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The dangers of mental health promotion in schools

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Abstract

Much of Western media has promoted the idea that we are facing an epidemic of mental illness and psychiatric emergencies in contemporary Western society and worldwide, and that young people are a particularly vulnerable group. Schools have become a prominent site of concern and focus for this discourse as mental health problems are said to start early in life; thus, targeting intervention at people in their early years and greater mental health awareness amongst staff and pupils are perceived as important mental disorder prevention strategies. However, the belief that mental disorders can be classified and investigated using the same tools as physical health has led to a system of knowledge that lacks validity being constructed. This ideology, far from leading to enlightened progress that will prevent and/or ameliorate future mental health problems, inadvertently sets young people on a path towards alienation from, and suspicion of, their emotional lives and a lack of curiosity about, or tolerance of, suffering. This article explores how a lack of understanding about what sort of 'thing' a mental health problem/disorder/diagnosis/illness is leads to confusion about the meaning and consequences of experiencing mental distress and/or mental difference. Interviews with secondary school teachers carried out by one of the authors (ZT) show how awareness of mental health and mental disorder has increased in UK secondary schools over the last decade and how this has led to an expansion in the numbers of students thought to have mental health problems that required professional intervention. As a result, teachers now identify many

behaviours and experiences they previously deemed ordinary and/or understandable as likely mental health problems that required professional expertise they lacked. Rather than preventing mental health problems, it is likely that this ideology, and the resulting practices it encourages, are creating them.

KEYWORDS
critique, diagnosis, mental health, schools, young people

INTRODUCTION

Much of Western media has promoted the idea that we are facing an epidemic of mental illness and psychiatric emergencies in contemporary Western society and worldwide and that young people are a particularly vulnerable group. Schools have become a prominent site of concern and focus for this discourse as mental health problems are said to start early in life; thus, targeting intervention at people in their early years and greater mental health awareness amongst staff and pupils are perceived as important mental disorder prevention strategies. However, the belief that mental disorders can be classified and investigated using the same tools as physical health has led to a system of knowledge that lacks validity being constructed. This ideology, far from leading to enlightened progress that will prevent and/or ameliorate future mental health problems, inadvertently sets young people on a path towards alienation from, and suspicion of, their emotional lives and a lack of curiosity about, or tolerance of, suffering. This article explores how a lack of understanding about what sort of 'thing' a mental health problem/disorder/diagnosis/illness is leads to confusion about the meaning and consequences of experiencing mental distress and/or mental difference. Interviews with secondary school teachers carried out by one of the authors (ZT) show how awareness of mental health and mental disorder has increased in UK secondary schools over the last decade and how this has led to an expansion in the numbers of students thought to have mental health problems that required professional intervention. As a result, teachers now identify many behaviours and experiences they previously deemed ordinary and/or understandable as likely mental health problems that required professional expertise they lacked. Rather than preventing mental health problems, it is likely that this ideology, and the resulting practices it encourages, are creating them.

This article has been written in a more 'journalistic' style to allow readers an opportunity to understand some basic assumptions that structure and frame our current mainstream beliefs about, and practices in, mental health. There are many sources for more detailed and evidence-supported critiques of the use of diagnosis in mental health practice (e.g., Johnstone, 2014; 2020; Timimi, 2014, 2020, 2021). It is beyond the scope of this article to discuss broader questions around the philosophy of science and the differing epistemologies for generating knowledge. It is also beyond the scope of this article to critique the limits of healthcare and medical science more generally; much of which experiences problems with medicalisation and a preoccupation with the technical aspects of care, often to the exclusion of the relational and contextual aspects that are of importance for any practice that is predicated on human social interactions. The purpose of the article is simply to lay bare the basic assumptions that structure the current paradigms for identifying and intervening in what we have come to call mental health problems/disorders/illnesses. The implications for education are then explored, partly through discussing the results of some research carried out with secondary school teachers. It is also beyond the scope of this article to outline more detailed solutions to the issues raised (if indeed that is what is needed) beyond a few generic implications.

WHAT IS A MENTAL DISORDER?

