (see Deci and Ryan 2008; Bauer et al. 2008; Wood 1998) and does not regard happiness as a necessary function or end-state of wellbeing and a good life. Importantly, the focus of eudaimonia and *Bildung* is on the processes involved in wellbeing and living well – a vastly different target to hedonic conceptions of wellbeing as outcomes of processes (Ryan et al. 2008, p. 140). This point of contestation is important if we consider long running debates over the differences in indicators measuring objective and subjective wellbeing. Objective definitions of wellbeing assume that the criteria measuring wellbeing can be defined without reference to the individual's own attitudes and ideals, whilst subjective wellbeing is concerned with an individual's evaluation of their own life (Pavot and Diener 1993).

As an educational concept and tool, *Bildung* has witnessed a revival since the 1960s, mostly within Nordic and Germanic countries (Aase et al. 2007, p. 7). Given its more abstract, less vocational uses, it was originally utilized within more elite schools, but its influence spread to into the wider educational culture within these countries (Aase et al. 2007). The European Network of Education Councils (EUNEC) considers *Bildung* to be education through ongoing learning processes, themes that are legitimate in the eyes of the broader society, as a way of allowing pupils to develop their own talents, and of fostering the development of responsible human beings (EUNEC 2011).

A relationship can be identified between education practices that promote wellbeing through values education and those that do so via pastoral care. This is

particularly so when eudaimonic wellbeing is framed as a maturation process. From this perspective, wellbeing is linked to ego development, improving as a person's capacity to think and reason develops in an increasingly integrated manner, and is based on "appraisals of a wider range of human capacities and development" (Bauer et al. 2008, p. 84) and not only on feelings or states of subjective wellbeing.

It remains a struggle to incorporate such existential concerns within contemporary debates about the purposes of schooling. Writing on current educational policy in the UK and EU, Griffiths (2012) argues that "the purpose of education is taken to be primarily economic and instrumental with only a small amount of attention paid to its intrinsic values" (p. 667). The "good life" does not exist in a political vacuum and an education tied to the achievement of national economic goals can work to negate the importance placed on the intrinsic value of education.

Conclusion

On one level, it is difficult to conceive of a schooling system that does not have at its foundation, a concern for the wellbeing of its students. Yet, as I have noted, what is meant by the concept wellbeing in schools is not always clear. Arguing that wellbeing is not a neutral concept, in the chapter I have aimed to identify and make explicit the normative dimensions of wellbeing in relation to the wider goals of schooling. These implied goals were grouped under the broad analytic categories of Wellbeing for the National Health Agenda; Educational Attainment; Socialization and Bildung. Whether wellbeing is viewed as essential to addressing the national burden of mental illness and disorder, to overcome barriers or provide support for learning, or as part of the broader approaches to socialization or the "pursuit of happiness" or the "good life" are questions that warrant further exploration and much greater levels of interdisciplinary debate. In addition, if the pursuit of a particular version of wellbeing is considered an acceptable goal for schooling, can it compete with the range of other socially-valued goals schooling is currently responsible for such as; academic achievement, equity, citizenship, economic prosperity and social cohesion.

Drawing attention to some of the distinctions between facts and values in wellbeing as a goal for schooling is an important task. Not because the "epistemology police" (Latour 2004) should be on hand when the boundaries are crossed, but rather that we are more conscious that that the call for wellbeing in schools, particularly in its contemporary forms, often relies implicitly on educational goals that are normative directives imbued with significant moral and political values about the outcomes schools should pursue. However, whilst the normative dimensions of wellbeing in schools remain implied or "hidden", it is difficult to engage in a serious democratic debate about its place, what we really want the focus on wellbeing to achieve and at what cost it will come. Whilst some of the approaches mentioned above have addressed such concerns with histories of debates and tensions, others are yet to appreciate the full force task of untangling some of the epistemological

questions from the moral and political questions of wellbeing as an educational goal. Such a pause may give opportunity for further interrogation of these dimensions in a way that considers that "no attempt to research or advocate for a systematic knowledge about outcomes of schooling is without its consequences" (Ladwig 2010, p. 115). And these consequences, as educators know, can be great; much is at stake when we think about wellbeing in schooling.

Acknowledgements I would like to thank Mr. Antoine Mangion for his excellent research assistance in the preparation of this chapter.

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Chapter 10
Social-emotional Learning: Promotion of Youth Wellbeing in Singapore Schools

Wan Har Chong and Boon Ooi Lee

Abstract As with many other nations, Singapore recognizes that an education based on a traditional subject-based curriculum with a narrow focus on academic standards is no longer adequate to prepare young people for the future. A broad-based and holistic education that integrates academic, intellectual, moral, physical, social, emotional and aesthetical aspects is now regarded as necessary, both to cater to the diverse needs of students and, importantly, to promote their wellbeing. This chapter examines the Social-emotional Learning (SEL) Framework, which was rolled out in Singapore schools in 2005 to provide an "organizing structure" to conceptualize, formulate and design school-wide affective programs. While acknowledging the value of an overarching framework to guide affective programs, we suggest that there is need to closely examine the appropriateness and relevance of some of the underpinning assumptions guiding SEL practice. In this chapter, we discuss the importance of attending to the social and cultural contexts in which such ideas are developed and consider the implications of adapting educational models, notably those aimed at promoting youth wellbeing, across national contexts.

Keywords Social-emotional learning • Sociocultural context • Singapore • Wellbeing

Introduction

In Singapore, as elsewhere, widespread social transformations have resulted in substantial changes to the life experiences of children and adolescents. Families are now regarded as more permeable, open and vulnerable to outside influences, and consequently may not be positioned to offer children the security and protection they need (Elkind 1994). Many parents no longer see themselves as solely responsible for the emotional needs of their children or think of the latter as requiring them to

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K. Wright, J. McLeod (eds.), *Rethinking Youth Wellbeing*,
DOI 10.1007/978-981-287-188-6_10

offer directions, firm limits and boundaries, and clear values. Because many young people present as savvy, resourceful and having the capability to cope with the new demands of growing up, this façade can give a false demonstration of their adaptability, which in turn may encourage parents and the wider society to be less vigilant. Increasing incidence, particularly at a younger age, of a diverse range of juvenile behaviour problems (such as violence, bullying, anorexia, self-harm, teenage suicide and depression) in recent years may be suggestive evidence that this generation of young people are facing some serious problems relating to their "adjustment" and "adaptation". This poses a key challenge to schools in preventing problem behaviours and promoting positive development. It also suggests an urgent need to re-examine how education can be made more relevant to help the youth of today navigate the complex demands of contemporary life (Weissberg and O'Bien 2004).

In response to the rapidly changing social and economic landscapes, many nations in the West have recognized the need for a new curriculum to foster skills and dispositions that permit children and young people to strengthen their capacity to meet challenges and adversity ahead, and be prepared to take risks (Chong et al. 2013). As a small nation with a colonial past, Singapore has always looked abroad for tested and successful models and ideas, particularly from the West, from which to adapt many of its educational initiatives. Singapore's education system provides a strong academically focused curriculum. However, as with many developed nations in both the West and the East, it recognizes the need for education to move beyond the traditional focus on achieving academic excellence to also preparing the young to live successfully with the complexities arising from the technological age (Ministry of Education 2008, 2009b). A quality, competitive, and broad-based education is thus now considered necessary to nurture, develop, and prepare young people for the future.

In the light of this, the intent of this paper is to lend our observations on the adoption of the Social Emotional Learning (SEL) framework as a preventative approach to promote the positive wellbeing of children and adolescents in Singapore schools. The SEL movement has made a valuable contribution by drawing to the attention of educators and policymakers the role of emotional wellbeing in successful schooling. Specifically, it introduces and attempts to enhance educational practice to support the building of students' emotional competencies for both intrinsic (e.g. sense of accomplishment from mastery of experiences) and instrumental purposes, such as school achievement and personal success (Hoffman 2009). Moving forward, we thought it timely to reflect on some possible implications of SEL practice on the wellbeing of students in Singapore schools. We begin with an explanation of the rationale and nature of SEL programs and then review the contribution of this framework in promoting positive youth development. In so doing, we hope to provide a platform to encourage further discourse on the subject and new insights for educational practice, both in Singapore and beyond.

Holistic Education in Singapore: An Overview

Singapore is an island city-state situated at the southern tip of the Malay Peninsula. Approximately 714 square km in size, it has a population of just over five million people of which about 18 % are below the age of 14 years. Its diverse multi-racial make-up consists of three major ethnic groups: ethnic Chinese who comprise about 77 %; Malays 14 %; Indians 7.6 %; and other ethnic groups 1.4 %. A highly urbanized country, its major economic activities are diversified to include international banking and finance, and capital-intensive, high-wage, and high-technology activities, and to provide the infrastructures for manufacturing, financial, and communications facilities for multinational firms. Singapore has very limited natural resources except for its people. The economy is, therefore, highly sensitive to and dependent on the international economic environment. Education is thus seen as a critical pathway through which to maximize the nation's advantage in the global economy.

As with many developed nations, the Singapore government recognizes that an education based on a traditional rationalist, subject-based curriculum with narrow academic standards is no longer adequate. Desired outcomes of education have been identified by the Ministry of Education (Ministry of Education 2009b), with a strong emphasis on the development of an innovative and enterprising spirit, and the essential core life skills and attitudes such as ruggedness in character, a spirit of inquiry and adept social-emotional being in students. This entails the development of a broad-based and holistic education that embraces academic, intellectual, moral, physical, social, emotional and aesthetical aspects of the students' development to cater to varied student needs (Chong et al. 2013). In this way, the contemporary school system affords much flexibility and offers a diversified program for students to develop different interests and ways of learning so as to nurture each child and adolescent to become a confident person, self-directed learner, active contributor and concerned citizen of the country (Ministry of Education 2014).

In working towards these desired outcomes, competence in thinking, communication, collaboration, problem-solving, management skills, and literacies in various modes of technologies have been identified as the dispositions and skills necessary to position Singapore's young people for the future (Ministry of Education PERI Report 2009a; Shanmugaratnam 2005). A whole-school framework has been adopted in the identification, assessment and provision of varied facilities to enhance key learning experiences for students. The Social-emotional Learning (SEL) Framework, rolled out since 2005, provides schools with the "organizing structure" in which to conceptualize, formulate and design many of the school-wide affective programs (SEL Resource Pack for Singapore Schools 2008), such as sexuality education, life skills training, service learning, career guidance and co-curricular activities.

Importantly, the SEL model provides a framework to help students "recognize and manage their emotions, develop empathy and concern for others, and establish positive relationships" (Ee 2009, p. xi). The cultivation of these personal attributes is regarded as critical for young people to develop the skills required

to make responsible decisions and manage challenges. Specifically, it is seen as a process of acquiring and developing five core competencies: Self-Awareness, Social Awareness, Self-Management, Relationship Management and Responsible Decision-Making (Durlak et al. 2011). Research in the United States in particular has well-documented that SEL-based curricula and programs have led to varied positive outcomes such as improved student attitudes (e.g. high sense of self-efficacy, improved coping with school stressors, higher academic motivation and educational aspirations), behaviours (e.g. more prosocial behaviours, increased attendance, few absences and suspensions, reductions in fights and disruptions, more involvement in positive activities), and better academic performance and critical thinking skills (Durlak et al. 2011; Greenberg et al. 2003; Zins et al. 2004).

In the light of these findings, research on SEL strongly suggests that interventions targeting the psychological and emotional determinants of learning provide an effective approach to educational reform. In the United States, schools have increasingly become the sites for primary health prevention and promotion (e.g. weight control and smoking cessation), offering a much broader approach to the education of children and young people than the traditional academic curriculum (Roeser et al. 2000; Wang et al. 1997). Similarly, SEL in Singapore schools has been implemented as a primary prevention intervention across all educational levels. The aim is to build a broad set of student competencies and introduce them to "productive social networks" (Gilman et al. 2004, p. 33) that reflect societal values and that can provide the protective mechanisms for young people who are considered to be "at risk" (Pianta and Walsh 1996).

The Ministry recognizes, however, that equipping students with these social emotional competencies may not be sufficient in itself to engage them effectively. Indeed, the SEL framework adopted in Singapore schools also adheres to three other guiding principles. First, at its core are six values of the twenty-first century competencies – respect, responsibility, resilience, integrity, care and harmony – that underpin the development of these skills, knowledge and dispositions (Ministry of Education 2014). Second, schools are to play an important role in the teaching of these core competencies as school leaders and teachers are seen as role models in the students' development. Finally, it is reasoned that equipped with social and emotional skills which are anchored in sound values, young people will develop good character and citizenship. Aside from the SEL program, character and citizenship education (CCE) forms the other critical and essential school-wide vehicle through which these values and citizenship education are fostered, reinforced and affirmed. Together, these two programs provide complementary approaches to the holistic development of students as future citizens (Mayer and Cobb 2000).

It is recognized that successful skill development depends on the exposure of young people to multiple opportunities and contexts over time and from cumulative experiences, rather than single practice events. This is particularly true of complex developmental tasks, particularly those requiring a clear functional understanding in the application of the entire concept (Berkowitz and Begun 2006). Empirical evidence suggests that social emotional competence and academic achievement are interwoven and that students' potential to do well in school is maximized when both

cognitive and social-emotional competencies are integrated and/or incorporated in curriculum planning and classroom instruction (Greenberg et al. 2003). As such, SEL in Singapore schools is not necessarily taught as a stand-alone subject in assigned class periods. Instead, various ways of introducing SEL have been introduced across the curriculum. Indeed, SEL elements have been infused in a range of subjects and in fact schools have been encouraged to do so to enable students to see the link between the subject itself and their personal response to the meaning of a particular topic. SEL principles have also been introduced into instructional processes such as interdisciplinary project work and used to guide school discipline and behaviour management practices. Chang (2009), for example, has documented numerous primary and secondary schools programs in Singapore that have attempted to foster or infuse SEL into character and citizenship education, including the Community Involvement Program (CIP), leadership development frameworks and service learning. In addition, other informal platforms such as camps, project work, class committees, experiential learning, seizing teachable moments, and teacher-pupil contact time have been identified as SEL opportunities in these schools.

In the context of youth development and wellbeing in Singapore schools, the SEL model provides a framework with guiding principles for the coordination and planning of seemingly disparate affective education programs designed to meet varying student needs across schools. The psycho-educational approach adopted in the teaching of SEL provides young people with contexts in which to explore and develop competencies where these are expected to occur. Additionally, the program includes multiple opportunities for young people to address personal needs and problems and to support their relationships with peers and adults. While we recognize the timeliness in the adoption of an overarching framework to guide affective programs in schools, we suggest that it is also important to examine some of the underpinning assumptions guiding SEL practice in Singapore schools. Our observations suggest that these assumptions and principles may be drawn from and/or based on cultural models that differ from our Asian context. When school-wide programs have not been meaningfully reflected upon for their appropriateness and relevance, there can be important implications for practice that are not clearly understood. We begin by highlighting our concerns as to how these underpinning assumptions of the SEL approach can have unintended consequences for the wellbeing of young people in Singapore. To strengthen SEL application in schools, we argue for the need to attend to contextual conditions under which youth development is currently being promoted.

