School health education and promotion: current approaches and critical perspectives
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Background
This special issue of Health Education is first in the series of special issues planned under the framework of collaboration between Emerald and European Educational Research Association (EERA) www.eera-ecer.de/, part of which is Network 8, Research on Health Education. EERA consists of more than 30 member associations and is organised in topic-based research networks with members from all over the world, representing broad range of the interdisciplinary field of educational research. EERA’s annual conference ECER is attended by about 2,500 participants from across the globe.

The general objective of the network “Research on Health Education” is to provide an interdisciplinary forum to continuously explore and critically discuss dynamic relations between education and health, contribute to conceptual development as well as empirically based evidence for the schools for health approach across Europe, and play a part in enhancing the knowledge base within educational research in a broader sense (EERA Research on Health Education, 2011). The main overall research field includes education, learning and health and well-being promotion in schools. Health is considered as a multidimensional concept, including mental, emotional and social aspects, in addition to the physical dimension. Health is also viewed as a positive concept, encompassing well-being and quality of life, rather than solely absence of disease in bio-medical terms. These perspectives are embedded in a critical socio-ecological approach to health and well-being promotion and education, which looks not only at the health of individuals, but at the complex interplay of socio-economic, historical, political and other determinants of health and well-being.

Why critical perspectives on health and well-being education in schools?
School-based health and well-being education has long been a part of schooling. In many countries, health and well-being education is part of mandatory state/national curriculum architectures (e.g. Australia, Denmark, Finland, New Zealand). In other countries, health education finds itself vying for a place in official curriculum structures whilst being relegated to the status of non-statutory (Fitzpatrick and Tinning, 2014; Simovska and Mannix-McNamara, 2015; Leahy et al., 2016).

The health education curriculum also serves as an integral component of the “health promoting school” approach providing a platform for explicit teaching and learning about health, in addition to such broader features as policy frameworks, the whole-school environment and the collaboration between school and community (Fitzpatrick and Tinning, 2014; Simovska and Mannix-McNamara, 2015; Leahy et al., 2016).

While there is without doubt a significant amount of scholarship that has, over time, sought to examine health education and its role in enhancing children and young people’s health and education outcomes, the field has overwhelmingly been dominated by research that has emerged from public health and health promotion. Whilst a good deal is known about the impacts of different specific interventions and programs, there is little research that sheds light on the complexities and challenges of the everyday practices connecting health and education in schools. The lack of scholarship on the everyday of schooling means that there are significant gaps in what we know about the international, national and local formations of the health education curriculum and the mix of teaching, learning and assessment strategies that feature in health education classrooms. For example, who decides what do students learn about health and well-being in the everyday of schooling and what
broader effects does health work have on the school community? How are teachers prepared to tend to health education and how does this impact on how teachers negotiate multiple (public) health imperatives and education (curriculum) imperatives? What kinds of teaching and learning strategies emerge at the health/education interface? What are the intended and unintended effects of this work in schools? The aim of this special issue is to showcase research that engages with these kinds of questions.

In the call for papers, we placed a focus on research that adopts a “critical approach” to school health and well-being education and promotion. Critical health and well-being education in schools has emerged as a result of the “critical turn” which called into question the politics of health education via a focus on power relations and their effects (Gottesman, 2016). In seeking out papers that explicitly embrace a critical approach we intend to showcase how scholars engage with questions of politics, values, relations of power and inequality in their work. In other words, critical research on health and well-being education asks questions about the often taken for granted assumptions and practices such as curriculum imperatives, content and teaching strategies, and about the values and ideologies underpinning different research methodologies. We suggest that critical studies of health education have much to offer to the advancement of theory, policy and practice of health and well-being education and promotion in schools.

Overview of the papers
There are six papers in this special issue. The papers utilise different approaches to critical scholarship and provide insights into school health and well-being education across a range of countries including Ireland, New Zealand, Australia and Slovakia.

The first paper by Barry, Clarke and Dowling entitled “Promoting social and emotional wellbeing in schools” provides a critical perspective on the international evidence on promoting young people’s social and emotional well-being in schools. In the article, Barry and colleagues argue that the integration and sustainability of evidence-based social and emotional skills programmes within the context of whole-school systems is far from clearly established. In light of this, the authors discuss the value of applying a “common elements approach” to the development of school interventions. The paper presents findings from a pilot study that utilised a common elements approach in the development and implementation of an intervention. Initial results from the study highlight the potential of this approach in providing a set of core strategies that can be used in practice to address a range of behaviours of young people. However, the authors argue for more rigorous research to identify the best strategies for moving forward in integrating promotion of social and emotional well-being in schools.

The second paper also has a focus on social and emotional health and well-being in schools. In her article entitled “Towards dynamic and interdisciplinary frameworks for school-based mental health promotion,” O’Toole interrogates traditional individualistic, “expert-driven” conceptualisations of children and young people’s mental health and how such conceptions shape school-based intervention approaches. O’Toole argues that the field needs to engage with other perspectives, in particular insights from critical pedagogy and dynamic, emergent understandings of children and young people’s mental health which treat mental health as situated within socio-historical and cultural contexts, while aiming to confront the social injustices that impact children’s lives. In forging interdisciplinary critical connections and methodological synergies, O’Toole suggests that in this way we might be better able to harness strengths from the different philosophical and theoretical perspectives and develop fruitful innovative platforms for future critical work with promotion of mental health and well-being in schools.

The third paper, “Democratic school health education in a post-communist country” by Boberova, Paakkari, Ropovik and Liba, discusses the findings of an intervention programme
built on the concept of children’s health literacy, focusing particularly on its citizenship component. The intervention employed the “Investigation Vision Action Change (IVAC)” model for participatory, action-oriented teaching in which children are supported to investigate different health issues that affect them, create visions about desirable changes and act toward bringing about change. The paper gives an account of the political and social context in post-communist Slovakia where the majority of health education programs are behaviourally oriented, with little space afforded to children’s own perceptions and influence. The focus on student participation is therefore of crucial importance as it represents a significant move away from the taken for granted behaviour-regulation and from the teacher and curriculum-centred approaches that have so far characterised health education in Slovakia. The authors utilised a cluster randomized controlled trial design to study the impact of the IVAC model. The findings revealed that there were improvements in children’s well-being, their perception of school and in reduction of violent behaviour.

In the fourth article, “LGBTQ youth, activism, and school: challenging sexuality and gender norms,” McGlashan and Fitzpatrick examine lesbian, gay, bisexual, trans and queer youth activism in schools as a means to challenge existing gender and sexuality norms. Although the authors claim that previous research had found that schools are not inclusive spaces for LGBTQ young people, they are mindful to note that a continued focus on how LGBTQ young people are marginalised is itself a problem. In an attempt to counter the continual cycle of marginalisation, the authors adopted a “strengths-based approach” to examine the various activities of a group of LGBTQ young people attending a public high school in Auckland, New Zealand. The strengths-based approach offers a refreshing counter to the risk and deficit fuelled approaches that have characterised much of the literature on sexualities and schooling. By drawing on critical ethnographic approaches and poststructural theory, the authors explore how LGBTQ young people engage as leaders and participants in school health promotion efforts. The findings indicate that the hetero-norms within the school were challenged, however the work impacted on student visibility, which in turn created tensions as young people grappled with their identities and the public spaces of school.

Burrows’ conceptual paper “Children as change agents for family health” explores ways in which children and young people are being positioned as “change agents” for families through school health promotion initiatives in New Zealand. Burrows draws on poststructural theories to map policy discourses and initiatives that directly or indirectly regard children as conduits of healthy eating and exercise messages/practices for families. Burrows is interested in the politics of school health education and promotion and in what the different health education curriculum packages suggest in terms of how “healthy” families should live. Given the proliferation of family-focused health initiatives in New Zealand and elsewhere, Burrows suggests that critical perspectives may help in unpacking how children are expected to be engaged in these initiatives, a well-meaning effort with potentially harmful implications and outcomes.

The final paper in the special issue provides insights from health education teacher education in Australia. In their paper, “Working against ‘pedagogic work:’ challenges to engaging pre-service teachers in critical health education,” Fane and Schulz draw from Bourdieu’s concepts of “bodily hexis” and “implicit pedagogy” (how the personal combines with the social through the cultural imprints and bodily memory), to investigate the challenges of redressing the dominance of individualism that infuses pre-service teachers’ understanding of health. The authors discuss the findings from a study that involved analysing pre-service education students’ reflective writing based on student experiences of a course that sought to engage students in thinking about health in socially critical ways. The analysis of student reflections revealed however that this was not easy to sustain and that, while they attempted to engage with and demonstrate knowledge of a socially critical
view of health, contradictions or places where students unknowingly slipped into traditional risk-focused ways of thinking emerged frequently across the data. The article highlights some of the difficulties encountered by pre-service teachers and students when trying to engage with critical perspectives of health and schooling.

Endnote
This special issue portrays six different takes on critical health and well-being education in schools, highlighted through the discussions of a range of varied themes: social and emotional learning, mental health promotion, participatory pedagogies, LGBTQ student activism, positioning of children in family health and challenges of teacher professional development. With this portrayal, we hope to contribute to and advance the debate concerning the role, the position, the potentials and limitations of schools and schooling in the promotion of health and well-being, developing innovative approaches that aspire not only to improve students’ health status and related behaviours, but also to foster their critical competences and to engage with the contextual determinants of health and well-being.

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References
Promoting social and emotional well-being in schools

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Abstract
Purpose – The purpose of this paper is to provide a critical perspective on the international evidence on promoting young people’s social and emotional well-being in schools. The challenges of integrating evidence-based interventions within schools are discussed and the need for innovative approaches to research and practice are considered in order to support more sustainable approaches that can be embedded into the everyday practice of school systems.

Design/methodology/approach – A common elements approach to intervention development and implementation is explored. A case study is presented on piloting this approach with post-primary students, based on consultations with students and teachers concerning their needs in supporting youth social and emotional well-being.

Findings – The integration and sustainability of evidence-based social and emotional skills programmes within the context of whole school systems is far from clearly established. Research on the use of a common elements approach to evidence-based treatment and youth prevention programmes is presented and the application of this method to the development and implementation of social and emotional learning interventions is considered. Preliminary case study findings are presented exploring this approach in school-based intervention development for post-primary school students.

Research limitations/implications – The potential of adopting a common elements approach is considered; however, more rigorous research is needed to identify the most potent strategies for social and emotional skills development.

Originality/value – Identifying a common set of evidence-based strategies for enhancing adolescents’ social and emotional skills could lead to innovative approaches to intervention delivery that would extend the impact and reach of evidence-based practice across diverse educational systems and school settings.

Keywords Mental health, Schools, Learning, Young people, Children, Emotional well-being

Paper type Literature review

Introduction
Promoting the social and emotional well-being of young people is an important determinant of their positive development, enabling them to achieve positive outcomes in school, work and in life more generally (Durlak et al., 2015; OECD, 2015). A substantive body of research indicates that young people can learn to develop social and emotional competencies and that skill-based programmes in schools can positively impact on their social, emotional, academic and behavioural development (Durlak et al., 2011; Weare and Nind, 2011). However, the translation of evidence-based interventions into the everyday practice of schools presents significant challenges and is poorly developed in many countries. The majority of evidence-based programmes have not been adopted or scaled up at a country level. There has been an emphasis to date on the development and adoption of discrete single programmes rather than more comprehensive system-wide approaches. If the full potential of school-based interventions is to be realised then there is a need for greater attention to
how they are delivered, adopted and embedded within the diverse contexts of schools and educational systems across countries.

This paper provides a critical review of the current evidence on school-based interventions and considers what advances have been made in integrating social and emotional skills development within the school curriculum. The paper discusses how innovative research and practice paradigms could be used to support the development of more accessible and feasible approaches to social and emotional learning (SEL) in schools that can be integrated into system-level practices in a more sustainable manner. The common elements approach to SEL intervention development is explored and a case study is presented on piloting this approach with post-primary students in Ireland. This case study presents preliminary work on developing a revised version of the MindOut programme, a universal SEL programme for 15-18 year old post-primary students, incorporating a common elements approach combined with consultations with students and teachers. The revised programme is currently being evaluated at a national level and the case study outlines the process involved to date in developing this approach.

Background

The school is a unique setting within which young people’s social and emotional well-being can be promoted and critical skills for school, work and life can be taught and learned. A broad range of skills, including cognitive, social and emotional skills, are needed by young people to develop positively and be successful in life. Educational curricula are increasingly incorporating a more holistic focus on young people’s SEL alongside their cognitive development in the school curriculum (OECD, 2015). SEL is defined as the process of acquiring a set of skills or competencies to recognise and manage emotions, set and achieve positive goals, appreciate the perspectives of others, establish and maintain positive relationships, make responsible decisions and handle interpersonal situations constructively (Elias et al., 1997). The Collaborative for Academic, Social and Emotional Learning (CASEL) (2003) in the USA, which has pioneered the development of research and policy in this area, has described the goal of SEL programmes as being to foster the development of five interrelated sets of cognitive, affective and behavioural competencies; self-awareness, self-management, social awareness, relationship skills and responsible decision making. These core skills play a crucial role in empowering young people in realising their potential, maximising their participation in education, work and society and are key determinants of future mental health and well-being (Durlak et al., 2015; OECD, 2015; Viner et al., 2012).

Current evidence on promoting social and emotional skills in schools

There is a substantive body of international evidence that school-based interventions that promote SEL lead to long-term benefits for young people, including improved mental health, social functioning, academic performance and positive health behaviours (Clarke et al., 2015; Barry et al., 2013; Weare and Nind, 2011; Durlak et al., 2011; Payton et al., 2008; Adi et al., 2007; Jané-Llopis et al., 2005; Zins et al., 2004; Wells et al., 2003; Greenberg et al., 2001). The evidence also indicates that the development of social and emotional skills provides the skill base for the prevention of a wider range of problem behaviours such as substance misuse, anti-social behaviour and risky health and sexual behaviours (Weare and Nind, 2011; Institute of Medicine Report (IOM), 2009). A review of reviews examines evidence from systematic reviews, and meta-analyses only. Barry and Dowling (2015) conducted a rapid review of the evidence on social and emotional skills based intervention identified a total of two review of reviews which were relevant to this field. Synopsising the findings from these reviews of the international evidence, the following key findings are highlighted:

- School-based universal programmes have reported consistent positive effects on a range of social and emotional well-being outcomes for students including: targeted
social and emotional skills, self-confidence, attitudes towards self, others and school and enhanced positive social behaviours (Durlak et al., 2011; Weare and Nind, 2011; Adi et al., 2007; Sklad et al., 2012). Positive effects are also evident in reducing problem behaviours including the prevention of bullying, conflict, aggression and substance misuse, and reducing mental health problems such as anxiety and depression (Durlak et al., 2011; Weare and Nind, 2011; Adi et al., 2007; Sklad et al., 2012).

- Academic outcomes have also been reported with significant improvements in young people’s commitment to school and performance on standard academic achievement tests and grades, yielding an average gain in academic test scores of 11-17 percentile points (Durlak et al., 2011). The teacher’s role in programme delivery has been identified as being critical to achieving these educational outcomes (Durlak et al., 2011; Payton et al., 2008).

- Adopting a whole school approach, which embraces changes to the school environment as well as the curriculum, in keeping with a health promoting schools approach (WHO, 1998), is identified as being more effective in producing sustainable change (Weare and Nind, 2011; Adi et al., 2007). However, other reviewers suggest that some whole school approaches are failing to show impact (Durlak et al., 2011; Wilson and Lipsey, 2007) and attribute this to a lack of consistent and rigorous implementation, which is leading to diluted impact.

- With regard to equity impacts, while programmes have been successfully delivered to a diverse range of school children in varying contexts (Payton et al., 2008), including in low- and middle-income countries (Barry et al., 2013), the empirical findings on the differential impact of school-based programmes with regard to gender, ethnicity and socioeconomic status is inconclusive and no substantial clear results have been reported (Adi et al., 2007; Durlak et al., 2011; Weare and Nind, 2011).

- There is emerging evidence on the economic case for investing in school-based SEL programmes. Belfield et al. (2015) report an average return on investment for SEL programmes of $11 for every dollar invested, while McDaid and Park (2011) report a ratio of 25:1 for high-quality programmes that impact on young people’s mental health and well-being. Knapp et al. (2011) also report that school-based interventions are cost-saving for the public sector based on cost-benefits analyses in the UK, with savings accruing in relation to reduced crime and improved education and employment outcomes. Improved outcomes in relation to earning power as an adult have also been reported for children who received social and emotional skills programmes (Heckman, 2006).

For positive effects to be achieved, implementation quality and fidelity are identified as key factors in the effectiveness of SEL interventions, with effect sizes reported as being two to three times higher when school-based programmes are carefully implemented and free from serious implementation problems (Durlak and DuPre, 2008). However, few of the studies included in existing reviews provide detailed information on the quality of programme implementation or its impact on outcomes (Jones and Bouffard, 2012; Domitrovich et al., 2008). Using the findings from those studies that have measured and reported on implementation, Durlak et al. (2011) found that implementation quality was associated with significantly better student outcomes among teachers who effectively taught and integrated the programmes into their teaching practices. Durlak et al. (2011) also report that the most effective programmes were those that incorporated four elements represented by the acronym SAFE: sequenced activities that led in a coordinated, connected way to the development of skills; active forms of learning; focused on developing one or more skills; and explicit about targeting specific skills.

The other key characteristics of effective school-based interventions identified in the evidence reviews include: programmes with a strong theory base and well-designed goals...
using a coordinated and sequenced approach to achieving their objectives; an explicit focus on teaching skills that enhance social and emotional competencies; use of empowering approaches including interactive teaching methods, starting early with the youngest and continuing through the school grades.

Exploring the science-to-practice gap in implementing evidence-based approaches

While there is well-established and consistent evidence concerning the effectiveness of school-based SEL programmes from international studies, there is a science-to-practice gap in the translation of evidence-based interventions into mainstream educational practice. The adoption of evidence-based programmes as part of the core mission of schools presents significant challenges, especially in low-resource settings, as many interventions developed under well-resourced and highly controlled conditions are not easily implemented in settings where there is a lack of supportive structures and limited capacity (Jones and Bouffard, 2012). Schools may be presented with an array of different student issues and problems that need to be addressed such as bullying, substance misuse, anti-social behaviour, etc., making it difficult to make decisions concerning which interventions are likely to be most effective. In addition, there is often insufficient guidance and support provided for the effective implementation of interventions in school settings. Therefore, although these school-based programmes can achieve significant and sustained impacts on children and young people’s lives, the majority of these programmes have not been adopted or scaled up at a country level.

The most extensive evidence relates to studies on SEL programmes originating in the USA; however, the transferability and sustainability of these programmes across diverse social and cultural contexts is not rigorously evaluated in many cases. In the European region, for example, there is a paucity of interventions and empirical evidence developed for the European context (Sklad et al., 2012). Building solid knowledge about what works and under what conditions these interventions work is essential in terms of supporting effective local implementation. There is a need to determine how different cultural and social contexts influence programme adoption, implementation, impact and sustainability, especially across diverse educational systems, organisational frameworks and with diverse population groups. It is also important to determine whether universal evidence-based programmes can respond effectively to the needs of young people from different socioeconomic and cultural backgrounds, including disadvantaged minority and migrant youth at increased risk of poorer mental health, early school leaving and social exclusion. The increasingly complex social, cultural and economic climate in Europe presents growing challenges for young people, including increases in youth unemployment, migration, rising levels of mental health problems and youth suicide (European Union, 2015). Many EU countries have witnessed decreasing levels of youth mental well-being with levels of youth suicide for both young men and women aged 15-24 in Finland and Ireland being among the highest in the EU since the economic crisis (Thomson et al., 2014). Enhancing young people’s social and emotional skills development in school is a critical strategy in promoting their mental health and well-being, reducing risks, building resilience and supporting young people, especially those who are disadvantaged, in achieving positive outcomes in school, work and life (OECD, 2015). However, there is limited evidence available from existing studies to guide evidence-informed planning with regard to meeting the needs of different subgroups of young people. It is, therefore, critical to determine whether existing evidence-based interventions can reduce inequities with regard to social and emotional well-being and school achievement for diverse populations of young people, especially those who are at higher risk of poorer life outcomes.

Social and emotional skills development needs to be understood within the wider context of the social determinants of mental health and youth development (World Health Organization and Calouste Gulbenkian Foundation, 2014). Effective partnerships across the education, youth,
family and community sectors are critical to sustaining evidence-based programmes that can bring about enduring change to the lives of young people. The participation of young people and key stakeholders such as teachers and parents is critical in shaping the design and delivery of evidence-based interventions in order to ensure that the needs of end users are understood and met more effectively in the context of local capacities and resources.

Integrating SEL in schools

While the international evidence endorses the importance and the positive impact of developing young people’s social and emotional skills in schools, the integration of evidence-based interventions into the school curriculum, their optimal implementation within the context of a whole school system and their sustainability is far from clearly established. Among the challenges to integrating SEL programmes into routine school practices and systems is the competition for time and space in crowded school curricula. In practice, SEL programmes may not be perceived as important relative to more traditional academic subjects and, therefore, there may be a lack of dedicated time with limited support for their implementation and a failure to incorporate them into cross-curricular learning.

A school curriculum that integrates SEL skills within subject areas, with clear progression of learning objectives, delivered by trained teachers and with support for parents, is recommended in the literature (NICE, 2009; Weare and Nind, 2011). Jones and Bouffard (2012) outline guiding principles for developing a more integrated approach that includes: continuity over time and consistency, realisation that social and emotional and academic skills are interconnected and operate together, that social and emotional skills develop in the context of relationships and that classrooms and schools operate as systems. These principles underscore the importance of adequate training for teachers and the use of standards to guide schools in how to integrate academic and social and emotional skills as part of their everyday practice. For sustainable outcomes to be achieved, SEL programmes need to be embedded into the core mission of the school and integrated into educational practice and the wider school system.

A whole school approach provides a flexible framework within which to implement SEL programmes. Central to this is the implementation of a coordinated approach to bringing about change at the level of the individual, the classroom and the school in the context of the wider community. Initiatives such as MindMatters (Wyn et al., 2000) and KidsMatters (Dix et al., 2012) in Australia and SEAL in the UK (DfES, 2007) provide a whole school framework for the implementation of SEL in both primary and post-primary schools. Findings from evaluations of SEAL to date (Hallam, 2009; Banerjee et al., 2014) indicate that successful implementation is associated with commitment by school leadership, dedicated time for staff training, valuing of SEL principles by staff and allocation of sufficient preparation and delivery time.

Comprehensive evaluations of whole school approaches to SEL are quite rare as the majority of studies are based on highly structured classroom-based programmes. In addition, whole school approaches where changes are brought about at multiple levels are methodologically more complex to evaluate as they do not easily fit within traditional experimental study designs. A review of the health promoting schools literature by Samdal and Rowling (2013) suggests that effective whole school practices are supported by key implementation components including, school leadership and management practices, the school’s readiness for change, and the organisational and support context of the school. Attention to these broader contextual factors is critical to ensure effective integration of SEL within the wider school system.

Implementing interventions in the complex contexts of schools

A variety of contextual factors have been found to influence both the level and quality of implementation across school settings including: organisational capacity, management and
methods, leadership and teacher training and support (Greenberg et al., 2001; Bumbarger et al., 2010; Clarke et al., 2010). The implementation science literature emphasises the need to also consider how these influencing factors interact with each other, including characteristics of the intervention, the implementer, the programme recipients, the delivery and support systems and the setting or context in which the intervention is taking place (Chen, 1990; Greenhalgh et al., 2004; Fixsen et al., 2005). The successful implementation of whole school integrated approaches calls for greater attention to effecting change at a systems level through processes that focus on: context, including the role of the school's ecology in effecting change; content and clarity around what is to be delivered; and capacity, ensuring clarity on how it is to be implemented. This requires a shift in both current research and practice from a focus on discrete programmes to also consider whole school systems and how to strengthen the school’s capacity as a setting for SEL (Dooris and Barry, 2013).

**Effecting change at a systems level**

The sustainability of successful SEL interventions in schools is dependent on their integration into the core mission of the school and their adaptation and fit to the ecology of the school and community in which they are delivered. The development of organisational and system-level practices and policies that will ensure the sustainability of high-quality programmes and evidence-informed strategies within the context of whole school approaches is vital to realising the multiple long-term outcomes for positive youth development that these programmes can deliver.

At a policy and practice level, providing clear guidance and expectations for schools and teachers regarding the implementation of SEL programmes is critical for effective and consistent delivery. Professional development structures and capacity development for teachers at both pre-service and in-service training is required to support effective implementation. Support from the school organisation and management, including the school principal, is also critical and influences the overall readiness of the school to implement SEL programmes. Developing standards for the assessment of school practices and skills in the delivery of SEL will also raise its perceived importance in the school curriculum and assist in consolidating the interconnectedness of academic and SEL in the education and development of young people (Jones and Bouffard, 2012). Supportive policies, structures and practices are key to sustaining the quality of implementation necessary for positive youth outcomes to be achieved and for change to be sustained. Alongside the delivery of full programmes, further testing of specific evidence-informed strategies and implementation methods is required for integrating SEL into the daily practices of schools and the everyday contexts of young people’s lives.

**Need for innovative strategies and approaches**

Existing evidence reviews have usefully advanced the knowledge base concerning the type of SEL programmes that are effective in the school setting and lead to positive outcomes for young people. The majority of studies included in these reviews are based on randomised controlled trials of highly structured, manualised programmes and the findings tend to be presented on the basis of whether or not a particular whole programme is effective. However, as already outlined in this paper, there are several challenges to implementing and sustaining such comprehensive programmes in schools where time and resources for training and implementation may be very limited. This is especially the case in low-resource settings where challenging environments and a lack of resources limit the possibility of implementing programmes for young people who could benefit the most. As current evidence-based programmes tend to be designed to address specific health issues or problems (e.g. bullying, substance misuse, anxiety prevention, etc.), this can increase the
complexity of selecting which programmes to choose and the cost of providing training for teachers across multiple programmes.

To address these challenges, Jones and Bouffard (2012) call for the development of a continuum of approaches, ranging from full-scale programmes to specific evidence-informed strategies and practices, that could provide an integrated foundation for SEL development within the context of everyday school practices. This includes the use of less intensive approaches, such as routines for managing emotions and conflicts, that can be easily incorporated into everyday school practice, either independently or alongside a comprehensive curriculum, while still achieving meaningful outcomes for students. They describe this as moving from the use of specific packaged programmes or brands to the use of “essential ingredients” that can be integrated into school practices. An example of this approach in the area of prevention is the identification of “kernels” by Embry and Biglan (2008). Kernels are defined as “fundamental units” or activities of effective prevention programmes (e.g. use of praise, time out, self-monitoring, etc.) that have been shown empirically to effect behaviour change and can be used on a stand-alone basis as they are not tied to a specific programme. The development of these less intensive evidence-based practices places more emphasis on the need for quality assurance rather than strict whole programme fidelity, making them more attractive and feasible to implement for teachers in busy school settings.

