MENTAL HEALTH IN CHINESE SCHOOLS:
ADAPTING GLOBAL PARADIGMS IN POLICY AND PRACTICE

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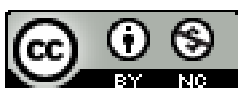

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Abstract

Mental health is an urgent global health challenge, and schools worldwide are increasingly tasked with promoting child and adolescent psychological well-being. In China, policymakers and practitioners have collaborated with institutions such as the World Health Organization to design school-based mental health education programs. This requires navigating tensions between global and local discourses of mental health, and evidence suggests disparities between policy rhetoric and the reality of practice in schools.

In this multi-level, mixed-methods study, I employed a combination of complementary theoretical approaches to explore the emergence of mental health education in China since the 1990s, with the aim of linking the macro-sociological processes described by institutional theory with the micro-level processes described by structuration theory. I first conducted a comparative content analysis of WHO publications on mental health and Chinese national mental health education policy documents, to explore how paradigms from global mental health discourse are encoded in Chinese national policies. Second, I interviewed students in the psychology and education departments of a Beijing university to investigate how policy-level paradigms are enacted by school counselors in training as they develop their practices and professional identities. Finally, I conducted a mini-case study at a Beijing middle school to understand how teachers and counselors navigate tensions between new and traditional educational paradigms during the process of piloting a progressive model of mental health education.

I found that certain global paradigms of mental health were also pervasive in Chinese education policy and practice. This included an emphasis on individual adaptive development, which mirrors broader movements towards individualism in Chinese education reform. In other areas, China's policy discourse diverged from global paradigms. For instance, while Chinese policy documents espoused a scientific approach to mental health education that resembled global discourse, clinical terms were rarely used to describe mental health problems among adolescents. The absence of scientific language at the policy level echoed a tendency for schools to overlook the importance of hiring professional, trained mental health educators with backgrounds in psychology, which emerged during interviews with school counselors in training. Highly trained school counselors, therefore, struggled with managing their career aspirations in an educational climate that challenged the professional legitimacy of their occupational status.

In addition to areas of discursive convergence and divergence, instances of discursive transformation also emerged. For example, while global mental health discourse stressed equity, social justice and human rights, Chinese national policy documents avoided those terms and focused more on the importance of mental health for individual outcomes and national development objectives. However, during interviews, I found that school counselors actually engaged deeply with themes of equity and social justice as they discussed the issues of stigma, shame and exclusion that surround mental health problems in Chinese society.

Meanwhile, the idea of morality was absent from the global mental health discourse, but emerged as a particularly complicated feature of mental health education in

China. National education policies promote integrating mental health education into existing moral education departments and curricula, but the school counselors I interviewed struggled to reconcile the principles of moral education with their professional training in mental health. Many expressed the feeling that moral education was more suitable for teaching "right and wrong" as opposed to helping students make individual adaptive choices, while at the same time expressing the belief that separating mental health and moral education would be impossible in China. Meanwhile, I found in my school case study that when challenged to implement a progressive model of mental health education, many teachers embraced the innovative subject matter while simultaneously enacting more traditional forms of pedagogy that resembled those of moral education.

A persistent theme that emerged throughout the study was the conceptual struggle between *rights* and *duties*. While global mental health discourse is driven by the concept of rights, the Chinese educational landscape retains a historically rich tradition of emphasizing duty, which pervades both mental health and moral education discourse. I suggest that for mental health education to become an institutionalized feature of Chinese schooling, moral education and the notion of *duty* must be negotiated as an entry point. Moral education is a long-established component of Chinese schooling, and enacting mental health policy recommendations will likely depend on delineating the objectives of mental health and moral education, while establishing ways for the two types of education to coexist effectively in schools. This process happens organically to a certain extent in school settings, where educators find ways to localize externally imposed

models of mental health education, but the process can leave both counselors and educators feeling confused about the results and unsatisfied with their level of success.

Mental health continues to grow as an urgent global health concern. Policymakers and professionals in diverse settings will increasingly face the challenges of adapting global paradigms of mental health to develop educational policy and models that work in local contexts. Schools will continue to be important settings for this work, and understanding how to navigate conflicting features of the discursive terrain can help educators in China and other countries develop mental health education programs that embrace innovation while honoring tradition.

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LIST OF ACRONYMS

CAMH: Child and Adolescent Mental Health
CCP: Chinese Communist Party
DALY: Disability-adjusted life years
GBD: Global Burden of Disease
MHE: Mental Health Education
MOE: Ministry of Education
PRC: People’s Republic of China
WHO: World Health Organization

CHAPTER 1. INTRODUCTION

Disadvantaged persons and many persons with mental disorders form a broad virtual "nation" of underserved people living dispersed within the many nations of the world.

--Nations for Mental Health, World Health Organization, 1997

A global concern

Mental health is a critical public health concern around the world, exacting an enormous toll on societies through the loss of community resources, financial burdens on health systems, and threats to social stability. The powerful global transformations of our time give rise to a host of psychological risk factors, including rising rates of income inequality, displacement, unemployment and the adoption of unhealthy lifestyle habits (Desjarlais & Eisenberg, 1996). Along with these changes, non-communicable diseases (NCDs, which include mental health disorders) have emerged as a global priority. In September of 2011, the United Nations General Assembly met for only the second time in its history to address a targeted health issue, which was the prevention and control of NCDs.[1] To understand the prevalence of mental health disorders worldwide, it is helpful to describe the role they play in the global burden of disease (GBD). According to WHO (2008, 2012), depressive disorders are the third leading cause of GBD measured in disability-adjusted life years (the loss of one year of full health), which is higher than heart disease, tuberculosis and AIDS. This does not include associated risks such as substance abuse and self-inflicted injury, which are separately represented among top health threats (Mathers, 2008, WHO, 2012). If GBD is measured in years lived with

[1] Center for Disease Control Global Health: CDC Global Non-communicable diseases (NCDs). Accessed at http://www.cdc.gov/globalhealth/ncd/

disability, mental and substance use disorders were the leading cause in 2010 (Whiteford et al, 2013).