What do people mean when they talk about mental disorder, mental health or mental illness? What sort of 'thing' is a mental disorder? Where are its boundaries? When does an experience or behaviour become abnormal or disordered or pathological and who decides based on what? Whilst the issue of where to place boundaries between the ordinary and not ordinary is something medicine often grapples with, when it comes to what we label as 'mental health' we have a whole new level of potential confusion, uncertainty and meanings to get through before we can assert something to be out of the ordinary, abnormal or disordered. In psychiatry the entire phenomena require interpretation, not just the boundaries.

Take for example the fairly straightforward situation where there is minimal confusion about what sort of 'thing' we are dealing with. Somebody has an accident and experiences extreme pain and some swelling in their leg and they can't walk on it. At the hospital, an X-ray reveals there is a fracture in the tibia (shin bone). In this scenario, the medical model is working at its best. The fracture of the tibia is what is known as a 'natural kind'; so in terms of classification, the diagnosis explains an abnormality in the person's physical body that can be empirically verified and measured. As a natural kind that can be seen, it exists out there in the world beyond our subjective hypothesis. It is a verifiable fact of nature, and we can develop knowledge bases that relate to this natural phenomenon. Medicine is particularly good at these emergency scenarios where there is an identified abnormality and where the treatment period is relatively short. We know what sort of a 'thing' a fracture of the tibia is. Once seen on the X-ray we have an explanation (a diagnosis) for what is causing the patient's pain, swelling and inability to walk and as a result can develop rational and testable treatment pathways.

Not all presentations to doctors follow this easy-to-understand idea of what sort of thing we are dealing with. Let's take diabetes as another example. The connection between symptoms and the underlying cause may not be as immediately apparent. The diabetes diagnosis refers to an abnormality of sugar metabolism, and this can be measured mainly through blood tests but also in other ways (such as through testing your urine for something called 'ketones'). Some abnormality of blood sugar metabolism may exist for a period of time without the patient displaying any obvious symptoms. They may just have some non-specific complaints such as generalised tiredness or loss of concentration, particularly in type II diabetes, which has an onset later in life when the body becomes resistant to insulin or when the pancreas is unable to produce enough insulin. Type II diabetes could present just as a susceptibility to infections and so could go unnoticed for months or even years. Nonetheless, there is still a physical parameter that can be measured, and there is a physiological process present in the physical body and that exists in the world external to the diagnoser, which is verifiable with independent data (such as a test for fasting blood glucose).

The diagnosis of 'diabetes' is, like the fracture of the tibia, explanatory. It is pointing to an abnormality that can cause symptoms in the patient and will cause more if not treated. But there are many disagreements in diabetes diagnosis and treatments; for example, when to consider the blood sugar has crossed a threshold justifying a diagnosis, whether to just use dietary approaches and for how long, when to use medication, how to deal with complications, the psychological impact of having a chronic disease, the social dimension of long term care and so on. But still, we know what sort of 'thing' diabetes is.

Now we start to get into medical conditions that can have recognisable symptoms and physical signs and sometimes objective tests, but in which there are mysteries as to the initial cause or explanation. Many types of headaches, such as migraines, are good examples of this category. Diagnoses such as migraine are mainly based on a description of symptoms. We are now moving towards a descriptive rather than explanatory system; however, given that there are characteristic physical symptoms (such as in migraine you may get blurring of vision, and specific pain behind the eyes on one side of the face), it is a reasonable assumption, although not yet proved beyond doubt, that it involves a physiological process. So, we kind of know what sort of a 'thing' migraine is, though we are now getting into some more fuzzy territory. With pain and the nervous system so involved, psychological aspects are becoming more prominent, and the boundary between physical and psychological is blurring. But the idea of diagnosis still stands, even if it is to

conclude that whilst the migraine is a diagnosis (in that it seems to explain the physical symptoms), it can be brought on, involves, or sometimes is even mimicked by, psychological factors.

Once we come to talk about mental disorders, we start to get into a whole array of new problems in order to support the idea that we have a 'thing' that can be considered a diagnosis. The territory for what we have been calling 'symptoms' of a mental disorder are now experiences and behaviours that have meanings and that may be interpreted differently by different cultures, different times and in different settings. This means we are not only shifting to an area of practice where there are disagreements and debates about where the boundaries are, but also taking into account the significance and relevance of the diverse meanings that can be attached to these symptoms, such that they are interpreted as symptoms in one interpretive framework, but not in another. We have no physical signs, tests and markers and so are entirely reliant on observations and reports of the person and/or their significant other(s). The disputes are no longer just about the boundaries but also about the parameters; indeed, about whether they can even be considered problems in the first place and, if they are, whether they can be thought of as medical in nature. We have now strayed into a different conceptual field.