SEL in an Asian Context

We alluded to the importance of attending to embedded cultural values when adopting models, such as SEL, that may be derived from cultures that differ from the Asian context in which these competencies are being taught and practiced.

We argue that some of the underlying principles in SEL, for example, were conceptualized from a cultural perspective that reinforces individualistic values of choice, personal responsibility, autonomy and the importance of subjective experiences. This emphasis on individualism conflicts with an Asian perspective, in which the family, community and nation is considered to have greater importance than the self (Markus and Kitayama 1991).

Asian cultural values place strong emphasis on the restraint of emotion, obedience to parents, dependence on the family and other-centered behaviours in interpersonal relationships. Self-worth and self-identity is closely tied to the family. We have been socialized to behave and respond in ways that enhance our connectedness with significant others in the community. While heavy emphasis is placed on academic success and competition, children are taught from a young age the virtues of filial piety and duty to fulfill family obligations by working hard and doing well in school. In many ways, educational demands are very much aligned with familial goals and expectations (Chong et al. 2006). In this aspect, Singapore's affective education model departs from individualistic models in one very important way. A key theme emphasized across these programs is the strong cultivation of shared values that bind the nation together and emphasizes the strong cultivation of family relationships to affirm family life.

The Asian notion of subjective wellbeing looks beyond the "individual" to include the collective, thus providing a more balanced perspective of the role of self and others and emotions than dominant Western notions of wellbeing (Markus and Kitayama 1991). To ensure a societal fabric that would withstand the erosion of the postmodernist age, the Singapore government works to foster a set of values that emphasize filial piety, self-restraint, self-discipline, social responsibility and not just personal fulfillment, desire, identity and responsibility. Consequently, it would seem a culturally appropriate response to construct the SEL framework so that it reflects these social values. Furthermore, an understanding of social context and cultural difference suggests that educators would benefit from a more in-depth understanding and appreciation of culture-specific psychological influences on children's and adolescents' social and emotional development. This knowledge base is important in promoting young people's competencies in ways that are congruent with social norms.

Therapeutic Beliefs: Regulation of Thoughts, Feelings, and Emotional Distress

What constitutes competence varies across cultures and is reflected in the underpinning beliefs and values of that particular culture. It is conveyed in the language used. Different forms of language provide different ways of thinking about one's self and the world. This helps people to learn to reason, reflect and respond to those around them (Healy 1990). Different forms of discourse thus affect abilities to think

abstractly, plan ahead and delay gratification, control attention, and perform higher-order analysis and problem-solving – the very dispositions and attributes that are demanded in today's technological age and that are so much at issue in schools. In schools and classrooms, the nature of this discourse becomes critical in shaping the kind of education young people receive because what is being said, written, or thought about in the classroom reflects shared understanding about what are significant and valued experiences in that cultural context. It provides the parameters for what and how to think or what to say and what is unimportant, inaccessible or unacceptable. The discursive context of the classroom also provides the vocabulary with which to integrate understanding of the nature of problems, their sources, and determine the focus and direction of remediation efforts.

In many SEL-focused activities, a new language is often introduced to provide young people with the facility to think, speak and act differently. Students are encouraged to reflect critically on the meaningfulness of their experiences in the classroom. To enable them to develop their faculty to "think before they act" and become effective thinkers, they may need to be taught to be reflective and conscious of their emotions, restrain from and manage impulsivity, and recognize the consequences of their actions on the self and others. As such, in SEL instruction, students are often engaged in activities that require them to appraise the lesson or activity cognitively (What happened?), affectively (Who has been affected? How do I feel?) and behaviourally (How can I make it right?). Many of the activities entail the use of metacognitive skills that teach various self-regulatory and self-management capabilities that include goal-setting, planning, monitoring of one's progress, and evaluation of one's efforts and strategy use. Although these activities encourage rational thinking and invite one to also consider the perspectives of others, the instructional processes tend to infuse questions about one's feelings, and evoke a personal and emotional response to the issue. The process of instruction and learning appears to have this tendency to draw one back to the "I" and/or "me" in various aspects of functioning.

Such forms of instruction implicitly introduce therapeutic insights and practices into pedagogical practices as an integral part of the curriculum. It may be considered to be an essential part of good teaching practice to cater to not just the holistic education of the individual but to meet the diverse learning styles of students. In their observation of the proliferation of similar affective programs and practices in British schools, Ecclestone and Hayes (2009) noted that such programs tend to use language that privileges emotion. This language attempts to understand, explain and interpret behaviours and emotions, but without an appreciation of underlying roots and psychological causes. Individual psychological deficits are seen as the cause of many of the social and educational problems. From this standpoint, students' apparently dysfunctional traits and disruptive behaviours are often understood to be an outcome of past experiences. Ecclestone and Hayes (2009) argue that such educational practices endorse and foster a "therapeutic ethos" that encourages a particular way of looking at the self and others, and reinforces an inward looking self that is self-centered and narcissistic. Therapeutic discourses and practices encourage

self-awareness, appraisal and expressions of one's feelings as a way of attaining emotional health and wellbeing. Yet they pay little attention to human capacities and potentials and, most importantly, the intellectual. As Ecclestone and Hayes argue, this can reinforce images of human vulnerability and deprivation. Although this observation remains propositional, it is highly possible that therapeutic language, when used pervasively, can undermine children's and young people's perception of their capability to cope with life's problems, and shape their thinking about the nature of human potential as they appraise, internalize and reinforce certain ideas about their sense of selfhood. That is, in subtle ways, it can encourage in young people a mindset that cultivates help-seeking behaviours when self-reliance needs to be fostered instead, thus compromising the desired outcomes in their psychological wellbeing.

Interactive Influence of Cognition and Emotion

In reviewing the SEL package (Ministry of Education 2008), it appears that the skills and dispositions embedded in the SEL model draws from dominant themes in western "therapeutic" models that featured heavily in western psychotherapy and counselling. Our analysis suggests that instruction of social emotional skills mirrors very closely the kinds of behavioural skills training employed in cognitive-behavioural therapy (Hoffman 2009). This form of therapy is structured, systematic, goal-oriented, and instructional, with its concepts being specific, concrete, and measurable. From this theoretical perspective, emotions are treated as cognitive information-processing skills and behaviours are understood as rational choices. Similarly, we noted that some of the therapeutic beliefs that appear to be underlying SEL skills include those found within existential-humanistic therapy (Mayer and Cobb 2000). Commonly identified terms such as "searching for one's meaning and purpose in life", "goal-setting", "the capacity to respect others", and "empathy", the skills derived from this form of therapy focus on promoting self-esteem and a positive self-image.

A basic underpinning assumption of cognitive-behavioural beliefs is that cognition is conscious and deliberate, and that people can be made aware of their thoughts and feelings. In a similar manner, the SEL concept of self-awareness is seen to provide the foundation for more effective self-management, such as having "the ability to seize and challenge the thoughts that trigger emotional outburst", and "the ability to de-escalate emotions" (Ministry of Education 2008). Effective self-management is posited to facilitate better relationship management and responsible decision-making. This assumption raises a number of questions that must be considered when introducing social emotional learning in schools. First, it assumes that cognition occurs before and "causes" emotion. Empirical findings from neuroscience, in particular, have shown complex interactions between cognition and emotion, rendering it meaningless to question which domain (cognitive or

emotional) takes precedence (Dennis 2010; LeDoux 1996). Cognition and emotion are integrated and collectively influence emotional regulation in children and adults. In the light of these empirical findings, it may be prudent for students to appreciate the interactive nature of the cognitive and affective dimensions as they come to influence their decision-making and problem-solving behaviours. Second, the belief presupposes that emotion and cognition can be identified, discovered, retrieved, recognized, and regulated, suggesting that they are conscious and controllable. Research evidence suggest otherwise, indicating that people may not be in control or aware of their thoughts, emotions, and behaviours as they believe they are (Bargh 2007; LeDoux 1996; Singer 1990; Soon et al. 2008). Some aspects of life experiences, such as daily social interactions, close relationships, and setting of life goals, are generally automatic or non-conscious. More importantly, when the focus is on developing behavioural and cognitive skills and when emotion is valued as a means to success rather than as a good in itself, there may be a tendency to move away from the essence of such emotional training – to enhance the quality of human relationships (Hoffman 2009), a concern which will be explored later in this paper.

The promotion of SEL competencies within a predominantly a cognitive-behavioural framework may resonate well with the Singapore education system; it appears to provide a good fit with the overall educational culture. This belief system may be socio-politically consistent with the capitalist structure of Singapore, which promotes rational thoughts, personal autonomy and independence, goal-pursuit, inner-directedness, and impulse-control. The emphasis of positivism and evidence-based practice in cognitive-behavioural beliefs are also in line with the emphasis of technological and scientific education in Singapore. Indeed, in a way, this may already be reflected in the congruence of the belief system with the programs in Singapore schools that promote critical thinking, creativity, and problem-based learning. This approach, however, is not without limitations.

As with all traditions of psychotherapy and counselling historically and socio-culturally constructed in Western society, cognitive-behavioural therapy represents only one of many therapeutic orientations, and may or may not be appropriately applied to promote the wellbeing of young people in school. To be effective we suggest that it is necessary that the techniques and instructional procedures in the package be used in a manner that is consistent with the cultural beliefs and life experiences of the intended population (Corey 2009). This can pose a challenge in a multi-racial society where different social and cultural norms may not necessarily align closely and in a congruent manner with those conveyed through school programs. Perhaps espousing the core values embedded within the Singapore SEL model may be a forward looking move in preparing the next generation of young people to live in a more culturally and ethnically diverse society. However, it is unclear what pathways and linkages have been identified and used so that both core values and SE core competencies are introduced and fostered in an integrated manner.

Cultural Differences in Patterns of Emotional Expression and Distress

Culture shapes how emotions are managed and regulated (Lee 2013). It is therefore important to highlight the erroneous assumption that patterns of emotional experiences and distress are homogeneous across cultures. Such a view ignores cultural differences in expressing and experiencing distress (Sue and Sue 2013). With this in mind, we note three interrelated emotional experiences that should be considered when adapting what may be understood as broadly therapeutic pedagogical strategies across cultural contexts: emotional suppression, somatization of distress, and ambivalence over emotional expression.

Unlike cultures with a more individualistic orientation, characteristic of East Asian cultures is the orientation toward a collectivistic self-construal in which interpersonal and social harmony are heavily emphasized and individuals are socialized to avoid interpersonal conflict by inhibiting emotional expression as a way to self-regulate (Chen et al. 2005). From this cultural perspective, emotional suppression may be considered as a form of cultural expression rather than negative emotional regulation. Strong emotional displays, on the other hand, are construed as signs of weakness and immaturity (Sue and Sue 2013), and excessive emotions, rather than emotions per se, are regarded as pathogenic and detrimental to health (Gai 2005). High value is placed on moderation and suppression of strong affective expression (Ho 1996; Lin 1981; Shek 1992). In the light of this understanding, Asians who suppress emotions report less negative emotions and may regulate and cope with these emotions in different ways such as embodying their emotions through somatization (Kleinman 1986). Indeed, Lee (2013) showed that among Singaporean students, those who present somatic complaints such as headache, weakness, or low energy may not be suffering from a disorder that indicates psychopathology, but their symptoms may in fact reflect a cultural expression of emotion (Kirmayer and Sartorius 2007).

Ambivalence over emotional expression is another way of understanding the complexity of what is spoken and unspoken in relation to emotional life and young people in Asian cultures (Lee 2013; Quinton and Wagner 2005). There would, in fact, be certain circumstances in which the expression of emotions may not be regarded as healthy and a lack of expression can be viewed as healthy instead (for example, expressions deemed disrespectful and as undermining the authority of elders). In cultural and social settings where there is a preference for emotional inhibition, one might feel stressed with not being able to express one's personal feelings. On the other hand, in cultures where expression of emotions is encouraged, one may feel equally stressed when not having the desire to share one's feelings. Such ambivalence over emotional expression appears to be related to emotional distress (Lee 2013; Quinton and Wagner 2005). In situations when individuals are ambivalent about expressing their emotions, they may be further distressed by rumination and inhibition of their distress (Chen et al. 2005). Maladaptive emotional regulation like this can thus lead to future ambivalence. It is important to note that

these associations with emotional distress often arise when one's expressive styles conflict with sociocultural norms of the culture (Butler et al. 2007).

In sum, research on cultural expressive patterns of distress indicates that emotional expression in itself does not necessarily foster and promote positive mental health. In addition, when many of the SEL skills and competencies are described at a high level of abstraction, this may obscure the fact that they can be understood differently across cultures and among individuals at different developmental stages in life. In a multi-cultural society like Singapore, appreciation of these factors would require astute thinking about how to facilitate effective implementation.

In the context of programs aimed at promoting the wellbeing of young people, schools need to appreciate possible cultural incongruence and ambivalence about emotional expression. This is particularly important when affective practices underscore both the importance of maintaining social harmony through developing tolerance of diversity and the expression of one's thoughts and feelings. Adolescents may have yet to develop the maturity to enable them to recognize and deal with such contradictions in thought and action (Steinberg 2005). As such, in the context of understanding the role of emotions in learning, the question for many educators may not be about asking young people to identify and express feelings but rather with how to identify the appropriate emotional expressive styles in different social situations (such as family, peers and school). Educators need to appreciate and recognize these cultural and individual differences in emotional experience and expression (King and Emmons 1990; Kirmayer 2005) and be sensitive to forms of emotional expression other than emotional verbalization. They will also need to be aware of their own cultural beliefs and values about emotions and behaviours, and how these may or may not fit with those of their students (Hoffman 2009). Failure to consider and deal effectively with these complexities can bring about undue distress in vulnerable young people in particular and compromise the true intent of primary prevention through SEL.

A Contextual Approach to SEL

One other important underlying assumption in school-based programs like SEL is that skills and dispositions are perceived as properties residing within the individual. This fails to acknowledge that important social and cultural contexts for development, such as family, peers and school, can influence the extent to which the individual can learn the desired behaviours successfully and use them outside the school context where they have been acquired. Components of social, emotional and behavioural competence such as emotions, social behaviours, attention, and self-control are often developed in the process of interactions between the individual and the situation. In class or school instruction, infusion of SEL concepts and ideas, and school-based interventions are insufficient to foster deep-seated learning that allows the individual to adapt the skills across out-of-school and other real life situations.

This is because behaviours and problems are often shaped and constrained by multiple factors within the school, home and community systems. As Hoffman (2009) has aptly argued, focusing on what is "wrong" with the individual and on what can be done to him or her directs "attention away from the equally if not more critical aspects of what can be done to change the social contexts and the cultural systems in which (the child) is a participant – those that highlight the deficiencies and make them significant in the first place" (p. 547).