There is a particular focus in the global public health community on mental health in developing countries, where conditions such as conflict, emergency situations, chronic illness and absolute or relative poverty contribute to the increasing prevalence of non-communicable diseases (WHO, 2006, Patel, 2008). In addition to being exposed to more risk factors, individuals in developing countries face challenges in accessing treatment for mental health disorders: it is estimated that between 76% and 85% of people with severe mental disorders in low- and middle-income countries receive no treatment for their mental health conditions, while the corresponding figures for high- income countries are also high but comparatively lower– between 35% and 50% (WHO, 2012). The proportion of the global burden of disease attributable to psychological, neurological, and substance abuse problems is expected to rise every year in the near future, particularly in the developing world (WHO, 2004, Kieling et al., 2010).

While the global health community is paying more attention and directing more resources to the *treatment* of mental health problems worldwide, *prevention* has received too little attention and too few resources (WHO, 2004). There is, at present, not enough clarity or understanding about the obstacles preventing developing countries from investing in the promotion of well-being before mental health problems begin (WHO, 2006). Adolescence is an important time to start the work of prevention and promotion, as an estimated three-fourths of mental health disorders have their first onset before the age of 24 (Patel et al., 2008). Mental health experts have coined the terms "new morbidity" or "millennial morbidity" to describe the emotional problems, conduct

problems and learning disabilities among youth that have come to the fore since the middle of the last century (Stengard & Appelqvist-Schmidlechner, 2010).

Given that adolescence is a pivotal point for determining adult outcomes, schools have emerged as an important setting for promoting child and adolescent health and well-being worldwide. Pragmatically, the preexisting infrastructure of schools makes them cost-effective for health promotion (Jamison et al, 2006). Schools have a central position in many children's development, especially when families are unable for various reasons to play a leading role (WHO, 1994). Furthermore, education and health are increasingly entwined in the era of globalization: as nations become increasingly committed to universal education, they must expand the role of schools to include health services which address factors that interfere with educational attainment (WHO, 1994). Across the world, schools are increasingly tasked with caring for the health of the whole child, as reflected in long-lasting initiatives such as WHO's Health Promoting Schools.

Despite the importance of schools as a space for mental health promotion and the prevention of disorder, there is a lack of existing research on the challenges that schools face in developing effective mental health education programs. Global discourse on child and adolescent mental health has proliferated, particularly in publications by international institutions like WHO. Evidence suggests, however, that education systems face challenges in adapting global discourse and imported models of school-based interventions to meet local needs, which leads to disparities between the rhetoric of school-based mental health initiatives and the reality of implementation in school settings. At present, there is very little research available to the international community that describes how MHE programs in different countries function. In this dissertation, I

consider China as a case study of a country going through the process of developing MHE policies and practices that alternately adopt, reject, and transform global paradigms of mental health.

Why China as a case study?

As an increasingly powerful player on the world stage, China has the attention of the global health and education communities, and among the major priorities outlined in China's WHO Country Cooperation strategy is to "improve bilateral health cooperation and greater participation in global health work and governance."[2] China's mental health challenges are formidable: amidst galloping social and economic changes in China, academic stress and disorders including anxiety, depression and heightened suicidal ideation are on the rise (Chen et al., 1995; Phillips et al., 2002; Hesketh et al, 2002). Mental health policies have been introduced by both the Ministry of Health and Ministry of Education, and Chinese ministry officials from different sectors have cooperated with global organizations such as WHO in the creation of China's system-wide approach to mental health. China's efforts in the area of mental health education have often appeared to proceed in a series of fits and starts: after a flurry of activity in the late 1990s and early 2000s, there was period of stagnation in which no new mental health education policies were generated between 2004 and 2012. While school-based mental health education is gaining a foothold in major metropolitan areas, it remains virtually unheard of in China's vast rural provinces, where most youth lack access to preventive, diagnostic or treatment

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[2] China-WHO Country Cooperation Strategy, accessed at http://www.who.int/countryfocus/cooperation_strategy/en/

resources for mental health (Higgins et al., 2008). These considerable challenges motivated the research questions that guide this dissertation.

Research questions

A rich description of China's emergent mental health education movement and its challenges required analysis at multiple levels: national policy, professional training, and school-level implementation. This multi-level approach allowed me to investigate how processes at each level influenced other levels in turn (Vavrus & Bartlett, 2006; Bray & Thomas, 1995). The three primary research questions guiding this dissertation were:

1) How are paradigms from global mental health discourse encoded or adapted in Chinese national mental health education policies?

2) How are policy-level paradigms enacted by school counselors in training as they develop their practices and professional aspirations?

3) To what extent do educators replicate or revise newly introduced paradigms of MHE content and pedagogy in the classroom setting?

Overview of methods

I used primary data collected during eight months of fieldwork in Beijing to analyze how conflicting discourses of mental health are negotiated at these three levels of policy and practice. A full description of my methods appears in each chapter. For research question one, I conducted comparative content analysis of WHO publications on adolescent mental health and Chinese national policy documents. For my second research question, I conducted in-depth semi-structured interviews with 55 students at the

prestigious Capital Teaching University (CTU)3, which is one of the first and few universities to prepare students to become school counselors in China. Students from both the Education and Psychology departments compete for similar positions after graduation, and I interviewed students from both departments to explore how the emerging generation of school counselors navigates areas of tension in the discursive terrain. Finally, for research question three, I conducted a mini-case study at a well-known Beijing middle school. In partnership with education faculty at CTU, the school had introduced a pilot project of themed classroom meetings *(zhutibanhui)* to address mental health topics, which I observed in person and on video. I also observed meetings with the teachers and administrators who comprised the reform team responsible for the zhutibanhui project. Finally, I conducted individual interviews and video-cued reflective group discussions with teachers, administrators, school counselors and moral education faculty to explore the process of integrating new and institutionalized educational practices relating to mental health.