Is that patient in front of me who reports intense sadness, difficulty getting to sleep, waking up before 5am every night and not able to get back to sleep, and has a poor appetite suffering from a 'depressive disorder' or experiencing understandable heartbreak and grief after the breakup of a longterm relationship a few months back? If you argue both can be true, then sure, culturally speaking, both depression and grief may be said to the patient as what they 'have'. One, however, cannot be a diagnosis (depression) as it explains nothing, just describes some aspects of the patient's experiences, the other (grief) could be a diagnosis as it has explanatory pretences. Grief (unlike depression) is, in this scenario, being used as an explanation. But I have no access to the patient's inner mental workings; none of us do. With grief, depression or both, I still do not know what sort of a 'thing' I am dealing with. Is it a medical disease in her brain, is it the psychological process of grief, is it the loss of a social network that she had with that partner, is it her concern about how this is impacting her son, is it the fear of returning to work after a long absence, is it all of these things? In truth I don't know anything about what has *caused* her presentation, neither does she. I can't escape my subjectivity or the patient's for that matter. I can only guess at the 'diagnosis' (proximal explanation).

When it comes to our emotional experiences, we just have embodied experience. We then use words connected with cultural meaning-making systems to attach to that experience. The meaning scaffolding we then use can itself transform our experience of the experience. '*You are broken hearted*' creates a different scaffold to '*you are depressed*', or to '*you are surviving and recovering from a painful experience*' or even to '*I can see how your suffering has helped you see your life in a transformed way*'.

Mental health, illness and disorder cannot be thought of as out there in the natural world, existing somewhere within the body of the person, in a way that is identifiable as a concrete 'thing'. It is not definable in a causal way in the same way as a broken leg or diabetes or even migraine. And yet this is the way we talk about mental health and illness—as if we know what sort of 'thing' this is and assume that it exists within a person regardless of their context as a known 'thing' that exists in objective reality and beyond the subjectivity of the person or the practitioner who pronounces you 'have' this thing. If you hear one in four of the population are possessed by or will be possessed by a mental disorder, be wary. It is an unfortunate mistake to make with potential adverse consequences for patients and professionals alike. One in four who have what sort of 'thing'? Where is this 'thing' located and how do I find it? How can I develop an accurate way of 'measuring' it if I can't locate it as an empirically knowable 'thing'?

THERE IS NO SUCH THING AS A PSYCHIATRIC DIAGNOSIS

In medicine, then, diagnosis is the process of determining which disease or condition *explains* a person's symptoms and signs. Diagnosis is a system of classification based on cause. Making an accurate diagnosis is a technical skill that enables effective matching of treatment to address specific pathological processes. Pseudo-diagnoses, for example attention deficit hyperactivity disorder (ADHD) or autistic spectrum disorder, cannot explain behaviours or experi-

ences as there are only symptoms that are descriptions (not explanations). Even using the word 'symptom' is problematic, as in medicine a symptom usually refers to patients' suffering/experience as a result of an underlying disease process and is therefore associated in our minds with a medical procedure leading to an explanation for the symptom.

We are meaning-seeking creatures and so have used classification systems extensively to classify all manner of things. Language is itself a system of categorisations with words that symbolise all sorts of phenomena. But different classifications serve different functions. A diagnostic classification is a classification by explanation, in other words by cause. That is why we say, '*My doctor said that the cause of my chest pain was acid reflux, not a heart attack.*' We usually go to the doctor to get the 'why' question answered and in the hope this will then guide towards the correct treatment.

But psychiatric diagnoses do not explain symptoms. Consider the following example: If we were to ask the question '*what is ADHD?*' it is not possible to answer that question by reference to a particular known pathological abnormality. We cannot say that ADHD is a neurodevelopmental disease that occurs due to the brain having abnormally low levels of dopamine. We cannot say that because no one has found any characteristic brain differences or abnormalities (despite extensive research), there are no tests done to confirm or refute this. Instead, to answer the question we will have to provide a description such as '*ADHD is the presence of "abnormal" levels of poor concentration, hyperactivity and impulsivity*' and so on.