Paying attention to the underlying meanings of behaviours, the developmental antecedents of behaviours, and the ecological contexts in which these behaviours are developed and maintained is critical to developing a holistic understanding of how to address the issues young people are facing today. That is, schools and educators need to understand the mechanisms that are responsible for successful skill development as it involves multiple systems acting in concert to shape new behaviours (Pianta and Walsh 1998; Weissberg and O'Bien 2004). In evaluating young people's success or otherwise, it is vital that attention is paid to these factors. For young people who are vulnerable and "at risk", paying attention to the mechanisms underlying psychological wellbeing is necessary to ensure that the gains made are sustainable over time and across different aspects of life. However, having said this, young people with emerging problems, established patterns of maladaptive behaviours or those who have been experiencing persistent challenging situations in life require more support than can be provided by the sorts of preventative skills that SEL programs can offer. Their personal resources to deal with these problems may be insufficient to support their efforts. Locating and situating the source of problems within the individual and providing a range of secondary and tertiary programs may be a step in the correct direction, but finding ways to collaborate with families and the community to support the efforts of these young people is paramount to ensure successful school engagement. Though well intended, when SEL is narrowly focused on promoting a set of competencies within the individual as abilities or deficiencies, it constrains personal change unless the social context of development is attended to in strengthening one's capacity for successful adaptation and adjustment. This is particularly the case for those young people who are already socially and/or economically disadvantaged.

SEL Engagement Through Meaningful Relationships

Although SEL provides the overarching framework, Singapore schools take ownership in assessing and determining the form and content of their preventative programs. They are therefore at liberty to adopt flexible approaches to SEL to provide a good fit with school circumstances and the characteristics of different school populations. Teachers are encouraged to use a range of teaching practices to foster SEL in class, across subjects and through other school-related activities such as service learning and co-curricular activities. There is evidence of these practices being translated and/or incorporated in a range of school-based activities

(Chang 2009) but anecdotal accounts from in-service teachers suggest that while teachers have instructional training on the use of SEL strategies, an integrated approach to SEL implementation at the student and school levels appears to be lacking in many schools. This can contribute to a fragmentation of the curriculum in which the essence and general meaning of SEL can be diluted and lost over the course of time. This is particularly so when systematic monitoring of its translation to classroom and subject-based practice, and across school-based activities has not been adequately thought out and/or planned for. It is difficult then to appreciate the impact of the SEL initiative on the wellbeing outcomes for students, especially with those who might be identified as at-risk. This is, however, not just a challenge faced in Singapore schools but is an issue of evaluating the effectiveness of school-based programs more generally, and how they are translated to ground level practice in a variety of contexts. In short, these are issues about ensuring implementation fidelity.

Well-designed SEL programs offer developmentally appropriate classroom instructions that build young people's connection to school through caring, engaging classroom and school practices that convey care, responsibility, and a commitment to learning. They seek to nurture students' sense of emotional security and strengthen relationships among students and their teachers and families, as well as their connections to school (Weissberg and O'Bien 2004). A narrowly focused skill development framework, however, fails to recognize the fact that people learn through interactions with another in a relationship. A growing body of research has underscored and highlighted how relationships with significant adults are closely intertwined with healthy developmental processes that foster and shape wellbeing and competence (Baker et al. 2003; Chong et al. 2006; Davis 2006). Adult figures form the critical regulators of development that supports what young people are asked to do in school – learn to get along well with others, stay focused and persistent, have the motivation to perform, work hard and do well, and be compliant but yet assertive. Relations with these figures are essential resources for sustainable outcomes regardless of risk level (Pianta and Walsh 1996, 1998) and maximize opportunities for developing the skills needed to thrive in the real world. Unfortunately, this equally important emphasis on the qualities of relationships between students, teachers and the school in which these skills and behaviours are contextualized is often overlooked.

From this perspective, effective SEL implementation, then, requires teachers to be skilled not simply in teaching students topics and skills associated with SEL. It should be about teachers distributing social and emotional learning throughout the school day – by showing personal acts and attitudes as they transact and interact with the students and others in school (Noddings 2006). Nurturing the teacher-student relationship in this way forms the basis in bringing out the true essence of SEL. To enable this, teachers will need to move from seeing their role as instructor and educator to one that involves facilitation and enablement. Although one of the guiding principles of the SEL framework sees school leaders and teachers as important role models in teaching these competencies, it is unclear the extent to which this is being practiced and how it is being carried out.

We argue that because teachers are trained to educate and instruct, many of them may not have the necessary relational skills that allow them to interact with young people in ways that enable them to connect with the experiences and struggles of those trying to make good sense of school as it relates to their future wellbeing. For this to happen, professional teacher training development should turn its focus on teaching so-called soft skills that help teachers with identifying, assessing and using appropriate enabling strategies to promote meaningful interactions with students. This training, largely grounded in psychological and developmental principles, should enhance teachers' understanding of adolescent development and the life circumstances of young people, the processes that produce problems, and knowledge about what contextual factors trigger, perpetuate and alter the problem(s). This would include the knowledge and skills needed to facilitate communication with children and adolescents and to enhance teacher-youth relationships. In essence, teachers will require a shift in their mindset about the beliefs and values they hold on what education and learning entail and the educational practices that are needed for them to remain relevant in the contemporary classroom. Like Noddings (2006), we think a good way to begin is for teachers to learn the art of listening to young people first as opposed to teaching these kids social skills such as listening.

Conclusion

A systematic preventive framework involving the identification, assessment, and implementation of school-wide and student-focused interventions has been put in place to support the diverse learning needs of youth in Singapore schools. These programs have been implemented with the aim of promoting both the capability and the wellbeing of young people. Secondary and tertiary issue-specific interventions are provided to those young people who continue to experience difficulties and fail to benefit from primary measures. Across this whole-school approach to promoting mental wellbeing of students, the SEL model provides the overarching framework to guide all other school-based program initiatives aimed at fostering and strengthening their capacity (Chong et al. 2013). Indeed, the SEL movement has made very significant contribution by highlighting to educators and policymakers the need for more focused attention to the emotional domain of schooling through understanding how emotions can impact the school outcomes of young people (Hoffman 2009). Despite the concerns that we have articulated, this skill-based approach does offer a systematic and organized way to foster the self-regulatory skills needed during the critical period in adolescence when a developmental disjunction between adolescents' affective experiences and their ability to regulate arousal and motivation can lead to poor calculations to engage in risk-taking behaviours (Steinberg 2005).

Although the SEL framework provides important general information about protective and risk factors in youth development and wellbeing and where to target intervention efforts, we have identified the role of specific underlying processes

or mechanisms pertinent to facilitating positive adaptation and development in young people. We reason that enhancing development and reducing problems will not result without identifying and addressing these underlying processes (Small and Memmo 2004). Our recommendations for action involve an approach that appreciates the importance of the nature of contexts and relationships instead of products and outcomes (Pianta and Walsh 1998). Finally, we are unclear about the extent to which schools use evidence-based prevention programs or use them with fidelity since research on SEL is only just beginning to emerge in Singapore. However, schools will need to recognize that their practices and the theory driving the SEL model should not be divorced from one another if they wish to continue drawing on empirical-based practices that come predominantly from the west and use these in local schools. It may not be reasonable to expect all programs to be grounded in all these principles across every school practice if schools are to capitalize on their available resources to promote the positive outcomes. However, there remains a gap between research and current practice that perhaps only locally driven research can address, both from a cultural and contextual viewpoint (Durlak et al. 2011). Considering the investment of SEL in education in Singapore, this is a prime area for more intensive research to inform about the ways and the extent to which this educational reform has and can contribute to the desired outcomes of young people in the country.

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Chapter 11
Happiness, Wellbeing and Self-Esteem: Public Feelings and Educational Projects

Julie McLeod

Abstract Wellbeing is now firmly part of the lexicon of education and youth policy, deployed as a rationale for many different interventions and inevitably generating mixed effects and meanings. It circulates as a common-sense phenomenon, a set of qualities that it would be hard to argue against, its absence signifying a lack in individual students and also the failure of schools, other social institutions and families to properly nourish its development. This chapter maps the beginning of an historical sociology of youth wellbeing, and asking, "what does wellbeing do?" it looks sideways and backwards to the self-esteem movement in feminist education as a point of comparison. It argues that aspirations for wellbeing are not typically connected to a broader educational and political project of change and are largely indifferent to gender or other forms cultural differentiation. Canvassing arguments about the turn to happiness and public feelings, it proposes that such approaches to the study of feelings in public life suggest productive new ways of exploring wellbeing and self-esteem, underscoring their ambivalent registers and the historically located and socially differentiated form of their subjective address.

Keywords Wellbeing • Self-esteem • Happiness • Public feelings • Feminism • Historical sociology

Introduction

The reach of wellbeing as an educational discourse is extensive. Notions of student wellbeing saturate contemporary educational practices, from promoting healthy school environments, to dedicated programs, to curriculum initiatives. As a concept it distils multiple ideas and disciplinary traditions, with its genesis in part in psychology yet now moving across the social sciences and the social care professions. As a phrase it has entered everyday talk, a state of being and a frame of mind against which it is hard to argue. What could possibly be wrong

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K. Wright, J. McLeod (eds.), *Rethinking Youth Wellbeing*,
DOI 10.1007/978-981-287-188-6_11

with wanting young people to experience wellbeing, or with having educational programs that promote student wellbeing? The presumed antithesis of wellbeing seems undesirable, even if it is not always entirely clear what the absence of wellbeing might look like or what would be its consequences. The proliferation of wellbeing talk in education can be mapped in a number of ways, with it being expressed much more frequently from the 1970s onwards in relation to personal wellbeing in comparison to its use in the post-war period in reference to national or economic prosperity and wellbeing (Sointu 2005). The personalization of wellbeing and its spike in use parallels significant cultural change and the impact of social movements, from the "personal is political" orientation of second-wave feminism, to the reflexive, self-making individual emblematic of late modernity. By the turn of the twenty-first century, wellbeing is typically used as a personalized noun, conjuring feelings of emotional security, resilience and self-efficacy, and often called upon as prophylactic against negative thoughts, failure, despair and inertia.

In calls for educators and schools to address wellbeing, both pragmatic and altruistic purposes are envisaged, conveying present-day and future-oriented aspirations. Within school curriculum, a focus on wellbeing as a specific topic has been commonly aligned with the health or personal development curriculum domains. Yet the spread of wellbeing discourses extends beyond any particular curriculum home, and functions as well as a whole-of-school or cross-curriculum approach, one that also underpins the values that education systems and school sectors should broadly embody. This is evident in various national and state-based educational policies and declarations of purposes. A current statement of principles guiding school education in Australia – and to which all state departments of education are signatories – identified one of its two main goals as producing students who become "successful learners, confident and creative individuals and active and informed citizens" (MCEETYA 2008). Wellbeing, as a personal quality and as a feeling and way of being that schools should uphold, has a central place in this statement of aspirations: "Schools play a vital role in promoting the intellectual, physical, social, emotional, moral, spiritual and aesthetic development and wellbeing of young Australians, and in ensuring the nation's ongoing economic prosperity and social cohesion" (MCEETYA 2008, p. 4). The responsibility to promote wellbeing does not reside solely in any specific curriculum programs or school interventions, although some exist and are widely taken up (e.g. MindMatters 2012). What is most remarkable, however, is the pervasiveness of wellbeing as a touchstone idea.

The new national curriculum (the first such one in Australia) includes guidelines for specific subject areas as well as identifying seven general capabilities that should be threaded across the entire curriculum. These include the capabilities of "ethical understanding", "intercultural understanding" and "personal and social capability" (Australian Curriculum 2014). The latter capability expresses many of the qualities attributed to wellbeing and "involves students in a range of practices including recognizing and regulating emotions, developing empathy for others and understanding relationships, establishing and building positive relationships, making responsible decisions, working effectively in teams, handling challenging situations constructively and developing leadership skills" (Australian Curriculum 2014).

In these curriculum documents, wellbeing denotes attention to the "whole-person" of the student, to the student as more than or not only a learning machine. It also evokes earlier but still resonant ideas of the fully-rounded student, and of the role of schooling in building the character and capacities of students, of attending to their virtue and values (McLeod and Wright 2013; Meredyth and Thomas 1999). Other curriculum areas have previously addressed (and continue to do so) some of the aspirations underpinning such a focus on holistic conceptions of wellbeing. Civics and citizenship education and the English curriculum, for example, have both explicitly operated with normative conceptions of the good student, of the fully-rounded pupil and future citizen – a student who is discriminating, reflective, socially capable, culturally and civically literate. Such curriculum areas are seen as responsible for enhancing students' personal dispositions and ethical capacities, not only ensuring the command of a specific body of curriculum knowledge. In the contemporary era, the good student is one who can display and perform wellbeing – demonstrating pro-social behaviours, for example – and one who is not held back by negativity or lack of resilience – embodying optimism and self-starting qualities. As the above Declaration on educational goals asserts:

> Confident and creative individuals have a sense of self-worth, self-awareness and personal identity that enables them to manage their emotional, mental, spiritual and physical wellbeing – have a sense of optimism about their lives and the future – are enterprising, show initiative and use their creative abilities. (MCEETYA 2008, p. 9)

Wellbeing's highly ambitious and ambiguous signification invites an interrogative reading, one that starts to unpick its lineage in order to fully understand its claims and effects in the educational present. In this chapter, I consider what are both pre-cursors and parallels to the rise of wellbeing exhortations, specifically attending to the concept of self-esteem. I take a close-up view at second-wave feminist educational initiatives and the integral role that self-esteem played as a site and strategy of personal and social reform. Looking historically and comparatively at the circulation of self-esteem in educational programs reveals some commonalities with current wellbeing claims, but more importantly brings into sharp relief some significant differences. In particular, I address self-esteem's (proclaimed) connection to projects of personal and social transformation and its highlighting of gender as a salient marker of difference in the negotiation and achievement of self-esteem, and compare these features to wellbeing discourses in the present. In doing so, I note an undertone of aspirations for wellbeing being realized within the parameters of the present as it currently exists, rather than connected to a broader educational and political project of change, which characterized the vision for self-esteem. Enhancing wellbeing appears ultimately to be framed as a personal project with personal benefits. One overall aim of the chapter is to provide the beginnings of a more historical account of wellbeing and its cousin concepts; and a second is to expose some blind-spots, both in how wellbeing is mobilized, as a personal and policy solution, and in critiques of its take-up and effects.

Explanations for the rise of concepts such as self-esteem or wellbeing within education are not confined to the logic or internal policy machinations of a specific

field of practice, such as education or youth and social care. The gripping power of these concepts is connected to wider cultural moods and moves, and in the following section I flesh out this claim with a brief consideration of the "public feelings" (Berlant 2011a) of happiness and optimism. In short, the study of public feelings "draws our attention to how and why feelings and emotion (assumed to be a private, personal experience) influence politics and notions of social belonging and intimacy" (Berlant 2011b). This has resonances with feminism's ambitions to make the personal political, evident in the social orientation of feminist educators' appropriations of self-esteem in their reforming projects. I propose that such approaches to the study of feelings in public life suggest productive new ways of thinking about wellbeing and self-esteem, underscoring their ambivalent registers and the historically located and socially differentiated form of their subjective address.

What Does Wellbeing Do?