Background

Child and adolescent mental health in China

In China, swift economic development brings with it social changes that strongly impact child and adolescent well-being. While academic pressure is not new to youth in China, the burden of cutthroat competition and pressure to succeed academically in light of uncertain future prospects has intensified as the gap between rich and poor families widens (Hesketh et al, 2002; Phillips et al., 2002; Adams & Hannum, 2005; Fong, 2006). Heightened academic stress, combined with changes in family structure, environmental

[3] The name of the university has been changed

stressors and associated pressures of modernization can accumulate and strain an individual's ability to cope (Evans et al., 2007). Existing research suggests that children and adolescents in China experience an equal or higher level of psychological strain compared with adolescents in North America in the areas of social skills, depression, self-esteem and anxiety (Chen et al., 1995; Chen, 2000). In a comparative study, Verhulst, Achenbach and colleagues (2003) administered the Youth Self-Report (YSR) to adolescents in seven different countries, and found that adolescents aged 12-18 in greater China scored much higher in the anxious/depressed domain of internalizing problems compared to U.S. adolescents, and above the mean compared to six other countries. Unipolar major depression has been the second largest contributor to the burden of disease in China for the past twenty years (Murray & Lopez, 1996).

Fear of failure at exams has been shown to lead to anxiety, depression and heightened suicidal ideation among Chinese youth (Chen et al., 1995; Phillips et al., 2002; Hesketh et al, 2002). In recent decades, children and adolescents in China have experienced higher and higher levels of familial and social pressure to succeed academically in light of changing conditions in higher education. While overall access to higher education has increased, this expansion has not benefitted all student groups equally; tuition increases, coupled with increasingly uncertain employment prospects, have intensified the burden on the student to make higher education a feasible and worthwhile family investment (Ding, 2006). Academic pressure is exacerbated by the deterioration of publicly funded healthcare and social services and smaller family sizes resulting from China's family planning policies, which combine to turn only children into their families' only hope for economic survival (Fong, 2006).

While China's tradition of therapeutic medicine and healing dates back 2,500 years, along with a deep history of psychological thought grounded in centuries of Chinese philosophy (Higgins and Zheng, 2008), western ideas of psychological diagnosis and treatment are more recently established. The counseling profession has grown in response to increased incidences of behavioral and emotional problems associated with development, but under-diagnosis remains a serious problem because of the lack of trained specialists, stigmatization, and a common tendency for patients to somatize mental health problems (Chen et al., 2000; Hesketh et al., 2002 Higgins & Zheng, 2008). China's health sector has paid increasing attention to mental health and non-communicable diseases, as reflected by a growing number of related press releases and reports by the National Health and Family Planning Commission of the PRC.[4] Pressure to succeed among China's young people continues to grow, to the point that some universities ask new incoming students to sign "suicide waivers," as reported by *Time* (Jiang, 2013). China's growing presence in the global public health arena means that other countries will be looking to China as an example of how schools can function to promote positive mental health development and prevent the onset of disorders. Scholars and practitioners in China are calling for investment in research to find out which school-based approaches are most successful and to strengthen international collaboration (Higgins & Zheng, 2008). Such research must take into account the complexity of negotiating global and local paradigms of mental health to develop school-based interventions that will succeed in supporting youth to cope and thrive.

The role of schools in China's mental health response

[4] http://en.nhfpc.gov.cn/diseases_6.html

Beginning in the early 1990s, amid rising reports of adolescent stress and suicidal ideation in recent decades, officials from various ministries in China participated in a series of high-profile international conferences and workshops on mental health (WHO, 2002). Meanwhile, a proliferation of Chinese education policy documents began to mandate that schools hire school counselors *(xīnlǐ lǎoshī)* and incorporate psychological development into their moral education curricula (Chen, 2000; Lee & Ho, 2005). Along with the evolution in policy, a handful of universities began training students in a new career: school counseling. These departments have partnered with US, Hong Kong and Taiwan institutions with the explicitly stated purpose of adapting curriculum and training materials from other contexts for use in Chinese schools (Zhou et al., 2001, Ye & Fang, 2010).

According to national policy, mental health education is meant to be integrated into Chinese schools' existing moral education (*daode jiaoyu*) departments. For primary, secondary and higher education students, moral education is a fundamental component of schooling, and focuses on drawing connections between social, interpersonal values and political values (Ping et al., 2004). By integrating mental health and moral education, schools could achieve two purposes: promoting student well-being, and making moral education more attractive by introducing topics that appealed to modern students' interest in psychology and individual development (Cheung and Pan, 2006).

Evidence from China suggests a high degree of disparity, or "loose coupling," between the rhetoric of education policy and the reality of mental health services within school gates. Despite the measures described above, the generation of new national educational policies about mental health in China has stagnated since 2004, and

implementation of existing policies remains limited at the school level (Ye & Fang, 2010). Most schools in China do not have functioning counseling offices or other specially trained staff, particularly outside of major cities such as Beijing, Shanghai, Guangzhou, and Shenzhen (Higgins & Sun, 2010).