Rotheram-Borus et al. (2012) call for the scaling up of user-friendly tools, products and practices that draw on what has been learned from evidence-based interventions. Framing this as a disruptive innovation, Rotheram-Borus et al. (2012) argue that this approach would result in a simpler version of strategies derived from structured approaches that would extend the impact of evidence-based interventions and create new modes of intervention delivery that could have a wider reach and impact at a lower cost. This innovation requires a shift in focus from seeking to determine whether or not a specific programme or intervention works to also consider what are the essential components of effective approaches and what insights can be gleaned about the mechanisms of change within and across programmes.

In the youth mental health treatment and prevention literature, research has sought to identify the component strategies that characterise evidence-based interventions and map what specific strategies are common among successful interventions (Chorpita and Daleiden, 2009; Boustani et al., 2015). This common elements framework has resulted in systematic efforts to identify the most potent evidence-based strategies from existing successful interventions, thereby facilitating the implementation of core elements of effective approaches that have been tested as being efficacious. In defining the common features of evidence-based interventions, core practices can then be selected to custom design and adapt intervention plans to suit local settings and specific population needs. This approach also facilitates the provision of training in a set of common practices, including how to select practices for different clients’ needs, which could be significantly less complex and less costly than providing training in multiple different and independent evidence-based approaches.

Research in evidence-based treatments for children’s mental health has examined the common components across treatment programmes tested in multiple RCTs and developed models for integrating them within existing service systems. Chorpita and Daleiden (2009) applied a Distillation and Matching Model (DMM) to systematically review and distill the common components across evidence-based programmes for common problems such as depression, anxiety and disruptive behaviours, and then match specific practices to specific client needs and characteristics. For example, among the common practice elements identified from intervention protocols for children with anxiety, are exposure, cognitive restructuring, psychoeducation, relaxation, modelling, parent psychoeducation and self-monitoring. The identification of these most common, and potentially most potent,
treatment components is then applied to develop a modular approach to treatment, whereby the content, sequencing and duration of specific treatment components are tailored to meet each child’s needs. Data from clinical trials reveal promising results with the modular approach to child mental health treatment outperforming both usual care and standard evidence-based treatment (Weisz et al., 2012; Chorpita et al., 2013). This approach provides an alternative paradigm for evidence-based practice by providing a common set of core strategies that can be applied across a number of domains and behaviours and their implementation can be tailored on a modular basis to match client needs thereby maximising efficiency in improving outcomes in everyday practice.

Boustani et al. (2015) applied codes from the DMM, as described above, to five categories of evidence-based youth prevention programmes – substance use, life skills, sexual health, depression and anxiety and violence prevention. The programme content was categorised into practice elements and instructional elements. Practice elements were described as a particular skill or set of skills that youth learn as part of the programme, e.g., problem-solving skills. Instructional elements were described as methods of information delivery used by the programme facilitator (e.g. modelling, role play, etc.). Across all programme categories, problem solving emerged as the most common practice element (present in 76 per cent of all programmes), followed by communication skills (45 per cent), assertiveness training (45 per cent) and insight building at 38 per cent (i.e. perspective taking, emotional exploration and self-awareness). Other practice elements included: cognitive coping, social skills training, coping skills, goal setting and support networking. Among the instructional elements, psychoeducation emerged as the most common (62 per cent), followed by modelling (31 per cent), and role play (21 per cent). It is interesting to note that for the life skills programmes, the most common elements were insight building and self-efficacy (57 per cent), while cognitive coping (75 per cent) was the most common element for depression and anxiety prevention programmes.

The findings from this study suggest that youth prevention programmes, despite their distinct goals, are comprised of overlapping practice elements and that a small number of core skills such as problem solving, insight building and communication skills, appear to have broad applicability across evidence-based prevention programmes. With regard to the instructional elements, the findings indicate that teaching methods that provide students with opportunities to model, discuss and practice skills will maximise reach and impact. Based on these findings, Boustani et al. (2015) concluded that identifying common practice elements for building a core set of skills that underpin common risk and protective behaviours factors for healthy development could facilitate the use of the most potent prevention strategies with the greatest potential for impact.

Adopting a common elements approach to SEL

It is useful to consider whether similar research on identifying the most essential components across effective SEL interventions could identify core skills that are appropriate for all youth and exhibit potential for greatest impact. Identifying a comprehensive set of core evidence-based strategies for enhancing adolescents’ social and emotional skills development could lead to innovative approaches to intervention delivery that would increase their applicability across a broad range of health behaviours and enhance their accessibility and integration into school practices, thereby reaching a wider population of young people in school.

The theoretical and empirical rationale for developing this common elements approach is that there is a clustering of common risk and protective factors that are shared across a broad range of youth mental health and behaviour problems (IOM, 2009). Similarly, as shown by the work of Boustani et al. (2015), there are a number of common elements that underlie evidence-based strategies used across different social and emotional interventions.
These common elements address a common set of core skills for positive social and emotional development, such as those identified by CASEL (2003). As risk behaviours among youth tend to co-occur, interventions which can address a broad range of skills deficits across domains are likely to have broadest relevance and greatest impact in empowering young people and equipping them with critical skills for life. Integrating these common elements into practice also supports the adoption of innovative approaches to delivery with more accessible and less expensive alternatives to packaged programmes.

Case study
This case study presents preliminary work on developing a common elements approach to SEL in Irish post-primary schools.

Background
The MindOut programme provides a structured resource for promoting the mental health and well-being of adolescents aged 15-18 years in post-primary schools in Ireland through strengthening their social and emotional skills and competencies for healthy development. The programme has been implemented in post-primary schools across the Republic of Ireland over the last ten years and is delivered in the context of the national health education curriculum Social Personal and Health Education (SPHE), which is a mandatory curriculum subject focusing on students’ development of generic skills for personal development, health and well-being within a supportive whole school environment (NCCA, 2011). Building on the original programme development and evaluation (Byrne et al., 2004, 2005), and working in collaboration with the Department of Education and Health Service Executive, the MindOut programme has been revised and updated to take into account current issues in the lives of young people and to align more closely with recent policy, practice and research developments. Based on consultations with young people, teachers and professionals with experience of the programme, the revised version seeks to address skills of relevance to young people, and adopts a common elements framework in developing a range of interactive instructional approaches, take-home activities and whole school resources for students and teachers (Dowling et al., 2016).

Developing the revised programme
Updating the MindOut programme involved reviewing the key components of programme content, teaching strategies, language, timing, whole school initiatives, etc., and making adjustments to ensure the programme reflected the needs of current users and key stakeholders. It was also important to ensure that the revised programme would reflect the more recent evidence concerning effective approaches and strategies and align with policy developments, including the guidelines on “Well-being in Post-Primary Schools” (Department of Education and Skills, Health Service Executive, Department of Health Interdepartmental Sub-Group, 2013). The original programme was labelled as a “mental health” programme and had a focus on coping with difficulties. In keeping with the well-being guidelines and current evidence, it was deemed necessary that the revised version would have a clearer focus on student’s well-being and the development of core social and emotional skills. The following section outlines the process which was undertaken in updating the MindOut programme.

Method
The development of the revised programme was informed by feedback and information collected from three principal sources:

1. A review of existing resources: drawing on the findings from syntheses of the evidence on school-based SEL programmes (Barry and Dowling, 2015; Clarke et al., 2015), details of the main evidence-based programmes developed for adolescents were extracted to
determine their core components. In view of the importance of a whole school approach, priority was given to interventions that clearly embraced this approach, e.g., MindMatters (Wyn et al., 2000), Gatehouse (Glover et al., 2005) and Positive Action (Allred, 1977). In addition, the existing SPHE and well-being frameworks and evidence-based programmes already in use in the educational system, such as the FRIENDS programme (Barrett et al., 2000), were also included in the review. Following an initial review of the content of the relevant programmes, the common practice elements that were most frequently used across the interventions were identified. Although a systematic coding process, such as that used by Boustani et al. (2015), was not employed, a number of common practice elements were identified. All the programmes examined included practice elements that focussed explicitly on: recognising and managing emotions (which corresponds quite closely to what Boustani et al., 2015 labelled as insight building), managing thoughts, positive thinking and coping skills. In addition, the following practices were also used by a majority of the programmes: identifying personal strengths, sources of social support, problem solving, decision making, communication skills and social skills. Also included, though less frequently, were empathy, managing conflict and help seeking. The most frequently used common instructional elements across the reviewed programmes included: collaborative learning such as group work, group discussion, reflection, use of games, scenarios and worksheets for structured activities, followed by role play.

(2) Consultation with a National Working Group: members included representatives from education, health promotion, educational psychology and mental health services, who were consulted throughout the development process. A number of key recommendations for programme improvement were made, which were grouped into five focussed areas:

- **Content** – align with existing resources and guidelines: include current and more relevant topics for the target group (i.e. social networking, cyberbullying, etc.); place a stronger focus on well-being rather than on “mental illness”.
- **Teaching strategies** – reflect the different stages of experiential learning (SPHE framework); use of class discussions and group/pair work, relevant multi-media resources (i.e. YouTube clips, Apps, websites, etc.); incorporate take-home activities.
- **Language** – reflect the language of well-being as used in current frameworks; ensure that the language used is accessible for young people with literacy difficulties or for whom English is not their first language.
- **Timing** – the programme should be delivered within one academic year, be comprised of roughly 12 sessions and each session should fit within the given class time slot (i.e. 35 minutes).
- **Whole school initiatives** – include a menu of options to practice skills at a whole school level; provide resources which students can access if they need additional support; include efforts to strengthen teachers’ professional development and integrate parents/home links more fully into the programme.

The Working Group had face-to-face meetings and also maintained close contact throughout the entire development process. Their work also involved reviewing and providing feedback on the newly updated materials.

(3) Consultation with young people: two approaches were used to ensure the voices of young people were included. Consultations were conducted with 55 students (aged 15-18 years, 62 per cent males) from three post-primary schools that had recently received the original MindOut programme, and a second consultation at a
later stage was held with a selected group of seven young people (15-18 years) who were engaged with a national youth organisation in the writing of a youth-focused website (http://spunout.ie). Further details of the consultation process may be found in McCrohan (2015). Overall, the programme was valued by young people as 65 per cent rated the programme very favourably and 70 per cent reported periodic use of the skills learned. A participatory workshop was employed to explore students’ views on important issues in their lives that needed to be reflected in the revised version, and specific recommendations for programme content, teaching activities, language and timing. Based on the recorded data, a thematic analysis identified the following key themes that were recommended for inclusion in the revised programme by the student participants:

- **content** – update scenarios and make the programme more relevant to young people in terms of the topics addressed, language and scenarios used;
- **teaching activities** – increase the range and diversity of teaching activities, i.e., more interactive approaches, including games, group work and videos;
- **programme delivery** – use of a comfortable environment, consider the time of day the programme is delivered; and
- **programme structure** – views varied regarding the length of the programme with the majority suggesting longer and more detailed modules, but male students tended to recommend shorter versions.

Students were also asked to suggest the main topics that should be covered, including the issues they found most relevant, and that were challenging or stressful in their daily lives. Their responses were analysed using thematic analysis and the following summarises the main themes identified across the issues explored:

- **friendships** – communication, romantic relationships and friendships and conflicts;
- **feelings** – dealing with anger, depression and being self-conscious;
- **bullying** – cyberbullying, discrimination and non-inclusion;
- **mental health** – symptom recognition, self-harm and eating disorders;
- **education** – sexual health, use of drugs and drink and getting a job;
- **school** – exams, how to study and school balance; and
- **peer pressure** – drugs/alcohol, image, relationships, social media and sports.

The second consultation was conducted with seven young people recruited through a national youth organisation and a participative workshop was again employed. Building on the themes identified by the school students, the participants were asked to identify real-life situations that young people of their age find challenging and to draft scenarios that could be referenced in the revised programme. This exercise sought to ensure that the issues and scenarios would be topical and relevant for the age group and expressed in appropriate language. In addition, a further online consultation was conducted with the same participants at a later stage to review the revised resources and provide feedback.

**Development process**

Drawing together the feedback from the three principal sources – review of evidence-based resources, consultations with young people and the Working Group – a revised structure for the new programme was drafted. The five core competencies for social and emotional skills
development as identified by Collaborative for Academic, Social and Emotional Learning were used as an overarching theoretical framework for the development of the revised programme and the common practice and instructional elements identified in the review process were mapped onto this framework. The feedback from the young people and the Working Group was then used to design and shape the content of the core practice and instructional elements and the inclusion of supporting materials.

A draft version of the programme was forwarded to the Working Group for their feedback. In addition, the young people from the youth organisation were given the revised materials and selected video clips and activities to review. Following feedback, a draft programme was printed and piloted in five post-primary schools to examine feasibility of its implementation in the context of the local schools. Teachers were consulted regarding their experience of implementing the revised programme in their school, and in one school, students \((n = 24)\) were also consulted regarding their perceptions of the acceptability of the revised programme. Based on this feedback, further adaptations were made.

**Updated programme elements**

The updated MindOut programme consists of 12 sessions with structured interactive activities and resource materials and aims to promote social and emotional skills and competencies for positive mental health and well-being. All of the sessions contain specific well-defined goals and a programme USB with supplementary resources including PowerPoint slides to assist classroom delivery, relevant video links and whole school resources for teachers’ use. Further details of the revised programme content can be found in Dowling et al. (2016). Table I summarises the programme content and the main SEL competencies that are addressed.

The revised programme balances input from evidence-based interventions with the reality of school contexts and the needs of students and teachers. The programme content is based on the core competencies of SEL and the common practice elements identified in the review of evidence-based resources. Interactive teaching strategies, including collaborative learning, structured games and scenarios are incorporated to engage students in exploring current issues in a more interactive manner together with the use of multi-media resources. The programme is closely aligned with the SPHE curriculum in order to promote its coordination and integration into the curriculum and school environment, thereby increasing the programme’s sustainability. A menu of whole school strategies are provided for use by school staff, including guidelines for cross-curricular and community-related supports and activities. Whole school strategies are also embedded in the programme through “practice-at-home” activities and a “Teacher Reflection” section encourages teachers to strengthen their own social and emotional skills.

The revised MindOut programme is currently undergoing a comprehensive national evaluation of its implementation in the context of disadvantaged post-primary schools. A cluster RCT will determine its impact on students’ social and emotional well-being, mental health and academic outcomes. A complementary version of the revised programme is also being developed for delivery in youth sector settings, including second chance educational provision for students who have dropped out of mainstream education. This version will also explore the development of a modular approach to programme delivery, whereby specific evidence-based strategies can be selected and prioritised for implementation to meet the needs of specific groups of young people.

**Conclusions**

Existing evidence-based school interventions can improve young people’s social and emotional well-being if they can be effectively adopted and integrated into school practices and sustained over time. The effective implementation and scaling up of evidence-based
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<tr>
<th>Session</th>
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<td>1. Minding your mental well-being</td>
<td>Self-awareness</td>
<td>To explore the topic of mental well-being and the importance of recognising personal strengths</td>
<td>7. Communication and managing conflict</td>
<td>Relationship management</td>
<td>To practise skills for communicating successfully with others and manage conflict effectively</td>
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<td>2. Dealing with your emotions</td>
<td>Self-awareness and self-management</td>
<td>To recognise and explore a range of emotions and learn how to manage these effectively</td>
<td>8. Managing online behaviours</td>
<td>Responsible decision making</td>
<td>To reflect upon unhelpful online behaviours and learn how to improve these</td>
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<td>3. Thoughts, feelings, actions</td>
<td>Self-management</td>
<td>To explore the connection between thoughts, feelings and actions and learn how to challenge unhelpful thoughts</td>
<td>9. Help seeking</td>
<td>Relationship management</td>
<td>To build help-seeking behaviours by identifying online and local support services</td>
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<td>4. Coping with challenges</td>
<td>Self-management</td>
<td>To identify a range of helpful coping strategies that can be used to deal with stressful situations</td>
<td>10. Problem solving and decision making</td>
<td>Responsible decision making</td>
<td>To explore a five-step approach for problem solving and responsible decision making</td>
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<td>5. Support from others</td>
<td>Social awareness</td>
<td>To increase awareness of supports and recognise the differences between helpful and unhelpful sources of support</td>
<td>11. Happiness and well-being</td>
<td>Self-awareness</td>
<td>To explore practical strategies for promoting happiness</td>
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<td>6. Walking in someone else’s shoes</td>
<td>Social awareness</td>
<td>To help students increase their awareness of the thoughts and feelings of others and to show compassion</td>
<td>12. Review</td>
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<td>To reflect upon the range of skills developed throughout the course of the programme</td>
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approaches to SEL presents many challenges in the school setting and requires a focus on both simplification and customisation to local contexts in order to develop intervention methods that are feasible and usable and can be embedded in everyday practices. A common elements framework was explored in this paper as an innovative approach to developing evidence-based strategies that are easy to implement and can be tailored to suit the needs of specific student groups and school contexts. The findings from research on children’s mental health treatment and youth prevention programmes indicates the potential of this approach in providing a set of core strategies that can be used in practice to address a range of youth behaviours.

The MindOut case study reports on preliminary work developing a common elements approach to SEL in the context of Irish post-primary schools. Drawing on the consultations with young people and teachers, and a review of the common practice elements in current evidence-based interventions, the revised programme employs interactive teaching strategies in addressing core SEL skills of relevance to young people in the context of the national health education curriculum. The current evaluation of MindOut is being undertaken in designated disadvantaged post-primary schools in order to determine its impact on students who are at higher risk of poorer mental health and well-being, early school leaving and unemployment. The differential impacts by gender and subgroups of young people will also be examined. In applying this approach to SEL interventions, existing work is very much at an exploratory stage and it is clear that further rigorous research is needed to identify the most potent strategies for the development of core skills, including the relative potential of individual components and their optimal combination for successful outcomes in the context of diverse school settings. Identification of the most potent practices from existing evidence-based interventions would facilitate the development of a more customised and modular approach to intervention delivery. This would allow for the tailoring of the content and sequencing of intervention components to meet the needs of specific student populations and school contexts, thereby ensuring greater usability and acceptability of evidence-based approaches.

Applying what we know works in improving young people’s SEL will close the science-to-practice gap in promoting the positive development of young people. Innovative approaches to research and practice are needed to support the integration and scaling up of effective evidence-based practices in the everyday context of schools, especially those in low-resource settings. Current SEL interventions need to be firmly embedded in educational policies and school practices to ensure that the determinants of positive youth development are addressed and that supportive school environments are created that will empower young people and enable them to grow and flourish.

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Towards dynamic and interdisciplinary frameworks for school-based mental health promotion

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Abstract
Purpose – The purpose of this paper is to scrutinise two ostensibly disparate approaches to school-based mental health promotion and offer a conceptual foundation for considering possible synergies between them.

Design/methodology/approach – The paper examines current conceptualisations of child and youth mental health and explores how these inform school-based prevention and intervention approaches. The dominance of discrete, “expert-driven” psychosocial programmes as well as the potential of critical pedagogy is explored using frameworks provided by contemporary dynamic systems theories. These theories call for a situated and holistic understanding of children’s development; and they look beyond static characteristics within individuals, to view well-being in relation to the dynamic social and historical contexts in which children develop.

Findings – Psychosocial interventions and critical pedagogies have strengths but also a number of limitations. Traditional psychosocial interventions teach important skill sets, but they take little account of children’s dynamic socio-cultural contexts, nor acknowledge the broader inequalities that are frequently a root cause of children’s distress. Critical pedagogies, in turn, are committed to social justice goals, but these goals can be elusive or seem unworkable in practice. By bringing these seemingly disparate approaches into conversation, it may be possible to harness their respective strengths, in ways that are faithful to the complex, emergent nature of children’s development, as well as committed to correcting inequalities.

Originality/value – The current paper is unique in bringing together contemporary psychological theory with critical pedagogy perspectives to explore the future of school-based mental health promotion.

Keywords Empowerment, Education, Multi-disciplinary, Dynamic, Children, School mental health

Paper type Conceptual paper

Introduction
Within the field of child and youth mental health, it is acknowledged that psychological well-being is related to the relationships, socio-cultural practices, ideologies and institutions that children experience in their daily lives (e.g. Merikangas et al., 2009). Despite this, most current conceptualisations of mental health, as well as approaches to prevention and treatment, continue to take an individualistic approach (Orford, 2008). Such conceptualisations emerge from psychological and health literature, grounded in a positivist paradigm, which assumes that there is an objective reality that can be observed, measured and understood outside of its social context. In contrast, critical educational theorists (Freire, 1970; hooks, 1994) place a critique of the structures and processes that maintain inequality at the centre of their analysis. From this perspective, any attempt to improve well-being necessarily involves critical awareness of oppressive conditions, as well as individual and collective actions to change those conditions. These educational theories are rooted in interpretivist and postmodern paradigms, which view phenomena as socially constructed and which challenge the idea of fixed realities and objective truths.

The seemingly incompatible nature of these approaches and their respective paradigms presents considerable challenges for research and practice in the area of school-based mental health promotion, most particularly because this is an area that straddles the
disciplinary fields of education, psychology and health. In recent years, there have been increasing calls for a closer alignment between mental health services and education (Fazel et al., 2014). There is, therefore, a pressing need to scrutinise current approaches in schools and to develop conceptual models that resonate with researchers and practitioners across the disciplinary boundaries.

Of course, it is not necessarily the case that all research traditions in psychology, health and education are aligned to these paradigms in strict "either/or" terms. For instance, most school-based interventions that are underpinned by positivist or neo-positivist traditions acknowledge the importance of children’s social context and recognise how issues such as poverty and inequality influence well-being. Nevertheless, these interventions are the products of the theoretical and philosophical assumptions that underpin them. Thus, it is one thing to acknowledge that individuals are influenced by their social context, it is quite another to recognise that people are constituted by, and are inseparable from, the relationships and interactions that unfold within their social, cultural and political worlds, as is recognised by interpretivists. Fundamentally then, the issues are created at the level of paradigm and must be explored there. This paper seeks to unpack core assumptions underpinning these two contrasting paradigms and to explore the tensions and controversies that emerge from them. In so doing, it argues for a shift away from simple, reductionist models of human functioning towards innovative and dynamic prevention and intervention approaches. It also emphasises the distinct contribution of education theory and practice, as well as the need for approaches that ensure the genuine participation of children and young people, and links to broader educational goals of inclusion, democracy and participation. Although primarily a conceptual paper, some suggestions on practical ways forward are presented towards the end of this paper.

**Conceptualising child and youth mental health**

Positive mental health and well-being is crucial to enable children and young people to lead fulfilling lives, personally and socially as well as academically. While most children report generally good levels of both physical and psychological health, it is widely acknowledged that mental health problems are common and are becoming an increasing concern. For example, Fazel et al. (2014) suggest prevalence rates of 8 to 18 per cent, with many more children experiencing varying degrees of psychological distress. The most common problems include anxiety and mood disorders, attention deficit and hyperactivity disorders, behaviour disorders and substance-use problems (Green et al., 2005; Harden et al., 2001).

Traditionally, the causes of both physical and mental ill health were reduced to biological factors (biomedical model). However, over the past few decades a biopsychosocial model has become influential (Engel, 1977). This model represents a way of understanding how suffering and illness are affected by multiple levels of organisation, from biological (e.g. genetics, neurophysiology) to psychological (e.g. mood, thoughts, personality, behaviour) and societal (e.g. cultural, familial, socioeconomic) (Borrell-Carrió et al., 2004). This model has been useful in drawing attention to the complex and multifaceted determinants of mental health difficulties and in galvanising a commitment to non-reductionist and integrative clinical practice (Benning, 2015).

However, the biopsychosocial model offers no safeguards against slipping back to reductionist biomedical thinking. Indeed, Cornish (2004) argues that the model has failed to challenge the dominance of the traditional biomedical approach and has not proposed theoretical relationships between biological, psychological and social levels. In the absence of satisfactory theorised relationships, understandings of children’s mental health and approaches to intervention tend to be individualistic and de-contextualised (Orford, 2008). Hence, despite the broad appeal of the biopsychosocial model, when identifying and diagnosing mental health difficulties, emphasis is firmly placed on individual attributes, which are interpreted as pathological regardless of whether they arise from
neurophysiological changes, intra-psychological stressors, troubled relationships or problematic structural inequalities such as poverty (Dewees and Lax, 2008). Likewise, when it comes to intervention there is a tendency towards individualised, short-term, discrete approaches that focus on symptom change rather than reworking problematic relationship patterns or confronting structural inequalities (Greenspan, 2008).

This approach is problematic because it assumes that the cause of children’s distress resides within children themselves and it places the burden for change on the individual child rather than broader social structures and relational networks.

One promising way forward is to place a central focus on relationships – those between individuals and between groups in a given ecological setting – rather than focusing solely on individuals. Dynamic systems approaches offer an interdisciplinary set of principles that emphasise relationships rather than individual elements, change processes rather than stable states, and emergent possibilities rather than one-way, cause and effect determinism (Overton, 2007; Overton and Learner, 2014). The core idea is that the characteristics and behaviour of entities (whether they be cells, human beings or social systems) depend on the nature of relationships between components rather than the properties of the components themselves (i.e. the whole is more than the sum of its parts). This central tenet gives rise to a number of other ideas (including emergence, non-linearity, hierarchies and boundaries) that together can be used to facilitate an understanding of children’s mental health that is embedded in the social relationships that exist in families, schools and communities, and influenced by the broader socio-historical and cultural context (Fogel and Kawai, 2008). From this perspective, stable patterns of behaviour are understood to emerge from, and be maintained or transformed by, the mutual relationships between constituents. Such an approach is more faithful to the complex and holistic development of individuals within their ecological contexts (Overton and Learner, 2014).

While dynamic systems approaches facilitate a more holistic understanding of children’s development and socio-emotional well-being, they can also be used to understand the functioning of complex organisations, such as schools. Dynamic systems perspectives both inform and cohere with a settings-based approach, which are currently garnering support in health promotion literature (Whitelaw et al., 2001; Dooris, 2009). Such approaches are of considerable relevance to health-promoting schools, which have their foundation in the Ottawa Charter for Health Promotion (WHO, 1986), and which emphasise the environment’s impact on health, thereby shifting from a sole focus on individual behaviours to the creation of supportive, whole-school environments (WHO, 1998; Simovska and Mannix-McNamara, 2015). A settings-based approach can support these goals since it represents a move away from a reductionist focus on single issues, risk factors and linear causality towards a holistic vision of health and well-being determined by a complex interaction of environmental, organisational and personal factors within the contexts and places in which people live their lives (Dooris, 2009).

On balance, however, a dynamic systems lens may not go quite far enough. Although it represents a fruitful interdisciplinary approach and has garnered support within education and other disciplines (e.g. Cofer, 2008; Evans, 2008), it does not offer a distinctly educational or pedagogical focus. Any meaningful attempt to discuss mental health in schools must draw on theoretical frameworks that speak to both fields (i.e. mental health and education). Furthermore, while Lerner et al. (2003) and Lerner and Overton (2008) assert that systems theories may be used to correct social injustice, these approaches have not been deployed in any wholesale way to challenge the structures and ideologies that are often a root cause of children’s mental ill health. Therefore, in considering school-based mental health, there is a need for theoretical frameworks that challenge social inequalities[1] as well as advance the role and distinctive contribution of education. This paper, therefore, draws on both dynamic systems perspectives and critical educational theories (e.g. Freire, 1970) to explore how...
schools can best respond to child and youth mental health difficulties. In so doing, this paper brings together two diverse bodies of literature. The aim is not to pitch one approach against the other, nor to collapse or attempt to reconcile the differences between them. Rather, the approach is to explore the challenges, confluences and possibilities that emerge from this juxtaposition, and whether it may support deeper understandings and more innovative responses to childhood mental health difficulties.