While commonly allied with mental health – as in the couplet, young people's wellbeing and mental health – wellbeing also denotes, as observed above, a more diffuse set of emotional and psychological orientations, ones not necessarily tied to clinical symptoms. Even so, the rise of wellbeing talk in tandem with the increasing calibration of young people's conduct and social identities according to psychopathology and clinical psychology frameworks has been well-documented (Harwood and Allan 2014; Graham this volume). This chapter, however, brings another dimension to current critical scholarship on wellbeing, one that can be easily overlooked in accounts that focus predominantly or exclusively on the dangers of extending the categories of clinical diagnosis and pathology to either all students or to specific groups. Wellbeing is variously represented as a solution to student disengagement and unhappiness, a technique to fix problems in students and as something of which all young people should simply have more: it is not simply a synonym for mental health in a narrow clinical sense. Its target is not necessarily a specialized group of students with wellbeing or mental health problems; rather the broad student population is constituted as at-risk of not having enough wellbeing, of not possessing the capacities and emotional resources needed to function well in school and in the world beyond. Wellbeing has become a catch-word for registering a vague "something else" – a personal quality, a set of dispositions, an outlook, a way of coping in the world, an understanding of the self – which is both necessary and elusive, both personal and public. Wellbeing is understood here as an idea and practice that distils a set of capacities, moods and dispositions which are desirable for all students, and this, in turn, is part of a longer history of amorphous concepts that are put to work to make and manage better students and future citizens (McLeod 2006; McLeod and Wright 2013).

Wellbeing's impact on conceptions of young people and education also arises, as I argue below, in relation to broader cultural moods concerning the valuing of

emotions and psychologized or therapeutic ways of understanding everyday life (Wright 2011). Looked at in these ways, wellbeing invites a genealogical account of its invention as a concept with performative dimensions, and one that has practical effects in the field of education and in other agencies directed to enhancing the lives of young people. Revisiting feminist engagements with self-esteem is one way of defamiliarizing wellbeing's claims, and is offered here as a contribution towards developing a historical sociology of the concept of wellbeing.

Margaret Somers' outline of an historical sociology of concept formation provides a useful starting point for this task. "First, it directs us to take a reflexive approach to concepts; second it defines concepts as relational – that is, they exist not as autonomous categories but relational patterns; and, third, it treats concepts as historical and cultural artifacts, rather than as labels for pre-existing external objects" (Somers 2008, p. 204, 1999, pp. 132–134). She argues that such inquiry helps us to "analyze how we think and why we seem obliged to think in certain ways" (1999, p. 132), and emphasizes the "historicity of thinking and reasoning practices" (2008, p. 173). Accordingly, working with this broadly Foucauldian framework, the account here begins from the premise that the categories with which we analyze the world, and in this case, those that structure educational discourses, are not self-evident but warrant interrogation, and that even seemingly benign concepts such as wellbeing or self-esteem are "historical objects", "truth claims that are the products of their time" (Somers 1999, p. 134). Moreover, the meaning of such concepts is not stable; it is derived from their contingent relationship to other concepts and contexts.

While my focus is specifically on wellbeing and self-esteem as keywords in education, their purchase is also inevitably part of a wider zeitgeist shaped by, among many influences, the impact of diverse psy-knowledges – from positive psychology to psychopathology (Harwood and Allan 2014) – and a cultural mood directed towards the search for happiness. Ahmed (2010) analyzes what she terms a "happiness turn" in which the cultural and personal quest for happiness has become a defining feature of contemporary life, a desire that structures everyday interactions and governs our expectations and conduct. The pervasiveness of the desire for happiness and its appealing promise as a cure or antidote for all range of problems is evident in, for example, the rise of scholarship on the "science of happiness", the invention of indexes to measure national happiness, and the popularity of positive psychology which, among other propositions, sees the search for individual happiness "not so much as a right as a responsibility" (Ahmed 2010, p. 9). According to Ahmed, one of positive psychology's premises is that "We have a responsibility for our own happiness insofar as promoting our own happiness is what enables us to increase other people's happiness" (p. 9). Happiness has benefits other than immediate personal gratification or pleasant feelings: happiness itself takes you on the pathway towards the good life, with positive psychology providing the much needed "guide posts". Martin Seligman, a leading figure in the positive psychology movement, "closely identifies happiness with optimism". Happy people are more optimistic, he believes because they "tend to interpret their troubles as transient, controllable, and specific to one situation" (Ahmed 2010, p. 9). We can see here

immediate resonances with the operation of wellbeing strategies and educational programs, providing young people with the necessary skills to navigate out of difficulties towards optimistic futures.

Drawing on the work of Richard Layard, a prominent advocate for the science of happiness, Ahmed suggests that a key principle underpinning such research is that happiness itself can be measured. Happiness is defined by Layard as "feeling good, and misery is feeling bad", with levels of happiness and feeling good typically measured by self-reporting. As Ahmed argues: "Much of the new science of happiness is premised on the model of feelings as transparent, as well as the foundation for moral life . . . The science of happiness thus relies on a very specific model of subjectivity, where one knows what one feels, and where the distinction between good and bad feelings is secure, forming the basis of subjective as well as social well-being" (Ahmed 2010, p. 6). Against the self-knowing subject and the simple polarization of good and bad feelings, or of happiness and unhappiness, Ahmed proposes a psychoanalytic reading of "how ordinary attachments to the very idea of the good life are also sites of ambivalence, involving the confusion rather than the separation of good and bad feelings" (p. 6). Lauren Berlant (2011a) develops a related double-reading of the paradoxes of everyday and seemingly positive emotions. In contrast to the confident optimism of positive psychology, Berlant writes of the emergence of a "cruel optimism", of an adjusted and fragile optimism existing in the face of mounting evidence and experience of the precarious nature of the political and material conditions that make a good life (the goal of happiness) possible. The precariousness of the grounds for optimism is in turn differentially experienced, shaped by structural and locational inequalities, and affective disjunctions (Berlant 2011a, pp. 1–22).

While it is beyond the scope of this paper to engage fully with either Ahmed or Berlant's arguments, their work illuminates important elements of the movement of emotions in the historical present and offers rich provocations for exploring the purchase and mixed effects of wellbeing in education. Both accounts underline the significance of increasing attention to emotional life and the life of emotions in the public sphere, and identify some of the ambivalences and complexities – culturally and subjectively – of the attachment to happiness and the hold of optimism in the present era. Growing concern with students' wellbeing arises in these contexts and not only in the (related) context of the normalizing gaze of psychological measurement and the accompanying spread of testing as a commonplace technology for regulating all aspects of students' schooling lives – their learning, desires and dispositions. The notable intensification of calls for enhancing student wellbeing, or making young people more resilient, more optimistic, more "can-do", arises at an historical moment when, as Berlant's analysis suggests, the practical realization of wellbeing and optimism is becoming more fragile and fraught for many groups of people; and second when the quest for happiness is both normal, normalizing and troubling. Ahmed's guiding question is "not so much 'what is happiness?' but rather 'what does happiness do?"' (Ahmed 2010, p. 2). In much the same way, the question motivating and kept alive in this chapter is not so much what is wellbeing (or indeed, self-esteem) but rather what does wellbeing do – in organizing educational practices, in regulating student subjectivities, in asserting mind over matter.

I now turn to briefly consider debates about the related notion of self-esteem, as a prelude to exploring its deployment within feminist and radical education in the 1970s. This provides a counterpoint for considering the signifying power and effects of wellbeing claims in the present, and is part of historicizing and defamiliarizing its commonsense allure. Self-esteem is perhaps an easy target for doing a critical job on the soft end of the happiness turn – easy to caricature with self-involved people and the "Me generation" demanding ever more praise. But here I want to draw out other dimensions to self-esteem in the 1970s, and explore its highlighting of feminist and gender-based concerns and, in comparison to current notions of wellbeing, its more overt mobilization in relation to social and educational projects of change – notwithstanding self-esteem's limitations as a concept, or its heritage in pop psychology or its favoured place in the homilies of the Sunday magazines.

Feeling Good About Myself

Like wellbeing, self-esteem has a self-evidently sensible feel to it – feeling bad about yourself, lacking self-confidence, being unsure about what to do – these are familiar enough experiences, and enhancing self-esteem is regarded as an antidote to such debilitating feelings. The explosion of self-help books and magazines is one striking manifestation of the rampant movement of notions of self-esteem into everyday life, attesting as well to a therapeutic turn in contemporary culture (Wright 2011; Ecclestone and Hayes 2009). Self-esteem has been extremely influential in school pedagogies and policy reforms, sharing some of the qualities of wellbeing in its construction as a solution for both specific problems and a more general malaise among young people (Cigman 2004, 2012; Eckersley et al. 2006). In teacher education programs, promoting students' self-esteem also has a commonsense and redemptive appeal. The perceived value in praising achievement is often connected to fears of the self-fulfilling prophecy that underpin pedagogies of teacher education, such that positive reinforcement is seen to promote success while criticism and negative comments are judged not only to undermine success and sense of self-worth but also to threaten producing the failing child you hoped to ward against.

Yet, self-esteem has been roundly criticized from many quarters – educators, psychologists, parenting experts – as perhaps not offering the kind of desirable solutions to personal or social problems that it once promised, and is now widely viewed with a degree of distrust (Cigman 2004). This is not because of a preference for students to suffer from low-esteem but from concern, among others, that the movement for permanent praise and feel-good feedback associated with self-esteem has given rise to an epidemic of narcissism, and the need for affirmation and celebration, regardless of how trivial the so-called achievement might be (Twenge and Campbell 2009). Critics of the rise of self-esteem in schools have argued that a concern with "feeling good about myself" has displaced the moral and knowledge functions of schooling, emptying out the curriculum in favour of a self-focussed agenda (Stout 2000). In reference to the UK and the US, Frank Furedi has rather dramatically observed that "the therapeutic objective to make children feel good

about themselves is [increasingly] seen as the primary objective of schooling" (Furedi 2009, p. 190). In addition, self-esteem fixes, as with the injunctions to wellbeing, have been criticized for their individualized solutions for complex social and structural problems (Kenway and Willis 1990a) – a kind of neo-liberal blame-the-victim strategy that focuses attention on individuals' shortcomings, and overstates the impact of an introspective gaze as an effective strategy for navigating social life.

Other scholars have attempted to retrieve the positive benefits that self-esteem might still offer for education, despite these well-documented critiques, and propose refinements in the conceptualization of self-esteem (Cigman 2004; Kirstiánsson 2007). Ferkany (2008), for example, outlines an "*attachment account*" that sees self-esteem as "importantly connected to the confidence and motivation children need to engage in and achieve educational goals" arguing that it "can and should be facilitated socially" (p. 120). A distinction between "situated self-esteem" and "simple self-esteem" is offered by Cigman (2004, p. 95), who proposes that the "first is our ordinary, evaluative concept; the second is a simplification and corruption of this". And it is the simplified version of self-concept that, she argues, dominates discussions and uses of self-esteem in education, muddying in one term a range of emotions and dispositions. If the aim is to identify and promote healthy self-esteem, then everyday uses of ordinary terms such as shy, under-confident, or smug and conceited are more nimble and accurate in conveying the variety of temperaments and feelings that currently are subsumed under the ell-embracing social science construct of simple self-esteem (Cigman 2004, p. 93; see too Kirstiánsson 2007, pp. 248–49). Cigman's preferred concept of situated self-esteem avoids, she argues, twin errors: "the philosophical error of solipsism and the psychological error of narcissism" (p. 96). She proposes an understanding of self-esteem "fostered through encounters with reality" and people's everyday experiences (p. 101), and argues this conception of self-esteem continues to matter in education. In particular, Cigman suggests that situated self-esteem, in contrast to simple self-esteem, can properly help redress a continuing problem in education, which is the crippling effects of actual low self-esteem experienced by some pupils.

While not engaging here with the finer points of Cigman's distinctions, I take from her arguments and other philosophical refinements of the self-esteem concept, an interest in delineating the effects of the self-esteem construct, including its productive possibilities and multi-faceted dimensions as an enacted idea. Such a focus is somewhat obscured in many of the more sociological critiques and global rejections of this notion. This is not to produce a balance sheet of the good and the bad, the negative and the positive aspects, but following Ahmed (2010), to acknowledge the ambivalent effects of self-esteem. And, in the spirit of Foucauldian genealogy, to pursue a line of thinking that attends to the productive not only the negative and disciplinary aspects of technologies such as self-esteem. Accordingly, without minimizing the well-founded criticisms of self-esteem's pitfalls and dangers, I want to bring another element into the discussion, as a way to introduce additional ways of thinking about self-esteem (and, in turn, wellbeing) in relation to personal and social projects of change.

Following Wright's (2011) analysis of the contradictions of therapeutic culture, we could similarly look to self-esteem's mixed and unintended effects. Yes, it is guilty of many of the charges laid against it, and in domains such as education or the self-help industry, it has generated a swathe of superficial and banal techniques, contributing to the self-responsibilization of social problems and strengthening the hold of notions of the rational, self-knowing subject, always ready to be improved and praised. However, there are other elements to the self-esteem movement that warrant some re-assessment at this point in time, when notions of wellbeing have arguably eclipsed those of self-esteem in the enhancement projects of educational and youth policies. Of specific interest here is the role of self-esteem in radical and feminist politics of social and subjective transformation. These initiatives looked to the possibilities for schools and curriculum to become non-sexist and to more properly and fairly enable the flourishing and self-realization of girls' and boys' potential. Enhancing students' self-esteem, and especially girls' self-esteem, was crucial to this, functioning as a code and necessary pre-cursor for their empowerment. In order to develop this argument, I briefly revisit feminist reforms in education in Australia during the 1970s. The aim here is not to give a comprehensive account of feminist education during that period or indeed to track all uses and detours of self-esteem across these pedagogical and curricular reforms. Rather the purpose is to highlight some key features, practices and promises associated with feminist entanglements with self-esteem in order to begin telling a different history of self-esteem. In doing so, I raise questions for rethinking critical responses to the invention and mobilization of youth wellbeing in education.

Fixing Self-Esteem, Fixing Girls

The upswell of anti-sexist and equal opportunity initiatives in education across many parts of the world during the 1970s identified the lack of choices facing girls and young women as a significant confining feature of their schooling (Yates 1983). In the mood of second-wave feminism, freedom of choice, personal fulfillment and non-sex specific aspirations were key elements of school-based programs and policy reforms (McLeod 1998). Moreover, the lack of options – in curriculum, future plans, anticipation of work and post-school life – was seen to lead to a diminished sense of self for girls (Kenway and Willis 1990a; Kenway et al. 1997). Underpinned by the social psychological categories of the sex role and role models, the impetus for equal opportunity interventions was to challenge sex-role stereotyping, provide positive role models for girls – in curriculum texts, careers advice, pedagogies of role play and values clarification – and open up their choices and sense of personal capacity and possibility (McLeod 2006). The concept of self-esteem was utterly implicated in this work. Fixing low self-esteem was the lynch pin to remediating girls' confinement and freeing them from the strictures of sexist traditions. In Australia at commonwealth and state levels, departments of education were instigating reports on equal opportunity in schools and documenting the circumstances of girls and

the most effective ways to redress the inequalities and discrimination they faced. These types of programs and system level initiatives, however, were not confined to Australia, and much has been written about the interventions of second-wave feminism into schooling across many OECD countries (Kenway 1990; Skelton and Francis 2009; Yates 1993). Moreover, they often accompanied a repeated sense that schools were in the midst of unprecedented social changes that were challenging not only the very purposes of schooling and modes of teaching, but also students' identities and inter-personal relations.