Theoretical framework

In order to obtain a rich description of processes underlying the emergence of mental health education in China, I adopted a multi-level, integrated approach that examined sociological factors at both macro- and micro-levels. My theoretical approach is based on the idea that while macro-level forces turn mental health education into a "gesture," or "script," marking conformity to a globally legitimate model of education (Meyer, 1977; Boli et al., 1985, Barley & Tolbert, 1997), the actual mechanisms driving change involve individual actors working within a set of professional constraints. Endowing local and individual-level understanding with as much significance as official, authoritative knowledge structures leads to a more comprehensive and balanced interpretation than possible through single-level analysis alone (Vavrus & Bartlett, 2006; Bray & Thomas, 1995).

Figure 1 presents my conceptual map. I drew upon two strains of theory to form this map: institutional theory and structuration theory. Institutional theory posits that global forces, such as the policies of international organizations or the spread of organizational forms, influence institutional processes within developing countries and create "recipes" or "scripts" for attaining a universalistic vision of progress (Ramirez, 1997; Meyer, 2010). The evidence for this is that nation-states' educational and

organizational activities are increasingly similar across the globe, as more and more subscribe to these cultural models of progress.

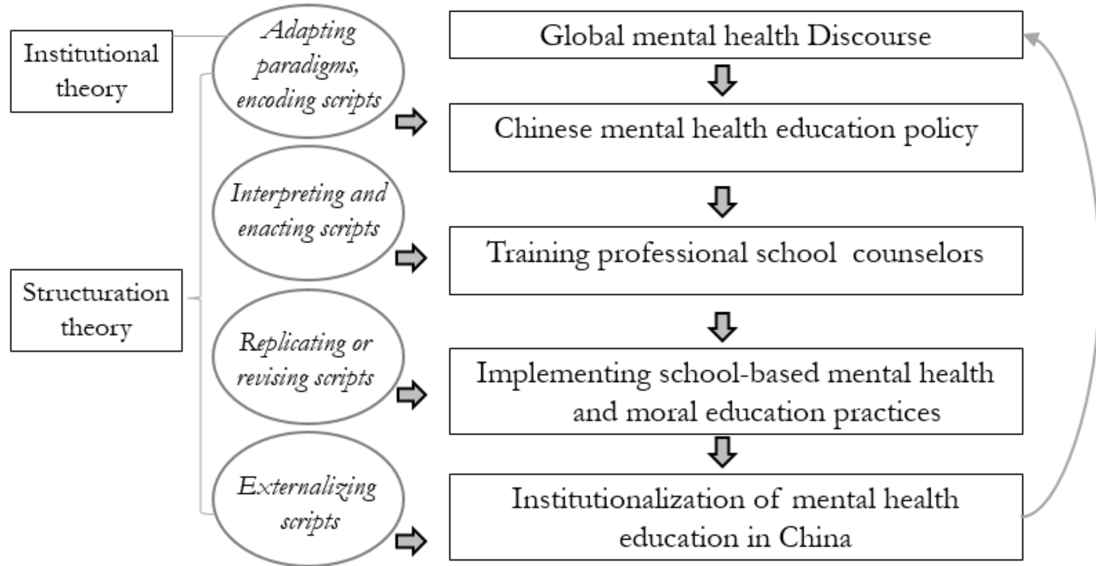


Figure 1 Conceptual map

The emphasis is less on coercion or imitation but rather the world models' highly legitimated and professionally articulated visions of progress that command transnational adherence (Ramirez, 1997). Importantly, policy-makers are often largely concerned with the ritualistic and symbolic power of performed gestures, viewing them as legitimating "initiation ceremonies" and espousing rhetoric which falls short of what is enacted on the ground (Meyer, 1977). This approach helps to account for the evidence of loose coupling between the rhetoric of China's mental health education policies and their actual implementation.

My first research question is based on the proposition that organizations like WHO imprint national governments with the understanding that mental health is a core social concern.Previous research has applied this argument to both the expansion of education (Meyer, 1977; Boli et al, 1985; Ramirez, 1997) and the expansion of

international organizations concerned with health (Inoue, 2003; Inoue & Drori, 2006). Inoue (2003) pointed out that the legitimacy of international cooperation in the promotion of health is increasingly taken for granted, and that nation-state behavior around health is increasingly isomorphic (Inoue, 2003, p. 4). I extend this argument to include mental health education as a marker of legitimate cooperation in a global model of schooling.

While a macro-sociological institutional framework can help to describe the transmission of global models in education, institutional theory is largely concerned with top-down explanations of idea transfer. In this study, I aimed to integrate both macro- and micro-level factors to explain the processes by which institutions arise and are maintained. Thus, my second and third research questions were informed by structuration theory, which provided a framework for investigating how discourse and practices imported from distant contexts are incorporated, rejected or transformed by the counselors and teachers charged with the mandate of enacting policies in Chinese schools.

Structuration theory, originally put forth by Giddens (1979), has been reformulated by scholars including Sewell (1992) and Barley & Tolbert (1997). Structuration theory emerges from the idea that individuals can modify or eliminate institutions through choice and action. Barley and Tolbert (1997) posit that institutions arise through *scripts*, which are observable, recurrent activities and patterns of interaction characteristic of a particular setting. According to this model, institutions arise through a four-step process:

1) Institutional principles are *encoded* through scripts used in specific settings, which may take the form of sanctioned behaviors, formal organizational rules and procedures, or even mental models.

2) Actors then *enact* the scripts through either intention or the unconscious choice to follow established protocols.

3) Scripts are either *replicated* and become institutionalized, or *revised* to change the course of the institutionalization process.

4) Finally, if scripts become institutionalized, there is a process of *externalization* in which patterns become disassociated from particular actors and take on a normative quality.