Schools – merely convenient sites for prevention and intervention?
Schools are widely acknowledged to be crucial settings for mental health promotion (WHO, 2001). Given the global drive towards compulsory education, schools are settings in which nearly all children and young people congregate for a large portion of their day and they therefore provide ready access to almost entire populations. Indeed, the “reach” of schools is increasingly recognised, especially given that only a minority of children with mental health problems access mental health services (Ford et al., 2008; Merikangas et al., 2009). School-based mental health interventions (e.g. mindfulness, social and emotional skill programmes, interventions based on the principles of cognitive behavioural therapy (CBT)) may be targeted specifically at children and young people who are considered to benefit most, such as those who have encountered significant adversity or risk. However, they may also be delivered as part of a universal preventative approach which offers the potential to enhance the lives of all children and not just those experiencing difficulties (Huppert, 2009). Universal and preventative approaches are appealing in terms of reducing stigma associated with accessing specialist services and on being cost-effectiveness (Kuyken et al., 2013). Indeed, economic arguments are gaining considerable attention given the substantial public sector costs associated with child and youth mental health difficulties, and particularly given that the bulk of these costs are borne by frontline education and special education services (Snell et al., 2013).

Given these arguments, it is unsurprising that there are strong calls for a closer alignment between health and education systems. Fazel et al. (2014) argue that mental health services routinely embedded within school systems can create a continuum of integrative care that improves both mental health and educational attainment for all children. However, it is noteworthy that within these arguments, the school is considered merely a convenient site for mental health prevention and intervention. Beyond a narrow focus on raising educational attainment (i.e. academic test results), there is no consideration of the role of education per se, hence, the transformative and enabling possibilities that education offers have been overlooked.

This contrasts with a health-promoting school framework, which tends to favour an educational approach that is interested in developing not only knowledge and understanding, but also real-life competencies that support young people in becoming active citizens who can make a difference through their actions (Simovska, 2012a). Nevertheless, even within health-promoting schools, mental health (as opposed to physical health) has received insufficient attention (Clarke and Barry, 2015). Educators seeking responsive solutions to children’s mental health difficulties have found a range of psychosocial intervention programmes, some of which are accompanied by helpful manuals and well-designed activities (see Table I for examples), but they have less guidance with regard to supporting children’s mental health through their ongoing educational or pedagogical practice.

Promoting well-being and positive mental health in schools: psychosocial interventions or critical pedagogy?
The following section considers the strengths and weakness of psychosocial interventions, which are currently dominating school-based mental health promotion, and critical
pedagogy in the spirit of Freire (1970, 1974). In doing so, it must be recognised that critical pedagogy is but one example of a distinctly educational approach that links to the promotion of well-being; educational theorists and practitioners could suggest numerous others (by drawing on areas like citizenship, voice and participation, service learning, ethics of care, etc.). However, psychosocial interventions and critical pedagogy are perhaps most clearly positioned as being at odds with each other, and therefore, there is much to be gained by bringing these two approaches into conversation. If researchers and theorists aligned to these viewpoints can enter into meaningful dialogue, then the path is paved for those offering a range of other approaches.

**Psychosocial interventions: the promise and perils**

Over the last two decades, there has been considerable growth in mental health research and interventions and there are currently thousands of school-based mental health interventions in operation around the world (Weare and Nind, 2011). In many jurisdictions there are strong calls for “evidence-based programmes” that are supported by rigorous research and evaluation (e.g. Langley et al., 2010). Among the most popular and widely researched school-based interventions are mindfulness-based programmes and the FRIENDS for Life programme, which are based on the principles of cognitive behaviour therapy (Barrett et al., 2000). Table I provides a brief illustrative overview of each of these approaches.

### Table I.

<table>
<thead>
<tr>
<th>Mindfulness</th>
<th>FRIENDS for Life</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Background</strong></td>
<td>“FRIENDS for Life” is a standardised emotional resilience programme based on cognitive behavioural therapy (CBT) principles, which aims to prevent and treat depression and anxiety in school age children (Barrett et al., 2000). It has been designed to be facilitated by classroom teachers as well as mental health professionals.</td>
</tr>
<tr>
<td><strong>Activities, skills and competencies</strong></td>
<td>FRIENDS for Life is delivered over ten sessions and has three main components based on CBT principles: first, learning/behaviour, which involves helping children to solve problems, use coping skills, identify positive role models and support networks; second, cognition, such as helping children to use positive self-talk, challenge negative self-talk; and third, physiology, which involves teaching children to be aware of their body clues and use relaxation techniques.</td>
</tr>
<tr>
<td><strong>Research evidence</strong></td>
<td>Studies have found reductions in anxiety for up to four years after completing the programme, which has led the World Health Organisation to cite “FRIENDS for Life” as the only evidence-based programme effective at all levels of intervention for anxiety in children (World Health Organization Report on Prevention of Mental Disorders, 2004).</td>
</tr>
</tbody>
</table>

Mindfulness is a contemplative practice derived from Eastern Buddhist traditions, which involves the cultivation of awareness and non-judgmental acceptance of one’s moment-to-moment experience (Kabat-Zinn, 1990). When mindfulness is practiced regularly, thoughts and emotions come to be observed and noted as mental events that arise and pass away, rather than as aspects of the self or as important truths that must dictate behaviour (Baer, 2003).

Mindfulness activities for children are generally light-hearted, with a focus on fun and with less emphasis on long periods of silence. They are typically grounded in concrete experience, with less time spent on enquiry (the unpacking of experiences) (Weare, 2013). Concrete activities such as “rocking a stuffed animal to sleep while breathing” (Kaiser Greenland, 2010) or “sitting still like a frog” (Snel, 2013) help children to be still, relax and notice what is going on in mind and body.

Studies show that school-based mindfulness can be successful in both the prevention and treatment for childhood mental health difficulties, with reductions noted on measures of anxiety, stress and depression. Mindfulness has also been found to enhance cognitive functioning particularly in the area of attention regulation (see O’Toole et al., 2017 for an overview of relevant research).

**FRIENDS for Life** is a standardised emotional resilience programme based on cognitive behavioural therapy (CBT) principles, which aims to prevent and treat depression and anxiety in school age children (Barrett et al., 2000). It has been designed to be facilitated by classroom teachers as well as mental health professionals.
Research into the effectiveness of school-based interventions is burgeoning. While much of this work has focused on the effectiveness of discrete interventions, there is now a growing interest in developing a broader understanding of the characteristics of successful school-based mental health initiatives (Macnab et al., 2014; Rowling, 2009; Stewart-Brown, 2006; Weare and Nind, 2011; Wells et al., 2003). For instance, Weare and Nind (2011) reviewed 52 existing reviews and found that, in general, school-based mental health interventions had small-to-moderate, short-term positive effects on a range of mental health, social, emotional and educational outcomes. There was general consensus across reviews that the teaching of skills and competencies (such as those highlighted in Table I) is a central part of any comprehensive and effective intervention. Furthermore, successful programmes tend to have explicit, specific, well-defined goals, and are underpinned by coherent, well-established principles and a sound theoretical base (Browne et al., 2004; Weare and Nind, 2011).

Another key determinant of the success appears to be effective implementation (Barry and Jenkins, 2007; Rowling and Samdal, 2011). Many studies show that complete and accurate implementation leads to more positive outcomes, suggesting that fidelity to programmes is important. On the other hand, it is also acknowledged that the involvement of teachers and children in programme content or delivery may be crucial for ensuring that initiatives address the needs of the local school community and are sustainable in the long term (Weare and Nind, 2011). This latter focus on end-user involvement, which draws on values of participation and democracy, is reflective of the ethos encapsulated by health-promoting schools. These schools emphasise the importance of bottom-up actions that are initiated by schools themselves, which suggest a place for flexible and less prescriptive programmes. Nevertheless, fidelity to prescribed programmes continues to emerge as an important theme in the literature, hence there is increasing interest in harnessing insights from implementation science to explore the transfer and sustainability of evidence-based programmes in complex real-world settings (Durlak and DuPre, 2008; Fixsen et al., 2005; Greenhalgh et al., 2004).

It is clear that the types of evidence-based psychosocial interventions, currently endorsed across primary and second-level schools, have a valuable role in promoting positive mental health. They tend to offer a range of interesting, well-designed activities and are often associated with noticeable improvements in children’s coping skills, at least in the short-term. For schools seeking to respond to children’s distress, these discrete programmes offer considerable promise and garner widespread support. However, psychosocial interventions have a number of limitations that also warrant explication.

*Undermining the centrality of relationships?*

Current models of psychosocial interventions tend to privilege the acquisition of various skills/competencies and place considerable focus on the technicalities of programme delivery and implementation. In so doing, there is a risk that they displace the centrality of the ordinary, everyday interactions that children experience with teachers and peers. Research from dynamic systems perspectives highlights the fact that approaches to improving children’s well-being cannot be separated from the relationships systems within which children develop (Granic, 2008). In fact, the most important aspect of any programme may not be the skills and competencies *per se*, but the ways in which teachers and children who are involved in the programme, mutually and simultaneously engage with programme content, and in turn, adjust in their relationships to each other over time. Change is not the result of teaching content in a step-by-step, pre-planned sequence, rather it emerges based on shared convergence or divergence between people and may happen “in the moment” when people are fully engaged with each other (Fogel et al., 2008). Given the continued emphasis on discrete interventions and skill sets, it is unsurprising that there is currently little evidence for long-term sustainable effects, at least in the absence of “booster sessions” which aim to “top up” an intervention by regularly revisiting the learning at later points in time (Weare and Nind, 2011).
The focus on skills/competencies and programme implementation has necessitated specific training courses for teachers to equip them to deliver programmes with fidelity. Such training is not problematic in and of itself, but there is a danger that it gives way to the idea that only those teachers who have undertaken the relevant training have the competence to respond to children with mental health difficulties. The “expert knowledge” gained on such courses tends to be valued to a greater degree than teachers’ own experiential knowledge and professional judgement. Ultimately, this may be disempowering, especially if it undermines teachers’ own capacity to respond to children’s distress with humanity and compassion. Indeed, Hammersley (2004) cautions that while it is assumed that evidence-based practice enhances professionalism, its devaluing of experience and professional judgement may in fact lead to a weakening of professional practice. Hence, there is a need to reassert the centrality of relationships, recognising that the most effective teachers are those who can adjust dynamically and creatively to specific circumstances, while still using their skill sets and accrued wisdom (Fogel et al., 2008). Psychosocial programmes need to acknowledge the experiential knowledge and professional judgement of teachers and find ways to promote ethical, in-the-moment responses to the needs of children within their particular ecological contexts.

Individualistic and de-contextualised?

It has been widely recognised that school-based mental health interventions are more successful when programmes are embedded within a whole-school approach, rather than implemented as a curriculum “add-on”. Clarke and Barry (2015) argue that a focus on discrete programmes is not enough and that for optimal impact, skill work needs to be embedded within a whole-school, multi-modal approach. However, most of the studies within the field continue to focus on classroom-based or topic-based programmes and neglect the more wide-reaching features of the health-promoting school approach (Simovska, 2012b). Indeed, in their review of primary prevention programs, Durlak and Wells (1997) found that 85 per cent of the 177 interventions for children and adolescents targeted individuals rather than their environment.

As illustrated in Table I, school-based mental health programmes target children’s individual thoughts, emotions and physiological states. Thus, as part of mindfulness and CBT-type activities, children are supported to notice and interrupt negative thought patterns, recognise physiological signs of anxiety and learn how to relax the body. As such, these programmes teach children how to adapt to and cope with the stressors they experience. Yet many of these “stressors” are rooted in social inequalities and emerge as a result of children’s relatively marginalised position in society (Greene, 2015). Children’s distress occurs in relation to social and cultural institutions and therefore solutions cannot be located solely within individuals. Indeed, by suggesting that the solution to children’s distress lies in altering children’s own thoughts and emotions, intervention programmes are in danger of reinforcing a form of rugged individualism – the idea that individuals can change their circumstances by sheer dint of personal effort. As such, they maintain the status quo by placing the burden for change on children, thereby letting political and social institutions off the hook. This prompts the need for a critical approach, which foregrounds social justice and illuminates a distinctly educational vision for change.

Advancing positive mental health through education: the role of critical pedagogies

Since the pioneering work of Paulo Freire (1970, 1974, 1994) in Brazil, it has been acknowledged that individual and collective well-being can be enhanced through educational practices that are grounded in bottom-up processes of empowerment, democracy and participation. Freire and other critical social theorists have been instrumental in drawing attention to structures and processes that maintain dominant and oppressive traditions (Freire, 1974; hooks, 1994; Moane, 2011). Such theorists are acutely aware that mental health difficulties are more likely amongst oppressed and marginalised groups; hence, critical awareness of
Oppressive conditions is central in any attempts to improve well-being. Prescriptive solutions by detached experts are not the answer, precisely because experts often form part of the dominant, powerful and oppressive culture. Marginalised groups must apprehend reality in their own way and must themselves become agents in a process that Freire calls “consientization”. These perspectives and approaches are typically set in opposition to those that underpin psychosocial intervention, as outlined in Table II.

Although Freire worked predominantly with adults, there is considerable interest in adopting Freirian principles in primary and second-level school curricula. Freire (1970) suggested a “problem-posing” model whereby participants engage in dialogue around themes, work together to connect the issues to their own lives and take individual or collective actions to improve their situations. Such work is always related to the specificity of particular school communities, including the available resources, the histories that students and teachers bring with them to the classroom, and the diverse experiences and identities they inhabit (Giroux, 2011).

### Table II. Comparison of psychosocial interventions and critical pedagogy in school-based mental health promotion

<table>
<thead>
<tr>
<th>Psychosocial interventions</th>
<th>Critical pedagogy</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Aim</strong></td>
<td>Support people to apprehend their own situations and empower them to take action to enhance their own well-being and that of others</td>
</tr>
<tr>
<td>Reduce psychological distress; strengthen well-being, coping and resilience</td>
<td>Collective: emphasis on self and others, with commitment to citizenship and democracy</td>
</tr>
<tr>
<td><strong>Key features</strong></td>
<td>Particular: involves a situated understandings of the challenges encountered by individuals/groups and tailored responses to their unique needs</td>
</tr>
<tr>
<td>Individualistic: emphasis is on the self; one’s own thoughts and emotions</td>
<td>Bottom-up: actions are participatory; designed and initiated by those intended to benefit</td>
</tr>
<tr>
<td>Universal: principles assumed to be transferrable across time and place</td>
<td></td>
</tr>
<tr>
<td>Top-down: interventions are developed by “experts” and delivered to end-users in standardised formats</td>
<td></td>
</tr>
<tr>
<td><strong>Values</strong></td>
<td>Explicit values of social justice, equality, participation and inclusion</td>
</tr>
<tr>
<td>Assumed to be objective, value neutral</td>
<td></td>
</tr>
<tr>
<td><strong>Why schools?</strong></td>
<td>Schools are fundamentally about education, which has the potential to transform the lives of individuals and groups</td>
</tr>
<tr>
<td>Schools are convenient sites for reaching all children as well as specific target groups</td>
<td></td>
</tr>
<tr>
<td><strong>Role of teacher/educator</strong></td>
<td>Equal partner in a negotiated curriculum and a “power sharing” classroom</td>
</tr>
<tr>
<td>Implementer of prescribed (often manualised) programme</td>
<td>Processes and mechanisms underpinning empowerment practices tend to be vague and elusive</td>
</tr>
<tr>
<td><strong>State of research and support</strong></td>
<td>Strong theoretical rationale but a dearth of empirical research</td>
</tr>
<tr>
<td>Processes and mechanisms underpinning the effectiveness of interventions tend to be clearly specified</td>
<td>Lack of robust research coupled with broad, idealistic goals and unspecified/open-ended outcomes makes approach seem unworkable</td>
</tr>
<tr>
<td>Supported by theory and rigorous research and evaluation</td>
<td></td>
</tr>
<tr>
<td>Strength of evidence on key outcome measures means that these approaches are attractive to policy makers and stakeholders</td>
<td></td>
</tr>
<tr>
<td><strong>Worldview/epistemology</strong></td>
<td>Interpretivist/transformative paradigm, which views phenomena as socially constructed and challenges the idea of fixed realities and objective truths</td>
</tr>
<tr>
<td>Positivist/neo-positivist paradigm, which assumes that there is an objective reality that can be observed, measured and understood outside of its social context</td>
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</tbody>
</table>
Broadly consistent with this approach are current conceptualisations of critical health literacy. While health literacy has been defined in different ways, most definitions focus on people’s ability to become empowered to take care of their own health and the health of others (Chinn, 2011; Nutbeam, 1998, 2000, 2008; Paakkari, 2015; St Leger, 2001). There is an important distinction between functional health literacy, which is about providing basic information necessary for health choices, and critical health literacy, which brings about a capacity to change living conditions so as to contribute to better health for oneself and for others (Paakkari, 2015). The former involves the transmission of knowledge about health from teachers to students, which is akin to the “banking” model of education whereby knowledge is deposited in pupils’ heads, much like money into a bank (Freire, 1970). The latter involves consideration of the social, economic, educational and cultural determinants of health, and promotes social justice by prompting the taking of individual or collective actions that change those determinants (Chinn, 2011; Nutbeam, 1998).

Paakkari and Paakkari (2012) make an important contribution in conceptualising the health literacy concept in educational contexts, and advocating for the inclusion of critical health literacy as a learning outcome. They propose that health literacy is composed of five distinct components: theoretical knowledge, practical knowledge, critical thinking, self-awareness and citizenship; and they provide practical illustrations of what critical health literacy might “look like” in classroom contexts. Their approach is one that seeks to educate pupils to be critical and active citizens who will be able to seek, evaluate and construct knowledge, use this knowledge to make ethically informed decisions, as well as take actions that benefit not just themselves, but also other people and the broader community (Paakkari and Paakkari, 2012). Along similar lines, Matthews (2014) discusses how Freire’s ideas can be combined with pedagogical techniques and she makes a case for an explicitly Freirian critical pedagogy in health education. These authors offer valuable insights and much needed suggestions regarding how a critical pedagogy for health education might be realised in classroom contexts. However, considerable challenges remain.

Challenges for critical pedagogy approaches
The literature on critical health literacy in health education tends to focus on physical health. There is much less work that is specific to mental health literacy, and what is available tends to focus on basic functional literacy aimed at improving recognition of mental health conditions and prompting help-seeking behaviour (Wei et al., 2015). While the domains of physical and mental health overlap, the neglect of mental health is a significant gap, not least because the issues tend to be particularly sensitive and are often difficult to broach. Without adequate theorising, empirical research and practical guidance, teachers seeking responsive solutions for children with psychological problems have little recourse except to discrete psychosocial interventions.

Critical pedagogies require a major shift in current thinking, especially in relation to how schools are organised, how curricula are designed/negotiated and to widespread practices that cast students and teachers in “us/them” relationships. Critical pedagogies emphasise the need for a social critique of power to enable understandings of the structural and ideological forces that impact well-being and give rise to mental health disparities. Karavoltsou (2015) argues that in order for children and young people to understand the social and political structures that constitute their lives, they must begin with those structures that they have direct experience of. This means that:

[…] teachers must enable children to identify and understand the power that they, the teachers, have over them; the strategies and tactics by which this power is exercised and paradoxically the strategies and tactics by which they could be empowered to take over their own learning (p. 171).
School support for such a proposal may be quite far off. Theorists like Freire (1970) and Foucault (1977) have persuasively discussed how schools can be oppressive environments for children and young people and indeed, studies show that many schools continue to be characterised by huge power differentials, autocratic structures and a lack of democratic participation (Horgan et al., 2015; Leitch and Mitchell, 2007; Lundy, 2007).

Even when schools work towards creating safe, inclusive and democratic spaces for learning, there is a danger that power differentials remain. Such differentials include not just those between teachers and students, but also amongst students themselves. Indeed, it is recognised that children and young people’s relationships are often characterised by status hierarchies (Rodkin and Hodges, 2003), and thus, there remains the potential for the voices and agendas of more dominant members to prevail. The pursuit of one topic or agenda over others, particularly in a learning environment that is ostensibly democratic and inclusive, may serve to perpetuate unequal relationships and reinforce the marginalisation of those whose experiences are not reflected in the topics chosen for discussion (Ellsworth, 1989).

Furthermore, it must be recognised that in drawing attention to power relations and injustices, critical pedagogy has the potential to open up a range of unsettling or even distressing emotions such as anger, hopelessness, despair and guilt (Berila, 2016). Inequalities impact young people’s lives in multifaceted and complex ways and they are not often within the power of individuals to change in any substantive way. Thus, it is possible that raising awareness of such issues without concomitant attention to enhancing concrete coping skills could in fact lead to a decline in well-being. Hence, despite its broad and noble goals, none of what is imagined in critical pedagogy is straightforward in practice. The concepts underpinning critical pedagogy (empowerment, student involvement, democracy) are contested and open to multiple interpretations (Laverack and Wallerstein, 2001; Mohajer and Earnest, 2009). Very little attention is paid to unpacking the conceptual makeup of these skills or to how they may be linked to improvements in health and well-being (Chinn, 2011). This is an issue, particularly when it comes to younger children because although there is a large literature on youth empowerment, the process of empowerment in younger children has been neglected; perhaps because it is assumed that children do not need, or ought not possess power or control (Prilleltensky et al., 2001).

Moving towards innovative and interdisciplinary school-based approaches

Both critical pedagogies and psychosocial interventions have considerable strengths, but also a number of weaknesses. Their differing worldviews are set in trenchant opposition, which presents sizable problems for researchers and practitioners in the field of school-based mental health, especially those interested in harnessing the disciplinary strengths from across health, psychology and education (O’Toole, 2016). However, there is scope for genuine dialogue and synergies across these perspectives. Indeed, Overton (2007) presents a meta-theoretical framework for dynamic systems theorists which challenges the polarised worldviews and Cartesian splits inherent in much contemporary theorising. Furthermore, the philosophy of critical realism (Bhaskar, 1978, 1986, 1989) provides a coherent framework that transcends epistemological divides and offers a range of new possibilities. Essentially, Bhaskar’s critical realism represents a two-fold critique of established worldviews (positivism and interpretivism). Rather than posit a great divide between the natural and social sciences as is common, Bhaskar argues instead for the stratification of nature, in which lower order mechanisms can explain, but cannot replace higher levels of explanation. Neural and physiological mechanisms may help explain a child’s anxiety, but they cannot replace, and are no more adequate than, explanations that draw on social or cultural mechanisms (thus critical realism is an emergent, non-reductionist philosophy). Furthermore, Bhaskar expounds the role of social sciences in human emancipation and societal transformation. Through sound empirical and theoretical enquiry, social sciences can critique commonly held explanations.
and offer truer or better accounts, particularly accounts that expose the power and interest, which may be implicit in commonly held explanations. Thus, critical realism represents a defence of the critical and emancipatory potential of rational enquiry against both positivist and postmodern challenges (Collier, 1994) and offers a dialectical synthesis that might support interdisciplinary work around school-based mental health promotion.

In practical terms then, it may be fruitful to consider harnessing the strengths of approaches that at face value seem diametrically opposed. It should be possible to draw and build on the strengths of psychosocial interventions, but in ways that are more egalitarian and more committed to the promotion of social justice and development of solidarity. Such ideas are not new and have been drawn on in therapeutic contexts, particularly by feminist therapists (Ballou and Gabalac, 1985). Critical pedagogues are similarly recognising the importance of individual competencies to enable students to process and cope with the difficult emotions that may arise as part of meaningful critical dialogue. Mindfulness, for instance, has been advocated to support genuine dialogue in anti-oppression pedagogy in higher education (Berila, 2016). There is much in these areas of research and practice that could usefully be applied in school-based contexts.

A more concrete example might be found in programmes like Free Being Me (2017). Free Being Me is a cognitive-dissonance-based body-acceptance programme (supported by the World Association of Girl Guides and Girl Scouts and derived from a larger Body Project; Stice and Presnell, 2007). It is designed to help girls notice and resist socio-cultural pressures to conform to narrow and unrealistic norms of feminine beauty. Girls are also supported to take self/group-initiated actions within their communities to spread their message and support others in resisting social pressures. This type of programme serves as a useful model because it focuses not just on the thoughts and emotions that go on inside the heads of individuals, it also recognises the importance of forging alliances and connecting with broader civic society. Thus, in moving forward, there is a need for less blinkered approaches to school-based mental health promotion; approaches that enhance individual skill sets, but also open young people’s eyes to the power structures (e.g. advertising and entertainment industries) that have a vested interest in the maintenance of particular beliefs and attitudes. Such programmes may give young people a better insight into their inner thoughts and emotions, as well as allow them to become more aware of, and more connected to, their broader social and cultural worlds. In building solidarity, this type of initiative might support young people to resist harmful media messages and collectively create positive change for themselves and others. It could be argued that given the range of interdisciplinary expertise in health education, the field is ideally placed to craft these types of school-based initiatives.

The field of school-based mental health also requires further conceptual analyses as well as empirical research using a range of different qualitative and quantitative methodologies. As noted by Davis (2004), the types of questions asked in education and related fields require a breadth and depth of knowledge that goes beyond any particular research methodology. Further work on critical pedagogies in school and classroom contexts is necessary in order to identify and unpack the processes underpinning these approaches as well as examine their symbiotic relationship with health and well-being. While there is a large volume of research on school-based interventions, most of this involves measuring the linear impact of discrete programmes on individual students (Clarke and Barry, 2015). Participatory and rights-based methods are needed in this field to ensure that interventions are initiated by or responsive to the children intended to benefit and to explore children’s subjective experience of them (O’Connor, 2016). There is also a need for evaluation methods that capture the dynamic interplay between individuals and groups as well as the impacts of multiple interdependent initiatives, which might include both critical pedagogies and psychosocial interventions. Case studies and theory-based evaluation methods, including
realist evaluation (Pawson and Tilley, 1997), which emphasises the importance of processes and context, may be useful to this task.

Furthermore, although systematic reviews and research syntheses have been criticised for their positivist orientation and apparent “empty empiricism”, these approaches can provide a firmer foundation for primary empirical studies, challenge existing theories and provide a tool for sharpening conceptual categories in particular fields (Andrews, 2004). Systematic reviews can also take an explicit equality lens to investigate the impact of particular types of interventions on mental health inequalities (Kavanagh et al., 2009, see also O’Toole et al., 2017).

In conclusion, this paper has argued for a dynamic, emergent understanding of children’s mental health that is situated within children’s socio-historical and cultural contexts, and demonstrates a commitment to confronting the social injustices that impact children’s lives. It remains to be seen whether dynamic systems perspectives can be meaningfully integrated with critical pedagogies, and whether the confluence of these two approaches might offer fruitful avenues for research and practice. However, some authors are already suggesting valuable possibilities (Cofer, 2008; Evans, 2008; Haggis, 2008; Stirling and McGloin, 2015). Indeed, it is the central theme of this paper that a philosophical and theoretical convergence, together with an openness to learning from each other, has much to offer for the future of school-based mental health. As encapsulated in the Irish proverb: Ní neart go cur le chéile: there is no strength without unity.