"We live in exciting times, in times when changes of a fundamental nature occur with almost alarming rapidity", observed the Victorian Minister of Education, Mr. Lindsay Thompson in 1978 (Thompson 1978). In the following year, the Assistant Minister for Education, Mr. Norman Lacy, expressed similar concerns about the extent of social change, associating it with a kind of moral and ethical dislocation: "Common values held by earlier generations are rapidly losing their traditional roots and are being reformulated by the young and by the adult community". In their professional journals, teachers wrote of the challenges facing schools in a time "when such a tide of changes are to sweep through society". As teacher and curriculum reformer Gil Freeman, observed: "Changes in the young [are] caused by different modes of upbringing, increased social mobility, vastly changing value structures and an increasingly internationalised culture". A particular concern was the disappearance of certainties that had once "stabilised the school and kept patterns from generation to generation". He lamented that in the new era, "the young do not have the solid and stable adult roles and life style patterns that they can copy. They can't expect to follow in the footsteps of their parents as they once did" (Freeman 1978, p. 11).

Such perceptions of unprecedented change and a redefinition of fundamental and once cohesive values existed alongside an equally strong faith that schools would and should cope. The 1979 "Ministerial Statement on the Aims and Objectives of Education in Victoria" (issued by a Liberal-conservative government) emphasized the role of schools in promoting stable and democratic values in the face of potential social disorder. Establishing the link between education and democracy was a central concern of the Statement: "For the individual in a democratic society the essence of democracy is that each person has the opportunity to make informed choices and to accept responsibilities" (Lacy 1979, p. 6315). The Statement recognized the contradictions in social life, but asked schools "to promote social co-operation", underpinned by the belief that "Society is characterised by educational, social and economic inequalities, yet we value equality of rights, duties and opportunities" (Lacy 1979, p. 6315). Equal opportunity for girls in education was completely consistent with these classic liberal political values.

A committee on equal opportunity in schools established by the Victorian Department of Education in the late 1970s undertook several small-scale research studies and found that sex-role stereotyping in curriculum materials, subject choice and school practices, poor career counselling for both sexes, but especially for girls, and inadequate Health and Human Relations education, were all common

features of schooling in the state of Victoria at that time (Victorian Committee on Equal Opportunity in Schools 1977). "We recognise that schools alone cannot bring about a state of perfect social equality, where only genetic differences exist between the sexes", observed the authors of this Report. But, they confidently believed, "the experience of schooling should not be such that it directly contributes to a lowered self-esteem, motivation or achievement for either sex, as has been reported to us from evidence gathered in this State" (Victorian Committee on Equal Opportunity in Schools 1977, p. v). Like the earlier 1975 Commonwealth report, *Girls Schools and Society* (Schools Commission 1975), the authors of the Victorian report emphasized the need for pupils to recognize the importance of making informed choices and that their education, career and indeed their personal happiness were not to be constrained by any sex-specific characteristics. An unquestioned mantra was that children needed "to understand that the full range of human characteristics and abilities is present in each sex and that it is the aptitudes or feelings of each individual which are important" (Victorian Committee on Equal Opportunity in Schools 1977, p. vi). Strong self-esteem was associated with non-sexist aspirations that transcended gendered choices, and low-esteem was linked to lack of choice and conventionally gendered conduct.

Throughout this time, numerous teacher-ran newsletters and magazines on equal opportunity in schools were distributed via Departments of Education and the teachers' unions. These included reports on school-based projects, curriculum planning advice, examples of successful strategies, bibliographies and curriculum resources, as well as general encouragement and advice on how to implement non-sexist principles in schools: such commentaries were a form of professional development, which if consciously followed would lead one to become a good non-sexist, girl-friendly teacher. While the advice was typically expressed in a collegial tone, there was no doubt that the demonstration of non-sexist principles and conduct was now expected by equal opportunity advocates (and, at least rhetorically, by the senior administration of the Education Department) to be part of a teacher's repertoire. "[U]nless affirmative action and counter-sexism is taken as a professional responsibility", advised the Equal Opportunity co-ordinator, Deborah Towns, "girls will continue to be disadvantaged while at school and in educational outcomes" (Towns 1983, p. 12).

An early issue of the Equal Opportunity Newsletter carried plans for lessons to help build girls' self-esteem: "This program attempts to modify their sex-role stereotyping, and encourages students to reflect on their experiences and link these experiences with those of the other group members" (Equal Opportunity Newsletter 1982). This pedagogy required girls to participate in a series of "getting-to-know-you" exercises, in which they reflected on what they liked about themselves, qualities they admired in other women, and what they saw as the negative and positive effects of sex-role stereotyping on girls and women. Activities included small and large group discussion, making posters about themselves, and role-play to practise saying positive statements about themself and other girls. At the end of the

first lesson, the girls were hailed as the uncompromising, choice-making individuals of modernity and of feminism:

> You are who you are.
> You have choices about what you do, how you look, how you behave.
> You can change things about you. (p. 12)

The overall message of such lessons was that social agencies, such as the media, constructed negative images of girls and women, and these in turn served to lower their self-esteem. Questioning pervasive sex-role stereotyping was presented as an effective way to ward against such threats to self-esteem. More powerfully, girls were exhorted to take action and transform their attitudes about themselves. This message was delivered through a mixture of feminist analysis of sexism and a humanist social psychology committed to nurturing the personal growth of individuals. In combination, these orientations demanded that non-sexist teaching enable pupils, and especially girls, to be emancipated from emotionally and socially limiting self-concepts through a pedagogy that placed the self as the object of rational reform, a process that it was believed would ineluctably enhance self-esteem and contribute to reducing systemic gender inequality.

Teachers were subject to similar exercises in self-improvement. In the same issue of the Newsletter, teachers were presented with a "Sexism?? Classroom Checklist" to help them assess the extent of their sexist behaviour and attitudes, to flush out unconscious sexist acts and to demonstrate non-sexist professional conduct and new codes of commonsense. Teachers were asked: "Do you draw attention to pretty girls and pity those who are not? Do you draw attention to athletic boys and pity those who are not?" or "Do you plan different activities for boys and girls?" (Anon 1982). These were common professional development strategies, interpellating ideal teachers as self-scrutinizing role-models, willingly monitoring their conduct and open to the persuasion of rational messages. Once alerted to the errors of sexist teaching they would, it was anticipated, change their ways. In doing so they provided the pedagogic conditions in which pupils could also refashion themselves as non-sexist and ameliorate impaired self-esteem.

An optimistic faith in the transformative power of schooling, a commitment to examining personal values, positive role modelling, and a set of programmatic reforms designed to undermine the accumulation of sexist social learning, were some of the features of the early reforms in equal opportunity education. The many reports and policies published during this time all produced the evidence of and confirmed girls' disadvantage. At this time, it was rapidly becoming commonplace knowledge that girls were under-represented in mathematics and science, that women worked in a narrow range of socially undervalued occupations, suffered from restricted aspirations and ambitions, lacked confidence and persisted in believing in outdated sex-role stereotypes. In light of this, a massive amount of work was undertaken to change their minds and make them understand that sex roles could be changed, if only they worked hard enough to interrogate their own values, and build their self-esteem.

The Paradoxes of Self-Esteem's Project of the Self

I want to build three points from this snapshot account of self-esteem in 1970s feminist education. First, an exploration of the regulatory aspects of feminist self-esteem pedagogies as "technologies of the self"; second, a reconsideration of earlier critiques of the limit of self-esteem as a feminist strategy; and third, the radical dimensions of feminist self-esteem are set against contemporary wellbeing discourses, as a way to both keep open and problematize questions about social and personal change, and to reflect upon the broader debates concerning the turn to happiness and the place of public feelings in educational projects.

Feminist self-scrutinizing pedagogies sought to cultivate an enhanced self-esteem and, as I have argued previously (McLeod 1998, 2006), these were not simply superficial feel-good strategies. They were profoundly implicated in producing new norms and forms of (gendered) subjectivity, in part by repudiating then dominant ways of being male and female, girl and boy. Such pedagogies exemplified what Foucault described as "technologies of the self", techniques for acting on and fashioning the self. I will reiterate briefly here what has become a rather familiar argument and, for the purposes of this discussion, leave to one side the numerous critiques of this approach so as to highlight self-esteem interventions as forms of subjectification. Technologies of the self "permit individuals to effect by their own means or with the help of others a certain number of operations on their own bodies and souls, thoughts, conduct, and way of being, so as to transform themselves in order to attain a certain state of happiness, purity, wisdom, perfection, or immortality" (Foucault 1988, p. 18). In this case, the transformation from confinement towards sex-role freedom, and positive self-esteem was both an artifact of and essential to such a process of refashioning. One way then to understand self-esteem, as Cruickshank has (1993), is as part of a repertoire of techniques in service of modern forms of (self) government, with government understood as "the way in which the conduct of individuals or groups might be directed … To govern, in this sense, is to structure the possible field of action of others" (Foucault 1983, p. 221). The modern form of government produces and relies upon self-disciplining individuals who internalize governmental imperatives, making them their own. Within this analysis, individuals are "educated and solicited into a kind of alliance between personal objectives and ambitions and institutional or socially-prized goals and activities" (Rose 1989, p. 10).

Lessons in self-esteem, values clarification, role-plays – these can all be understood as pedagogies that encourage pupils to take on governmental norms (in this case those of feminist reformers and equal opportunity advocates). Complications arise, however, when considering projects of governmentality in relation to progressive or radical movements for social change, such as feminism, and the paradoxes of normalizing counter-hegemonic imperatives – to be non-sexist, to challenge the status quo, to make new identities and collective and individual futures. The point I am somewhat laboring here is that feminist engagements with self-esteem had

productive ambitions and consequences, for the teachers who were transforming themselves and their students, and for the students whose self-esteem was being fixed in the creation of a feminist project of radical change – the personal was indeed political.

Feminist self-esteem projects were not without their critics, including from among feminist academics and advocates. Critiques of self-esteem as a focus of school pedagogies and feminist activities targeted the ways in which self-esteem solutions attributed students and especially girls with personal responsibility for structural gender-based inequality. This was seen as not only trivializing the extent of entrenched disadvantage but also the nature and scope of feminist political and educational projects, as if pointing out a mistaken sense of self was a sufficient strategy to combat inherited patterns of gender relations. In a critical review of self-esteem in policies regarding the education of the girls, Kenway and Willis (1990b) observed that "claims being made on its [self-esteem's] behalf as an explanation of school failure and as an elixir for both school success and the 'liberation' of girls seem simplistic to say the least" (p. 2). Moreover, they argued, there has been a tendency to treat "girls' self-esteem in a universalistic manner and thus to ignore the specific cultural circumstance of girls and the manner in which their culture intersects with gendered educational achievement and ambition" (Kenway and Willis 1990b, p. 11).

Such criticisms were undeniably well-justified, identifying the pitfalls and presumptions of a reform politics based on the mobilization of the self-esteem construct. They were vital in unsettling the rationalist dream of feminism bent on reforming the self through exposure to ever more and better advice and opportunity to abandon attachment to gender-based norms. Yet there remained an ambivalence at the heart of self-esteem endeavours, even in its critical reception, with its potential productive benefits not entirely dismissed. As Kenway and Willis (1990b) acknowledged, their critique was not intended to undermine the work of teachers directed to improving girls' self-esteem or to oppose those projects "concerned with developing among students a positive sense of self in an atmosphere of mutual regard" (p. 2.). Even so, the overall tenor is skeptical, and calling for caution.

Critique, like its objects of analysis, is also and always of its time. Without becoming romantic about a lost feminist political project, or calling for the reinstatement of the sex role or self-esteem solutions, I do want to keep in view the larger social and feminist project in which self-esteem was nested. Within 1970s feminist agendas, a socially-critically edge of self-esteem is evident – notwithstanding all the cautions – yet this has been somewhat subsumed by the prevalence of critiques of self-esteem as variously victim blaming, naively rationalist, universalist, thoughtlessly individualizing and so forth. Robust criticisms of self-esteem have been important and timely interventions, but revisiting the flourishing of this enhancement construct in comparison to the movement of wellbeing raises important questions about the place of these self-improving technologies in connection to wider social projects. In other words, it offers a point a critical comparison with the highly individualized project of wellbeing, a cluster of discourses and programs that (like self-esteem) is treated in a universalizing manner, yet in striking comparison to self-esteem, tends also to be gender-blind.

Kristiánsson (2007) observes that a common problem with prevailing conceptions of self-esteem is that "all social problems become construed as personal problems of self-adjustment and self-affirmation: a nugatory inward gaze toward a self-enclosed world thus replaces any serious attempts to change the external world for the better" (p. 249). However, even the brief account offered above of feminist self-esteem agendas reveals the ways in which such common critical assessments are simultaneously insightfully accurate and overstatements. Similar arguments could be made about wellbeing discourses today. Indeed, the more speculative element of my argument is that wellbeing agendas now are more likely to be caught up in securing wellbeing within the terms of the present, rather than seeking to "change the world for the better" or to embrace the kind of radical remaking envisaged by the feminist self-esteem movement.

Conclusion

I began by asking what does wellbeing do, calling for an historical view on to its ambitions as a task of defamiliarization and I identified some preliminary lines of analysis. As part of this, I have looked at the construct of self-esteem, seeking to bring to the surface its transformative elements, which have been somewhat muted in recent scholarship. This is part of rethinking how to tell the story of these social science and psychological categories in the history of radical education and social change movements. It is also part of troubling how we think about the invention and movement of wellbeing in the present, including looking out for blind-spots in endorsements as well as critical responses. On the whole, wellbeing is represented as a universalizing and universally desirable quality, not only regarded as essential for all students but rarely sensitive to cultural diversity or gendered differences in how wellbeing matters, manifests or is mobilized. Most strikingly, and in comparison to the uses of self-esteem, it is largely treated as gender-free and typically not connected to projects of collective transformation.

I also began by inviting an account of agendas for personal enhancement and positive emotions in education in relation to a wider cultural turn to happiness and the movement of public feelings (Ahmed 2010; Berlant 2011a). While justifiable critiques of wellbeing abound, there is nevertheless value in giving pause to consider the productive and even contradictory aspects of wellbeing's invention, and to take seriously injunctions to explore the paradoxes at the heart of public feelings, as Berlant's work invites us to do. Collective and personal desires for happiness reverberate throughout wellbeing discourses, and underpinning both, as Ahmed (2010) reminds us, is an abiding ethical and practical concern with how to live a good life and with questions about what it means to desire such a life. Her observations in regard to this bear repeating in these concluding remarks: "ordinary attachments to the very idea of the good life are also sites of ambivalence, involving the confusion rather than the separation of good and bad feelings" (Ahmed 2010, p. 6). Looking at the invention of youth wellbeing from this vantage point, and not

simply as evidence of the rampant and reductive psychologization of education, or as the disciplinary pathologization of young people, suggests fruitful possibilities for rethinking the history of wellbeing and surfacing its contradictory effects and potentialities.