This model was a useful tool for examining the emergence of mental health education in China. Because it is a newly developed feature of Chinese education, it lacks the degree of institutionalization achieved by, for instance, moral education. Through policy analysis and interviewing school counselors in training, I was able to draw inferences about the first (*encoding*) and second (*enacting)* of the four stages outlined above in the analyses presented in Chapters 4 and 5. In the mini-case study presented Chapter 6, I explored the third stage (*replicating or revising*). The fourth stage (*externalization*) is outside the historical scope of this study.

Taken together, the results of my dissertation point to the challenges of developing mental health education policies and practices that reflect participation in global normative discourse, while at the same time honoring national objectives and harmonizing with institutionalized values. Of particular importance to my findings are the contrasting notions of *rights* and *duties* that drive global mental health discourse and Chinese educational discourse, respectively. In the following chapters, I explore how those contrasting notions emerge in the distinct features of mental health education policy and practice in China.

Outline of dissertation

In Chapter 2, I discuss the function of schools as settings for mental health promotion from both technical utility-based and institutional perspectives. I also discuss the role that organizations such as WHO have played in promoting global discourse about mental health. Chapter 3 provides background information about mental health and moral education in China. Chapter 4 presents a comparative content analysis examining the extent to which the language of national education policy in China aligns with "scripts" in global mental health discourse, as represented by WHO publications. For the analysis in Chapter 5, I took the discursive patterns that emerged from my policy analysis and explored how they were enacted by individual agents of educational change: a sample of students training to become school counselors in China. Chapter 6 presents a mini-case study at a Beijing school to illustrate the challenges that teachers faced when introduced to new content knowledge and asked to adapt their instructional methods to carry out a pilot project in mental health education. In Chapter 7, I present conclusions from across the three phases of my dissertation, discuss the limitations of my study, and suggest implications for future research and school-based mental health program development.

CHAPTER 2. THE RISE OF GLOBAL MENTAL HEALTH DISCOURSE: AN INSTITUTIONAL APPROACH

The latter half of the 20th century has seen a dramatic expansion of health interventions and education programs based at schools across the globe, including mental health. Why have schools become a primary setting for mental health promotion in both the developed and developing world, and why is the language used to describe such programs becoming increasingly standardized? Overwhelming evidence shows that good mental health leads to positive educational and health outcomes for individuals, greater economic productivity for nations, and societies that are more equitable and more just (Suhrcke et al., 2007; Patel et al, 2007; Stengård & Appelqvist-Schmidlechner, 2010). I suggest that the global expansion and standardization of school-based mental health programs represents more than a series of utility-seeking technical solutions to these health-related, economic and social challenges, but also reflects macro-sociological forces that have turned school-based mental health programs into a marker for educational isomorphism. In the discourse of the modern world, where many of society's problems are now widely assumed to have both their roots and their solutions in education, mental health interventions have become another ingredient in the recipe for creating schools that conform to the globally legitimate model of mass education.

A technical solution-based argument for the promotion of mental health in schools

A 1994 WHO Division of Mental Health report entitled "Mental Health Programmes in Schools" outlined nine reasons that schools were the best place to develop a comprehensive mental health program for children, as excerpted below:

- Almost all children attend school at some time during their lives.
- Schools are often the strongest social and educational institution available for intervention.
- Schools have a profound influence on children, their families, and the community.
- Young peoples' ability and motivation to stay in school, to learn, and to utilize what they learn is affected by their mental well-being.
- Schools can act as a safety net, protecting children from hazards which affect their learning, development, and psychosocial well-being.
- In addition to the family, schools are crucial in building or undermining self-esteem and a sense of confidence.
- School mental health programmes are effective in improving learning, mental well-being, and in treating mental disorders.
- When teachers are actively involved in mental health programmes, the interventions can reach generations of children.
- Teachers have often received some training in developmental principles. This makes them potentially well qualified to identify and remedy mental health difficulties in school aged children.

As countries across the globe strive to achieve the goals of the Education for All movement by 2015, and address the Millennium Development Goals of universal basic education and gender equality in education access, school health programs are being increasingly touted as cost-effective ways to bring large benefits for children's human capital (Suhrcke et al., 2007; Jukes et al., 2008; Stengård & Appelqvist-Schmidlechner, 2010). After all, the provision of quality school, textbooks, and teachers can only result in effective education if the child is present, ready, and able to learn. A mountain of empirical evidence from studies in public health, epidemiology, and cognitive and educational psychology shows that good health, including mental health, is a prerequisite for effective learning (Jamison et al., 2006;, Surhcke et al., 2007; Stengard & Appelqvist-

Schmidlechner, 2010). Health has been shown to have dramatic impacts on a wide array of schooling outcomes including access, enrollment, cognitive development, achievement and aspirations (for a comprehensive review, see Jukes et al, 2008).

Beyond the level of individual and community well-being, research suggests that health interventions in childhood and adolescence can yield considerable economic benefits through returns to wages and productivity if they translate into improved cognitive functioning in adulthood, and increased school attainment and participation (Lopez et al, 2006). The cost-effectiveness of school health programs (compared to other educational inputs such as raises for teachers, reduced class sizes and provision of instructional materials) have led many researchers to refer to them as a "quick-win" solution for economic development (Lopez et al, 2006, Jukes et al, 2008). This is because the preexisting infrastructure of the educational system, and the fact that low-income countries typically have far more teachers than they do nurses, means that schools are a cheap route for the delivery of simple health interventions and health promotion (Jamison et al, 2006). Furthermore, promoting mental health at a young age can stem the tide of public expenditure across different sectors, as only an estimated 6% of the costs of mental illness among children and adolescents falls directly on the health sector (Suhrcke et al. 2007).