Note

1. This paper recognises that in advocating for theories that challenge social inequalities, it is making a value statement which may sit uneasily with many in health and psychological sciences, since there is a longstanding tradition of viewing facts (which can be uncovered by science or reason) and values (judgements about what ought to be) as entirely separate. However, in recent decades, support for a fact/value distinction has begun to collapse, in part because it has been recognised, both in the natural and social sciences, that areas chosen for investigation can be determined by contentious ideological interests. Also, if researchers succeed in uncovering truer or better accounts of the causes of human distress, then there is no great leap involved in moving to criticise those causes. See Bhaskar (1986) and Putnam (2002) for a discussion of the issues.

References


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Democratic school health education in a post-communist country

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Abstract

Purpose – The purpose of this paper is to discuss the findings of an intervention program built on the concept of children’s health literacy, particularly on its citizenship component. This intervention program employed the Investigation-Vision-Action-Change model for action-oriented teaching, where children were supported to investigate different health issues that affect them, create visions about desirable changes, and act toward desirable change. The intervention was implemented in the conditions of a post-communist country (Slovakia) where the majority of health education programs are behaviorally oriented, without giving space to children’s own perceptions and decisions. The study seeks to explore whether fostering children’s participation in forming the school environment improves the three selected factors of school well-being, namely, children’s perception of school, their subjective well-being, and violent behavior in school.

Design/methodology/approach – A cluster-randomized controlled trial design was used where ten classes of children aged nine to ten years were randomly assigned to either experimental (n=89) or control group (n=96). The dependent variables were pre- and post-tested using measures drawn from the Health Behavior in School-aged Children study for Slovakia.

Findings – The intervention program was shown to yield empirically robust effects, given the significant improvement in children’s perceptions about school, violent behavior, and their well-being, with medium-to-large effect sizes (Hedges’s g ranging from 0.74 to 0.96).

Originality/value – The present study offers an effective approach to enhance the respect for the children’s views on issues that affect them, particularly within post-communist conditions.

Keywords Health education, Schools, Citizenship, Health literacy, Investigation Vision Action Change, Well-being, Violence

Paper type Research paper

In the twenty-first century, the broad purpose of health promotion and health education could be stated as creating a learning environment that links what pupils and students learn at school and what they experience and learn in their everyday lives (Marks, 2012). Therefore, the aspects of citizenship specifically aimed at emphasizing the need for civic engagement to build stronger, healthier, and safe communities are, in general, currently regarded as essential aspects of health promotion and health education. The recently published Global Strategy for Women’s, Children’s and Adolescents’ Health 2016-2030 (Every Woman Every Child, 2015, p. 38) states that “[b]y 2030, a world in which every woman, child and adolescent in every setting realizes their rights to physical and mental...
health and well-being, has social and economic opportunities, and is able to participate fully in shaping prosperous and sustainable societies.”

Citizenship has become one of the most discussed components of the health literacy concept. Although health literacy is not an entirely new concept, its meaning has been moved from its original use in the medical context, in terms of being able to read and understand medical information, and now often refers to a broader perspective as an important competence for everyday living in a modern society (Kanj and Mitic, 2009; Wagner, 2008; Nutbeam, 2000; Zarcadoolas et al., 2005; Kickbusch, 2008). There are many components of health literacy such as health-related knowledge, various practical skills, and critical thinking skills including media literacy (see Paakkari and Paakkari, 2012). Citizenship competences, or “civic literacy,” can be seen as important components of health literacy, helping people to become empowered to act in a social context, and make appropriate health decisions and ethics (Paakkari and Paakkari, 2012; Kanj and Mitic, 2009; Sørensen et al., 2012; Laura and Paul, 2010; Eurobarometer, 2014).

Including citizenship competences and active participation in public life as aspects of school health intervention may have a particular meaning in countries where they do not have a long tradition of doing so.

In Slovakia, one of the post-communist countries, democracy was established in 1989. Before 1989, the state-party and its ideology had an absolute monopoly on educational institutions, and there was no recognition of the contributions of other stakeholders. Education, like in other post-communist countries, was a tool of mass indoctrination, where teacher training stressed ideological themes in all subjects, teachers and pupils did not have sufficient freedom to choose contents and methods, and the curriculum was the same everywhere across the country, without local or regional variations (Glenn, 1995; Birzea, 2012; Birzea, 1996). Collectivist values were predominant (sense of belonging, loyalty, social mobilization, discipline) while individualist values were mostly suppressed (freedom, independence, critical spirit), arguably leading to individuals’ lack of awareness of their own importance and their responsibility towards the society (Birzea, 1996). Schwartz and Bardi (1997) in their study confirmed the low importance for egalitarianism and autonomy values in the Eastern European samples, suggesting reluctance to assume responsibility for their own actions.

During this period, the health education in Slovakia was not an explicit part of the curriculum; there were only general aims of school education, primarily within the school subjects such as physical education (which was oriented towards physical performance), biology (with focus on primary prevention), and national defense education (which was aimed at the protection of life). The school doctor and the school dentist were part of the school system for disease prevention. Health education was seen, as Nutbeam (2000) has put it, “in a rather limited way as contributing only to improvements in individual knowledge and beliefs about risk factors for disease, and as having only a limited role in promoting behavior change in relation to those risk factors” (p. 261).

After 1989, the political changes induced systemic reforms based on the principles of democracy in all societal areas (policy, economy, and culture), including education. However, as Birzea (2012) points out, the post-communist transition toward democracy cannot be seen as only a simple regime change or linear translation process. Cultural reforms, including educational reforms, were the slowest and the most difficult, spreading over a period of at least one generation (25 years). Birzea (2012) describes six major orientations of the educational curriculum in the central and eastern countries in the transitional process, namely, democracy and democratization, strengthening of citizenship, strengthening of humanist values, strengthening of values associated with nationhood, rediscovery of religion, and the reconstruction of the European ideal (see also Birzea, 1996). In brief, the education reforms were oriented toward increased freedom for
teachers, the encouragement of local initiatives, and the development of private schools (Glenn, 1995). These reforms included a focus on the skills required for social participation and shared responsibility, and encouraged political socialization at school, promotion of civic rights and duties, individualization and personalization of teaching methods, promotion of national identity, and the learning of the national language, history, and culture (UNESCO – IBE, 2012). The reforms introduced a European dimension to the school curricula, the teaching of foreign languages, and the promotion of intercultural education, while still putting emphasis on the reinforcement of national identity and the willingness to become involved in the European integrative processes as well (Pastuovic’i, 1993).

In the case of Slovakia, these trends led to new school subjects, such as citizenship education, religious education, ethics education, and western foreign languages (UNESCO – IBE, 2012), and cross-sectional themes, such as multicultural education, media education, environmental education, regional education and traditional folk culture, and the protection of life and health, themes which are usually taught within other subjects or within the school projects (Eurydice, 2009/2010).

Although all the mentioned trends brought new educational perspectives, the position of health education had not significantly changed. While health education was set as a priority in the National Program of Care for Children and Youth in Slovakia for the years 2008-2015 and the Strategy of the Slovak Republic for youth for the years 2014-2020, health matters are represented as general aims within other school subjects with focus on individual health; the position of health education is not explicitly specified in the national curriculum (Eurydice, 2009/2010). The school doctor and the school dentist are no longer part of the school system. Although extracurricular health education programs and activities are common in the school practice, most of them are focused on behavioral changes with the focus on increasing physical activity, changing nutrition behavior, preventing smoking, including sex education, and strengthening children’s mental health and well-being (Bizikova, 2011; Liba, 2010; Slovikova, 2012a, b). However, such behaviorally oriented interventions may miss out on the children’s and youth’s perceptions of good and healthy life (Jensen, 1997).

There was only one national initiative within the public health promotion in schools where Slovakia joined the European Network of Health-Promoting Schools in 1993. Within ten years, the Slovak Network of Health-Promoting Schools (SNHPS) had been established, counting 2,051 schools, out of which 979 were kindergarten, 960 elementary schools, and 112 secondary schools (Foldes, 2004). All certificated schools were supposed to elaborate a comprehensive school project, which was implemented during one school year, and the schools were certified based on the project evaluation. Thus, the Slovak national model of health-promoting schools was based on the concept of school project. The institutional support for the elaboration of the projects was by means of recommendations published by Slovak Ministry of Education (Held, 2006). However, the analysis of the recommendations shows that all the templates of school projects were mainly focused on changes in risk behavior, represented mostly by discussions with experts (police, psychologists, doctors), educational concerts, or simple transmission of health information by frontal presentations or posters. In addition, there was no particular recommendation for children engagement within the process.

Since 2005, the Ministry of Education has published a call “Health in schools” where all schools may apply for a one-year funding (no more than 1,500 euro per project). However, the last complex national report about SNHPS was published in 2004 and no comprehensive report about the structure, undertaken actions, or recommended evidence-based practices within the network has yet been published. It is legitimate to question the current role of SNHPS, given the fact that more than 2,000 schools are in the network.
Democracy in health education, health education for democracy
Although it is 27 years since the transition toward democracy, the latest periodic United Nations (2016) Slovak report about the children's rights reiterates its previous recommendations to enhance respect for the views of the children. The Committee on the Rights of the Child recommends the development of toolkits for public consultation, including consulting with children on issues that affect them, conducting programs and awareness-raising activities to promote the meaningful and empowered participation of all children within the family, in the community, and in schools, and institutionalizing permanent participative structures to facilitate the effective engagement of children (United Nations, 2016, p. 5).

Many international studies (Program for International Student Assessment (PISA); Health Behavior in School-aged Children (HBSC)) have repeatedly reported on the generally low levels of happiness and satisfaction among the Slovak students within school environment (OECD, 2013; Currie et al., 2012; Inchley et al., 2016), which makes it clear that the issue of the active participation of children in the improvement of school environment should be addressed urgently. The WHO survey HBSC (www.hbsc.org/) focuses on understanding young people's health in their social context monitoring the school environment at several levels. The percentage of Slovak school-aged children that like school is one of the lowest across all age groups (11, 13, and 15-year old) among HBSC countries (Inchley et al., 2016, p. 53). The HBSC study also reports a low level of participation by Slovak school-aged children in the in-class decision making and at the school level (Madarasová Gecková and Dankulincová, 2015). The same trends have been shown by the PISA (www.oecd.org/pisa/), which also examines students’ (15-year old) evaluation of their happiness and satisfaction in relation to school, providing a good indication of whether educational systems are able to foster students’ overall well-being. The percentage of Slovak students who feel happy at school is one of the lowest (ranked 62 out of 64) among PISA-participating countries and economies (OECD, 2013, p. 32). Furthermore, the decline of Slovak students’ sense of belonging and attitudes toward school between 2003 and 2012 is one of the most pronounced across participating countries (see OECD, 2013).

Previous studies have suggested that the characteristics associated with a positive view of school are the student participation in, and responsibility for, school life, the perception of justice and safety within the school environment, and a good relationship with teachers (Samdal et al., 1998). Previous research has linked negative disposition toward school to low academic performance and other negative outcomes, such as low levels of emotional well-being, risk behavior (Samdal et al., 2000; Garcia-Moya et al., 2015; Griffiths et al., 2012), and bullying (Wormington et al., 2016; Harel-Fisch et al., 2011).

Konu and Rimpelä (2002) introduced the school well-being model where well-being is seen as an important factor in the overall school setting. The authors divided the indicators of well-being into four categories, namely, school conditions, social relationships, means for self-fulfillment, and health status. Each category contains several aspects of children’s life in school. The school environment is seen as an important factor for promoting the health and overall well-being of children and youth (Samdal et al., 1998; Vieno et al., 2005; John-Akinola and Gabhainn, 2015). Moreover, the school environment is also usually the first environment in which children experience a sense of belonging to an institution, where they observe, experience, and start to learn how society works (Luff and Webster, 2014).

Like in most post-communist countries, Slovak school-aged children and students were born in democratic regime while the majority of Slovak teachers either lived their youth in or studied during the communist regime. Birzea (2012) describes this phenomenon where the new institutions and values co-exist together with mentalities and behaviors of “residual communism.” It is therefore important to focus not only on democratic aspects in education, but also on education for democracy citizenship and civic engagement with
the aim to promote the health and well-being of children and youth. “Democracy is primarily participation and therefore education for democracy actually means qualification for the role of a competent participant” (Simovska, 2004a, p. 203). Schools should see children as citizens with current rights and not just as future citizens of the society (Paakkari and Paakkari, 2012).

Given this perspective, there is a need to identify appropriate educational conditions where all students can learn to act as responsible and health-literate citizens. We highlight the concept of democratic health education as defined by Jensen: “Democratic health education has to be based on a holistic health concept, be action-oriented and involve the active participation of pupils” (Jensen, 1997, p. 422).

The democratic approach actively involves pupils and students in making their own decisions about the health and articulating their own perceptions of a healthy life and healthy environment (Whitman, 2005). The concept of “action competence” and an educational approach called Investigation-Vision-Action-Change (IVAC) were introduced to serve as a framework for action-oriented teaching (Jensen and Schnack, 1997; Jensen, 1997, 2004). Action-oriented teaching stresses the “civic dimension,” meaning that the environment and health should not be separated if pupils and students are to acquire a coherent understanding of the dynamics behind health matters, and develops a vision for healthy life and healthy environment in which the students feel involved (Whitman, 2005; Jensen, 1997, 2000).

To date, a few studies have been conducted to explore children’s health literacy (Paakkari and Paakkari, 2012; Borzekowski, 2009; Jain and Bickham, 2014; Fairbrother et al., 2016; Kostenius and Bergmark, 2016; Kilgour et al., 2015) or measurement of a related competence (Ormshaw et al., 2013; Paakkari et al., 2016). To date, there is almost no research exploring the influence of a school health literacy intervention on the school well-being in children. The theoretical and empirical treatment of the concept of health literacy has so far been focused on the level of an individual. There is a need to go beyond the individual level (Paakkari and Paakkari, 2012; Higgins et al., 2009) to extend the focus to the community level, to help young people become competent enough to engage in community collaboration. The IVAC didactic model provides an important platform for the development of children’s experience with taking actions, different forms of children’s participation, and initiating health-promoting changes based on the school-community collaboration (see Simovska, 2004b; Simovska and Jensen, 2003).

The principal purpose and aim of this paper was to examine whether action-oriented teaching, using the IVAC didactic model, built on the concept of children’s health literacy, particularly around citizenship, improves children’s well-being. Our intention was to help children develop their citizenship competences and to foster their participation in forming the school environment, and to examine how this influenced the three selected factors of school well-being (Konu and Rimpelä, 2002), namely, children’s perception of school, their subjective well-being, and their violent behavior in school (being bullied, being a bully, physical fighting).

Such a program is fairly new in the Slovak educational context. Moreover, this study is particularly needed, given the findings on the low levels of happiness and school satisfaction among Slovak students (OECD, 2013; Currie et al., 2012; Inchley et al., 2016) and the need to enhance respect for the views of children (United Nations, 2016, p. 5), which we have discussed earlier.

**Method**

**Study population**
The target population was represented by Slovak children attending the fourth grade of elementary school (modal age of nine to ten years). The sample inclusion criteria were as
follows: the schools which the participants attended had to be regular state elementary school (special schools and schools with mixed-grade classes were excluded); the schools had to follow the national core curriculum for elementary education, without any relevant history of implementing extracurricular activities related to health education or civic-based health education.

By random number generation, five elementary schools based in the eastern region of Slovakia were selected. Within each school, two fourth grade classes were randomly selected, randomly assigning the experimental treatment (intervention program) to one of them. As a result of this cluster sampling procedure, the final sample comprised 180 children (experimental group \( n = 87 \); control group \( n = 93 \)). In terms of gender, the sample happened to be balanced with 52 percent boys and 48 percent girls. The age of participants ranged from 9.4 to 11.5, with the mean age of 10.3 years (SD = 0.4).

**Ethical considerations**

Schools were contacted by cover letters addressed to school principals with the aim of making an appointment. The school principals were informed about the aims, conditions, and process of the research. The introduction letters and information sheets were sent to schools for pupils and their parents. Informed consent for the child’s participation in the study was obtained from parents. The entire data collection process was anonymized.

**Study design**

The study utilized a cluster-randomized controlled trial design. The intervention program (implemented in the treatment group) called Voices for Health had been designed as an intensive course spanning over 16 weeks. Control group classes followed regular curriculum plans without any extra activities related to health education. Both groups were pre-tested for baseline equivalence. The intervention was carried out solely by the first author so that the possibly confounding variables like teachers’ competence, form or content of the intervention delivery, or any other personal aspects were held constant across all the experimental groups. It was hypothesized that the given intervention program induces a significant positive change in children’s perception of school and subjective well-being and, at the same time, leads to a decrease in the prevalence of violent behavior.

**The intervention: Voices for Health**

The conceptual framework of the intervention program Voices for Health was built on the concept of children’s health literacy, particularly on its citizenship component (Table I). The intervention Voices for Health applied the action-oriented teaching using the IVAC didactic model. It employed a number of perspectives (Table I) to be addressed in collaborative work (order of phases was flexible) aiming to actively involve children (Jensen and Simovska, 2009).

The intervention comprised four steps: understanding of health; investigation of school setting; action; and achievement (Table I). The first step of the intervention focused on children’s perception of health. As suggested by Jensen (1997), any health information campaign should take into account the subjective well-being aspect (as defined by the WHO definition of health), where the target group has to be invited to take part in the discussion and be taken seriously. Given this perspective, the daily regime was seen as an appropriate framework where children were able to link generally known health information (nutrition, sleeping, physical activities, oral health, family, school, peers, etc.) with their own everyday lives. Child-centered activities aimed at health mapping were
<table>
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<tr>
<th>Steps</th>
<th>IVAC phase</th>
<th>Content</th>
<th>Aim</th>
<th>Educational activity</th>
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</thead>
<tbody>
<tr>
<td>1st: understanding of health</td>
<td>Investigation</td>
<td>Personal perspectives</td>
<td>Open health concept</td>
<td>Classroom-based critical and descriptive reflection, photo voice, health mapping (body/town map), diary “My daily health”</td>
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<td></td>
<td>How would you describe your health by using different adjectives, adverbs or interjections?</td>
<td>To explore subjective dimension of health from personal and collective perspective</td>
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<td></td>
<td>How would you describe your health by using your senses?</td>
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<td></td>
<td>How do your daily activities affect your health?</td>
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<td></td>
<td>How do your descriptions, explanations, and understanding of your health relate to your everyday life?</td>
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<td></td>
<td>Collective perspectives</td>
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<td>May our descriptions, explanation and understanding of health affect others? How?</td>
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<td></td>
<td>Is your notion of health different from your schoolmates’ view?</td>
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<td></td>
<td>What is different (similar)? Why?</td>
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<td></td>
<td>What makes these it different? What do we understand/imagine by the term health?</td>
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<tr>
<td>2nd: investigation of school setting</td>
<td>Investigation</td>
<td>How does the school environment affect our health?</td>
<td>School environment and health</td>
<td>Health mapping (school map), participatory dialogue process, action-oriented school project</td>
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<td></td>
<td>What influences are we exposed to and why? Why is this issue important to me?</td>
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<tr>
<td></td>
<td>What is it significant to us/others, now and/or in the future?</td>
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<tr>
<td>Vision</td>
<td>School environment as a community</td>
<td>To explore and evaluate the influence of school environment on health</td>
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<tr>
<td></td>
<td>Which alternatives are possible in general? Which alternatives are possible for us? Which alternatives do we prefer? Are these alternatives suitable for everyone (for us)? Why?</td>
<td></td>
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<tr>
<td></td>
<td>To evaluate the appropriateness of various alternatives from personal and collective perspective. To discern what is good for me from what is good for us</td>
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<td>Ethical and collective reflection, school elections “Voices for Health”</td>
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Table I. The description of the intervention program “Voices for Health” (continued)
used (Crivello et al., 2008), utilizing sensory aspects of health (Jensen, 1997) where children were asked to think about their health through their senses and feelings. To give an example, children were given a task-oriented project “My daily health” where they were asked to monitor their health within one ordinary week (working days and weekend) by noting all activities and feelings during the day throughout the whole week. Children could also use a camera to take pictures, with the aim of enhancing sensory aspects of health. Children were then asked to individually reflect on a set of questions about how their daily activities and feelings were linked to their health. The awareness of the open health concept was stimulated by classroom discussion where children were guided to reflect on their experience and express their own experience and understanding of their health within the daily regime in a descriptive, critical, and collective manner (Paakkari et al., 2011). First, children were asked to answer “how” or “what” questions, which were linked to their health within the daily regime (see Table I). These questions helped them in discovering their own personal meanings of health. Then they were asked “why” questions, which were aimed at the reasoning of their ways of behaving or
thinking (see Table I). After questions on their own experience and understanding about their health within the daily regime, it was important to find out what they think about the health beyond their own perspective. This led to the following questions: “What do my classmates or we (as a group) regard important in relation to health? What can be done to improve their or our health and well-being?” (Paakkari and Paakkari, 2012).

The second step of the intervention focused on the school environment as a social determinant of health (Inchley et al., 2016). The children were supported to investigate the school environment in relation to their health. The children were given a map of the school area and they were asked to mark the particular areas which they felt fostered or hindered children’s health and well-being, based on perspectives in IVAC approach (see Table I). The children identified the factors in their school environment they wanted to concentrate on, in order to improve their school well-being. The children then engaged in collective reflection with other pupils, teachers, and school principal about the factors of the school environment that they felt were relevant from the perspective of their health and general school well-being. To give an example, the children organized a school election and a debate called “Voices for Health” to select a particular school environment factor with the aim to improve their school well-being.

The third step of the intervention was focused on concrete action within the school environment in terms of collective selection of the particular school environmental factor. The children were asked to make a plan for implementing the action-oriented project. They were asked to collectively identify what they saw as desirable changes, actions for achieving the desirable changes, and the barriers which might prevent them from carrying out these actions. Afterwards, children collectively reflected on their plan with school principal and conducted the actions aimed to improve school well-being. The following actions were conducted – school A: “School breaks outside of school;” school B: “Improving hygiene in the canteen;” school C: “Painting the classrooms and school corridors;” school D: “Annual school event day and night in school.”

The fourth step of the intervention was focused on the assessment of personal and collective achievements from action-oriented teaching. The children were asked to explore what they learnt from the experience of conducting action based on critical and descriptive reflection.

Data collection and measurement

Subjective well-being. Subjective well-being was measured by KIDSCREEN-10. It is an optional scale included in the HBSC study (Currie et al., 2014). It consists of ten five-point Likert-type items covering affective, cognitive, psycho-vegetative, and psychosocial aspects of mental health. The measure had been extensively cross-validated in various cultural settings (including Slovakia). The scale has a unidimensional factorial item structure, which was shown to be invariant across age groups, nationality, and socio-economic level, and an adequate internal consistency for comparisons of groups, \( \alpha = 0.82 \).

School setting aspects. With the aim of measuring school-related outcomes, the present study focused on children’s perception of school and children’s violent behavior. The scale-type measure comprised the chosen mandatory Likert-type items drawn from the HBSC study (Currie et al., 2014) in order to measure two variables, namely, perception of school and violent behavior in school. The former was a formative index (unweighted sum score) defining school satisfaction in terms of liking school and school pressure items; the latter was an index merging physical fighting, bullying others, and being bullied items. For the bullying items, the questionnaire explicitly described and explained what kinds of behavior were classified as bullying.
Results
When the children were asked to explore what they learnt from the experience of conducting action based on critical and descriptive reflection, they felt that the following were some of their personal and collective achievements:

[…] at first, we thought nothing is going to change because it has been always like that […] but we could see that our voices might be heard.

[…] I think that the main reason for the change in our school was that we asked all in school what they want to change.

[…] we had a fear to present our plan in front of school principal.

[…] it was really exciting to see how our visions comes true.

[…] my mother said me to not criticizes something in school because I will have problems in school […] but we wanted to improve our school not criticizes something.

[…] we found out that is much harder to make a plan for action and change than only to complain for something.

[…] my parents didn’t believe that we are able to change something.

[…] I feel more confident to express my wishes or visions at home.

Data screening
Data analysis was preceded by a screening phase. All of the variables were checked for improbable values. Apart from that, no value was regarded as an outlier. The 4.9 percent of missing data were assumed to be missing at random and handled by pairwise deletion. The actual sampling method (cluster sampling) with entire classes representing the clusters was expected to largely mitigate self-selection and other kinds of systematic biases that could, possibly, affect the results. Next, the distributions of the variables were assessed for normality. For the variables significantly deviating from Gaussian distribution, no transformations were done; thus, all the variables were preserved in their raw scales. The group distributions for most of the variables (except for the measure of well-being) significantly deviated from normal distribution (mostly due to the ordinal character of the data the measures produced).

The employed sampling plan required a test to find out the presence of possible cluster effects. In the given sample, with a mean cluster size of 18.1, the intraclass correlations were rather negligible and ranged from $r_{ic} = 0.003$ to $r_{ic} = 0.055$, leading to design effects ranging from 1.01 to 1.94. Thus, since the magnitudes of design effects for all the variables were below the acceptable cut-off of 2 (while most fell well below that value), the data were considered to lack any multilevel structure that would need be taken into account.

Hypotheses testing
The data were analyzed using the analysis of covariance with post-test score as a dependent variable, treatment group as a between-subjects factor, and the observed pre-test score as a covariate. All the below reported means were adjusted for the effect of the covariate.

The effect of the intervention program was first assessed with regard to children’s perception of school. Here, the experimental group subjects ($M = 4.23$, $SD = 1.57$, $n = 77$) reported a significantly more positive perception of school than the control group subjects ($M = 3.20$, $SD = 1.01$, $n = 81$), $F(1, 155) = 28.6$, $p < 0.001$, and $\omega^2 = 0.13$. In terms of standardized mean difference, it represented a medium effect size of Hedges’s $g_s = 0.78$.

Further on, it was tested whether the intervention will lead to a positive effect in another variable, namely, well-being. On average, after controlling for the baseline condition, subjects
in the experimental group showed higher scores in the standardized measure of well-being “KIDSCREEN-10” \((M = 36.92, SD = 4.03, n = 77)\) than the controls \((M = 32.63, SD = 4.79, n = 81)\), \(F(1, 155) = 42.6\), and \(p < 0.001\). Based on these self-reported values, \(\omega^2\) of 0.20 denoted quite a large effect, i.e., the adjusted mean of the experimental group was almost one standard deviation above the mean that was estimated for the control group, Hedges's \(g_s = 0.96\).

Lastly, it was expected that the implementation of the given intervention program would lead to a significant decrease in the prevalence of violent behavior among children. The data proved to be consistent with that hypothesis. The experimental-group children reported lower incidence of violent behavior \((M = 3.50, SD = 0.99, n = 76)\) than the children from the control group \((M = 4.81, SD = 2.26, n = 81)\), \(F(1, 154) = 25.1\), \(p < 0.001\), and \(\omega^2 = 0.11\). Such difference in means was associated with a medium effect size of Hedges's \(g_s = 0.74\).