Contrast this with asking the question '*what is diabetes?*' If a doctor were to answer this question in the same manner by just describing symptoms, such as needing to urinate excessively, thirst and fatigue, they could be in deep trouble as a medical practitioner as there are plenty of other conditions that may initially present with these symptoms, and diabetes itself may not present with these symptoms in a recognisable way. In order to answer the question '*what is diabetes?*', they will have to refer to its pathology involving abnormalities of sugar metabolism, as in, '*Diabetes is a disease that occurs when blood glucose (sugar) is too high*'. To move from a hypothesised to a confirmed diagnosis, they would get independent (to their subjective opinion) empirical data to support or otherwise the hypothesis about what may be causing the patient's described experiences (such as testing the urine for ketones and/or blood for levels of fasting glucose). In most of the rest of medicine, therefore, a diagnosis explains and has some causal connection with the patient's experiences/symptoms. Thus, diagnosis sits in a 'technical' explanatory classification framework.

The problem of using a classification like 'ADHD' to explain an experience (i.e., as a diagnosis) can be illustrated by asking another set of questions. If this doctor was asked by someone why their child is hyperactive and answered that this is *because* they have ADHD, then a legitimate question to ask is '*how do you know that this hyperactivity is caused by ADHD?*' The only answer they can then give to that question is that they know its ADHD because they are hyperactive. In other words, if we try to use a classification that can only describe in order to explain, we end up with what philosophically is known as a 'tautology'. A tautology is a circular thinking trap. A description cannot explain itself. Using ADHD to explain hyperactivity is like saying the pain in my head is caused by a headache or my cough is caused by coughing disorder. In psychiatry, therefore, what we are calling diagnosis will only describe but is unable to explain and therefore it isn't a diagnosis.

The failure of decades of basic science research to reveal any specific biological or psychological marker that identifies a psychiatric diagnosis is well recognised. Unlike the rest of medicine, which has developed diagnostic systems that build on a causal and physiological framework, psychiatric diagnostic manuals have failed to connect diagnostic categories with any causes or physical markers. Thus, there are no physical tests referred to in any mental health diagnostic manual that can be used to help establish the categories used as diagnoses; in other words, the labels we use in psychiatry cannot migrate from a descriptive to a diagnostic system of classification. Despite the belief that psychiatric disorders have a significant genetic loading, molecular genetic research is failing to uncover any specific genetic profile for any psychiatric disorder. Possible genetic abnormalities appear to account for an insignificant percentage of possible associated causal factors, and whatever genetic contribution has been found crosses diagnostic categories rather than having a distinct profile for each diagnostic category. Similarly, brain imaging studies are coming up empty handed. The evidence cupboard, despite the billions in funding allocated to such biological research, is empty. The most likely reason for not finding any evidence of physiological or genetic abnormalities is that there are no genetic or other brain abnormalities causing what we call psychiatric diagnoses (Timimi, 2020).

A CHANGE FROM SOUL TO 'PSYCH'

There is a basic discrepancy between ontologically different kinds (in brief, ontology refers to theories about the nature of being), such as body and psyche, and the epistemology we can use to investigate them (in brief, epistemology refers to the methods of study used to gather knowledge). By using the epistemologies created by a 'scientific' approach of measurement and quantification, mainstream psychology and psychiatry cannot discover valid knowledge on psychic phenomena, because the human mind isn't the same sort of 'thing' as a kidney. This is an ontological issue. A medicine of the mind cannot be the same as medicine of the kidneys. We can measure metabolites produced by the kidney, study biopsies of it under the microscope and measure how well it is filtering through blood tests. Kidneys will not get anxious or excited by reading out kidney functioning tests. The mind is a different object, where all we have are theoretical models of the mind. Unlike the impact on kidneys, telling us that what we are writing is delusional will have an impact on our mental state. We cannot escape the subjective, meaning-making, space. The story of *Breaking Bad* will not reveal itself by examining the TV hardware for patterns of electric current activity. We cannot measure meaning.

What we have are different philosophies that we apply to phenomena that enable us to construct meanings. Psychology is but one branch of philosophy expounding a particular Western-centric view of the mind.