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Chapter 12
From Targeted Interventions to Universal Approaches: Historicizing Wellbeing

Katie Wright

Abstract Concern about high rates of mental health disorders amongst young people has underwritten a proliferation of social and educational policy aimed at improving youth wellbeing. This chapter examines educational concerns with mental health through a critical analysis of wellbeing as an object of educational policy and practice. It begins by considering the construction of mental health as an educational problem, in the past and in the present, and the policy solutions that have been developed in order to address this. It then explores how rising concern with the wellbeing of young people has fostered a shift from the historically narrow educational focus on targeted interventions – for students experiencing problems or identified as being at risk of mental health difficulties – to the more recent emphasis on universal approaches and preventative programs. The chapter concludes with some reflections on the seductive power of ideas of prevention and "psychological immunization" and considers the implications of this for contemporary educational policy and practice, and ultimately for understanding and promoting youth wellbeing.

Keywords Educational policy • Mental health • Targeted interventions • Universal approaches • Youth wellbeing

Introduction

Late in 2012, the Australian media reported with alarm that 10 % of children under 5 years of age experience mental health problems, and that a further 9 % of preschool aged children are at risk of developing a mental health disorder (Edwards and Martin 2012). This followed the announcement earlier that year of plans for the expansion of a federal government funded program, "The Healthy Kids Check", to provide screening for 3 year olds "for early signs of mental illness" (Stark 2012). The inclusion of measures to assess social and emotional

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K. Wright, J. McLeod (eds.), *Rethinking Youth Wellbeing*,
DOI 10.1007/978-981-287-188-6_12

development in the Healthy Kids Check is just one of a range of preventative strategies developed in recent years with the aim of improving the wellbeing and mental health of children and young people through interventions in primary health care, community and educational settings. For schools and early childhood centres, there are now frameworks for supporting mental health and wellbeing that cover the period from infancy through adolescence. MindMatters (2012), KidsMatter Primary (2012) and KidsMatter Early Childhood (2012) are prominent Australian examples in which prevention, early intervention and mental health promotion form a three-pronged approach to improving mental health and wellbeing in educational contexts.

Underpinning the development of these frameworks is recognition that mental health is "the single biggest health issue facing young Australians" today (headspace 2014). The idea that early intervention for children and young people who experience social, emotional or behavioural problems can prevent the development of mental health disorders in adolescence and adulthood is hardly new. Indeed since the early twentieth century, the value of early intervention has been widely endorsed and is now established orthodoxy. Educational settings have similarly long been regarded as key sites for the identification of a range of problems experienced by young people. Since the 1990s, however, the traditionally narrow focus on targeted interventions for young people diagnosed with disorders or considered "at risk" of developing problems, has been supplemented by the embrace of large-scale, universal preventative approaches aimed at improving the mental health and wellbeing of entire student populations.

In light of the prevalence of concerns about young people and the proliferation of policy directed towards improving youth mental health, it is timely to reflect critically on the these matters. Guided by the provocation that examining the past offers a powerful way to defamiliarize the present, this chapter takes a broadly genealogical approach to analyzing the construction of mental health and wellbeing as an educational problem (Foucault 1984). The analysis draws from the field of critical policy studies, a body of work which underscores how policies do not simply respond to social problems already formed and "out there", but actively "constitute the problems to which they seem to be responses" (Yeatman 1990, p. 158). This approach argues for the need to problematize rather than accept an a priori knowledge of a problem as it is represented in policy (Bacchi 2012; Ball 2012; Webb 2014). Problematizing wellbeing is not to suggest that educational concerns with the mental health of young people are necessarily misplaced. Rather, it is to illuminate the discursive construction of concepts like mental health and wellbeing and critically reflect on their effects. The analysis developed here, therefore, explores the interrelated processes by which mental health and wellbeing are constructed in official discourses, in turn are understood as problems *for* education, and the responses this generates, specifically, the development of school-based strategies and interventions.

A central aim of this chapter is to unsettle what is taken for granted in relation to both conceptions of wellbeing and how it is operationalized in educational contexts. This calls for examination of antecedent concerns with mental health. That is, to

"understand the conditions that produce problems" (Webb 2014, p. 372), I suggest, requires historically situating the construction of problems as well as responses to them. In doing this, I draw on Bacchi's (2009) "what's the problem represented to be" (WPR) approach to policy analysis. WPR provides a useful conceptual and methodological framework for thinking critically about mental health and wellbeing as a social ideal and an educational policy goal.

Focusing on two periods, the early decades of the twentieth century (1920s–1930s) and the late twentieth century to the present (1990s–2010s), I examine dominant ideas about young people's psychological health and the remedial strategies developed on the basis of that knowledge. While extensive historical analysis is beyond the scope of the chapter, ideas and approaches to wellbeing and mental health are considered in relation to the historical conditions that have enabled particular ways of thinking about and responding to these issues. This involves exploration of the problem-solution nexus to show how prominent strategies have changed over time, from the remedial interventions characteristic of approaches during much of the twentieth century to the health promotion and preventative strategies that are dominant in schools today.

In light of recent scholarly critique of the possibilities of "psychological immunization" (Craig 2009), the final section of the chapter considers the powerful appeal of ideas of prevention and early intervention and reflects on the implications of embracing the pursuit of wellbeing as an educational aim. Critical questions that are raised include whether current approaches have overcome the deficiencies and pathologizing tendencies of past practices, the extent to which problems of mental health are conflated with social disadvantage, and the possibility that the focus on wellbeing as a psychological issue may undermine the goal of actually achieving it. To begin an exploration of these matters, I turn first to the issue of "problem representation" (Bacchi 2012), beginning with the question of how mental health became an educational concern.

Mental Health as an Educational Problem

In the early twentieth century an important dimension of the New Education movement was the emphasis placed on developing scientific solutions to educational problems (McCallum 1990). Of the various influences that came to bear on the construction of mental health as an issue for schooling, the development of new understandings of children made possible by the fields of child study and psychology was central. By the interwar years in Australia there was much enthusiasm about the utility of the science of psychology for education, particularly through the application of "mental tests" and the establishment of psychological clinics (Wright 2012a). The fervor of psychology and mental testing was fuelled by excitement about the ability to measure intelligence, which provided a scientific way of identifying children of "subnormal", "normal" and "supernormal" ability (see for example, Miles 1921).

The scientific investigation of childhood, which itself was part of a broader rationalization of social life during the late nineteenth and early twentieth centuries (Reiger 1985), was pivotal to the production of new normative understandings of the child. Of course the construction of abnormality is only possible alongside a conceptualization of what is "normal" and, as Turmel (2008) has noted, "a child is recognized as normal when categorized as such" (p. 13). This occurred first through the fields of paediatrics and public hygiene, and increasingly, during the first half of the twentieth century, through the discipline of psychology and the paradigm of developmentalism (Turmel 2008). It was within this broader context that the child became subject to various forms of categorization within educational settings, first with measurements of height and weight, and then assessments of intelligence. By the interwar years, mental testing had generated interest not only in normal and abnormal patterns of development but also in individual differences and "personality types". This resulted in an emergent view that "different types of children must be managed differently in order to avoid 'mental disease'" (Reiger 1985, p. 167). These ideas were, in turn, reflected in educational discourses that increasingly acknowledged the importance of psychology to schooling.

In 1930, for example, Mildred Muscio, school principal, women's activist and President of the National Council of Women of New South Wales (Foley and Fulloon 1986), presented a paper entitled "Some principles of education" at the Conference of the Australian Federation of University Women. In Muscio's view there were, overall, two aims of education: "the happy development of the child and his or her usefulness to the community" (Muscio 1930, p. 73). To achieve these educational aims, she argued that "a child must be kept strong and well if he is to become a happy and useful citizen". However, "the psychological problem", according to Muscio, was a major issue confronting the modern teacher (p. 74). She advanced a progressive view of the role of schooling, particularly for girls, and criticized authoritarian forms of education that encouraged fear and in so doing were "often laying the seeds of future nervous troubles and mental ill-health" (p. 81).

Already by the early 1930s the discipline of psychology was recognized, as Muscio suggests, as having "revolutionized teaching" (p. 74). Muscio drew on psychology to advance a view of education as having the dual role of producing happy and useful citizens, which included recognition of women as equal members of society. While her paper provides an insight into how psychology buttressed a particular current of progressive educational thought of the time, it is useful to consider the broader context in which such ideas were circulating, in particular, the influence of the mental hygiene movement.

The period between the two world wars was a time of significant change in understandings of mental disorder and its treatment. This involved not only changing approaches to the treatment of major mental illness, but also recognition of less severe psychological problems and the utility of treatment across the spectrum of disorders – from those classified as relatively minor to those at the more severe end. "Even more ambitiously", as Thomson (1995) notes, "there was an expansion of interest in prevention of mental disorder and promotion of environmental conditions to encourage mental health among the normal population"

(p. 283). These developments, which largely emanated from the United States but spread throughout the developed world, constituted key dimensions of the mental hygiene movement (Thomson 1995).

In Australia, enthusiasm for the principles of mental hygiene was reflected in the establishment of Mental Hygiene Councils in the early 1930s, which sought to replicate the work of the National Council for Mental Hygiene in Britain and the National Committee for Mental Hygiene in America. This included research, public education and the provision of treatment through clinical services. While mental deficiency and mental disease were undoubtedly cause for major concern, the mental hygiene movement advanced an optimistic view that mental health promotion and early intervention could prevent the onset, or at least curtail the prevalence and limit the severity, of mental illness. The aims and objectives as stated by the Victorian Council for Mental Hygiene (VCMH), established in 1930, throw light on both the contemporary situation and the aspirations for social change:

a) To improve the mental health of the community.
b) To give greater prominence to mental hygiene and allied subjects in the general education of the community, and to remove the popular prejudice against the word mental.
c) To study mental hygiene of child life in relation to parental responsibility and education.
d) To encourage scientific investigation into the causes of mental deficiency and acquired mental disorder with a view to their prevention and cure.
e) To improve the methods of diagnosis, treatment, and care of mental disorder and deficiency.
f) To study causation and prevention of mental disturbances arising from modern vocational activities.
g) To study the problems of delinquency and criminality.
h) To secure for psychology and psychiatry a position in medical education commensurate with their importance.
i) To serve as a liaison between all societies, associations, and other bodies interested in or concerned with mental hygiene, and, so far as this Council is able, to co-operate with them.
j) To co-operate with other State bodies having similar aims, and to become affiliated with the National Council for Mental Hygiene in Great Britain, and kindred societies in America and elsewhere. (VCMH 1931, p. 2)

I have included the aims and objectives of the VCMH in their entirety to illuminate the scope and range of concerns about mental health and hygiene during the interwar years in Australia. It was within this context that mental health was constructed as a pressing concern for education, which in turn led to the establishment of the kind of school-based services and interventions that I consider below. Yet, what is striking in reviewing the VCMH's stated aims of almost a century ago is the extent to which many of the aspirations of the mental hygiene movement remain relevant today. While the terminology has changed, and anxieties about mental deficiency have receded, the goal of destigmatizing mental illness, the importance of public education and the critical role of early intervention remain high priorities.

As its objectives make clear, the VCMH recognized that a range of strategies was required if its goals were to be realized. An important one centred on the

identification and treatment of "problem children". At the instigation of the VCMH, and with funding from the newly established Australian Council for Educational Research (ACER), an important research project was undertaken in Australia in the early 1930s. It sought to quantify the prevalence of "problem children" in Melbourne schools and delineate the behavioural and emotional abnormalities they exhibited (ACER 1931). As stated in the report that followed, the investigation aimed to produce an approximation of "the number of children in typical schools or institutions in Melbourne whose general behaviour or educational failure appeared to mark them out as cases calling for individual investigation and special treatment" (Cunningham 1932, p. 75).

The study classified just over 14 % of school children as "showing abnormalities of physical, mental, educational, emotional or social development". Half of this number, some 7 % were considered to have "abnormalities of a serious or marked nature" (Cunningham 1932, p. 85). Just under 20 % of all reported abnormalities related to mental retardation, around 12 % were considered educational defects, and just over 14 % were deemed to be physical problems. The remainder – almost 54 % of so-called problem children – was classified as such in light of perceived personality defects (neurotic, hyperactive, emotional, egocentric), conduct disorders (truancy, delinquency, disciplinary problems) or because of unacceptable habits (nervousness, sexual deviations, sleepwalking) (Cunningham 1932, p. 82). Critically, the research indicated that both defects of personality and conduct disorders were more common than cases of mental retardation. Yet, while the total number of problem children was cause for concern, an optimistic tone was struck, with the report noting that unlike retardation, personality defects and conduct disorders were "relatively amenable to treatment" (Cunningham 1932, p. 83). It was thus recommended that a child guidance clinic be established in Melbourne in order to meet the needs of children requiring treatment for psychological and behavioural issues.

The "problem children" study is an example of the kinds of investigations undertaken during the interwar years in Australia that contributed to new understandings of childhood. Beyond a concern with atypical children, however, was recognition of the value of psychology and mental testing for education more broadly.[1] Indeed the classroom was recognized as one of the first sites to which emergent psychological knowledge could be usefully applied. This included understanding processes related to learning, memory, thinking and motivation as well as a new appreciation of individual differences and problems of "adjustment" (O'Neil 1987, p. 42). Institutional developments that made possible such emergent knowledges included the establishment of a psychological laboratory at the Melbourne Teachers' College in the first decade of the twentieth century, the introduction of intelligence

[1]This is reflected in the range and number of studies funded by ACER in its first year of operation. Other projects included studies to investigate variations in the Intelligence Quotient (IQ) of subnormal children, mental tests for student teachers, class grouping and intelligence tests, mental tests for vocational guidance, the relative merits of mental and scholastic tests, tests of aptitude for teaching, standardization of intelligence tests, the prognostic value of intelligence tests in high school, and more (ACER 1931).

tests in the 1910s, the appointment of psychologists in state education departments during the 1920s and the establishment of ACER in 1930 (see O'Neil 1987; Turtle 1993; Wright 2011a).

The founding of ACER in particular had a dramatic effect on the educational landscape in Australia, resulting in the development of a large research program, much of which was psychologically oriented (McLeod and Wright 2013). In addition, then, to drawing on international theories and research, there was a growing body of Australian studies to underpin educational reform efforts. This gave greater impetus to initiatives already underway and further buttressed the work of psychologists in education departments, especially in the area of mental testing and the classification of atypical children. Mental testing was particularly important in this regard, for it enabled the categorization of children based on a comparison of "mental" and "chronological" age, which in turn provided the basis for the classification and placement of children deemed to be "mentally retarded". Yet, while concerns about mental deficiency and educability loomed large, new understandings of mental health and mental ill-health were becoming increasingly influential, made possible by the production of new forms of specialized knowledge, particularly in the fields of psychology and psychiatry. It is the take up of this expert knowledge, as it pertained to children and young people, and its application in the domain of education during the interwar years, which I now consider.