The data suggest that the proposed intervention leads to a significant change in all of the measured variables, i.e., children's perception of school, the prevalence of violent behavior among children, and their well-being. In the given sample, the magnitudes of the observed effect sizes ranged from medium to large. The proposed democratic approach employed by the implemented long-term intervention program was thus shown to yield empirically robust effects.

For the sake of transparency and reproducibility of the data analysis, full data and \(R\) code are freely available at: https://osf.io/m5cth/.

**Discussion**

The results show that the intervention Voices for Health leads to a significant change in all measured variables.

The results of the present study corroborate the findings of previous studies that a positive attitude toward school is associated with student participation in and responsibility for the school life, with the perception of justice and with safety within the school environment (Samdal et al., 1998; Gustafsson et al., 2010). Previous research documents provide a link between different characteristics of the school environment and children's well-being (John-Akinola and Gabhainn, 2015), but there is a lack of evidence on how the school environment that fosters genuine children's participation impacts the school well-being in children. Previous research on action-oriented teaching through the IVAC approach has focused on the form of participation (Ruge et al., 2016), on social and emotional competence (Nielsen et al., 2015), and on the development of learning outcomes, defined as a change in children's action competence (Carlsson and Simovska, 2012). However, previously there has not been much investigation of the influence of the IVAC approach on children's school well-being.

In the intervention program, it may well have been the twinning of health literacy and the IVAC approach, with its descriptive, critical, and collective reflection (Paakkari and Paakkari, 2012) which was effective in promoting some aspects of school well-being.

The intervention showed robust effects despite lasting only one school semester (16 weeks). It suggests the strength of allowing children to feel that they are able to influence factors that contribute to their own school life. This impression is supported during the fourth step of the intervention program when children evaluated their experience from the action they carried out. The experiment-group children expressed their surprise on the fact that, after the program, they were able to present their visions and plans for a healthier school environment as a collective reflection to the school principal and, particularly, that their visions and plans were heard and incorporated in school life. Moreover, they expressed the strong feeling that changes were actually possible, although, at first, they thought nothing was going to change because “it has been always like that.” This could be seen as a core aspect of the intervention in relation to Slovak cultural context as post-communist country.
Such results lead us to suggest that there is a need to actively promote the concepts and competences that enhance democracy, active participation, and citizenship in Slovak educational conditions, although, as Birzea (2012) states, the post-communist transition toward democracy lasts over a period of at least one generation (25 years).

This intervention based on the IVAC model would appear to be an effective way on how to implement children’s health literacy and children’s participation into the existing curriculum (Eurydice, 2009/2010).

The action-oriented teaching to foster children’s health literacy in terms of active participation presents a challenge to Slovak schools and teachers, in terms of their ability to support the development of action competences in the existing cultural climate. St Leger (2001) reports that the comprehensiveness of health literacy is largely dependent on the type of school (autocratic or democratic), and on the cultural and political practices of the region or country in which the school exists. In Slovakia, this has a particular significance, given the fact that like in most of the post-communist countries, the period of moving from one type of society to another is characterized by an interregnum culture, where the new institutions and values co-exist together with mentalities and behaviors of “residual communism” (Birzea, 2012). Teachers need to ask themselves whether they have the skills and attitudes to promote action competence, and whether they are able to take into account the different kinds of students with different personal characteristics, competences, capabilities, and views (Paakkari and Paakkari, 2012).

The present study has some limitations. First, although we studied the effects on well-being, children’s perception of school, and violent behavior using measures derived from the HBSC study, the questionnaire items relied on self-report. Due to the fact that children’s perception of school and well-being are by definition a subjective perception of the phenomenon, we consider the self-reported data as the most valid information available. The results show that the intervention leads to a significant change in all the measured variables in an immediate post-test but the long-term sustainability of the effects is yet to be demonstrated. Second, due to the low statistical power for that purpose, the actual cluster sampling design with \( n = 5 \) experimental group clusters did not allow for any formal hypothesis testing concerning differences between experimental group schools, and any interpretation of the post-data differences would be subject to the capitalization on chance variation, lacking any control of error rates. Detailed analysis of the intervention effect by studying selected individual-differences aspects of the sampled school would require a large-scale cluster design.

Lastly, the characteristics of the sample allow us to draw inferences on a population of western Caucasian children of the given age but the results may not generalize across age groups other than those studied (backed up by the data). The program might be expected to induce positive changes in various dimensions like children’s health literacy, citizenship competences, children’s engagement, or children’s action competence; however, any claims that go beyond the actual data in terms of intervention program effects other than the measured outcome variables are unwarranted and should be rather taken as a hypothesis. These assumptions need to be examined in further research where the changes in children’s citizenship competence or children’s level of health literacy will be tested using appropriate measurement.

In order to be able to implement Voices for Health in many schools in such cultural climate, it is necessary to study the implementation of the program in terms of institutional support at schools and factors related to teachers’ knowledge and skills. As Schwartz and Bardi (1997) reflected, the process of shifting the values (from communist to democratic) is slow and it requires people to be truly able to experience the “new values” through transformation of the actual conditions to which they are exposed. The values that were prevalent in “Voices for Health” should not only be
experienced during short interventions; instead, they should become evident in various aspects of the school day (e.g. curriculum, relationships, school ethos). Only then will the pupils learn the competencies and values relevant for taking care of one’s health and that of the others in a democratic manner.

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LGBTQ youth activism and school: challenging sexuality and gender norms

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Abstract

Purpose – Previous research examining the experiences of lesbian, gay, bisexual, trans and queer (LGBTQ) youth in schools suggests that schools are not inclusive places for non-heterosexual students. Some scholars, however, suggest that a continued focus on how these young people are marginalised is itself a problem, and that research should also focus on strengths and what is working. The purpose of this paper is to examine the activities of a group of LGBTQ students in one school in Auckland, New Zealand.

Design/methodology/approach – The study employed a critical ethnographic approach in a diverse co-educational, public high school in Auckland, New Zealand. The researcher spent 3-5 days per week at the school throughout three terms (32 weeks) of the 2016 school year and participated, observed and interviewed students and teachers. Post-structural theory was used to analyse the ethnographic materials.

Findings – The study found that LGBTQ students actively challenged the heteronorms of their school. They met regularly to discuss issues, support each other and to plan activist initiatives. These initiatives, in turn, impacted the environment of the school and made LGBTQ students more visible. This visibility, however, also created tensions as students grappled with their identities and the public space of school.

Originality/value – Despite a wealth of research in education on the exclusion of young people at the intersection of gender, sexuality and other identity positions, there is very little research that reports on school-wide health promotion initiatives that both engage young people as leaders and participants in their schools, and work towards creating safe and empowering spaces for LGBTQ youth.

Keywords Gender, Health promotion, Schools, Youth, Lesbian and gay issues, Sexuality and gender

Paper type Research paper

Introduction

Magdalena, one of the school counsellors and the “teacher in charge” of the Rainbow group, stood at the classroom door and welcomed each student as they arrived. The students sat in a circle of chairs, or on the ground on brightly coloured cushions. In an excited voice Magdalena thanked everyone for coming to the first Rainbow meeting of the year. Magdalena introduced herself and explained her role in the group, stating that she was also a counsellor in the school and that her door was always open. She then talked about the purpose of the Rainbow group: “we are a group who celebrate diversity and actively work towards social justice at Kahukura High School. It doesn’t matter if you are lesbian, gay, bisexual, transgender, straight or questioning – everyone is welcome here”. The senior students around the room gave a few little cheers and clapped.

This narrative draws on the first author’s experience with a rainbow group at a diverse high school in New Zealand as part of a critical ethnographic study of lesbian, gay, bisexual, trans and queer (LGBTQ)[1] students. As the opening story suggests, the group provided a space for students in the school, it also enabled them to take action to challenge exclusionary practices and the marginalisation of non-heterosexual students. While in many ways exemplifying what can be considered a “critical” approach to gender and sexuality, students in the group also experienced the messiness of being in a diverse group. The activities of this group of students, and the teacher, Magdalena, are particularly interesting given the substantial and compelling evidence that schools tend to reinforce and reinscribe narrow gender and sexuality norms (Paechter, 2000, 2006; Youdell, 2005, 2011). This is evident in
both the wider school and in school-based sexuality and health education classes. Allen (2005), for example, argues that sexuality education classes tend to reinforce biological notions of sex and sexuality, while excluding discussion of diversity, desire and romantic relationships (Allen, 2004, 2005, 2007a, b; Allen et al., 2014; Epstein and Johnson, 1998). Mayo (2009) argues, however, that highlighting the problems associated with LGBTQ youth in schools tends to portray these young people as victims, rather than individuals who have agency and resilience (Mayo, 2014). Lucassen et al. (2014), likewise, advise against problematising lesbian and gay students and rather advocate for a focus on their strengths. However, Talburt and Rasmussen (Rasmussen, 2010; Talburt and Rasmussen, 2010; Talburt, 2010) have argued that focussing solely on “liberatory and emancipatory” objectives actually emphasises homonormative notions of LGBTQ inclusion that end up privileging white middle-class queer subjectivities. Kumashiro (2015, p. 1) notes that the subjectivities of queer youth reflect complex identity articulations, and he argues that “everyday practices in schools often comply with or contribute to racism, sexism, classism, heterosexism, and other forms of oppression”.

While there is a body of work on sexuality support groups in schools (see, e.g., Elliot, 2016; Mayo, 2013; Quinlivan, 2013), there are few examples of positive school cultures for LGBTQ students. In this paper, we consider how critical practices within schools both open up new possibilities for students, and complex gender and sexuality articulations. We employ the theoretical tools of Foucault (power and resistance) and Butler (the heterosexual matrix and intelligible subjects) to conceptualise and interpret the relations of power evident in LGBTQ students’ interactions in this school, and how the critical practices of the Rainbow group allowed them to both explore their own identities and engage the wider school. We first provide background to the research, before introducing the theoretical framework and the methodology. We then explore two key themes that emerged from the research and end with some conclusions.

**Background: heteronormativity, pedagogy and schooling**

There are many opportunities for schools to employ critical approaches to teaching, curricular and wider school environments. Such approaches may help to open up space for gender norms to be exposed, challenged and critiqued by students. Elsewhere (Fitzpatrick and McGlashan, 2016) we argue that, what we call “straight pedagogy” actively reinforces both the heterosexual matrix and normative forms of gender and sexuality. Pedagogical practices that ignore gender and sexuality serve to silence alternative identities. There is potential, however, for schools to engage with transformative and critical approaches (Fitzpatrick and Enright, 2017). Ukpokodu (2009) argues that transformative approaches to schooling are “an activist pedagogy combining the elements of constructivist and critical pedagogy” (p. 43). He notes that such moves should centralise students’ perspectives, but also require a critical examination of “beliefs, values, and knowledge with the goal of developing a reflective knowledge base, an appreciation for multiple perspectives, and a sense of critical consciousness and agency” (Ukpokodu, 2009, p. 43). This, of course, is complex, messy and often at odds with power relations operating in schools and wider social contexts.

One critical approach evident in schools is the facilitation of gay-straight alliances or, what many in New Zealand are referring to as, a queer-straight alliance (Quinlivan, 2013, 2015). QSAs vary considerably in their makeup and intention (see Quinlivan, 2013, 2015; Talburt and Rasmussen, 2010; Youdell, 2011; Mayo, 2009; Kosciw et al., 2012). However, they are commonly known as an extracurricular, student-centred group where (LGBTQ) students, along with their heterosexual and questioning allies, gather for conversation, learning activities and mutual support (Mayo, 2013). Quinlivan (2013) discusses some of the tensions inherent in school-based QSAs, both within the group itself, and in relation to wider school politics. She argues that,
if the intent of the QSA is to provide a safe space for queer youth who need support, then this can position them as “abnormal” or “at risk” and further increase the divide between being heterosexual and being queer. However, Quinlivan (2013, 2015) and others (Mayo, 2009, 2013; Talbut and Rasmussen, 2010) also highlight how critical approaches to learning in QSAs can allow for the exploration of fluid subjectivities and non-normative understandings of gender and sexuality.

Recent moves in the New Zealand education system may make such approaches more possible or, at least, more visible. The New Zealand Ministry of Education recently released a revised policy document: Sexuality Education: A Guide for Principals, Boards of Trustees and Teachers (Ministry of Education, 2015). The guide was written to support school boards, principals, and teachers to deliver effective, quality, sexuality education programmes. This guide takes a socio-critical approach, and explicitly advises schools to review the gendered nature of their environments and make changes, not only to curriculum, but also to school toilets, uniforms and exclusionary cultures. The guide states that:

Sexuality education in New Zealand schools supports and acknowledges diversity among students. Schools should work to question gender stereotypes, and assumptions about sexuality. School programmes and the wider school environment should take opportunities to acknowledge the sexual diversity of New Zealand communities and recognise the rights of those who identify as lesbian, gay, bisexual, transgender, intersex, and other sexual and gender identities (Ministry of Education, 2015, p. 11).

Wider social and political moves are also making gender and sexuality issues more visible. The New Zealand government recently included a third gender option on passports (“Gender X”) and the term, “gender diverse” will now be used in addition to “male” and “female” in the reporting of official government-sponsored national statistics (Statistics New Zealand, 2014). In addition, recent attention on transgender issues globally is also impacting gender norms. Not only are trans people becoming more visible, but also the tone of this exposure has dramatically shifted from a rhetoric of perversion, deviance and pathology (see Richardson, 2010) to one of understanding, and even celebration. This commentary is, however, also raising questions about gender binaries (Bornstein and Bergman, 2010; Elliot, 2009). Large-scale survey research with New Zealand youth in schools also shows interesting shifts over the last 15 years. The most recent New Zealand Youth2000 survey series, a survey of over 9,000 13-17 year olds between 2001 and 2012, (Lucassen et al., 2014) shows that, in 2012, a majority (53.1 per cent) of same/both sex attracted young people had “come out”[2] to someone close to them about their sexuality (in the previous study in 2001 the figure was only 31.3 per cent). However, Lucassen et al. (2014), also noted that, despite some positive changes, “same/both-sex attracted young people are often exposed to environments that are challenging and discriminatory, and this in turn affects their well-being” (p. 5). The report states that, youth who are same/both sex attracted are more likely than opposite-sex attracted students to be bullied or physically harmed at school (Lucassen et al., 2014, p. 5).

Given these changing social contexts, we are interested in whether it is now more possible for students to trouble gender at school, to engage with what Atkinson and DePalma (2009, p. 19) call “queering consensual heteronormativity”, and to make schools better and more inclusive places for LGBTQ students.

Theoretical framework
In this study, we employ the post-structuralist theories of Foucault and Butler to understand the experiences and actions of the LGBTQ students in this school. Foucault’s underpinning desire was to “understand how people, throughout history, have created knowledge about humans and how such knowledge has shaped the experience of being
human’” (Markula and Pringle, 2006, p. 24). Understanding power was central to this analysis. For Foucault, power is:

[…] exercised rather than possessed; it is not the “privilege”, acquired or preserved […] but the overall effect of its strategic positions; an effect that is manifested and sometimes extended by the position of those who are dominated (Foucault, 1995, pp. 26-27).

Discourses of sexuality can both transmit and produce power as well as challenge it by providing spaces for resistance (Nixon and Givens, 2007, p. 453).

When sexuality is recognised as discursively constituted it is possible to see the role that schools play as social institutions. As Quinlivan (2013, p. 57) states “Given the structural, ideological and affectively normative cultures of schools, researching queer sexualities and difference will produce conundrums”. These institutions “reflect and constitute the broader socio-political discourses in operation, including those that uphold the constructed superiority of heterosexuality” (Ferfolja, 2008, p. 108) and heteronormativity. Heterosexuality then is generally accepted as “normal” and is, therefore, associated with a range of dominant discourses (such as men being expected to be masculine), not only because it is widely accepted, but because it is also securely entrenched in powerful institutions. As a consequence, non-heterosexual and non-gender-conforming students are more likely to experience marginalisation in schools (Allen, 2007b; Epstein and Johnson, 1994; Epstein et al., 2003; Quinlivan, 2006). Foucault (1980, p. 142) argued that “there are no relations of power without resistances; the latter are all the more real and effective because they are formed right at the point where relations of power are exercised”. Indeed, the LGBTQ youth in this study employed particular strategies to negotiate the gender and sexuality norms of their school.

Butler (1999, p. 24) maintains that gendered relations of power exist within a kind of matrix wherein sexuality is a product of “regulatory practices that generate coherent identities […] and asymmetrical oppositions between ‘feminine’ and ‘masculine’”. Youdell (2005, p. 250) refers to this as a sex-gender-sexuality constellation. Such a constellation, Youdell argues, constitutes sex, gender and sexuality in particular ways “that open up possibilities and set limits for ‘who’ a student can be”. Within this constellation:

[…] the female body is already feminized, the feminine is already heterosexual, the hetero-feminine is already female. Sex-gender-sexuality, then, are not causally related; rather, they exist in abiding constellations in which to name one category of the constellation is to silently infer further categories (Youdell, 2005, p. 256).

The power of this constellation is partly to do with what (or who) is intelligible, including in school contexts. We are interested here, however, in understanding whether, given the changing social contexts outlined further above, LGBTQ students are challenging the seemingly “natural” nature of such constellations, and how they are engaging issues of gender and sexuality in their schools.

We next outline the methodology before exploring the key themes of the research.

Methodology
In this study, a critical ethnographic approach was employed to explore how one group of LGBTQ students challenged gender and sexuality norms in their school. The school (which we given the pseudonym Kahukura High School) is located in Auckland, New Zealand and is a large (2,000 students) co-educational, culturally diverse, state high school (years 9-13, students aged 13-18).

Traditional ethnography involves researchers becoming part of the community of people involved in the research, living alongside them in the hope that a better understanding of their lives will result (Denzin, 1997; Tedlock, 2000). The traditional approach tends to emphasise the researcher’s role in controlling interactions in the field and in reporting their
findings in a disengaged way. Critical ethnography on the other hand, examines the assumptions behind this methodology and applies critical social theory to ethnographic materials and methods (Madison, 2012).

Thomas (1993) describes critical ethnography as “conventional ethnography with a political purpose” (p. 4). This approach places the focus on issues of equity, juxtaposing an in-depth epistemological account alongside an analysis of societal issues. Madison (2005, p. 5) argues that “critical ethnography begins with an ethical responsibility to address processes of unfairness or injustice within a particular lived domain” (p. 5). She defines ethical responsibility as a “compelling sense of duty and commitment based on morals principles of human freedom and well-being, and hence a compassion for the suffering of living beings” (p. 5). Critical ethnographers aim to disrupt the status quo, unsettle both neutrality and taken for granted assumptions by bringing to light underlying and relations of power. This methodology then requires researchers to move from “what is” to “what could be” (Thomas, 1993; Carspecken, 1996; Noblit et al., 2004).

Critical ethnography then was the overarching methodology within which the following methods were employed: interviews, observations, conversations, narrative inquiry and immersion in the field of study (Madison, 2012; Clandinin and Connelly, 2000; Fitzpatrick and May, 2015). The researcher – Hayley – was present for 3-5 days per week at the school throughout three terms (32 weeks) of the 2016 school year. During her time at the school, Hayley engaged in conversations with teachers, students, and management. She experienced school life at Kahukura High School, observing classroom lessons, visits from outside providers, assemblies, award evenings, school performances, cultural groups and a range of student-led groups. She also analysed school policy documents that focussed on LGBTQ identities in order to understand the “political” nature of sexual and gender diversity within the school. Using a critical ethnographic approach enables us to explore how teachers’ and students’ understandings of sexuality are framed by wider social and political circumstances. In the wider study, we also draw on narrative inquiry (Clandinin and Connelly, 2000), utilising observations, focus groups and semi-structured interviews to weave together narratives of students’ experiences, and analyses of the culture of sexuality within the school, including discourses, sexuality education programmes and school policies.

Trust, respect and reciprocity were fundamental in this research. Trust was developed through a dialogue of honesty, and Hayley was explicit about her own intentions as a researcher. She shared her desire to “walk” with the rainbow students within multiple contexts, to engage with and immerse herself in the lives of LGBTQ at Kahukura. Madison (2005) suggests that “dialogue” between the researcher and the other is the first step in mitigating and exposing relations of power within research. This was especially important because Hayley identifies as heterosexual. The second author, Katie, also identifies as heterosexual. We both work in the fields of health and sexuality education, and engage in ethnographic research across multiple school contexts. Herdt and Boxer (1993, p. xix) argue that “when our identities remain hidden to the reader, it is difficult to both understand the conduct and validity of the research and to compare the results (positive or negative) to other studies”. Both of us are aware of the slipperiness of trying to talk about gender and sexuality (Rasmussen, 2010; Paechter, 2006) and also of our own, unfixed and fluid gendered subjectivities. Our own gendered embodiments could be labelled “cis-gendered” although, like all subjectivities, these are both shifting and contextual. We each experience heterosexual privilege, but our respective family environments are anything but normative.

The primary space of observation and participation in this ethnography was the schools’ sexual and gender diversity group, which we will refer to as the Rainbow group. The group was established in 2012 by one of the school counsellors (Magdalena), who continues to facilitate the group as well as numerous other health promotion initiatives in the school. Magdalena has been working at the school for 21 years. She is the head of guidance in the
school and has three other counsellors in her team. All four of the counsellors are, or have been, teachers and also drive numerous school-wide health and well-being initiatives. We would like to note here that, while the connection between counselling and queer youth is fraught historically in schools (see Quinlivan, 2013; Youdell, 2011), we lack the space in this paper to explore this tension. In total, the study included 30 students and five staff members (all names, including the school name, are pseudonyms). The participants in this study were not only diverse in regards to sexual and gender identities but they also represented a range of ethnic, cultural, religious and social class identities.

There is no room in this paper to report on all of the themes that emerged in this study. This paper focuses on two key themes: complex identities and the use of pronouns, and being an activist group in the school. These two themes are explored in the following two sections.

Findings

Complex identities and the use of pronouns

The existence of the Rainbow group provided space for queer subjectivities and, furthermore, legitimation of intelligible subjects (Butler, 2004). In the preface of “Gender Trouble”, Butler (1999) stated that “If there is a positive normative task in Gender Trouble, it is to insist upon the extension of this legitimacy to bodies that have been regarded as false, unreal, and unintelligible” (p. 24). Drawing on both Butler and Foucault, Youdell (2005) states that “identity categories, including those of gender and sexuality, constitute subjects. These categorical names are central to the performative constitution of the subject who is unintelligible, if not unimaginable, without these” (2005, p. 252) (italics in original). Making the unintelligible intelligible was a key task for some members of the Rainbow group at Kahukura High School. Tensions of intelligibility were evident in the groups’ use of pronouns (he, she, them) to name themselves. Students would use the naming of pronouns to establish and assert their identities. For example, if a student who appeared to be masculine, used the pronoun “she”, then gender norms were disrupted but discussion of pronouns was a constant source of tension in the group. In the very first meeting of the year one student, Tiata, wanted to begin with a round of names and pronouns. Magdalena resisted this request and used her power as a facilitator to stop this from happening. She suggested, instead, that students just share their names. Her intention in doing this was to “protect” the transgender students (from having to choose a particular pronoun and label themselves as “he”, “she” or “them”). However, in subsequent meetings, as the students developed more confidence and autonomy, some began to assert the use of pronouns and use them as a form of celebration of their intelligible (named) gender categories. Magdalena eventually relinquished her fear of “outing” the trans students and joined in this practice. For the remainder of the year each meeting started with students introducing themselves along with their preferred pronoun (examples are “he”, “him”, “she”, “her”, “they”, “them”). From observation, the cis-gendered students (those who conformed to expected gender norms, e.g. a boy who is masculine) within the group relished this opportunity to celebrate their congruent sex/gender identities. Through this practice, they named and owned stable identities. In some ways, while the naming of pronouns exposed gender categories, it also reinforced sex/gender binaries by allowing those who did perform normative gender identities to further their legitimacy. However, those students within the group who identified as transgender also subscribed to the pronoun practice as a celebration of their queer identities. Those students used the gender pronoun that represented their gender performance. For example, the four transgender females in the group always used the pronouns she/her with flamboyant confidence. Some students also used pronouns to disrupt gender labels by changing their pronouns at each meeting, or by refusing to use pronouns at all. Although pronouns might achieve intelligibility by attributing a clear label, for many queer people “intelligibility” is not desirable and is actually at odds with their politics. The
use of shifting pronouns illustrates the parody of heteronorms and thus, actively “troubles” the heterosexual matrix (Butler, 1999). Through the use of diverse and fluid pronouns, the students in this study were rendering themselves as queer subjects, while also pointing out the potential fluidity of gender identities. Socratis, for example, (who used them/their most often for their preferred pronoun) quite commonly moved between gender and sexual identities when introducing themself; they reflected that “from a young age we think that sex is just about the act of sex and then we learn it can be used interchangeably with gender, but I didn’t know there was space for this to be different until I joined the Rainbow group”. Socratis continues to explore this in a follow up interview. At this point, they were in the process of hormone replacement therapy and explained that they were currently experiencing gender dysphoria which was why they quite often moved between gender and sexual identities. Socratis did desire to be a male, however, did not feel comfortable having sex-reassignment surgery (SRS). Socratis explained that they did not want to forgo their queer identity and had no intention of identifying as a heterosexual male. Socratis stated in the second interview with Hayley: “I just don’t feel straight even though I guess I am […] I still want to be queer. I like being queer”. Socratis is, and will remain “biologically” female, but will identify as male and, yet does not want to be seen as straight. They are remaining unintelligible to resist gender norms (Elliot, 2009). Transgender people who refuse the sex/gender binary can be seen by those within the gay/lesbian, queer framework to be more politically progressive than transsexual people and are often praised for not conceding to the sex/gender binary (Elliot, 2009; Namaste, 2005). Students then within the Kahukura Rainbow group who had the desire to be, not only the opposite gender, but also the opposite sex, resisted the use of pronouns because there was not always a clear congruence for them within the binary system. As one student, Vinny – a transman, who says he will one day have SRS but for now uses testosterone and chest binders – explains “testosterone makes me feel comfortable enough for it not to be overly dysphoric for me anymore”. It was often not until Vinny began to see physical changes that Vinny felt comfortable to claim his right to live as a man.

Foucault (1978) describes subjectivity as something made not found. He argues that it is constantly being re-worked as people engage with different ideas, contexts and others. Indeed, gender norms and the production of certain intelligible subjects contributed to the messiness of the LGBTQ students’ subjectivities. The groups’ navigation of gender pronouns highlights how they contested homogeneity and continued, even when seeking legitimation, to disrupt heteronorms.

This resistance moved beyond the binds of the group and into the wider school. The group engaged in practices of activism, to create a culture within their school that “reflected and accepted sexual and gender difference and multiplicity” also (Elliot, 2016, p. 50). One example was the group’s involvement in the school’s Peace Week “Embracing Diversity and Anti Violence Day”.