In order to understand and be able to therapeutically control psychic phenomena, the impulse, since scientific cosmology came to dominate how knowledge was produced, has been to turn to the ontology and epistemology of the natural sciences and the technologies that are assumed to be built on this knowledge. The scientific method itself came to be worshipped (like a religion—a social process often referred to as 'scientism'), and the difference between the ontological status of its 'objects' was overlooked. Somehow, it is believed, 'science' (as an abstract socially valued concept) could transcend the problem of categorising, measuring and quantifying psychic phenomena, to show how there are some special traits that can be mapped onto predictable, law-like, templates. Thus, our approach to the mind has become dominated by attempts to categorise experiences and behaviours into specific domains imagined to be 'natural kinds' that can be universalised.

From this point of view, the professions of the 'psy-complex' have suffered from the incompatibility between their 'object' (ontology) and the method that they use for researching and consequently understanding and developing technology to control the object of their study (epistemology). A science of the 'psych' is like trying to plough the sea. It can be argued that following the 'enlightenment', epistemologically speaking we began replacing the idea of the 'soul' to be studied and understood by the epistemology of theologians with the idea of the 'psych' to be studied and understood by the new guardians of knowledge—scientists. Each epistemology then creates (rather than discovers) a set of meanings to attach to our human experiences, feelings and behaviours.

The object of psy-disciplines remains basically unknown, whether we call it the mind, the psych or the soul. Scientific knowledge of the psyche is impossible because it is not a material object that can be captured objectively and without interpretation and supposition; thus, scientific methods cannot help us unfold its attributes. The epistemology of science is inappropriate for the ontology of mental functioning. But the idea that the psy-professions are scientific has far reaching consequences.

WHAT HAS ALL THIS TO DO WITH MENTAL HEALTH POLICY IN SCHOOLS?

Back in 1996, the World Health Organization predicted that, by 2020, depression will be the second-leading cause of disease burden globally. Since then there has been relentless messaging that we are experiencing a rising tide of mental health problems—with anxiety and depression leading the way—such that today much of Western society shares an idea that we are facing an epidemic of mental illness and psychiatric emergencies. Young people are often picked out as a particularly vulnerable group, who, we are told, are ravaged by undiagnosed and untreated mental disorders.

Schools have become a prominent site of concern and focus for this propaganda, as mental health problems are said to start early in life. This way of thinking keeps the focus on the idea that it is individuals that have the disease and so it is individuals who need to be identified and treated. The role of systems around them is to adjust to help them with managing their disorder. A population/community-wide approach is only that which improves detection rates and provides more services that should give early intervention. Consciousness of the way schools are set up, testing regimes, job security, financial security, community support and so on is banished when we are trained to be sympathetic to our 'ill' children.

Yet in this propaganda, from both media and professional bodies, what is not made clear is what is meant when they use terms like mental 'health', 'disorder', 'problem' or 'illness'. Mental disorders are what experts define them to be and, of course, open to wildly differing interpretations because of inescapable subjectivity. Young people, their parents and their teachers read alarmist media headlines and have a growing 'awareness' that these illnesses are all around us, and you could be one of those affected. You start to notice how bad you feel sometimes and wonder why you feel like this. Could it be that you are developing a mental disorder?

In tandem with this media coverage, mental health has also risen up the UK government education agenda as it has, throughout the last decade, dedicated more time and funding to programmes, initiatives and support, particularly in schools, to 'improve' young people's mental well-being. In 2018, the UK government announced that an additional £1.4 billion was being made available to 'transform' children and young people's mental health services with the primary emphasis being increasing training and access that builds upon what is already done by schools and colleges.

A reinforcing loop of 'moral panic' has developed where the problem effectively inflates itself. The more those in the mental health professions talk about there being a crisis in the mental health of the young, the more we notice it, and the more we talk about it as a result. Media then reports this, calls it a scandal, so government responds with more funding, which further highlights this epidemic. Young people, their parents and teachers are exposed to this, so they start noticing their emotions and behaviours in a new way, searching for signs of this epidemic having been sensitised to its existence and the importance of early intervention.

Expanding our ideas of what mental health problems are affects peoples' self-understanding and behaviour. Changing ideas will change people. In a kind of social self-fulfilling prophecy, new demand that didn't previously exist is created, meaning more people talking about 'mental health', more evidence of the epidemic, more media attention and so on. Thus, more of the population of young people and their carers start looking at their (or their children's) emotions and behaviours looking for signs of something going 'wrong'. Rather than being able to tolerate the variety of struggles and strains that are an inevitable part of growing up, a growing fear of emotions, particularly more intense emotions, develops.