An institutional approach to mental health education

Institutional theory and global health discourse

Going beyond school-based mental health education as a technical solution to health and economic challenges, as described above, I also argue for an institutional explanation of the proliferation of such programs across the world. Keiko Inoue and Gili

S. Drori (2006) found that the proliferation of health-related international organizations shows a clear pattern of institutionalization over time. Based on data on health-related international organizations compiled from the Yearbook of International Organizations published by the 1999/2000 Union of International Associations, they suggested a two-dimensional process of globalization: a dramatic expansion of the network of health-related international organizations, and a change in the understanding of health by such organizations, marking a discursive shift in the perception of the social role of health (Inoue & Drori, 2006). Their data reveal that the period between 1650 and 1997 has brought four major thematic shifts in the framing of health as a social concern: evolving from (1) the earliest international health-related organizations which conceptualized health services as an act of charity; to (2) organizations framing health as a professional activity, with an emphasis on "scientized" language and rationalized references to procedures, criteria, evaluation, standards and ethics; then (3) organizations couching the social role of health primarily within the goal of development promotion; and finally (4) an emphasis in recent decades of health as a basic human right (Inoue & Drori, 2006). In Inoue and Drori's model, international organizations imprint national governmental and non-governmental structures with the understanding that health is a core social concern and with the specific understanding of the social role of health. In this sense, they argue that the network of international health organizations constitutes a 'world culture' which dictates, and is dictated by, global health standards and norms (Inoue & Drori, 2006). Inoue (2003) points out that the legitimacy of international cooperation in the promotion of health is increasingly taken for granted, and that nation-state behavior around health is "increasingly isomorphic, making cooperation and relative consensus at the international

level a possibility" (Inoue, 2003, p. 4). In accordance with institutional theory, Inoue finds no evidence of coercion or hegemonic influence in this process.

Integrating education and mental health in an institutional framework

Vast numbers of international organizations, which Finnemore (1993) called "teachers of norms" have initiated programs to promote mental health in schools, which shows that mental health is part of a globally legitimate model of schooling. According to WHO, schools have experienced the greatest increase in the number of adolescent mental health (ADMH) actions initiated by international development organizations and NGOs (WHO, 2012). The increase in school-based mental health initiatives suggests that the policies and preferences of international organizations are shaping a world model of school-based mental health initiatives as legitimate components of mass schooling, in accordance with the principles of institutional theory. In addition to increasing in number, these programs have experienced a discursive shift towards conceptualizing mental health as a basic human right, in that school health programs have stopped favoring a purely medical approach aimed at treating existing mental disorders, and have instead begun to adopt a preventive approach targeted to all children, particularly the poor and disadvantaged (WHO, 2012).

This model is diffusing from core high- and mid-income countries to the developing world, influenced by global norms and shared objectives. For instance, as countries strive to achieve EFA and Millennium Development Goals, the degree to which countries adopt the ingredient of school mental health promotion as part of the "recipe" for mass schooling accelerates (Patel, 2008). Today, a majority of low-income countries

have recognized the need for general school health programs and seek to implement them (Jukes et al., 2008).

Loose coupling

In light of the expansion of school-based mental health programs, questions arise as to what extent policy-makers and international organizations merely 'talking the talk' of school-based metal health. Does the reality of implementation reflect the rhetoric? Individuals, organizations and nation states adhere in varying degrees to world models, known as "loose coupling" (Weick, 1976). Often, the doctrine of a world model will be espoused without being fully enacted, which is a result of policy-makers "sampling from a world educational menu for individual and national development" with less consideration of "local ingredients" (Ramirez, 1997, p. 55). Sometimes it is just a matter of time before reality catches up with rhetoric; for example, Inoue (2003) points out that there was a 30 year lag between the WHO's declaration of health education as one of its eight primary principles and the next major event in actual health education and promotion.

There is much evidence of loose coupling found in the study of school-based mental health programs, in large part because the enactment of such programs relies on cooperation between a multitude of different stakeholders. In most cases, the Ministry of Education is the lead implementing agency for school mental health programs in China, but the education sector must share this responsibility with the Ministry of Health, particularly because the latter has the ultimate responsibility for health of children. It is also apparent that any given program's success depends on the effective participation of

numerous other stakeholders, including civil society, and especially the beneficiaries and their parents or guardians. The children and their families are the clients of these programs, and their support for program implementation is critical to the program's success. Without the participation of all of these stakeholders, there is an increased risk that implementation will be de-coupled from policy objectives.

David Labaree (2007) writes about a similar process of "gatekeeping" as it relates specifically to educational reform in the U.S., presenting a model of how reform movements must travel through four different levels of the educational system. In Labaree's model, reform initiatives begin (and often end) at the level of rhetoric, sometimes pushing through to the formal structure of schooling, but rarely penetrating the core levels of education, which are classroom practice and student learning. Using the language of Labaree's model, the increase in school-based mental health programs suggests that the model has penetrated the outer circle and become part of our global educational rhetoric. However, school health initiatives meet with many obstacles along the way from rhetoric to implementation, such as clashes with school culture and school needs, the inability to develop integrated programs because funding is issue-specific, political conservatism that prevents inter-sectoral collaboration, and communication problems rooted in cultural differences between professions (Deschesnes, 2003). All of these obstacles can undermine the implementation of comprehensive action plans.

The World Health Organization's role in shaping global mental health discourse

The creation of the World Health Organization as a UN agency in 1948 represented the first organization with a truly global focus on health as 'a concern without

borders,' and the beginning of the true institutionalization of international cooperation in health (Inoue, 2003). It remains the most influential and important health-related international organization: Inoue and Drori's (2006) review of data from the Yearbook of International Organizations reveals health-related international organizations form a tightly woven network with only three to four central organizational nodes, most pronouncedly centered around WHO. First intended as a medical assistance program, subsequent organizational change and expansion at WHO also ushered in changes to the understanding, or meaning, of health.