Being an activist group in the school

Peace week at Kahukura High School is a weeklong event which Sue (another one of the school counsellors) organises with the student peer mediators. The peer mediators were a group of students who worked on conflict resolution, helping others and “increasing peace” at Kahukura High School. Around 200 students apply at the beginning of each year, and 100 are selected to take part in the initial training process with The New Zealand Peace Foundation. Many of the Rainbow group were also peer mediators. The role of the mediators is not only to help students resolve conflict behind closed doors in a confidential mediation room, it is also about being ambassadors of social justice. Mediators were supposed to lead in the school community by “promoting and modelling fairness and respect for others, watching out for harassment and bullying, and by supporting students to get help when needed”. Mediators led in the celebration of International Peace Week at Kahukura High
School during the week of the 8-12 August. Peace week is a student-driven and student-owned campaign, where all the mediators are meant to collaborate together.

During peace week, mediators and school counsellors organised a number of activities, such as: a peace assembly presentation, face painting, peace badge making, the wearing of white ribbons for peace, painted peace banners and t-shirts. On the Wednesday of peace week, they facilitated an "Embracing Diversity and Anti Violence Day". On this day, the hall was filled with information stalls from outside agencies and NGOs such as Manalive[3], SHINE[4], Rape Prevention Education, Youthline[5], Fonua Ola[6], plus student run stalls such as the Rainbow Group, "Violence is not ok campaign"[7], Peer Sexuality Support Programme, Amnesty International, Live4Tomorrow[8], Body Image Leaders, Refugee awareness, Crane making and Peace Badge making. The Rainbow group were involved in the lunchtime expo and had organised their own stand. Tiata organised the Rainbow group members on Monday and Tuesday to make the banners and to plan the design and purpose of their stand. The group made little "sandwich boards" which said "Rainbow Group – gender and sexual diversity – do you have a rainbow flag?" The Rainbow group decided to reward students who came to the stand, and those wearing a rainbow ribbon shirt pin, by giving them rainbow candy. They also sourced brochures containing information about gender and sexual diversity and relationships to hand out to students. Over the two days before the expo, members of the group worked on two dazzling brightly coloured and glitter-covered flags. One was the bisexual flag[9] with the words "gender and sexual diversity" written on it and the other was a bright rainbow with "Rainbow Group" boldly written in the middle of the flag.

The day arrived and the group were full of energy and excitement. The students worked together to create their shrine to the Rainbow group. Pushing some tables together and hanging a bright rainbow flag which said PEACE over them to create the atmosphere. The students set to staking their claim to the area they had, and hung their flags with delight up high behind their stand. They poured big bowls full of rainbow coloured candy and placed them around the tables. The LGBTQ brochures were displayed in rainbow shapes over the tables, reading: "You, Me/Us – Our People our Relationships", “Affirming Diversity” and “Queer and Trans 101 – A super simple comic guide”. On a concrete beam beside the stand, the group hung a poster picturing two young men sitting together, the words "It's OK to be who you are” were written on the poster.

The bell rang and students started flowing out of the classrooms and racing to the hall to be the first to get the giveaways and prizes at the stalls. The Rainbow group rushed around urgently trying to complete their stand. Asti, who identifies as bisexual, exclaimed "quick, quick – who is going to put the [sandwich] boards on?!" The group all looked at each other, panicked. The hall was filling up and the realisation hit. For some, this was their first time been associated with the Rainbow group in a public space. The students suddenly realised that walking around the hall and out into the playground with a sign that said "Rainbow Group – Gender and Sexual Diversity" was an extremely visible and isolating action. Two members of the group, Rushdi and Tiva, finally decided they would wear the boards; they both identified as heterosexual. The other board was taped to the stand.

Foucault (1984) notes that collectivity is inexplicably related to issues of power. He states that “We are all governed and, as such, bound by solidarity” (p. 1526). Golder (2013, p. 183) also explains that “[…] if this solidarity is not natural, it is not unthinkable. For all subjective protest has meaning only if it can connect with a ‘concrete’ we, whatever the form that this may take”. The solidarity of the Rainbow group inhered in their united presence at the stand. In this sense, the group were strategically reinstating homogeneity, an explicit contrast to the desire for heterogeneity exemplified in the discussion of pronouns. It was clear that they felt “safe” behind the Rainbow stand but less so if they “stepped out” into the school grounds alone. Those who identified as LGBTQ did not feel comfortable walking around alone, making a “subjective protest” with their sandwich boards as they were not.

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“bound by solidarity” – they were isolated and in a position of vulnerability. Indeed, the power of the heterosexual matrix, heteronormativity and cisnormativity were more keenly felt when students were alone and away from the rainbow group. Reflecting on this in a later discussion, Hayley asked Raven about this:

Hayley: Was everyone supportive that you talked to that came up to the stand?

Raven: Yeah, I think so yeah.

Hayley: Did anyone ask any questions?

Raven: I saw one guy he was like “What is this?” I said: “We are the Rainbow group, we support gender and sexual diversity, do you support equal rights?” He was like “Yeah, of course!” So I gave him a handful of candy and a high five.

Hayley: Cool, how did it make you feel?

Raven: It was fun, like I enjoyed it because, like, people, I don’t know, could see our group.

It was clear, however, that the group felt torn between having an activist presence in the school, and being too exposed. Magdalena was also torn. She commented that, “I love the passion the students have, however, I still feel protective of them”. Magdalena’s worries did not preclude her support of the students’ actions, but she wanted them to be cautious. The tension which Magdalena felt between increasing the visibility of the LGBTQ students while also maintaining safety was mirrored in the Rainbow students’ actions and thoughts. This was evident in the group’s hesitation to wear the sandwich board; only those who identified as heterosexual felt confident to do so. Hayley later asked Socratis about this:

Hayley: So why do you think this year was the first time the Rainbow group had a stand at the Peace stall?

Socratis: Um, because Magdalena had wanted to keep it on the low down.

Hayley: What are your thoughts about that?

Socratis: Well it’s good because we don’t want to “out” anyone. But, at the same time, we’ve got these people who aren’t out that want to come but don’t know anyone, you know.

It is evident from this discussion that the group experienced tensions between visibility and exposure. The Rainbow group was the most visible it had ever been in 2016. However, the thoughts, and ultimately actions of the group gave greater visibility to the students themselves, not only to the narrow nature of gender categories consistent with the heterosexual matrix (Butler, 1999). Butler (2004, p. 218) notes that “if gender is performative, then it follows that the reality of gender is itself produced as an effect of the performance”. For students to question the reality of (only) binary gendered performance potentially exposed them. As Sykes (2011, p. 94) argues “The proximity and possibility of lesbian, bi, queer and gay sexualities threaten to reveal this phantasy […] to reveal the constructed ontological basis of heterosexuality”. While students were comfortable naming and questioning gender norms within the Rainbow group meetings, moving out to do this (alone) in the wider school was more challenging. Indeed, the messiness of the desire to be heterogeneous yet sometimes “needing” to perform homogeneity was evident here. However, this did not prevent them from continuing the peace week stall, nor did it prevent them from strategically identifying collectively and publically as Rainbow group members. While the “compulsory system” of heteronorms (Butler, 1999) continues to circumscribe possibilities in this school, students were also (perhaps) beginning to trouble it publically in the school. Atkinson and DePalma (2009, p. 21) argue that engaging in “unbelieving the matrix” might actually begin from, not only collective struggle, but such “a place of uncertainty”.
Conclusion

While evidence suggests that schools remain problematic and constraining spaces for LGBTQ students and staff, wider social and political shifts are impacting school environments. This paper reported on a critical ethnographic study, the purpose of which was to explore how LGBTQ students experience schooling, and how an active Rainbow group at the school challenged narrow conceptualisations of gender and sexuality. Contestation for heterogeneity within the group ultimately opened up what was possible for the students to achieve beyond the group. In this sense, these students grappled with ways to explore and express their own diverse identity positions, yet strategically join as one to challenge wider school culture. In so doing, the students in this study demonstrated their own use of capillary power. Conscious of the limits of capillary power, they engaged in collective action. As Foucault (1995, pp. 26-27) states, “[...] power is exercised rather than possessed; it is not the ‘privilege’, acquired or preserved, of the dominant class, but the overall effect of its strategic positions [...]”. The strategic actions that students undertook in the wider school highlighted heteronormative power, but also challenged it. Such moves invariably create feelings of exposure and uncertainty. Atkinson and DePalma (2009) note, however, that such uncertainty can be productive in shifting attention away from the power of the heterosexual matrix, and moving towards “queering” practices in schools.

In this study, the critical practices of the school counselor, Magdalena, were central in opening up possibilities for the LGBTQ students. The Rainbow group she created and facilitated provided a space for students to explore their own uncertainties, to express diverse identities and to engage in processes of legitimation and making-intelligible (and, for some, embracing un-intelligibility). The group provided space for the Rainbow students to recognise the parody of heteronorms and to begin to trouble the constraints of the heterosexual matrix in the wider school. These meetings, actions, discussions and initiatives were moments of resistance in the school: times when a greater diversity of gender and sexual identities were visible. For students, this resistance to heteronormative practices meant a more inclusive culture was possible. As Raven said about the Rainbow group stall at Peace Week “It’s good because it makes me think it is getting more inclusive at school because now we are actually doing that”. But, students also wanted to remain “queer”, they liked being queer. The Rainbow group navigated the complexities of intersectional subjectivities within the group in a battle for heterogeneity – in a desire to remain queer. Indeed, this battle continued to reproduce intelligible subjects and to reinstate forms of othering within a celebration of difference and equality.

Notes

1. In this paper, we use particular terminology when discussing gender and sexually diverse identities. We have chosen to use the acronym LGBTQ, and the terms “rainbow” and “queer”. While terminology is contested in the field of gender and sexuality, these terms are generally accepted as inclusive of a range of identities, while also signalling gender fluidity (de Lauretis, 1991; Warner 1993; Jagose, 1996).
2. Lucassen et al. (2014) defined the term “come out” to mean that those attracted to the same/both sex told people close to them about their sexuality.
3. ManAlive is a community group who work to promote positive manhood and strong relationships through a range of integrated services (http://manalive.org.nz/).
4. Shine is a national domestic abuse charity and runs a domestic abuse helpline to help keep people safe from domestic abuse and family violence (www.2shine.org.nz/).
5. Youthline is a national organisation which was “established to ensure young people know where to get help and can access support when they need it. At the core of Youthline’s work is the development of leadership and personal skills in young people” (www.youthline.co.nz/).
6. Fonua Ola is a social services which predominantly supports the local Pacific community within New Zealand, with strengths based social services (www.fonuaola.org.nz).

7. “Violence is not ok” campaign is a student-led group at Kahukura High School who actively work to promote safer relationships and advocate against domestic violence.

8. Live4Tomorrow is a student-led group at Kahukura High School who work to promote messages around inclusion and empathy. The focus on de-stigmatising mental health and to increase awareness and acceptance of mental health.

9. The bisexual flag is three horizontal strips: pink, lavender, and blue (ratio 2:1:2). The pink colour represents sexual attraction to the same sex only (gay and lesbian), the blue represents sexual attraction to the opposite sex only (straight) and the resultant overlap colour purple represents sexual attraction to both sexes.

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Further reading


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Children as change agents for family health

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Abstract
Purpose – The purpose of this paper is to explore ways in which children and young people are being positioned as change agents for families through school health promotion initiatives in New Zealand.
Design/methodology/approach – The paper maps and describes the kinds of policies and initiatives that directly or indirectly regard children as conduits of healthy eating and exercise messages/practices for families. Drawing on post-structural theoretical frameworks, it explores what these resources suggest in terms of how healthy families should live.
Findings – Families are positioned as central to school health promotion initiatives in New Zealand, especially in relation to obesity prevention policies and strategies. Children are further positioned as agents of change for families in many of the resources/policies/initiatives reviewed. They are represented as key transmitters and translators of school-based health knowledge and as capable of, and responsible for, helping their families eat well and exercise more.
Social implications – While recognising children’s agency and capacity to translate health messages is a powerful and welcome message at one level, the author need to consider the implications of requiring children to convey health information, to judge their family practices and, at times, to be expected to change these. This may create anxiety, family division and expect too much of children.
Originality/value – The paper takes a novel post-structural perspective on a familiar health promotion issue. Given the proliferation of family-focussed health initiatives in New Zealand and elsewhere, this perspective may help us to explore, critique and understand more fully how children are expected to be engaged in these initiatives, and the potentially harmful implications of these expectations.

Keywords Family, Sociology, Education, Health, Childhood obesity

Paper type Conceptual paper

Introduction
“It’s about whānau (family)” (I/AW) sings the “overlay” on a New Zealand quit smoking television campaign (Grigg et al., 2008). “We feed our families because we love them [...]. We’re giving our families too much love” (Ministry of Health, 2015) declares a New Zealand Olympian on an anti-obesity television advertisement. And, from the pages of a New Zealand health education resource comes the imperative: “Lead by example – encourage your family and whānau (family) and friends to make healthy food choices” (Ministry of Health, 2012).

These are just three of a raft of current public health initiatives that start and finish with a focus on families. These kinds of instructions about “how to live” (Foucault, 1977) and who to live for appear not only in New Zealand, but across multiple countries and regions of the globalised world (Burrows, 2009; Fullagar, 2009; Maher et al., 2013; Pike and Leahy, 2016). They are mere dots in a juggernaut of family-focussed health interventions that position children as either victims of unhealthy adult practices or the reason why adults should change what they do (Vincent and Ball, 2007).

Perhaps nowhere is the family focus more evident than in policies and practices linked to obesity. Fuelled by a prevailing yet contentious assumption that obesity is a lifestyle disease (see Gard, 2011; Gard and Wright, 2005), linked predominantly to sedentary behaviour, poor nutrition and an obesogenic environment (Swinburn et al., 2015), corporate and public health interventions tend to focus on attitudinal and behavioural change in families. For example, “Fighting fat isn’t a one-person job – it’s a family responsibility [...]” according to a US Weight Watchers study (cited in Crawford, 2010). “Healthy Eating and Active Lifestyles Begin at Home” according to Harvard’s School of Public Health. And, in New Zealand,
Healthy Families New Zealand encourages “families to live healthy lives by making good food choices, being physically active, sustaining a healthy weight, not smoking, and drinking alcohol only in moderation”. Claims such as “70 per cent of parents of overweight children did not realise or accept that they were overweight” (Taylor cited in Gee and Anderson, 2016) and “poor people are obese due to a lack of food knowledge” (Coleman cited in Shuttleworth, 2015) pepper the reporting accompanying the release of the New Zealand initiative.

These kinds of refrains frame the obesity “problem” as one related to parental failure to “know” and to “act” in ways that will halt the rise of childhood obesity. As many scholars have pointed out, mothers in particular are the parent charged with ensuring their children eat well, exercise appropriately and maintain a healthy weight (Fullagar, 2009; Maher et al., 2013; McCormack, 2012). In recent years, mothers’ culpability for the fat that exists (or not) on their children’s bodies has extended to concern about mothers-to-be. A new descriptor – “maternal obesity” – has entered public and medical discourse to categorise excess weight in pregnant women as a pathological state in need of medical management. As Parker (2012, 2016) suggests, the classification and management of “maternal obesity” as a high risk phenomenon within medical circles (and in popular media) has served to justify multiple practices of intervention and surveillance of mothers’ and would-be mothers’ lives.

In tandem with initiatives that harness parents to an obesity reduction agenda, children are also becoming implicated in the governance of healthy family lifestyles. Public health air space is rich with health messages that explicitly target children as change agents for families (Burrows, 2009; Pike and Leahy, 2016), and, arguably, nowhere is the role of children as transmitters of health information more emphatically realised than in schools. Mainstream, and rarely challenged, bio-scientific knowledge about obesity in particular is being recontextualised, repackaged and distributed in manageable and consumable chunks for young people in schools. They are then encouraged to transmit these morsels across the porous boundaries of school to home and family (Burrows, 2016; Leahy et al., 2016). The mediums through which this transmission occurs range from government policies to private agencies delivering health education outcomes in schools; from school-based education resources, to large scale public health campaigns; and from teachers to puppets. Even in the seemingly innocuous newsletters sent home to parents/carers in children’s school bags are countless imaginings of how and why children can act as change agents for health in their familial worlds. What kinds of expectations of children are embedded in these documents? How are parents drawn in to children’s health promoting endeavours? What do these resources suggest in terms of how healthy families should live?

The paper begins by canvassing the theoretical resources and data used to interrogate these questions before describing some of the ways in which children and young people are being positioned as change agents for families through New Zealand school health promotion and education initiatives, in particular those related to obesity. It then considers the implications of this for children, for families, and for the interrelationship between the two. While focussed on the New Zealand context, the mediums and modes used to convey messages are shared across the globalised world. So too, is the substance of many of the messages.

**Theoretical perspectives**

Post-structural theoretical frameworks have been drawn on by scholars to hone attention to the ways public health discourses, and obesity discourses in particular, generate notions about how families are expected to function and what work they are required to do (e.g. Burrows, 2009; Fullagar, 2009; Pike and Leahy, 2016). This paper, too, is informed by post-structural theoretical frameworks, particularly the concepts of discourse, subjectivity and power-knowledge.

Discourses, as conceived of by Foucault (1980), systematically form the objects of which they speak. They are collections of ideas, practices and language that together produce meaning.
As Ball (1990) suggests, discourses shape what can be said and thought about things and who can speak, and on what authority. At any point in time some discourses may be on the rise while others struggle to gain purchase. Methodologically, this encourages a questioning of what sets of circumstances, practices and knowledge (i.e. discourses) have produced a climate where young people can be represented as saviours for an adult generation. It means critically examining documents to interrogate the kinds of assumptions about who children are, their role/influence in family groupings, their living arrangements and the cultural and economic resources embedded within them. It also means paying close attention when reading documents and initiatives as to what is rendered “normal” and what is barely present or “unsayable” given the particular confluence of discourses assembled.

Subjectivity is another useful post-structural term that assists methodologically in understanding how children can and/or should be change agents for their families in health matters. Post-structuralist conceptions of subjectivity regard the self as something that is constantly in flux, being re-worked and re-made as one engages with different discourses, contexts and people. People, according to post-structuralist theorists, may be positioned differently in relation to any particular practice or thought depending on a range of factors, including status, ethnicity and gender (Wright, 2004). Thinking about subjectivity this way prompts questions about what kinds of children are hailed in particular health initiatives. It also generates questions about how diverse children engage with health initiatives and how doing so shapes who they are and can be. While this paper does not deal with children’s experience of health initiatives, reference to other work which has endeavoured to understand how children make sense of health, and what effect it has on their sense of themselves (e.g. Atkins, 2015; Burrows, 2011; Evans et al., 2008) can yield some insights here.

The post-structuralist notion that power and knowledge are intimately linked, with power being conceived as productive, useful and something that infiltrates all social relations, is useful when investigating children’s positioning as change agents for health. Rather than viewing power as something oppressive, held and exerted by an authority over others (e.g. teachers over students), power, in post-structuralist terms is regarded as capillary-like, stretching and roaming in multiple directions (Lloyd, 2005) and always productive of knowledge and vice versa. This way of thinking about power-knowledge orients the researcher to not only explore the ways health initiatives constitute and regulate the behaviour and dispositions of children and families, but also toward asking questions about how children and families may resist and re-work health knowledge in their day-to-day lives. It also supports an interrogation of the discursive effects emerging from a positioning of children and young people as agentic in family health concerns. What flows from an understanding that children can or will perform the pedagogical work of changing family health practices? What do resources like those described in this paper do to, and for families? How do instructions on “how to live” (Foucault, 1977), conveyed via children to families, shape who parents and children can “be”?

Sources drawn on throughout the paper include a range of health education and health promotion resources and policies used in New Zealand schools and communities over the past decade. These were initially collated by the author as part of a project designed to map the array of health and physical activity initiatives present in New Zealand schools (see Burrows et al., 2015). For the purpose of this paper, exemplars are selected on the basis that they yield some insight into how children are being positioned as change agents with regard to family health. Professional and lay commentary on families as health-enhancing sites, both in New Zealand and elsewhere is also included to contextualise the emergence of the aforementioned initiatives. These commentaries have been collated over the past decade (both on and offline) as part of on-going research investigating the discourses shaping young people’s engagement with health knowledge in New Zealand. While formal policies and programmes say something about what is planned and/or desired for children and
families, as Leahy (2012) attests, it is the ways that forms of health education and promotion are assembled, the linkages forged across politics, education, health and policy with pedagogy and curriculum, that breathe “truth” into particular ideas and practices in the health education realm. It is therefore important to understand something about the ways resources and policies are translated in popular and professional media.

**Children as family “health advisors”: mapping the terrain**

“What is the problem represented to be?” is the question driving policy theorist Carol Bacchi’s (1999) work. This post-structural question can usefully be asked in relation to contemporary concerns about obesity in New Zealand and elsewhere. As scholars writing about the topic of obesity have illustrated (e.g. Gard and Wright, 2005; Gard and Pluim, 2014), the obesity “problem” is, at its most basic level, predominantly represented as a problem of people failing to eat healthy foods and exercise in appropriate doses. Undergirding this shaping of the problem is an assumption that people don’t know what to do nor how to do it and so help, in the form of public and private agencies, is warranted.

Driving the proliferation of health resources with child as change agent seems to be a concern that many parents are failing to transmit and/or role model healthy habits for their young. In New Zealand, Pasifika and Māori communities, and those living in poverty, are particularly singled out for special forms of education, are targeted in public health initiatives (e.g. Healthy Families New Zealand) and resourced in ways that suggest a fundamental distrust in their capacity to provide their children with healthy nutrition and physical activity opportunities (Burrows, 2009; Hokowhitu, 2016; McCormack and Burrows, 2015). One expression of this ethos, as signalled in the introduction, is the recent airing of a government sponsored nutrition message on national television. In it, an iconic national athlete of Pasifika ethnicity suggests that parents may be “loving their children too much” by feeding them too much junk food (Ministry of Health, 2015). While the notion that it is possible to love a child too much is troublesome, it is the presumption that parents do not know, do not understand, and need to be told how to care for their youngsters that is startling. Similar sentiments can be found when reviewing televised weight-loss programmes. In 2006, for example, New Zealand’s “Honey we’re killing the kids” featured a Pasifika family with an avowedly overweight nine-year-old child. As reported in the *New Zealand Listener* during this show:

Iona (the mum) learnt that she was using too much fat in her cooking and too much junk food in the kids’ lunchboxes. She still cries when she talks about the photo the show mocked up of what Henry would look like if he didn’t change his lifestyle. As she exclaimed, ‘It wasn’t our Henry, it was horrible. We were killing him’ (Spratt, 2006 cited in Burrows, 2009, p. 134).

In the above excerpt, the mother’s culpability is clearly portrayed. Saving her child, according to the programme’s presenters, will necessitate a change in family lifestyle and habits.

Another expression of this ethos can be found when analysing the ways Pasifika bodies are represented in obesity science. As McCormack and Burrows (2015) reveal, brown bodies are regularly positioned as problematic on account of their avowed overweight with parents rendered culpable for the fat that accumulates on their children’s bodies. Even in scientific work that is ostensibly about mapping the scale of the obesity problem, unsubstantiated assumptions about parental failure to know or act regularly appear. For example, a New Zealand obesity researcher, speaking of extremely obese Pacific Island children, is quoted as stating:

> These children are already so obese that it is bad for their health [...] We need to convey this to their parents because many of them don’t realise the risks for children and don’t associate it with bad health (University of Otago, 2007 cited in McCormack and Burrows, 2015, p. 375).
Despite the fact there was no focus on parents in this scholar’s paper, nor any methodological apparatus used that would address parents’ role in producing fat children, Pasifika parents are presented as ignorant. As McCormack and Burrows (2015) suggest, normalising practices, and the constitution and application of discourses of ignorance, afford both the means and rationale for pedagogues and policy makers to constitute brown parents’ bodies as objects to be worked on.

Furthermore, as Parker (2016) and others contend, it would seem that most parents, regardless of ethnicity, are currently assumed to be ineffectual and/or ignorant with regard to their role as health enhancers. In Bacchi’s (1999) terms, if parents are the problem and, as signalled above, regularly regarded as something of a lost cause, then it is little surprise that children are currently being positioned by health agencies as the hope for the future, as able to achieve long-term change in health practices through both their own behaviours and through information they can carry back to their families.

Life Education is one agency that appears explicitly committed to the notion that children can and should transmit healthy habits to their families (Burrows, 2010). Life Education is a travelling bus that visits (on invitation) primary schools throughout New Zealand. It teaches health and nutrition to 245,000 Kiwi children each year. Harold the giraffe (a puppet) is Life Education’s mascot and in many ways its pedagogue. While a human being delivers information about body systems, self-esteem, nutrition and other matters, it is Harold who children remember. He is the mouthpiece for health messages and his influence is substantial according to parent feedback. Indeed, as Burrows (2010) found, often, Life Education and Harold in particular, are all that primary school children can recall about their experience of school-based health education. Tucked on the inside cover page of Life Education Trust’s *Take Home Work Book 2*, is the question: “KIDS, Why not get the adults at your home to help you learn why you’re so special and unique. Your friend Harold” (Life Education Trust New Zealand, 1996, p. 1). The back page inside cover reads “Kids! Grab your adult!” (Life Education Trust New Zealand, 1996, p. 18), the idea being that adults will ask children to rehearse what they learned about health in the Life Education Bus that day. A session on recycling ends with children writing a newsletter “to take home to their parents to ask for their help to cut down on the amount of packaging in their lunches” (Life Education Trust New Zealand, 2016a) and a healthy diet lesson urges children to eat with their family. Embedded in these resources is a direct appeal for children to take home and share health messages garnered from their time in the Life Education Bus. Indeed, as the following testimonial from a parent declares, children are not only hailed as ambassadors for healthy living, but some are accorded the status of family health advisors:

She came home and made a paper doll and put labels on the body parts she had learned on Friday, added the veins and arteries. She is now our Health Advisor in the Family!! (Life Education Trust New Zealand, 2016b).

Building on the successes claimed by Life Education, a recent partnership between this agency and a Garden to Table group will see a programme called Empower rolled out for 32,000 Kiwi children attending 170 schools in New Zealand over a two-year period. The main objective is to create a comprehensive and sustainable programme to reduce child obesity in New Zealand. As Life Education’s Chief Executive, John O’Connell (2016) suggests: “Through Empower, we want children to understand where food comes from and the importance it plays in our health so they can take that knowledge back to their families and communities”. In this scenario, producing thousands of young health advisors is the aim.

The New Zealand Heart Foundation also offers a plethora of resources with invocations embedded within them for children to reach out to their families for example the Heart Start: Toitoi Manawa’s “Spread the Healthy Word” (Heart Foundation, 2016). The Food for Thought nutrition programme (Food for Thought Education Trust, 2016) is another. In the
latter, programme nutritionists visit primary school classes, plan shared meals and facilitate field trips to local supermarkets. Presumably, given that most young children are not responsible for supermarket purchases, nor in charge of how meals are prepared, the idea is that freshly informed youngsters may be able to impart some of their newly acquired knowledge, thus shaping the content, size and shape of meals consumed in family homes. As the Food for Thought creators claim, “with one third of New Zealand children currently overweight or obese, the need for Food for Thought is particularly relevant today” (Food for Thought Education Trust, 2016). Other resources such as “Healthy Eating for Young People”, are more explicit about the direct ways children can influence family eating practices:

Help with preparing the family meals. You could even have one night a week when you cook for the whole family. Lead by example – encourage your family and whānau and friends to make healthy food choices (Ministry of Health, 2012).