More troubling is the fact that, despite an increasing number of people are being treated for mental health disorders (whether this is with medication or psychotherapy), it is not leading to better outcomes; in fact, it may be leading to worse mental health outcomes at a population level (Dalal, 2018; Davies, 2021; Gøtzsche, 2015; Timimi, 2014, 2020, 2021; Whitaker & Cosgrove, 2015). Whitaker (2010), for example, has documented a tripling of the number of disabled mentally ill people in the USA since the 1980s, as well as finding that the numbers of youth categorised as having a disability because of a mental condition had leapt from around 16,000 in 1987 to 560,000 in 2007. In the UK, mental disorders have become the most common reason for receiving benefits, with the number of claimants doubling between 1995 and 2014, while claimants with other conditions fell (Viola & Moncrieff, 2016). In fact, wherever you look in the Western world, increasing access to mental health treatments is associated with increasing numbers of people becoming categorised as 'disabled' because of their mental health and other indicators of worsening outcomes; the opposite of what you see when looking at outcomes in other areas of medicine (Davies, 2021). Real-life child and adolescent mental health services (CAMHS) show a similar poor record of improving outcomes. A new service configuration for CAMHS was rolled out to all CAMHS services in England and Wales in 2016, for which the pilot sites had found that the service models they used produced rates of 'clinical improvement' from treatment of between 3% and 36% (Edbrooke-Childs et al., 2015). This is not a record that you will find for effective services, but instead reflects that services have become better at creating long-term patients than alleviating suffering.

In 2019, one of the authors (ZT) carried out a piece of research as part of her undergraduate dissertation. ZT was aware of how often her peers spoke about 'mental health' or being 'depressed' and how difficult it was to know where common or understandable distress finished and became a mental disorder instead. She decided to look at how narratives of mental health were being constructed in secondary schools. She developed a semi-structured interview schedule and audiotaped interviews with 19 experienced secondary school teachers from three large state schools about their beliefs and practices in relation to the mental health of their students and how they perceived this had changed in their schools over the previous 10 years.

All the teachers she interviewed felt that awareness of mental health and mental disorder had increased and that this had led to an expansion in the numbers of students thought to have mental health problems that required professional intervention. Whilst she also found that there had been a substantial increase in mental health provision both within and outside the school system, teachers perceived these services as still woefully inadequate.

Teachers identified many behaviours and experiences they would previously have thought of as ordinary and/or understandable as likely mental health problems that required professional expertise they lacked. Even ordinary interactions like spending time talking to a distressed student were seen by their line managers as potentially problematic, as the student could be developing a mental disorder and they didn't have the expertise to know what the right thing to do is:

> [Speaking about a student he helped independently] '*He genuinely smiled and walked off… I think it was a couple of weeks later I mentioned it to the pastoral manager and there was a member of senior staff who said 'you should have logged that', but it was dealt with… it wasn't like I'd forgotten about it, I saw them the next day and they were fine, they were happy.'*

Many teachers were unsure where the boundaries for a mental disorder lay and how to differentiate that from 'unruly' behaviours or 'putting it on' to get some extra perceived benefits:

> *I think an increasing number of people who, not so much would make up mental health problems, but they see a label or tag and they want to be that. That's a problem as well as you have to sift out the genuine.*

> *It's trying to get that balance: are they playing the system or are they real? … in terms of my understanding of mental health it's a spectrum, and it's really defining when it turns into proper serious issues.*

When asked about what causes mental health problems, most teachers referred to everyday challenges such as exam stress, relationships, family, social media and bullying:

> *Stresses and strains due to ordinary everyday life as you get through each day then there are extra stresses which come from a work schedule, work and the demands of work, the stresses of social life.*

> *I think there are a lot of problems at the moment. In general stress, anxiety, and depression are the three I've encountered the most in young people.*

Despite the fact that teachers were oriented towards this everyday environmental model of causation, when it came to how best to help these children, teachers subscribed to a more medical model view that relied on 'trained experts' who could diagnose and treat the resulting disorders:

> *I thought we were here for teaching? We're not doctors? We're not registered clinicians.*

Lack of discussion or understanding in media, government policy or even academic papers on what sort of a 'thing' constitutes mental health and where/when special expertise might be helpful, coupled with this increased sensitivity towards identifying mental disorders early, leads to an increase in the number of students being deemed to require professional help that teachers, parents and friends can't provide. More referrals are then made, and despite external services expansion, they then have trouble dealing with the number of referrals, leading to access problems that lead to more media coverage of a 'crisis' in services, thus further increasing the volume of the 'mental illness in the young scandal' coverage and so on.