WHO's definitions of health and mental health

WHO broadened the definition of health beyond the absence of illness to health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO Constitution; see WHO, 2013). WHO's definition of mental health is "a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community" (WHO, 2012). Viewed this way, mental health is more than a mere absence of mental disorders; it has a positive dimension and is relevant to all people rather than only to those with a disorder (WHO, 2004). Mental health is also relevant to the society at large according to the emphasis on productivity in this definition. Activities for adolescent mental health, so defined, could include any type of initiative that aims to protect or promote psychosocial well-being or prevent or treat mental disorders (WHO, 2012).

The historical rise of WHO's school-based health initiatives and mental health programs around the world

Child and adolescent mental health (CAMH) began to emerge as one of WHO's core concerns in the late 1970s, when an expert committee was convened and it was incorporated into strategies for achieving "Health for All by the year 2000" (WHO 1994). Since then, WHO's work in CAMH has broadened in scope to include more and more prevention, promotion, focus on cultural context, and attention to low- and middle-income countries (WHO 1994, 2012). In the 1980s, the World Health Organization first proposed what has now become a major global initiative called "Health-Promoting Schools," which broadly defines a HPS as a school that continuously works to strengthen its capacity as a healthy setting for living, learning and working (Lee, 2009). The literature generally sets out three components or domains of activity that characterize the HPS approach: 1) a formal health curriculum giving school-aged children knowledge and social skills to make choices affecting their physical and psycho-social health; 2) a high-quality physical environment and school climate with adequate health services, and 3) school/community interactions (Deschesnes et al, 2003). In addition to HPS, WHO's Global School Health Initiative (GSHI), launched in 1995, seeks to mobilize and strengthen health promotion and education activities at the local, national, regional and global levels. The initiative, designed to improve the health of students, school personnel, families and other members of the community through schools, includes projects in Asia such as Helminth Interventions with China in 1996, HIV/STI Prevention in China in 1997, and Health-Promoting Schools/Health Insurance in Vietnam in 1998 (Lee, 2009).

A priority of GSHI and HPS is to create networks and alliances between governments, NGOs, development banks, United Nations organizations, interregional bodies, bilateral agencies, and the private sector to help all schools to become Health-Promoting Schools (Lee, 2009). WHO aims to equip ministries of education and health and other national organizations to assess and improve their own capacity to promote health in schools through programs such as the Rapid Assessment and Action Planning Process (RAAPP), which prepares in-country teams to collect data and engage in customized action planning processes (Lee, 2009). Since 1980, WHO has carried out a number of national case studies in different world regions under the umbrella of "Nations for Mental Health," to systematically examine CAMH needs and resources by collecting data from different sectors such as education, social welfare, and health (WHO, 1994).

China became a participating country of "Nations for Mental Health" in the 1990s, coinciding with a growth in mental health policy across sectors. Ten Chinese Ministries and the World Health Organization (WHO) convened for a high-level mental health seminar in Beijing in 1999, resulting in a declaration that "all levels of government would improve their leadership for and support of mental health care, strengthen inter-sectoral collaboration and cooperation, establish a mental health strategy and action plan, facilitate the enactment of a national mental health law, and protect patients' rights" (Liu et al., 2011). The first National Mental Health Plan (2002-2010) was signed by the Ministries of Health, Public Security and Civil Affairs, and China Disabled Persons' Federation (CDPF) in April 2002. In the following chapter, I illustrate how this policy movement coincided with the rise of mental health in China's education policy, and how it relates to the institution of moral education in Chinese schools.

CHAPTER 3. MENTAL HEALTH EDUCATION, MORAL EDUCATION, AND EDUCATION REFORM IN CHINA

Background of mental health and moral education in China

Understanding the emergence of mental health education in China requires discussion of the history and structure of moral education, which in turn goes by many different names in China. Among the terms often used interchangeably in the literature are 'moral education' (*daode jiaoyu*); ideological education (*sixiang jiaoyu*); and political education (*zhengzhi jiaoyu*). Ideopolitical orientation and morality are often referred to as ideomoral and/or ideopolitical-moral qualities (*sixiang zhengzhi suzhi*) (Lee & Ho, 2005). This conceptual intertwining reveals the nature of Chinese moral education as a means of transmitting ideological and political values to both students and the public through interconnected channels (Lee & Ho, 2005). For primary and secondary students, moral education is a fundamental component of basic (compulsory) education, and focuses on drawing connections between social, interpersonal values (morality) and political values (ideology). At the university level, moral education more closely resembles what many would call political science (Ping et al., 2004). At all levels, students are assessed for their performance.

Policy and curriculum structure of moral education

At the national level, moral education policy is under the direction of the Ministry of Education. At the provincial level, the Propaganda and Education Office (also known as the Moral Education Office) establishes general guidelines for moral education. At

primary and secondary levels, the Moral Education Office and the Organization of the Young Pioneers provide guidance, and at universities this responsibility falls to the Social Science (or Marxism and Leninism) Office and the Committee of the Communist Youth League. At every level, these offices of the state design curriculum and content, establish standards for evaluation and oversee the development of all teaching materials (Ping et al., 2004).

The result of this many-tiered system is that often schools have a significant amount of flexibility about how they will implement policy directives within approved parameters (Ping et al., 2004, Zhao & Fairbrother, 2010). This fact arguably contributes to loose coupling between policy and practice. As will be explored in subsequent chapters of this dissertation, educators often receive directives for mental health education programs that differ in both content and pedagogical approach from the familiar, institutionalized models of moral education. Without the training or support needed to implement progressive models of mental health education, educators either revert to moral education models or create hybridized versions that incorporate style and content from both moral and mental health education.