Healthy Homework is another New Zealand initiative that gained considerable traction in some parts of the country five years ago. Recognising the porous boundaries between home and school and that much of a child’s behaviour and disposition is shaped in the home, this programme was explicitly designed to influence communities and families. Students took part in an eight-week programme, keeping a diary of what they ate and wearing a pedometer to record their activity levels. They were asked to complete healthy homework activities with their families with incremental rewards given (e.g. wristbands) as more and more healthy homework was completed (Atkins, 2015). As one journalist described it, “The leader of a $1.2m university study hopes to make Kiwi parents more healthy by giving their kids ‘healthy homework’” (Grunwell, 2011).

In these examples the usual pedagogical expectations are reversed. It is the child as knower who can advise her parents, garner knowledge, share it, and thus shape the practices and dispositions of the family. Here children are positioned as agentic, parents as ignorant yet “teachable”, and family homes as prime sites for anti-obesity and “health” work.

When thinking about what makes it possible to even imagine that children could perform such a transformative role in their families, shifting conceptualisations of childhood itself yield some insight. Perspectives from the sociology of childhood (e.g. Mayall, 2002; Prout and James, 1997; Qvortrup, 2009), together with emergent calls from government to “listen to the voices of young people” have garnered traction in New Zealand in recent years (Smith, 2013). The idea that children are thinking, feeling, knowing beings who can and do have important things to say and do in our worlds and that can contribute positively has seen agencies like the Office for the Commissioner of Children and Ministries of Youth Affairs, Education and Local Government increasingly seek the perspectives of children and young people (Smith, 2013). A broader discourse of child agency and children’s rights has to some extent superseded more traditional understandings of children as passive recipients of adult care. The active, agentic and knowing child is one who can and does assume responsibility for effecting change. The notion of a small child assisting his/her family to change their eating and physical activity practices seems viable, indeed necessary, within this discourse of childhood.

Another potential contributor to the positioning of children as family health change agents comes from an unlikely source: the New Zealand Curriculum (Ministry of Education, 2007). As an ever-expanding array of health initiatives flood school programmes in New Zealand (Burrows et al., 2015), agencies have found themselves competing with each other for access to the school environs. As a result, many not-for-profit and commercial resources are now anchoring their activities to the New Zealand Curriculum in an effort to provide teachers with a curriculum aligned ready made resource (Penney et al., 2015; Petrie et al., 2014; Powell, 2015). For example, the Food for Thought programme described above, explicitly links its content to several of the level 3 and 4 curriculum standards for Health and Physical Education (Ministry of Education, 2007).
While presumably its writers did not intend for curriculum achievement standards to be interwoven into commercial and public health initiatives, almost all of the obesity-related packages on offer currently do endeavour to harness their agendas tightly to these curriculum imperatives. In a sense, the curriculum itself creates a space for validating the notion that children can be and should be responsible for taking informed and responsible action in relation to people other than themselves. Families are a logical and accessible choice here.

There are undoubtedly many more contributors to the current surge in popularity of child as change agent initiatives, including neoliberal notions of shedding state responsibility for health care to individuals (Evans and Davies, 2014), developmental ideas about the innocence and malleability of youth (Mayall, 1994) and a recognition that boundaries between home and school are porous (Leahy et al., 2016). Given these circumstances, recruiting children as transmission agents seems to make sense, yet with what effects and affects for children and for families and indeed, for schools?

Consequences for children and families
In this section some of the potential consequences for children and families are discussed. Particular foci include the contradictions, anomalies, ethical and educational issues that arise amidst the rise and rise of family-focussed health pedagogies with children at their centre.

Double bind?
The kinds of resources and imperatives discussed throughout this paper appear relatively innocuous at first glance. On the one hand, having adults engaged in children’s education, encouraging their “interest” in what goes on in school-based curriculum practices (as is evident in the Life Education resources) is at first sight a useful thing. In the telling of what they learned, presumably children have a chance to re-think and re-frame what they learned in ways that might render the knowledge useful in the family and/or home context.

On the other hand, children may find themselves in a double bind, being regarded both as vulnerable future citizens in need of protection, and simultaneously, as agentic individuals capable and culpable for effecting long-term health change for their families and themselves. The injunction to convey health information back to their families, particularly when food and exercise practices are often framed as “good” or “bad” can provoke moral judgements about family members’ behaviour (McCormack and Burrows, 2015), it can alter family dynamics, roles and responsibilities (e.g. child as “family health expert”) and in some scenarios potentially prompt children to question the care and capability of their families (Pike and Leahy, 2012).

Anxiety
While there is little research that specifically investigates how children make sense of their role in taking home school health education knowledge, there are indications from other research that dissonances between school-based and family-based understandings about health can breed considerable anxieties for children (Backett-Milburn and Jackson, 2012; Burrows, 2010, 2011; Dagkas and Quarmby, 2012; Evans et al., 2008, 2011), some of whom worry about the present and future prospects for family members who they identify as unhealthy on account of weight or eating practices. Further, the potential shift in family relationships and dynamics as a result of children being positioned as family health pedagogues is a matter worthy of consideration (Vincent et al., 2013), particularly when, as suggested earlier, research to date reveals that an oft-unintended outcome of family health interventions is a positioning of parents as faulty and/or failing in their obligations (see Vander Schee, 2009).
Homogenised families
Not all children, even if they were willing to perform the transmitting function, have life circumstances, dispositions and/or the resources needed to take on a pedagogical role in their families. There seems to be little cognisance of differently situated families and the relative impact of anti-obesity and health promotion discourses on children within them. Despite a rhetoric of difference, diversity and recognition of the impact of socioeconomic, cultural and locale on family dispositions and behaviours (e.g. Healthy Families New Zealand), across much of the resources and public health messaging there are signs that family is largely construed as if it was a monolithic thing, a universally understood unit that will be (or ought to be) thoroughly invested in the procurement of a healthy ideal largely derived from westernised premises (Burrows, 2016). What makes a life good will be conceived differently by different families. As numerous scholars within and outside of sociology would attest, families are anything but uniform in their make-up, their cultural mores or their ways of functioning in relation to each other (Dagkas, 2016).

As Hokowhitu (2016) suggests, the invocations for children to improve, clean, fuel and render active, the bodies of their families amounts to not only an unreasonable burden on children, but also engages young people in what is essentially a colonist project. Children are being willed to act as agents of change for the fleshy indigenous bodies of their own families. The imperative to act is often represented as an opportunity to make a difference, to free loved ones from the burden of their unwellness, or potential unwellness, yet at what cost? As signalled earlier, research investigating children’s perspectives on their own and others’ health suggests that children themselves may already harbour worries about their family’s health status. When children are fearful about potential health outcomes for members of their family, an invocation to participate (and potentially fail) in improving their lot seems like an unreasonable burden.

Pedagogical burden
In New Zealand, a new policy requires all under four-year-old children identified as overweight to be referred for treatment (e.g. dietary advice, on-going monitoring). Having recognised on some level that weight stigma can interfere with successful interventions, nurses are currently undergoing in-service education to assist them in engaging sensitively with families around overweight (Cassie, 2016). If nurses need special training to do this, what would children need to work in their own families in ways that do not exacerbate existing anxieties? Other work has signalled the kinds of affects food policing can have on middle-class mothers. O’Flynn (2015), for example, ruminates on how she felt ashamed when the school sent her child home with the cake she had made for his birthday. The cake apparently failed to feature on the healthy food chart used in his class, thus the teacher returned it to the family. The cake apparently failed to feature on the healthy food chart used in his class, thus the teacher returned it to the family. If an academic, with ready access to resources to critique such practices can still “feel” bad about transgressing the “health code” at her son’s school, one can only imagine how parents from families who are regularly targeted by health initiatives might feel, having their own children reject their offers of food. In an important sense, for those groups regularly in the firing line of government or agency-imposed health initiatives (e.g. Māori, Pasifika, those living beyond the “poverty line”), home may well represent a sanctuary, a place where one can live as one wants to without state interference. Having their own children potentially judge, moralise, cajole and pester them about their health practices from the “inside” is something many might unsurprisingly find challenging.

Leahy et al. (2016, p. 1) suggest that health interventions need to be viewed in terms of what is possible and reasonable to expect of children. While bereft of direct empirical research data to add weight to his presumption, requiring children to bear and embed health messages within their families may be neither possible nor reasonable. The pedagogical burden, coupled with the potential impact on family relationships, raises questions about
the wisdom of deliberately positioning children as change agents for family health. Research that purposively seeks to understand how children comprehend and respond to this role will be crucial as more initiatives like those described in this paper are rolled out across the country. There is also a need for research that examines the lived and complex contexts of families and the relationships that mediate the transmission of public health messages. As Lindsay and Maher (2013) point out, expecting children to transmit messages about food and physical activity is far from a straightforward matter. Negotiations of care, consideration of social and economic resources available, together with relationships between siblings, parents and wider family members are all part of the mix. Research that engages the perspectives of those who are being called to act in the name of family health will be vital prior to further investment in children as agents of health change in families.

Who and what drives curriculum?
Finally, in terms of health and physical education in schools, the proliferation of external “experts”, whether these come in the form of resources produced by outside agencies or visits from the external agents themselves, can shape the substance and quality of a child’s education. For example, when one size fits all packages are introduced, some of which are sponsored, at least in part by corporate agencies (Powell, 2014), the learning needs and outcomes of schooling can shift in ways not necessarily conducive to children’s best interests, nor curriculum aspirations. As several New Zealand commentators have suggested, external providers need to be working with the teachers rather than on their students; programmes need to align, not simply with the achievement objectives specified in the HPE curriculum, but also with the underlying concepts, key competencies and principles of good pedagogy supported in that document (Petrie, 2012; Tasker, 2006). A flourishing desire to have children transmit health messages to families may well prompt a questioning by parents/carers of the functions and scope of the curriculum their children are engaging with.

Concluding thoughts
In October 2016, the author of a New South Wales Health report on schools’ nutrition and physical activity suggested adding physical activity measures to Australia’s National Assessment Program – Literacy and Numeracy (NAPLAN) was the best way to improve health among school children. She went on to claim that “the move should be part of a broader suite of measures which included limiting recreational computer screen time and working with families to improve children’s diet at home” (Vukovic, 2016). This recommendation was rejected by NSW Health, yet the fact that such a suggestion could be seriously advanced by a health expert illustrates the extent to which schools, and the children they serve can be, and are, harnessed to obesity fighting agendas. Those opposed to the recommendation to essentially make obesity (via reference to its avowed causes) a measure used to compare and rate schools agree that such a move would hinder rather than advance the interests of children. As Australia’s opposition education Spokesman Jihad Dib (cited in Vukovic, 2016) said, “we already know there’s a massive issue with body image among kids particularly with teenagers […]. The mandatory physical testing will only further contribute to massive anxiety among kids”. While the resources, interventions and people encouraging children to change their family’s health habits canvassed in this paper do not necessarily argue for including physical activity/diet measures in formal reporting programmes for schools, it is not a leap too far to imagine that they may do in the future. O’Dea’s (2005) principle that any brand of health intervention should first and foremost do no harm, would seem a useful one to bear in mind when contemplating further expansion of initiatives that position children as agents for family health change.
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Further reading


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Working against “pedagogic work”

Challenges to engaging pre-service teachers in critical health education

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Abstract

Purpose – Equipping pre-service teachers with the skills and knowledge needed to teach health in socially critical ways requires pre-service teachers to examine and critique individualistic understandings of health. The purpose of this paper is to use Bourdieu’s concepts of the bodily hexis (the body as both separate from society (autonomous individuals) and the body as socially mediated (the influence of social forces upon individuals)) and pedagogic work to investigate the challenges of redressing the reproduction of individualistic conceptualizations of health in teacher education.

Design/methodology/approach – The paper focuses on an analysis of 31 pre-service teachers’ reflective writing in a foundational health education course, which sought to engage students in thinking about health in socially critical ways. A systematic and procedural form of document analysis was employed to examine and interpret data to investigate the ways in which students were engaging with the socially critical health discourses and course content.

Findings – The findings evidence that while students attempted to engage with and demonstrate their knowledge of a socially critical view of health, contradictions, or places where students unknowingly slipped into individualistic ways of thinking appeared frequently across the data. Findings are presented to elucidate challenges facing pre-service teachers in teaching the ACHPE curriculum.

Practical implications – Findings suggest the need for teacher educators to employ pedagogic practices that can disrupt previous pedagogic work, serving to challenge and interrogate current constructions of health, and delve deeply into critical discourses through interchange and reflection.

Originality/value – This paper extends the current scholarship of Bourdieusian theoretical concepts in relation to critical health discourses and pedagogies.

Keywords Curriculum, Educational practice, Health education, Teacher education

Paper type Research paper

Introduction

While students come to university with a variety of educational backgrounds and experiences, what has been demonstrated is the remarkable consistency of students’ understanding and expression of health as an individual pursuit and choice (Garrett and Wrench, 2012; Perhamus, 2010; Webb and Quennerstedt, 2010; Welch and Wright, 2011; Wrench et al., 2014), and the prevalence of individualistic, liberal-humanist views of the world amongst pre-service Australian teachers more broadly (Boyd et al., 2007). The damaging and anti-health implications of highly individualised views of health (Ayo, 2012; Eckersley, 2005) in western countries are of key concern to those working in health education teacher education, particularly given the potential agency of new graduates to redress reproductions of individualistic health education messages in schools and communities. Internationally and within Australia, advocates of socially critical perspectives have supported their inclusion in K-12 curricula, such as health literacy and critical inquiry (see e.g. Ioannou et al., 2012; Macdonald, 2014). The inclusion of socially
critical perspectives within curricula continues to be a prominent theme, however, debate remains over how these perspectives ought to be taught (Cliff, 2012). Some practitioners focus primarily on “factors” (commonly known as social determinants of health), while others explore social and cultural contexts in which individuals live their lives. Both of these overlapping fields nonetheless support an inquiry-based approach (Leahy et al., 2015) with focussed attention on exploring and critiquing dominant constructions of health and power dynamics that reproduce social and health inequalities (Wright, 2004).

In 2014, the Australian Curriculum, Assessment and Reporting Authority implemented a new national curriculum which includes a combined Health and Physical Education (HPE) learning area, which attempted to engage with critical inquiry and socially critical perspectives. These orientations serve to challenge the overwhelmingly individualised and responsibilised biophysical and psychological narratives in previous HPE curricula (MacDonald, 2014). While the degree to which critical inquiry and socially critical perspectives were prioritised and valued within the highly politicised nature of the construction of the new curriculum is questionable (Leahy et al., 2013, 2015), the need to prepare pre-services teachers to engage with the new critical concepts in the ACHPE remains a prominent and continued challenge (Alfrey and Brown, 2013).

The new ACHPE presents a significant challenge for health education teacher educators charged with the task of teaching curricular concepts and ways of thinking to students which they may not have been exposed to in previous educational experiences, and which challenge their current ways of conceptualising health. Quennerstedt et al. (2010) argue that embracing this challenge requires contextualising and making connections between socio-critical approaches to health and students’ everyday lives. While there has been a significant amount of scholarly interest in examining physical education teacher education and how it might respond to similar challenges (see Tinning et al., 2006), health education teacher education has received far less attention (Leahy and McCuaig, 2014). The work of Leahy and McCuaig (2014) has been instrumental in recognising this gap in current knowledge and exploring the role of health education teacher education in maintaining or subverting problematic discourses in health. However, given the dearth of empirical studies in this area, and the diversity of health education teacher education courses and degrees throughout Australian universities, further investigation into how pre-service teachers engage with socially critical ways of thinking about health, which have been highlighted as key areas of the new national curriculum, is timely.

This paper reports on the efforts of two academics working in teacher education to challenge pre-service teacher’ understandings and conceptualisations of health through the introduction of health as a contested social construct. Through analysis of students’ reflective work during a health education course, we reflect on our utility as academics to support new ways of understanding health and health education. While there has been significant discussion of the effects of neoliberalism on western society’s conceptualisations of health, relying heavily on Foucault’s theories of discourse and governmentality, more recently, the theoretical work of Bourdieu has been applied to health education to further explicate current constructions of health (Pane and Ward, 2016; Wrench and Garrett, 2015). We seek to add to this scholarship by employing Bourdieu’s constructs of bodily hexis (which refers to the body as both separate from society (autonomous individuals) and the body as socially mediated (the influence of social forces upon individuals)) and pedagogic work to the wider debate, and how they impact upon contemporary health education. These constructs are used to explicate the role of previous schooling and learning on pre-service teachers’ ability to grapple with (what often turns out to be) new, socially critical, ways of thinking about health. More particularly, these insights are used to contemplate how pre-service teacher education can more effectively assist students in moving past individualistic understandings of health, with a view to becoming health educators who can confidently engage with socially critical health education curricula.
Current constructions of health education

The past four decades have seen the institutionalisation and consolidation of neoliberal ideas at the level of public policy. Though changeable and unsettled in nature, neoliberal ideas have profoundly impacted upon public institutions and the sectors of education and health. While popularly understood as a set of ideas which are concerned with the withdrawal of government from economic and social life through privatisation and de-regulation (Nicholls, 2010), neoliberalism may in fact be more accurately described as an interventionist political project which seeks to actively create the conditions under which markets can effectively operate through new forms of economic and social regulation or re-regulation (see e.g. Barry et al., 1996). Despite the pervasive idea that neoliberalism is the withering of the state, or a system of “laissez faire”, within “actually existing neoliberalism” (or the enactment of neoliberal ideologies by governments/societies) the state has maintained a pervasive presence in the regulation of economic and social life (Cahill, 2010).

This re-regulation, or purposeful crafting of social and economic life in neoliberal societies entails, as purported by Pellizzoni (2011), a “profoundly different conception of the relationship between action and the world” (p. 796), one which favours the separation of economy and social life by waging war on a social state to maximise profits (Bourdieu, 1998a, b). The prioritisation of profits and free markets results in limiting the social or welfare state, and necessitates the vision of a “good citizen” as one who prioritises and, individually, assumes responsibility for their own health. The prioritisation of the individual consumer – be it student or patient – above all else (Le Grand, 2003), works alongside the conception of “the good citizen” to obfuscate the role society and government could or, arguably, should play in supporting the health of individuals and societies.

Within the fields of health education and promotion, there is a great deal of interest in the impacts of neoliberal discourses on health, and the depiction of a “good citizen” as a “healthy” one (Gard, 2014; Leahy, 2013; Lupton, 1999; Tinning and McCuaig, 2006; Vander Schee and Gard, 2014). This interest stems, in part, from the degree to which neoliberal discourses are refracted through current health education policies, curricula, and pedagogies, and how they work through and constitute us in terms of “technologies of the self” (Peters, 2004). One of the primary ways this has manifested is through what Guthman (2008) refers to as responsibilisation, in which the individual, rather than the government or social institution, is charged with the task of becoming and staying healthy.

Over time, neoliberal discourses have exerted increasing influence over western (and other) society’s understanding of health and what constitutes a healthy citizen. These highly individualised and thus socially decontextualised ways of understanding the world and the role of citizens have impacted upon the construction of health beliefs and health education. Within this paradigm of responsibilisation, health education becomes a contact point (Rose, 1996) between political (health) imperatives and people’s everyday actions, thus fortifying neoliberal conceptualisations of health. In few places are the contact points between health education and the individual more concentrated than in young people’s schooling experiences, where individualistic conceptions of health are taught and reinforced through the clustering of individualising, responsibilising, and moralising discourses of risk (Leahy, 2013).

In what follows we provide a brief review of literature that focusses upon intersections between “health” and “neoliberalism”. We use this backdrop to elucidate how contemporary school health education can often constitute a deeply political and “troubling enterprise” (Fitzpatrick and Tinning, 2013) that informs students’ bodily hexis while impacting the work of teacher educators in preparing pre-service teachers for the challenges of engaging with and teaching health education in schools. Albeit an arguable limitation, we also use this backdrop to contemplate slippages in students’ work explicitly between “individualistic”
understandings of health which support the epistemological grounds of neoliberalism, and “socially critical” ways of understanding health, which formed the basis of the topic in which students were enrolled. We delimit our discussion to this binary while remaining conscious that drawing on resources beyond socially critical approaches may in fact prove helpful in addressing this longstanding tension – work that is beyond the scope of the present paper.

Risks, regulation, and surveillance: health education’s hidden “virtues”

The term “healthism” was coined by Robert Crawford in 1980, whose work identified how the ideological underpinnings of neoliberalism increasingly situated the problem of health and disease at the level and responsibility of the individual (Crawford, 1980). Since then, healthism and the ideological constructions of a “healthy citizen” in western heartlands of neoliberalism (Peck and Tickell, 2002), continue to feature prominently within health education and health promotion literature.

Foucault’s concept of governmentality has been frequently applied to critical health education (Leaby, 2013; McGillivray, 2005; Webb and Quennerstedt, 2010; Welch and Wright, 2011). Foucauldian conceptions of governmentality – or how subjects come to engage in self-regulating practices that constitute them as particular types of subjects (Markula and Pringle, 2006) – have greatly informed current understandings of health education. Within the construct of governmentality, we see that current conceptualisations of health and “healthy” in western nations are so insidious that their use as mechanisms of social control are obscured through the embodiment of these views by seemingly autonomous individuals, who wilfully regulate themselves in the interests of the state (Ayo, 2012).

The individualisation of risk (itself a product of neoliberalism) then generates a myriad of health imperatives with accompanying surveillance measures, including self-surveillance (Rich, 2010; Webb and Quennerstedt, 2010). Within this culture, as argued by Webb and Quennerstedt (2010), citizens need to be ever-vigilant in managing their own health, which in turn gives rise to a “greater fear of the consequences of risk than of risks themselves” (p. 787). It is also within the social and political confines of these contemporary risk-oriented understandings of health that we see increased concerns of health enhancement (McGillivray, 2005), and how health education and promotion have responded in kind with warnings and initiatives focussing on how individuals can avoid or mitigate risks of unhealthy lifestyles, for which they are “responsible”.

In response to the perceived risks of unhealthy lifestyles, those who participate in the self-regulating demands of healthism become part of, and perpetuate, what Petersen and Lupton (1996) have called the cult of the body. The cult of the body signifies how concepts of risk and responsibility have shaped conceptions and beliefs of health to the extent that physical appearance has become a signifier of worthiness, and the physical body a means by which the individual can publicly express self-control, self-discipline and will power (Petersen and Lupton, 1996). Rhetoric of the risks of unhealthy behaviour and the seemingly necessary regulation and surveillance that accompany this way of conceptualising health have long been enshrined within school health education and health promotion campaigns. These messages have reinforced the view that health is overwhelmingly in the control of the individual, and that health education should be centred on educating the individual on how to take personal responsibility for their own health.

This brief review highlights powerful and troubling aspects across the current terrain of health education in schools and broader society in which health educators are positioned. To further investigate the impacts of neoliberalism and healthism on health education, this paper adds to the literature by exploring the work of Bourdieu as another lens for conceptualising the effects of schools and schooling on societal views of health.
Theoretical framework

While Foucauldian theory has dominated critical health literature, since Williams’ (1995) initial work in applying Bourdieu to health and lifestyles, Bourdieu’s theories have been increasingly applied to the study of health and health behaviours and practices. Bourdieu’s theoretical utility in critical health discourses has been extended to teacher education in Wrench et al. (2014) application of Bourdieusian concepts of habitus, field, and capital to understanding embodied practices in pre-service teacher education. Their study demonstrated the value of these “thinking tools” in relation to recognising and identifying pre-service teacher subjectivities and dispositions and how they are formed, substantiated, and continued through their emerging pedagogical beliefs and practices. We now seek to extend the current scholarship of critical health discourses in teacher education through the exploration of Bourdieu’s concepts of bodily hexis and pedagogic work in an effort to increase our understanding of how some students’ prior learning experiences can limit their ability to identify and challenge neoliberal modalities of health.

Bourdieu’s theories make use of the term habitus, the set of values, dispositions, and expectations of an individual or social group. Bourdieu and Passerson (1977) describes habitus as the “product of structure, producer of practices, and reproducers of structures” (p. 72), thus the way individuals develop values and dispositions gained from social and cultural institutions and practices, or what he calls fields. The relationship between one’s habitus and the fields through which individuals experience the world functions to shape both individual and societal views of the body and bodily dispositions, the bodily hexis. Bourdieu argues that despite the indivisible interplay between individuals and society (fields), the dominant notion of the individual as a self-contained body is a product of the habitus itself:

> [the] body which indisputably functions as the principle of individuation […] ratified and reinforced by the legal definition of the individual as an abstract, interchangeable being […] [is open] to the world, and therefore exposed to the world, and so capable of being conditioned by the world, shaped by the material and cultural conditions of existence in which it is placed from the beginning (Bourdieu, 2000, pp. 133-134 as cited in J. Webb et al., 2002, p. 37).

Bourdieu’s concept of bodily hexis explicates the interplay between understandings of the body as separate from society (the body as individualised) and social influences (the body as socially mediated). This means that while individuals make choices about their bodies in relation to health and health behaviours (such as participating in health promoting choices such as “eating healthy” engaging in exercise, or accessing health services when needed, or choices that may precipitate negative health outcomes such as smoking, overuse of drugs, and alcohol), the individual is constrained or enabled in making individual choices through social influences and structuring forces. Social influences, such as class, gender, ethnicity/race, education are structures that structure society and greatly impact on the choices individuals make or are able to make. Bourdieu thus posits a subject who, having internalised structure in the form of habitus, possesses a mediated form of human agency to act in the world. Bourdieu’s cultural conception of agency differs from Foucault’s “deconstructed subjectivity”, which does away with “the individual” altogether, a position for which Foucault is often critiqued (McLaren, 2002; Zipin, 2004). Deconstructed subjectivity advances the idea that subjects are discursive constructs – products of “language” – neither entirely autonomous or enslaved, but essentially relay points for discourse (see e.g. Sawicki, 1994). Foucault’s “deconstructed subjectivity” provides a powerful counterpoint to individualised discourses of health, which limit our options for thinking about “health” or “identity” in terms that transcend the “responsible” neoliberal “individual”. While we acknowledge the utility of Foucault’s toolkit and do not offer an alternative here as much as a contribution to the critical debate that does not abandon a humanist stance entirely, we equally acknowledge the value of
Bourdiesian tools in offering a cultural conception of agency in response to the problems we see associated with neoliberal individualism:

From this standpoint, agency always operates within and through a social structure. Agency does not precede society and create it as a voluntary agreement of independent individuals. Individuals are always socially related. Therefore, any action that individual agency initiates (including action to transform society) always takes place from a social basis (Bhaskar, 1989, pp. 36-37 as cited in Ratner, 2000, p. 421).

Within societies that value individual choice and the prioritisation of markets above all else, Bourdieu and Passerson (1977) describes the creation of an exhaustible market for the production of products and services meant to uphold individuation and bridge the gap between is and ought in the realm of the body. Within this understanding of the body, the imposition of new uses of the body which produce the “corresponding needs, expectations, and dissatisfactions” (Bourdieu and Passeron, 1977, p. 153), which can be plainly seen within a highly individualised view of the body.