It should be no surprise, then, that a survey in 2019 (Wright, 2019) of 1000 young people found that 68% thought they have had or are currently experiencing a mental health problem and of those 62% thought that 'de-stigmatisation' campaigns helped them identify it. It also found that there had been a 45% increase in mental health referrals of under-18s in the previous two years. These are dizzying numbers, but not that far off a 2019 academic paper (Deighton et al., 2019) that, using a child self-report questionnaire methodology, came up with a prevalence figure for mental health problems in 11- to 15-year-olds, of 42%.

A 2020 study from New Zealand (Caspi et al., 2020) suggests these figures may be an underestimate. They reported that 86% of people will have met criteria for a psychiatric diagnosis by the time they're 45 years old, and 85% of those will have met criteria for at least two diagnoses. Exactly half of the population will have met the criteria for a 'disorder' by age 18.

CONCLUSION

In this article, we have discussed how mental health and its accompanying disorders resist attempts to define it as an identifiable 'thing' in the way most physical conditions can be. Psychiatric diagnoses are thus not really diagnoses; treating them as if they are has profound consequences. The idea that what we call 'depression' (for example) is an identifiable diagnosis creates a system of meaning that has the potential to alienate people from the ordinariness and/or understandability of their emotional experiences, creating more mental health problems at the same time as potentially scything away at people's natural resilience.

We have presented evidence on how secondary schools' teachers have got caught up in a moral panic about young peoples' mental health to the extent that it is influencing the discourse, culture and practice in secondary schools. Through processes of medicalisation and social looping, there has been a dramatic widening of what gets caught in the 'mental disorder' net. This has led teachers to inadvertently become part of a cultural discourse that is in effect mystifying ordinary reactions to social stress, existential anxiety, performance pressures and relationship challenges that would all have previously been considered part of the inevitable, but ordinary, struggles of growing up. The result is that both teachers and students risk becoming alienating from understandable everyday emotions, which they come to fear as something that could be a precursor to deeper problems and that therefore must be addressed professionally and rooted out.

It has led to a mushrooming of young people thought to be struck down with psychiatric 'fevers'. This sets us up for transforming the challenges, confusions, intensity and changes that happen as we grow and develop, particularly in our adolescent years, into potential obstacles, dysfunctions, dysregulations and disorders, that can be neatly packaged and given 'treatments' to get rid of them. This ideology is ripe for the growth of childhood depression/anxiety/ADHD/autism etc. as simplistic brands that our young are encouraged to identify and consume, along with simple remedies that they may wish to take, intermittently or continuously, for the rest of their lives. The crumbs of comfort people get by identifying with these socially constructed labels open the doors to a potential lifelong struggle with the consequences of this consumption.

The lack of a more critical discourse in both policy and teacher trainings may have left teachers feeling more responsibility, but lacking agency to deal with this responsibility. Teacher trainings would benefit from a change in approach, moving towards empowering teachers to be confident and comfortable with having a more elastic orientation to the

problems of their students, such that they feel able to deal with young people's understandable emotional responses and less obliged to initiate professionalised responses.

Greater exposure to mental health critiques would allow them to question many currently taken-for-granted assumptions about the nature of mental disorders, its boundaries and the outcomes achieved by the real-life services they feel are lacking. However, it must also be acknowledged that, given the dissemination of changing ideas about mental health from wider society, teachers are faced with a challenging scenario in which changes in wider cultural conceptions of mental disorder will likely affect how the growing numbers of people see themselves. This then puts pressure on teachers to do something more drastic, such as involving third parties. Thus, although recommendations for teachers' trainings can be made, tackling the problems of medicalisation will likely need to involve public education efforts that extend well beyond the realm of educational institutions.

Eventually, we hope that all medicalised language (such as psychiatric diagnosis, symptoms, dysfunction, dysregulation, disorder etc.) can be expunged from our mental health–related vocabularies. Until then, there should be no more funding or support for de-stigmatisation campaigns or school-based mental health initiatives that use such medicalised language and concepts.

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