The Development of Targeted Mental Health Interventions

The employment of psychologists in education departments across Australia in the 1920s (Turtle 1993) reflected the growing acceptance of psychological knowledge and its practical application, particularly for young people in schools. While much of the work of early educational psychologists involved mental testing as a measure of intelligence, there was also, importantly, an emerging interest during the interwar period in identifying children and adolescents who appeared to have problems of "adjustment". Key to this were constructions of normality and abnormality in relation to both personality and conduct, and these underwrote educational understandings of problem children as well as the development of policy responses to child and adolescent mental health. To explore this, I turn now to official documentation from various state education departments in Australia, first examining reports from the state of South Australia, as an example of emerging ideas and approaches of this time.

In 1925 the South Australian Minister for Education reported on the appointment of a psychologist, whose work was designed "to meet both present requirements and future developments" (Halley 1926, p. 25). This included overseeing the development of special classes for "supernormal" and "subnormal" children and the training of teachers for these classes, the provision of vocational guidance, and the carrying out of "experimental work". However, the key task of the psychologist was to examine individual children and make recommendations to teachers in relation

to pupils who were "retarded educationally", identified as "problem children" or deemed to be "delinquent". While the work of the psychologist was clearly wide-ranging, the predominant focus was on atypical children. As noted in the Report:

> Dr Davey's work embraces the examination of exceptional children for the purposes of diagnosis, prognosis, and advice as to future teaching and training. She reports that "These children may be those retarded in school work, they may be mentally dull and backward, they may be of an anti-social nature or possess delinquent tendencies, they are all those who in some way are maladjusted to their present environment of school, home or society". (1926, p. 26)

Explaining her work, Dr Davey noted that "the psychological examination is an individual one" and "no child is judged to be subnormal as the result of a mental test alone" (Halley 1926, p. 26). While developing ways of suitably educating "retarded children" comprised much of the work undertaken during the first years of her appointment, by the end of the 1920s the issue of psychological health had increasingly come to the fore. In the report for the year 1929, it was noted:

> Besides the individual work with the children of the Opportunity Classes, a number of teachers have asked for help in dealing with difficult children … It is often found that these temperamentally unstable children are those who, unless properly handled in school and home, become the delinquents of the future. Delinquency is now regarded by all cognizant with the problem as psychological—i.e., delinquency is a symptom of maladjustment to environment. It is therefore treatment and not punishment that is required. (Halley 1930, p. 31)

Growing awareness that behavioural problems should be remedied with psychological treatment was also reflected in the report of the following year, where it was noted that "among the children examined this year were more difficult and problem children than has normally been the case". Of delinquent children, the following comment was offered: "the need for psychological work with them becomes more and more apparent" (Halley 1931, p. 30).

The trend of increasing attention to mental health, alongside the growing demand for psychological services for "difficult" children, continued throughout the 1930s. Of the year 1936, the Chief Medical Officer of the South Australian Education Department commented: "It is interesting to note the increase in the number of parents who are seeking help … nearly twice that of any previous year (Christie 1937, p. 34). By the end of the 1930s, it was reported that there continued to be a steady growth in the number of enquiries from teachers, parents and guardians, particularly in relation to requests for "assistance with children whose behaviour is causing concern" (Christie 1940, p. 40).

The situation in other Australian states during this time varied according to the organizational arrangements of the respective education departments. Following the report, "Problem children in Melbourne schools" (Cunningham 1932), a child guidance clinic was established in Victoria. The clinic provided services for children and young people based on the American child guidance model, which included a multidisciplinary staff of psychiatrist, psychologist and social worker; it also offered vocational guidance services (Wright 2012b). However, while the Education Department in that state was supportive of the venture and promoted its services through its publication, *The Education Gazette* (e.g. Victoria 1934), it did not

provide financial support. Indeed it was not until 1947, with the establishment of the Psychology and Guidance Branch, that extensive services were developed under the auspices of the Victorian Education Department (Waddington 1950).

The institutional base of psychological workers in education departments was critical to the development of school or educational-based services, as the situation in New South Wales (NSW) illustrates. In that state, a psychologist was appointed for a short period in the early 1920s (Turtle 1993) but it was with the appointment of Harold Wyndam as a Research Officer in the 1930s that psychological work at a departmental level effectively came into focus. Wyndam had a vision that psychology could transform education and he introduced schemes of mass IQ testing and a School Counselling Service during the 1930s (Hughes 2002). In 1936 a Child Guidance Clinic was established, institutionalizing an educational commitment to "problem children" and mental health. In contrast to the School Counselling Service, concerned with educational guidance and placement, the Child Guidance Clinic was established for the diagnosis and treatment of children with social, emotional and behavioural problems. School personnel could refer children to the clinic who exhibited "nervous symptoms", those suffering from "personality disorders" and those "showing behaviour disorders" (New South Wales Department of Education c. 1936).

By the late 1930s, the NSW Department of Education had considerable infrastructure for the identification and treatment of problem children. While it was not typical of approaches across Australia at that time, it did reflect a model that was widely supported across the nation, in principle if not in practice. It is important to acknowledge in this regard the considerable obstacle that economic conditions posed. While the interwar period was an especially fruitful time in the generation of new ideas, and much educational research was made possible by the endowment from the Carnegie Corporation to ACER, the economic Depression prevented the realization of many educational aspirations of this time, including a fuller provision of psychological and clinical services. As a result, there was something of a disjuncture between the widespread support and enthusiasm for the principles of child guidance on the one hand, and the provision of clinical services on the other (Phillips 1946; Wright 2012b). With this in mind, it is useful to look to at the NSW Child Guidance Clinic as an ideal model of education-based clinically informed practice.

A variety of problems was identified in children referred to the clinic, including "nervous symptoms" and "personality disorders", and a range of treatment options offered. These included the "full treatment service" of medical and psychological evaluation, home visits from a social worker, and possibly therapy. The clinic also offered an "advice and partial treatment service" (Burton 1939, p. 22), as well as diagnostic and consultation services, mainly in the case of children referred from the Child Welfare Department. While space prohibits a fuller discussion of the form that educational liaison and clinical services took, for the purposes of this discussion it is sufficient to note that the clinic operated on a model of early intervention. The philosophy governing this approach was that early treatment both assists with the present difficulties of "maladjusted children" and plays a vital role in preventing future problems, particularly mental illness and delinquency. In calling for an

expansion of services, the psychologist at the child guidance clinic argued that "one of the main difficulties in all remedial work along lines of personality comes from the failure of the specialist to treat children soon enough" (Burton 1939, p. 261).

Before considering both divergences and continuities with regard to mental health discourses of the interwar period and the rise of wellbeing discourses in education more recently, it is instructive to reflect briefly upon established critiques of educational psychology during its formative years in the early to mid-twentieth century. A central concern, and one that remains relevant to today, is with the dividing practices of categorization and classification – based on normative conceptualizations of childhood, intelligence and development – that psychology ushered in. Children were (and still are) effectively codified in relation to their "proximity to normalcy" (Gleason 1999) and educational differences based on the disadvantages of social class were (and still are) individualized and legitimized (McCallum 1990).

On the one hand, emerging forms of classification marked out a new and highly visible population of "abnormal" children, separating them from the "normal" population, with the inevitable detrimental effects that exclusion and marginalization entails, including the psychological and subjective effects of the internalization of deficient categories. Yet as I have argued previously (Wright 2011a), the emphasis on psychological classification and expanding categories of abnormality or debility can obscure the complexity of these processes, and indeed the ways in which such categories have also worked in the interests of disadvantaged children who have benefited from the help of trained professionals or differentiated classes or alternative curricula. While there remains much to be critical of, it is important to recognize that alongside the dangers of pathologization, the provision of remedial assistance and other forms of support has immeasurably helped the lives of some children.

The value of early intervention, as noted at the beginning of this chapter, continues to be a key feature of contemporary approaches to both mental health treatment and the promotion of youth wellbeing. However, while some continuities may readily be identified in relation to initiatives developed during the interwar years and those that are prevalent today, there are also major differences that warrant explication. In the following section I consider how a marked increase in concerns about youth mental health, which arose in the context of a growing body of research evidence during the late twentieth century, fostered the shift from a rather narrow focus on interventions for problem children to a much broader promotion of mental health and wellbeing.

Current initiatives involve not only early intervention but increasingly emphasize universal approaches that focus on prevention and health promotion for entire student populations. This reflects, in part, a broadening of ideas about early intervention and how to achieve the best outcomes. However, as the aims of the Victorian Council for Mental Hygiene make clear, many of these ideas are not new. What has changed markedly is the intensification of concerns about youth mental health, a growing body of research documenting this problem and new approaches to mental health promotion, particularly those informed by positive psychology. This has taken place within the wider social context of increasing acceptance of the importance of

psychological health, greater levels of openness about psychological problems, and recognition of the value of psychological intervention (Wright 2011a). Within the educational sphere, these changes have led to an embrace of the idea that education has a key role in promoting wellbeing, not simply providing remedial services for young people experiencing educational, social or psychological problems.

The Rise of Universal Approaches to Promote Wellbeing

By the end of the twentieth century, both in Australia and internationally, the state of young people's mental health was recognized as a major social and public health issue. It is now widely accepted that mental health disorders are the leading cause of disability in young people globally and a major health issue affecting young Australians today (Gore et al. 2011; Sawyer et al. 2007). Prevalence rates indicate that mental health difficulties steadily increase from childhood through adolescence and into early adulthood. It is estimated that between 7 % and 14 % of children aged 4–12 years experience mental health problems; this increases to 19 % for young people aged 13–17 years, and rises again, up to 27 %, for young adults aged 18–24 (McGorry et al. 2007). Other studies suggest that one third of all young people experience "moderate to high psychological distress" (Muir et al. 2009, p. 17) while still others suggest "the prevalence of a more general malaise" amongst half of all young people (Eckersley et al. 2006, p. 7).

An important question raised by these figures is whether there has been an actual increase in mental health problems, or whether increasing levels of psychological literacy and awareness have led to higher rates of identification of social and emotional problems and a greater number of diagnoses of disorders. This is a contentious issue, and one that is fraught with epistemological difficulties. Certainly in the medical and psychological fields, there is broad consensus that during the second half of the twentieth century, there was a marked increase in mental health problems. As Twenge (2011) notes: "Almost all of the available evidence suggests a sharp rise in anxiety, depression, and mental health issues among Western youth between the early twentieth century and the early 1990s" (p. 469). In light of the prevalence rates cited above, the importance of schooling in the lives of young people and research linking social and emotional wellbeing with successful learning outcomes (Durlak et al. 2011), mental health is now an issue of central concern for education systems.

In the preceding section I pointed to some early developments in Australia, noting that historically, educational concerns with youth mental health largely took the form of the provision of clinical services for young people identified as "troubled" or "difficult". As the discussion above indicates, the value of early intervention has long been emphasized, supported by the widely accepted principle that problems can be mitigated if identified and treated early. This philosophy underwrote a problem-focused strategy. By the 1990s, however, there was a major shift in social and educational policy, with the embrace of more proactive, universal and preventative approaches.

An important backdrop to this development was the rise of positive psychology as a new branch of the discipline. It has been instrumental in broadening the remit of psychological research to include "the scientific study of positive human functioning and flourishing" (Compton and Hoffman 2013, p. 2). Positive psychology has appreciably reshaped the ways in which mental health is understood in educational contexts, and it has been central to the development of ideas around wellbeing. Another important development was the launch in 1995 of the World Health Organization's (WHO) "Global school health initiative", which reflected an emerging consensus that schools had an important role to play in health promotion (WHO 2014a). Since this time, there has been a proliferation of policy at all levels of government and across the health and education sectors, aimed at improving social and emotional wellbeing and youth mental health.

Before examining policy responses and the dominant forms that educational interventions have taken in recent years, it is important to note that by the late twentieth century, there was also, more broadly, increasing attention to the social and emotional domains of learning. By the 1970s, statements of educational aims in Australia begin to include aspirations for the development of the individual and the exploration of feelings (Barcan 1993). An overt concern with the psychological and emotional development of the child saw policies in some states mandate that schools should provide a caring and supportive environment, because this was recognized as important to children's capacity to learn (Victoria 1984). During the 1980s and 1990s, there was considerable enthusiasm about the promotion of self-esteem. The Hobart Declaration on Schooling (AEC 1989), for example, named the development of self-confidence, optimism, and high self-esteem second in its list of educational objectives. And this was reaffirmed a decade later with the Adelaide Declaration on National Goals for Schooling in the Twenty-first Century (MCEETYA 1999). There has, however, been a shift away from the idea that simply boosting self-esteem will lead to improved outcomes – either in terms of academic performance or mental and emotional health. In the present era, promoting more holistic notions of mental health and wellbeing is considered a useful strategy. This is reflected, for example, in the 2008 Melbourne Declaration on Educational Goals for Young Australians, which asserts that schools play a vital role in promoting the wellbeing of young Australians (MCEETYA 2008). And this sentiment continues to underpin policy approaches at both the state and federal levels.

Frameworks and strategies that take a universal approach to promoting mental health and wellbeing have constituted the dominant educational policy response since the 1990s. In the late 1990s, the now prominent MindMatters (2012) framework was developed for secondary schools and trialed across Australia "in recognition of the need to address the mental health and wellbeing of young Australians" (p. 1). While issues of implementation are not the focus of this chapter, it is instructive to note that by 2010, it was estimated that almost all Australian schools were "aware of MindMatters", with 65 % of secondary schools using it as a "key resource" and 38 % using it as "their main organizer for mental health promotion, prevention and early intervention" (MindMatters 2012, p. 2). The MindMatters

framework has also been taken up in a number of other countries, including the USA, Germany, Switzerland and Ireland (Mullet et al. 2004).

The overarching philosophy, as articulated in the 2012 iteration of the framework, is that: "Mental health and wellbeing is a school's business" (MindMatters 2012 p. 8). It strongly advocates the position that schools are a key site for the promotion of mental health and wellbeing and offers strategies for schools to achieve this. This includes developing "a positive climate of mental health and wellbeing", being "proactive in the promotion of mental health and wellbeing for all students", supporting prevention and providing "early intervention initiatives for young people with mental health and wellbeing challenges" (p. 1). The goals of the framework are summarized as follows:

> MindMatters adopts a universal school-based mental health promotion, prevention and early intervention approach. Such an approach targets the entire school population with the goals of enhancing strengths so as to reduce the risk of later problem outcomes and/or to increase prospects for positive development. Prevention strategies can be universal, selective or targeted and are designed to identify and counter risk factors. Intervention strategies are aimed at students who have some risk factors, mental health difficulties, or who have diagnosable disorders. (MindMatters 2012, p. 2)

The whole school approach encompassed in frameworks like MindMatters employs a range of strategies for preventing and managing problems of mental health and wellbeing. The bringing together of mental health promotion, prevention and early intervention reflects a tripartite best practice model. MindMatters also embraces the three key dimensions of the WHO Health Promoting Schools Initiative (WHO 2014b): a focus on school ethos and environment, curriculum, and internal and external partnerships. Key components of this include professional development for staff to ensure adequate knowledge and awareness of potential problems, curriculum initiatives such as health and values education, and attempts to cultivate school environments that make young people feel safe and valued. Fostering an ethos within the school in which help-seeking is supported is also critical, as is early intervention for "young people with mental health and wellbeing challenges" (MindMatters 2012, p. 1).