The continued societal construction of the bodily hexis as one that privileges the idea of the autonomous individual and their decision making over the socially mediated and influenced individual (enabled or constrained in their choices) impacts upon individuals through the work of the social structures surrounding them, which circulate these views and restrict opportunities for thought and action that attempt to incorporate or acknowledge structural influence. These strongly held conceptualisations of health as highly individualised sustain a system of “circular relations that unite structures and practices [...] hence reproducing [these] objective structures” (Bourdieu and Passeron, 1977, p. 203). In other words, social views of health, or views which run contrary to the idea of health as highly individualised, are frequently marginalised by dominant patterns of circulation between the individual and society. Bourdieu’s concept of bodily hexis is a useful construct for understanding how dominant messages of health permeate society and the thinking of individuals. In this way, it is unsurprising that students come to university having learned about health through a lens informed by individualism.

The way in which health has become a highly individualised, and thus an individually responsibilised construct is what Bourdieu and Passerson (1977) terms the cultural arbitrary. The cultural arbitrary is a set of beliefs or practices that are upheld and disseminated by a society; however, as denoted by the word arbitrary, this concept highlights that these beliefs or practices need not be so. The distinction of current conceptualisations of health as culturally arbitrary is an important one because it explains not only the current pervasiveness and power of neoliberal definitions of health, but contends that this is not the only, or most useful (in terms of providing accurate, responsive and socially just forms of health education) way of conceptualising health. If we accept that current conceptualisations of health are arbitrary and not necessarily in the best interest of individuals or societies, what then is the role of schools and teachers tasked with the job of disseminating health education? And how does this understanding of health impact upon students?

While the family or home is the first and likely most significant “structuring structure” in shaping the habitus of individuals, Bourdieu and Passerson (1977) asserts that in the case of the cultural transmission of the cultural arbitrary, it is the “combined effects of cultural transmission by family and by the school [...] [where the] value-inculcating and valuing imposing operations’ of the dominant cultural milieu take hold” (p. 23). The processes of institutional education are essential in the reproduction of the cultural arbitrary, or what Bourdieu terms pedagogic action. Pedagogic action works to inform the bodily hexis through the imposition of a cultural arbitrary in three ways: diffuse education (interaction with peers or other similar individuals), family education (education within the home), and institutionalised education (the work of schooling) (Bourdieu and Passeron, 1977).
In terms of previous health education that pre-service teachers have received via schooling and their primary habitus, the cultural arbitrary is understood to be the socially and politically supported views of healthism (or challenges to this discourse), that form the basis of health curricula and pedagogies in schools. The diffusion of health messages (or as we argue above, the transmission of covert modes of social control) is what Bourdieu refers to as pedagogic work:

\[ \ldots \] a process of inculcation which must last long enough to produce a durable training, i.e. a habitus, the product of internalization of principles of a cultural arbitrary capable of perpetuating itself after PA [pedagogic action] has ceased (Bourdieu and Passeron, 1977, p. 31).

In schools, this happens in two ways: first through implicit pedagogies or the unconscious inculcation of principles in their practical state; and second, through explicit pedagogies or methodically organised, articulated and formalised principles (Bourdieu and Passeron, 1977). Through pedagogic work explicit pedagogies in health education work together with implicit discourses and ideals concerning the "healthy" citizen to form the bodily hexis of students in ways that reflect dominant social and political ideologies – the cultural arbitrary. The most insidious aspect of the highly individualised and responsibilised messages found in school health education is that these beliefs and values instilled through pedagogic work are powerful enough that even after students leave school, the cultural arbitrary is internalised and perpetuated in the practices and understandings of health within the individual educated within these systems (Bourdieu and Passeron, 1977).

Despite an attempt by university students to incorporate new paradigms and ways of thinking about health, pedagogic work and the formed bodily hexis facilitate conscious and unconscious “slips” into ways of knowing that are familiar and that reinforce previous ways of understanding. In order to investigate this phenomenon, the following analyses explore a snapshot of the work of two academics teaching a university health education course designed to introduce students to socially critical ways of thinking. Students and teachers alike are positioned as cultural agents negotiating and reacting to topic information and social interactions, based upon the socially built-up habitus that each brings to the field, which forms the basis of their engagement in the “game” of critical health education (Bourdieu, 2000).

Methods
This paper derives from a larger study that sought to understand how first-year university students made sense of and articulated socially critical health education (Schulz and Fane, 2015; Fane and Schulz, 2015). The primary aim of the research was to examine the effectiveness of a first-year health education course in engaging students in a social view of health. The course is an elective within a bachelor of education degree, taken by students studying to become health and/or physical education teachers. Participation in the project, which was led by the two academics teaching the course and a third academic involved more broadly in the sociology of education, was open to all enrolled. Of 79 students, 31 (17 male/14 female) agreed to participate. Ethics approval was obtained from the University Social and Behavioural Ethics committee. The research project was explained to participants by a researcher involved in the project, who did not teach within the course. The researcher distributed and collected participant information sheets and consent forms while the course teaching staff were not present. The two academics teaching in the course did not know which students had chosen to participate until all student work was graded and returned to students. All participants were able to withdraw their participation at any time. The course was structured as a three-hour weekly workshop over a 14 week semester. The 79 students were divided into four separate workshops (two workshops taught by each of the identified academics)(1).
The two academics/pre-service teacher educators teaching in the topic met weekly to reflect on the previous week’s teaching, and to discuss content, prompts, and activities for elucidating upcoming themes[2]. Each academic kept a reflective journal detailing the week’s session. Journal entries focussed upon students’ learning and experiences, pedagogical successes or shortcomings, and challenging and/or uncomfortable questions and assertions that arose during workshops, which provided insights into students’ understandings, their formed bodily hexis, and the interplay of students’ and academics’ engagement with topic content. Throughout the semester, a variety of formative assessment strategies (such as weekly reflective writing tasks that engaged with course content and a larger reflective writing assignment due mid-way through the topic) and summative assessment strategies (a final reflective writing task requiring students to examine and reflect upon their cumulative learning experiences in the topic) were used by the teacher educators to assess students’ understanding of the subject content and changes in their thinking, which in turn provided a platform for the teacher educators’ critical self-reflections.

The aim of the course (and subsequent investigation) developed from the substantial body of literature which argues that school health is overwhelmingly comprised of socially decontextualised understandings of health (see Leahy, 2013; Quennerstedt et al., 2010; Sinkinson and Burrows, 2011). The course built on the knowledge that university is likely the first time that many students will experience non-individualised views of health, and with respect to the cohort who participated in the study, this was almost exclusively true (as borne out in the following analyses). The course therefore sought to explore the contested socio-historical and political dimensions of health that are otherwise obscured by a highly individualised focus.

To do so, students were first presented with the idea of thinking about health socially, as supported by concepts such as the sociological imagination (Mills, 1959 as cited in Germov, 2014) and the relationship between structure and agency – in other words, students were introduced to the notion that individual thought and action is always socially mediated as supported through activities such the sociological imagination template[3]. These ideas were explored through scaffolded activities, such as visual maps, that led students to carefully consider the origins of their (often times taken-for-granted) individual and collective existing beliefs about health, which in turn provided information to the academics about the knowledge students brought with them. Tools for reading and thinking critically were also used to support students’ comprehension of course content and its correlations with their existing viewpoints. These included guiding questions to help students identify, in set texts and in workshop discussions, “new ideas” and how these ideas challenged or complemented their existing beliefs provided a wealth of classroom discussion points. Examples of these guiding questions included:

While [author of the set text] does not discuss it, we are interested in education. In what ways does a sociological imagination shape your thinking about what good health education might be? Give consideration to the Sociological Imagination Template in developing your response.

The authors of this week’s reading ask you to reflect upon the “blaming the victim” ideology and how it serves to cover the underlying causes of historically and socially patterned ill-health. Bring your thoughts to this week’s session.

The course was designed to challenge highly individualised and “healthiest” understandings of health. This purview informed the course’s theoretical underpinnings, content, and pedagogical practices. The course aimed to respond to important hurdles the academics felt were faced by pre-service teachers in their ability to understand and teach socially critical health education. First among these was a decontextualised view of health (i.e. neoliberal orientations), which divests all but individuals of responsibility for sustaining “good” health. Second, was adaptation of the new HPE curriculum that seeks to redress
troubling issues plaguing school health education by co-opting critical public health perspectives (Macdonald, 2014).

To map the health educators’ efforts to open students to sociocultural awareness, the study involved three data collection methods: analysis of three student assessment tasks (a midterm essay, final essay, and semester long reflective journal), semi-structured post-topic student interviews, and teacher academic journals that included observational notes that implicated the educators in the complex teaching-learning nexus. This material collectively introduced and extended students’ knowledge of socially critical viewpoints to support the educators’ efforts to explicate and deconstruct sociocultural perspectives in health education.

This paper is delimited to exploration of qualitative data gathered from students’ final reflective writing task which required students to respond to the question “What do you understand good health education to be, and why? This task provides you with the opportunity to demonstrate (through argument and with evidence) your (i) growth in thinking about health and health education in relation to the learning outcomes and aims of the course; and (ii) ability to critically reflect on your learning”. The systematic procedure of document analysis, as outlined by Bowen (2009), was employed to examine and interpret data from the essays to elicit meaning, gain understanding, and develop empirical knowledge. Through a process of document analysis, themes were manually coded to reflect students’ engagement with course content. Both authors manually coded data from the student essays, and then exchanged the coding to check for convergence and corroboration within the initial coding phase. Discussion and feedback then led to refinement of the codes, and final coding of the data.

During the iterative process of data coding, it became evident that while students attempted to engage with and demonstrate their knowledge of a socially critical view of health, contradictions, or what this paper will refer to as “hidden slippages” (places where students unknowingly slip into previous ways of thinking) appeared across the research materials. These hidden slippages coalesced in several overarching themes in students’ final essays, including: health as the possession of knowledge, health as personal choice or responsibility, and the teacher as health authority.

In presenting the findings, Bourdieu’s concepts of bodily hexis and pedagogic work are employed to explore how schools and society work to impart specific ways of understanding health, which pre-service teachers brought with them to the topic. These findings build on our previous work in which students’ existing beliefs about health, as derived from school, home, the media and their immediate communities, did not include socially critical perspectives, and has been explored with greater depth (Schulz and Fane, 2015; Fane and Schulz, 2015). Findings in this paper also highlight the challenges faced by the teacher educators in negotiating the persistent discourses of individualism which emerged in student essays. Specifically, we sought to analyse why many students, despite being presented with and acknowledging social conceptions of health, struggled to move past their prior health education experiences and knowledge.

Findings and analysis

Health as the possession of knowledge and behaviour change

A central theme in students’ essays was their equation of “knowledge” with good health education. From a pragmatic viewpoint, knowledge can be a powerful tool in ameliorating health outcomes; however, in this instance, student discourses of knowledge had the effect of reinforcing previous individualistic views of health. Despite assertions that they wanted to teach future students the broader concepts of health that they had learned at university, student reflections tended to centre on the notion that “knowledge”, as possessed by the individual, will empower individuals to make better choices. This mode of reasoning is highly informed by neoliberal politico-economic doctrine in the sense it relies on individual
behaviours rather than broader networks of structural reform as “the key” for redressing health inequalities.

This mode of rationalisation was evident in Cassie’s essay when she reduced health education to the notion that “good” health education will charge parents and students with “better” ways of “being” healthy, and that this is a change from previous health education. For example, Cassie noted:

Finding ways to educate and provide students and parents with the knowledge on weight, diet, physical activity and how to choose healthier options, I think, will change the way they view health and improve health and wellbeing and enhance health education.

Knowledge as a way to help individuals adopt “healthy” self-regulating practices was also echoed by Lesley, who explained:

I believe that good health education within a society such as Australia is about empowering and enabling young people to make informed good decisions within all aspects of their lives.

In contrast, Brad made a considered attempt to challenge the assumption that being healthy simply means following the information given to you at school or elsewhere, or that good health is necessarily an individual pursuit. Nonetheless, despite embracing a “questioning”, somewhat collective standpoint, Brad struggled to contextualise health within broader social, political, or historical relations, never quite reaching a socially critical viewpoint:

I don’t believe that good health education is where the person follows everything told to them to the letter. I feel that is needs to be something where the individual is given all of the information they need to be able to handle the problems that health may throw at them […] Health is something that every individual needs to have a basic idea of to live a healthy lifestyle for not only themselves, but to be able to give knowledge and assistance to others so that they can live healthy lives as well.

Student adherence to ways of thinking within the structure of their bodily hexis is explained by Bourdieu’s concept of the work of schooling where he argues that the least noticed effect of schooling is its success in obtaining recognition of legitimate knowledge and know-how (Bourdieu and Passeron, 1977). Here, the socially and politically sanctioned elements of control and surveillance, which underlie dominant health education messages, are reinterpreted as legitimate knowledge and “empowerment” by the pre-service teachers. For example, Priscilla explained:

Health education is a combination of learning experiences which are intended to help individuals and communities improve their health through increasing their knowledge or persuading their attitudes.

While these students’ reflections are laudable in that they value knowledge and the process of education, the prior pedagogic work of schools is evident as a limiting factor. From this standpoint, health is expressed as knowledge that will enable individuals to appropriately and responsibly demonstrate adherence to dominant health expectations. While Priscilla did include communities and not solely individuals in her statement, the onus is on the knowledge of the educator to give information and persuade individuals, rather than engaging individuals and communities in thinking about social, political, historical and cultural contexts and the complex interplay between these and the social determinants of health. This is what L. Webb and Quennerstedt (2010) express as the “contemporary vision of a healthy, neoliberal subject/citizen […] one who has the capacity to constantly examine and (re)construct him/herself in alignment with dominant beliefs (p. 211). The danger of this way of thinking is that the scale of change for ameliorating health is limited to the individual, while historical and political forces, which settle into powerful cultural “norms”
over time, escape the student’s critical gaze. This mode of thinking was reflected in Jane’s final essay when she surmised:

Essentially, health education involves providing people with the information required to live a healthy life.

Throughout the essays “individual knowledge” featured strongly as a measure of control or assurance of adherence to the health expectations of the cultural arbitrary despite students’ shared attempts to frame health knowledge as emancipatory. Moreover, this was despite that much of their reflective journal work, which had preceded submission of their final essays and is not the focus of this paper, spoke to the realisation that health is about “so much more than the individual” (removed for review, 2015, pp. 151-152). Students’ work in their final essays thus highlights the structuring effects of the bodily hexis and enduring impact of pedagogic work. It also highlights limitations in our approach to effectively challenge discourses of individualism via the pedagogic work of university.

Health as a personal choice and responsibility
A second theme to resonate strongly across the papers – overlapping with the last – was the expression of health as a personal choice and responsibility. In this respect, our research echoed findings of an earlier study undertaken by Wrench et al. (2014), in which the researchers explored first-year university students’ management of their health and well-being. These researchers found that students collectively believed in the need for the “individual” control of health, thus endorsing discourses of healthism and individualised responsibility, which, they argued, can lead to negative outcomes for students in terms of academic progress and transition to university. While the present study revealed similar trends (i.e. the sheer prevalence of individualistic beliefs amongst students), what is of specific interest is how “health as a personal choice and responsibility” emerged in student reflections despite their efforts to conceptualise health in “social” terms.

This dissonance emerged notably in student papers that contained internal contradictions. Such contradictions were often evident in student explanations of “good” health education, which attempted to combine “a social view” with previous “individualistic” understandings. For example, Mark began by explaining his “new” knowledge, yet as evidenced below, resorts – perhaps unwittingly – to an individualistic paradigm:

Understanding how health relates to individuals is a dynamic influence within a social construction. This is displayed within the social imagination template [...]. All individuals have the right to choose their own destiny regarding health, whether this be a good or bad personal decision. Here, we see what Bourdieu and Passerson (1977) calls “a system of visible and invisible constraints” (p. 108); a means by which implicit and explicit dimensions of pedagogic work shape the bodily hexis – or the socially mediated ways we come to learn about and act in relation to the body – in ways that constrain the adoption of new understandings. Reflections like Mark’s were commonplace among the essays and often featured an “add on” of the kind we see above whereby students would make mention of new ways of thinking only to revert to prior frameworks when these “new ways” could no longer be sustained. Bridget’s essay contained an “add on” of this nature when she reflected:

[...] we must educate students on all aspects of health and the consequences of bad health practices to enable them to make informed decisions regarding their health behavior [sic] (Emphasis added).

In this excerpt “all aspects of health” signals Bridget’s recognition of the course content, which highlighted “social” as well as “individual” viewpoints, or rather, individual viewpoints in social context. However, despite acknowledging a social view, like
Mark Bridget ultimately favoured the belief that “the individual” is responsible for sustaining good health, a view that obscures the need for structural reform. Likewise, Priscilla’s essay illuminated students’ struggles to incorporate a “social view” within the structure of their previous learning. Priscilla remarked:

[…] one’s life greatly reflects upon their health, intelligence, lifestyle choices, and the society in which they live.

While attempting to demonstrate “new” knowledge of the social dimensions of health, Priscilla’s reasoning bespoke an underlying adherence to the belief that, notwithstanding “the social”, good health ultimately boils down to “the individual”. Reflecting on our capacity to broaden student thinking, these “contradictions” may nonetheless be valuable in terms of highlighting moments of dissonance between individualistic and social discourses of health, and how these power relations entwine in students’ sense-making.

Almost without exception, the pre-service teachers’ essays conveyed genuine attempts to integrate new “social” conceptualisations of health alongside existing understandings. This was reflected in Mark’s attempts to employ the sociological imagination template, Bridget’s attempt to co-opt a more inclusive view of health, and Priscilla’s assertion that “society”, as well as individual choice making, influences health outcomes. Yet in these formulations, the structuring nature of the bodily hexis prevented students from destabilising the grounds of their existing standpoints.

Teacher as health authority

A third theme to emerge in students’ reflective work centred on their conceptualisations of their future practice. As in the work of Garrett and Wrench (2012), as well as Welch and Wright (2011), pre-service teachers adhered to particular health education “truths”, while viewing the role of the educator primarily as health authority. Similar to the contradictions mentioned previously, student reflections on the teacher as health education authority also contained contradictions. This was evident in Jason’s paper when he stated:

[…] understanding the social determinants and underlying foundations of health help a health educator to determine what good health and bad health is, therefore they are able to teach good health education.

Here, we can see that while Jason indicates the value of an expanded understanding of health, he determines that “the teacher” is the ultimate arbiter of “good health”. This relates an overly simplistic view in which, in the final formulation, the “social” is subsumed beneath the “individual”, who is charged with ultimate responsibility for good health. A similar sleight of hand was evident in Mark’s reflections on Health Promoting Schools (HPS) when he stated:

[[…HPS is] where the Australian education system should be basing its energy, where teachers have extensive knowledge of health which educates students on the importance of healthy lifestyle choices.

Despite introducing the HPS as a holistic way of engaging students in health education – a whole of school approach that is grounded in a socially critical view – Mark ultimately conceptualises the teacher as “the” arbiter of health. This view is problematic when the onus for health education is relegated to the individual, whose personal ideals may align more readily with discourses of healthism than with school models that seek to advance collective understanding and action.

The notion of teacher as authority rather than co-constructor of knowledge is what Bourdieu sees as the teacher’s adoption of “livery of the word”; or authoritative knowledge as the individual teacher’s signifier. To fulfil the role of pedagogic authority and sustain the
pedagogic work of schools, the teacher “must be equipped by the institution with the symbolic attributes of the authority of [their] mission” (Bourdieu and Passeron, 1977, p. 125). Through the mechanisms of pedagogic work, the teacher must embody and reproduce the cultural arbitrary through means identified previously, such as ascribing to the “cult of the body” and acceptance of responsibility for real and perceived health risks. This view of the teacher as authority was also conveyed by Shane who stated:

As a future educator, it is critical that I understand how to implement flawless health education and promotion within the classroom, which can also be taken [by the students] beyond the classroom.

Not dissimilarly, Jordan remarked:

Having a whole school approach to health education will allow students to follow the same views of health presented to them by their teachers throughout their schooling […] which will enable them to build on the concepts learnt in previous years and prevent any confusion with different views towards the topic.

In these excerpts, we see the impact of previous pedagogic work on students’ understandings and expectations, wherein the teacher “rightly” enacts the role of health authority, promoter, and surveyor of individualistic health behaviours – we also observe the overly simplistic belief that there is “one” way of being healthy or thinking about health, and that students ought to reproduce this accepted truth rather than engage in critical reflection and debate. Similar to the study by Webb and Quennerstedt (2010), who found that physical education teachers performed surveillance over themselves and students in upholding ideals of healthism, the pre-service teachers in this study adopted a rhetoric of healthism when advancing beliefs concerning “flawless health education” and “following in the footsteps of their teachers”.

While both Shane and Jordan reflected on the valuable knowledge learned at university concerning a wider approach to health education, like their classmates they undermined this view when constructing an ideal health educator who performs and holds tightly to individualistic notions of health. Isaac performed a similar move when stating:

To fittingly complete the semester and now armed with some foundations for thinking critically and analysing the world around us in order to lead as healthy a lifestyle as we possibly can, we were introduced to health promoting ideas that we might be able to employ as aspiring health educators […] And at the conclusion of the semester I feel equipped to lead a healthy lifestyle of my own, and persuade and encourage others around me to do the same.

Here, we see the way in which bodily hexis and pedagogic work not only constrain students’ abilities to engage with new ideas, they circumscribe pre-service teachers’ visions of their practice. As signalled previously, the “structuring structure” of previous learning contributes here towards the social reproduction of healthism, both at university and in schools, despite the work of a university course aimed at advancing socially critical views and informed debate.

**Discussion**

Identifying the “hidden slippages” impinging upon students’ meaningful engagement with socially critical health discourses provides us with valuable material for refining our approach. The excerpts presented here are representative of a wider story of the cultural reproduction of healthism. Students, teachers, schools, health promoters, government agencies, and media are implicated in this cultural industry; however, educators – particularly those in teacher education – have some agency to arrest the cycle of reproduction that implicates us all in complex ways. Bourdieu’s work has been particularly useful in this regard for underscoring the dispersed nature of the health messages with
which students and teachers are bombarded. By extension, his work elucidates challenges facing students when confronted with the task of adopting new ways of thinking.

If university health educators are to work effectively within these dynamics, we must understand the depth of our collective inculcation into these ways of thinking. It becomes essential for teacher educators to have this knowledge to be informed of the challenges pre-service teachers face in meaningfully grasping understandings of health, which run counter to their formed bodily hexis and internalised arbitrary. Bourdieu’s work helps to explicate that while students may be open to learning about socially critical views of health, previous pedagogic work that advances an individualistic purview is, for many, deeply ingrained. In this light, that the majority of participants in this study did not subvert the grounds of healthism, is unsurprising, and we view these students’ lapses into “individualism” as indicative of where our pedagogy and planning are amenable to review.

To this end, it is noteworthy that students’ hidden slippages were largely shared. This was clearly evidenced in their collective view that “good” health may be reduced to the acquisition of knowledge, that responsibility for good health ultimately belongs to the individual, and that “the teacher” be viewed as authority and role model for disseminating messages about “good health”. These themes emerged strongly in the students’ final essays despite that in classroom discussions and in reflective journals many had made valiant attempts to grasp a socially critical purview. In this respect, “the essay” itself may warrant reconsideration.

*Making hidden slippages a pedagogic tool*

These findings lead us to reason that the essay – traditionally situated when classes have concluded – may be better situated earlier, the question reframed to more effectively elicit students’ sociological imaginations, or the format itself reframed as a dialogic process. Re-imagining our assessment, we acknowledge the need for more opportunities to catch sight of students’ understandings and misunderstandings, which came to light in the final papers, in turn illuminating our reach as educators.

While we are hesitant to provide prescriptions for change in any definitive sense, suffice to say creating space in the form of shorter, more frequent, collective assessments would potentially provide space for constructive “dialogue” and group work, to interrupt individual “responsibilisation” for grasping health education. One potential avenue would be to replace the traditional final writing task (essay) with greater focus on the reflective journal. As the evidenced in a review of literature on the use of reflective journaling in higher education by Hubbs and Brand (2005), “the strength of reflective journaling lies in the collaborative opportunities for the instructor and student to employ common criteria to critique the student’s reflective skills […] [supporting students in developing] necessary skills of self-reflection” (p. 70). In this way, the journal can be reconceptualised as a basis for dialogic interaction between teacher, student, and whole group, hence serving to engage, challenge, and interrogate areas of shared interest or confusion through targeted exchange. Engagement with course materials and demonstration of scholarly writing could be built into this process; however, to better disrupt the effects of previous pedagogic work, our focus would necessarily centre on the development of students’ capacity to think in “social” rather than “individualistic” ways. Time in workshops could be devoted to tackling common “slippages” as a group, thus unsettling individualistic approaches to learning and assessment.

We acknowledge that ideas drawn from students’ reflective writing would require de-identification before being used as a basis for shared discussion. Saving this, engaging students with slippages, or the interplay between individualistic and social discourses of health, in workshops could be a powerful way forward in arresting the circulation of individualising beliefs. In addition to engaging students in dialogue concerning the “hidden”
ways that individualistic rhetoric is sustained, using hidden slippages as a pedagogic tool may open space for the co-construction of strategies for breaking this cultural cycle, which pre-service teachers could in turn employ as educators.

**Conclusion**
The decision to design a university health education subject grounded in a socially critical standpoint was a considered one. We saw this as necessary to challenge the overwhelming dominance of a neoliberal health paradigm within health education (within and beyond schools), and to better prepare pre-service teachers to engage with critical aspects of the new health education curriculum. While this paper has been limited to a brief exploration of one portion of our data set, we feel that its significance lies in what we have learned about the limits of our pedagogical reach. Despite scaffolding students’ critical engagement with core texts and leading them to contextualise their existing beliefs and practices through applying concepts such as the sociological imagination, students’ final essays evidenced a clear “slippage” into the individualistic modalities of thinking about health that many brought with them to university. To better intervene with the cultural reproduction of healthism through our work as tertiary educators, we posit that explicitly identifying students’ “slippages” through dialogic, one-on-one and collective, pedagogical strategies, and consciously working with these moments, is one potential way forward. Within spaces that allow for transformative dialogue there exists the possibility to connect theory and practice while supporting pre-service teachers to move beyond the reproduction of discourses of healthism. Conscious of the work that remains, we nonetheless offer this paper as a contribution to the ongoing conversation.

**Notes**
1. One of the academics was Jennifer Fane, lead of this paper, along with colleague Dr Grant Banfield.
2. Examples of themes explored during the course included but were not limited to, health as a social problem, global public health, class origins of health inequality, gendered health, Indigenous health, the social appetite, and sociology of health promotion.
3. An activity in which students are led to visually map social influences on individual decision making.
4. All proper names have been changed to protect participant anonymity.

**References**


Fane, J. and Schulz, S. (2015), “I thought it would just be about healthy eating and exercise’: what we can learn about school health education from students and its implications for teaching the new national curriculum”, paper presented at the ACHPER International Conference, Adelaide.


**Further reading**


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