School staff are encouraged to monitor all students for signs of distress, identify students who may be at risk of mental health or wellbeing difficulties, and discuss young people who elicit concern with other members of staff. This involves teachers reading particular behaviours as potential indicators of mental health problems. As in primary and secondary schools, this is also a feature of approaches in early childhood settings. Indeed, central to the ethos of preventative approaches is that very young children are ideal candidates for early intervention. As a result, screening programs to identify early signs of emotional, social and developmental problems, and frameworks to promote good mental health for all children in educational and care settings have been developed (KidsMatter EC 2012). Before exploring the provocative idea of "psychological immunization" and its promise of prevention, I conclude this section on universal approaches by briefly examining some notable developments in early education settings.

Following the success of MindMatters, KidsMatter Primary was developed in the mid-2000s, with KidsMatter Early Childhood (EC) following in 2010. The rollout of these frameworks, first for adolescents then primary school-aged children and most recently for preschool aged children, reflects the acceptance of early intervention as a guiding principle in the promotion of mental health and wellbeing, even for infants. A key assumption underlying KidsMatter EC is that "mental health problems exist and can be identified in early childhood" and that "certain risk factors" for depressive and anxiety symptoms are "present before 6 months of age" (KidsMatter EC 2012, p. 2). It is based on a "positive psychology philosophy" that aims to "improve the mental health and wellbeing of children from birth to school age", reduce mental health difficulties and "achieve greater support" for children experiencing mental health problems (p. 6). The framework includes four main components: creating a sense of community; developing children's social and emotional skills; working with parents and carers; and helping children who experience mental health issues. KidsMatter EC recognizes early childhood as critical to the development of wellbeing throughout life and identifies protective and risk factors that affect mental health. Strengthening "protective factors", for example, by fostering positive relationships and attachments, intentionally teaching social and emotional skills and promoting self-esteem, is the primary approach to mitigating "risk factors" (KidsMatter EC 2012).

The shift in emphasis from targeted approaches and early intervention for identified problems to the embrace of broader health promotion and preventative strategies signals a major change. In the current educational landscape there is considerable effort directed towards the development of frameworks, programs and interventions to improve mental health at a population level. Within this context, it is difficult to question taken for granted "truths", for example, that universal approaches to fostering wellbeing may prevent future mental health problems or that focusing on the development of social and emotional skills leads to better educational outcomes. It is also difficult to pose critical questions, such as the possibility that strategies aimed at promoting wellbeing could lead to undesirable outcomes. In the preceding sections, I have explored the rise of wellbeing and antecedents to current concerns about youth mental health by contrasting developments in the early decades of the twentieth century with more recent approaches. In seeking to problematize discourses of mental health and wellbeing I have focused on illuminating the "conditions and registers in which problems and solutions have been articulated" (Webb 2014, p. 369). In what follows, I consider what is left unproblematic in constructions of mental health and wellbeing and how these matters may be thought about differently (cf. Bacchi 2012).

Psychological Immunization and the Promise of Prevention

Promoting the mental health and wellbeing of young people now sits alongside traditional educational aims of knowledge acquisition, vocational preparation and the development of citizenship (Wright 2011b). The benefits of adopting policies

and practices to achieve this are often assumed to be self-evident, with little questioning of dominant approaches. Yet, as critical policy studies remind, there are sound reasons to consider all educational policies and practices with caution, even those that have worthy aspirations and appear incontrovertibly to be in the best interests of students. This not only includes attention to issues such as the gap between policy and practice but also, importantly, consideration of how inequalities or disadvantage may be reproduced, despite intentions to the contrary, and being alert to unintended consequences that may arise from the adoption of particular policies (Young et al. 2010). Alongside this, critiques of the therapeutic turn in education raise important questions about the effects of strategies aimed at promoting social and emotional skills and personal dispositions regarded as essential for wellbeing (Ecclestone 2012).

An important issue that arises from this analysis is that the concept of wellbeing is itself poorly defined (Amerijckx and Humblet 2013; Watson et al. 2012). It may be taken to simply mean "being well". However, its frequent coupling with mental health (i.e. "mental health and wellbeing"), prominent in much contemporary policy, suggests that wellbeing is often conceptualized in relation to psychological health. Certainly, it encompasses physical health as well, and indeed part of the appeal of wellbeing as a concept is that it not only overcomes some of the stigma carried by a term like mental health but it also reflects an embrace of notions of flourishing or optimal functioning, ideas that have gained prominence with the rise of positive psychology. Nevertheless, despite the extent to which it may be an all-encompassing term, the alignment of wellbeing with mental health means that the focus on improving wellbeing is often implicitly framed in terms of enhancing mental health or improving problems of poor mental health. Indeed, in a review of the literature on child wellbeing, Amerijckx and Humblet (2013) suggest that there is an "oddly pathogenic approach" to wellbeing; that is, much research on wellbeing has followed a pathogenesis model in which states reflecting the antithesis to wellbeing are foregrounded and investigated rather than the focus being on wellbeing itself (p. 1).

To extend this analysis a little further, while mental ill-health may be one problem that the promotion of wellbeing seeks to address, it is not the only problem. As it is an amorphous concept that reflects an idealized state of being, the range of problems to which the promotion of wellbeing may be drawn upon as a solution is left open. As noted above, wellbeing is increasingly linked to successful learning outcomes and academic engagement (Durlak et al. 2011; Watson et al. 2012). While this is strongly reflected in contemporary educational policy, it is useful to remember that this view has only risen to prominence since the late twentieth century, and has now become something of a taken for granted truth. Social and emotional learning, for example, is a highly influential model for conceptualizing the processes associated with the acquisition of skills and knowledge (Zins et al. 2004, 2007). The development of social and emotional skills, moreover, is considered important for being a "good student, citizen and worker" and deemed to play a key role in minimizing "risky behaviours" (CASEL 2014). Earlier, I examined how mental health became an educational problem by looking back to the early decades of the

twentieth century; a central part of this story being the embrace of contemporary medical and psychological knowledges that provided normative understandings of what constituted child (mental) health (Turmel 2008). More recently, positive psychology has played a major part in the rise of wellbeing, both as a concept and in the idea that promoting wellbeing can prevent the development of mental health problems.

There is, as Webb (2014) notes, "a pervasive logic that maintains educational *problems* can be *solved* in, with, or through policy" (p. 364). Certainly, the value of prevention has long been recognized, not only in educational contexts; expressions such as "an ounce of prevention is worth a pound of cure" and "a stitch in time saves nine", attest to the accepted common sense of preventative approaches. In the field of mental health, what is now referred to as "the science of early intervention" takes various forms, from biomedical models to more psychologically or socially oriented approaches (Slee et al. 2011, p. 38). Arguments supporting early intervention are advanced in relation to the physical, psychological and social benefits of intervening early. However, strong economic arguments, framed largely in terms of cost-benefit analysis, are also commonly used to demonstrate that there are considerable returns on investments made early in children's lives. Such a view posits that schools are "ideal entry points" for interventions that address mental health (Slee et al. 2011, p. 39). In recent years, this has seen the expansion of the parameters of early intervention, both in terms of the remit of what may be achieved (i.e., preventing mental illness by treating problems early), and the populations to which preventative efforts and the promotion of psychological health can be extended (i.e. infants and very young children).

There is clearly a demonstrable benefit to be derived from intervening before minor problems develop into major ones. Yet, how this is actually done in schools and other educational settings is an area fraught with difficulties. To return briefly to the MindMatters (2012) and KidsMatter EC (2012) frameworks, an important strategy for teachers and early childhood educators is that of "observation"; that is, staff are encouraged to be on the lookout for indicators of mental health difficulties in babies, children and adolescents. While it may be argued that this has long formed part of the pastoral work of teachers and carers, the systematic monitoring of young people, informed by indicators of psychological risk and distress, raises a number of issues.

For babies and young children, signs and risk factors include "pessimistic thinking styles", "impulsivity", "low IQ", "low self-esteem", "poor social and emotional skills" and "socioeconomic disadvantage" (KidsMatter EC 2012, p. 9). Deviations from normal patterns of development form one concern, indeed a highly psychologized one, but so does the problem of social disadvantage. Similarly, for adolescents, MindMatters (2012) offers a list of indicators for high school staff to help them assess whether students are in need of support for their mental health and wellbeing. These include some clearly worrying signs, such as "thinking about death, suicide or self harm", "stealing, vandalism and risk taking behaviour", and "abuse of drugs or alcohol". But they also include indicators such as being lethargic or having lots of energy, changes in eating patterns and changes in

academic performance or interest (MindMatters 2012, p. 99). Certainly, these *may* be signs of problems with mental health or wellbeing. However, what must also be considered are the risks that arise from this kind of surveillance and the potential for pathologizing variability in the behaviour, personality and disposition of infants, children and adolescents. Especially important in this regard is the extent to which social disadvantage becomes normatively tied to the risk for developing mental health problems (Graham 2012; Harwood and Allan 2014).

There are also more practical issues to consider, such as the distribution of finite resources, a perennial issue for education systems. With regard to current approaches to improving wellbeing, in recent years this has involved funding directed towards whole school as well as targeted programs. This raises questions about need and the effectiveness of interventions that aim to foster wellbeing through universal approaches. A recently published systematic review (Kidger et al. 2012) suggests that there is limited evidence to support claims that the school environment – a key focus of many approaches – affects student mental health. What this analysis does affirm, however, is not surprising: that is, that students' perceptions of teacher support and feelings of being connected to school are associated with better emotional health.

Importantly, current approaches also have a much broader aim than early intervention and the prevention of mental illness. For educational philosopher, Ruth Cigman (2012), the promotion of wellbeing is a central part of the contemporary enhancement agenda, which "aims to enhance so called positive emotions in children (optimism, resilience, confidence, curiosity, motivation, self-discipline, self-esteem, etc.) and inhibit negative ones" (p. 449). While Cigman argues, not surprisingly, that there are aspects of this to be welcomed, she cautions against the dangers of this type of polarized thinking, that is, the notion that some emotions are positive and some are negative, which is characteristic of positive psychology and is reproduced in educational policy that aims to improve wellbeing. Moreover, she warns of the potential of wellbeing being caught up in the contemporary climate of neoliberal accountability. In short, should young people be "answerable to a wellbeing test", and what happens to those who "fail"? (Cigman 2012, p. 450).

Finally, an implicit assumption in positive psychology and in approaches to promoting wellbeing is the idea of "psychological immunization" and the concomitant promise of "inoculating young people against depression" (Craig 2009). Yet there is little evidence, according to Carol Craig of the UK's Centre for Confidence and Wellbeing, that the effects of programs aiming to promote wellbeing are long lasting. She raises a variety of concerns about unintended consequences, including the privileging of the psychological at the expense of the physical; exercise, she notes, is a natural "anti-depressant". In her view: "Making movement an integral part of school life may have a more beneficial effect than psychological programmes" (p. 20). There is also the question of the extent to which the promotion of wellbeing may lead to self-absorption. Educational programs that aimed to improve self-esteem, popular in the 1990s especially, are now criticized for leading to an epidemic of narcissism (Stout 2000; Twenge and Campbell 2013). Might similar or related arguments be leveled at wellbeing in the future?

Concluding Remarks

Examining antecedents to current concerns with youth wellbeing – and the institutional changes that have accompanied them in the form of new ideas and programs – provides a way of historicizing and defamiliarizing present day educational approaches. The contemporary focus on wellbeing, in other words, is part of a longer history of educational concerns with the social, emotional and psychological development of young people (McLeod and Wright 2013). While my empirical analysis has focused on Australia, it reflects a more general international trend. In the first half of the twentieth century there are discernable similarities to some of the aspects that characterize educational directions today; yet there are also important differences. While the story of this development is complex, it is a reasonable generalization to say that over the course of the twentieth century there was a significant expansion of programs that aimed to assist young people with learning and other academic problems, but also with social and psychological problems. Moreover, if one takes a comparative look at the early and the late twentieth century, what is striking is the shift that occurs from a narrow focus on interventions for "problem children", to universal interventions and programs with the aim of improving social and emotional skills – and psychological health more broadly – for the entire population of young people.

Central to this has been the development of new understandings of child and adolescent mental health, alongside widespread views by the late twentieth century that mental health was a major social problem for advanced economies. These have underwritten concerns about youth wellbeing, and to a large extent, provided the rationale for developing universal approaches as a key strategy to address this issue. It is important to recognize, however, that the growing body of research on mental health disorders does not simply document an existing problem. It also plays a central role in the way that the problem itself is constructed. In other words, the production of psychiatric and psychological knowledge frames the ways in which mental health is understood, both in professional contexts and by the broader public, and forms the basis from which solutions or policies aimed at addressing the problem are developed. Importantly, the same period that saw mental health acknowledged as a pressing social problem also saw the rise of positive psychology. Positive psychology has taken a leading role in developing solutions that can be applied in educational contexts, notably, through the promotion of student wellbeing. It promises a more holistic, less pathological, approach. Yet, the ways in which notions of wellbeing are taken up in contemporary educational frameworks suggest that wellbeing is largely a proxy for mental health and that the "solutions" continue to be largely individualized. Moreover, there remains considerable potential for pathologization, and particularly worrying in this regard are the ways in which social and structural disadvantage are situated as problematic for mental health.

Youth wellbeing is clearly a complex issue. Not only is it widely regarded as a pressing social problem, but it is also presents interpretive and definitional

challenges with regard to what wellbeing constitutes, the question of its relationship to mental health and how appropriate the concept is as an educational aim and as an organizing framework for interventions to improve the lives of young people. I conclude, therefore, not with a definitive response or an evaluation of the historical shifts I have documented, but with a series of provocations that emerge from the foregoing analysis. From a conceptual or sociological standpoint, we may ask: What does the contemporary focus on youth wellbeing as a key aspiration say about our society today, and perhaps more importantly, what does it say about the enduring anxieties that we face in relation to young people? Important questions are also raised from critical perspectives informed by principles of justice and social equity: To what extent does the focus on wellbeing, vis-à-vis older concerns with welfare, detract from what are the actual social determinants of wellbeing and the need to address those – not least of which is enduring social disadvantage? In examining contemporary school-based approaches it is important to also acknowledge the seemingly inexorable rise of diagnosable disorders and lay understandings that shape educational attitudes towards mental health problems. This leads one to speculate on the overall impact of positive psychology and the rise of wellbeing as a central concern of education. A key question here is whether these more holistic concepts and processes have lead to a diminishment of the individualizing and dividing practices of categorization and the tendencies towards pathologization in educational psychology in the past. Or whether these practices have simply re-emerged, albeit in a rather different guise, in the form of wellbeing discourses.

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