Historical overview of moral education in China

Moral education has experienced changes in direction and orientation throughout China's history. Moral education has roots going back to the Zhou dynasty (1046–256 BC), when the political philosopher and statesman Zhou Gong initiated the concept of 'ruling the country by morality' (Ping et al., 2004). Later, the idea of morality was a central tenet of Confucianism, which was to rule supreme over any other ethical system

for the following two thousand years (Ping et al., 2004). With the establishment of the Peoples' Republic of China in 1949, moral education played an important role in education as a mechanism for political indoctrination (Zhao & Fairbrother, 2010). Schooling, once reserved for society's elite, became accessible to all, meaning that moral education became part of the basic education of all people, with the same moral and ideological message transmitted to everyone (Ping et al., 2004).

Lee and Ho (2005) identified three major directional thrusts in Chinese moral education policy over time: (1) politically oriented moral education (1949–1978); (2) moral education gradually independent from politics (1978–1993); and (3) de-politicized moral education (since 1993). Arguably, moral education in the 1949–1978 period was a form of indoctrination with a heavy ideological emphasis, designed to inspire obedience among China's citizens (Zhao & Fairbrother, 2010). Since the period of economic liberalization known as Reform & Opening began in 1978, moral education has, like the rest of the education system in China, been undergoing reforms in structure, orientation and content (Shanghai Education Commission, 2001; Zhao & Fairbrother, 2010). Since Reform and Opening, moral and citizenship educators have called upon students to develop emotional attachments to the nation and contribute to nation-building (Zhao & Fairbrother, 2010). In the mid-1980s, moral education began to be introduced as separate from political education, with more of a focus on students' behavior. In 1985, the Central Committee of the CPC granted a Decision that encouraged schools and teachers to promote a more independent academic environment for moral education, including "conducting investigation", "writing school-based teaching materials", "pooling ideas

together” and “testing new ways to improve moral education” (PRCPC 1985: 2302-3; quotations reprinted in Cheung & Pan, 2006).

The government-issued Outline of Moral Education in Secondary School (PRCSEC, 1988), implemented fully in 1991, was the first national policy to use the term ‘moral education’ independently without being prefixed by ‘ideology’ (Lee & Ho, 2005). Arguably, the conceptual distancing of morality from ideology created more space in moral education for the concept of the individual. The individual began to be represented in moral educational discourse as an actor capable of making independent moral judgments in an increasingly pluralist and open society, and thus in need of cultivating personal qualities to shape those judgements (Cheung & Pan, 2006). Psychological health emerged as a factor in determining the personal moral qualities important for facing the challenges associated with modernization (Lee and Ho, 2005). Topics such as self-image, self-management, personality development and the meaning of life have been increasingly represented in moral education curricula since the early 1990s (Lee & Ho, 2005). The first explicit mention of psychological health appeared in 1995’s Outline of Moral Education in Secondary School (PRCSEC).

Along with changes in the focus of moral education content, pedagogy has evolved to encourage open classroom climate and child-centered learning (Cheung & Pan, 2006, Zhao & Fairbrother, 2010). University policies have increased access to graduate degree programs in Marxist Theories and Political Education, so that moral education teachers, who were traditionally administrative staff serving political organs at schools, can learn new teaching methods. Researchers have found that moral education scholars increasingly draw upon Western educational theories while focusing on what will be

beneficial in the context of China. Examples of newer forms of moral education pedagogy include: Moral Education through Aesthetic Appreciation; The Dialogue Approach (which calls for family and community engagement), The Life Practice and Activity oriented Approaches, and The Affective Approach (Zhao & Fairbrother, 2010).

The introduction of mental health education policy

The first Chinese national education policy specifically addressing mental health was 1992's Basic Requirements for Mental Health Education in Primary And Secondary Schools (Trial), issued by the State Education Commission (former name of Ministry of Education). Since then, five national mental health education policies have been introduced, all of which will be analyzed in the following sections. As with moral education, several institutional structures are involved, from the national Ministry of Education to the provincial level to the schools themselves. The higher the level, the broader and more abstract are the policies, while many of the details of implementation are left to the discretion of individual schools and teachers (Ping et al., 2004). However, unlike moral education, schools do not necessarily have a designated office for mental health education, there is no specific national curriculum or set of guidelines for mental health education, and students are not assessed for their performance.

While features such as mental health education have arguably contributed to the modernization of moral education, have such changes have been substantial and enduring? Ping and colleagues (2004) suggested that while the language of moral education may have changed, the deeper message has remained the same. They pointed to the following

two statements made by the CCP and State Council 35 years apart, which are nearly identical in substance, both emphasizing the importance of cultivating young socialists.

> "Education should serve proletarian politics; education should be combined with production and labor; the work of education must be led by the Party in order to implement this guideline." [1958]
> "The basic task of moral education in school… is to educate students in Marxism-Leninism, Mao Zedong Thought, and in the Theory of Constructing a Distinctive, Characteristically Chinese, Socialism; to uphold the correct political orientation, and to cultivate a new socialist generation with lofty ideals, moral integrity and a sense of discipline." [1998]

Connections with other education reform in China

The evolution of mental health education in China in the 1990s coincided with related reform movements, most importantly the shift towards "quality education," or *suzhi jiaoyu*. As outlined in one of the central quality education reform documents in 1997, the state aimed to develop an education system that "served every student, recognized individual differences, met individual needs, and enabled each student to grow lively, actively, and proactively; and built a strong foundation for students to develop life-long learning abilities, creativity, and capacity for living and further development." (*Guojia Jiaowei* (National Education Commission), 1997, p. 1). In terms of pedagogical change, quality education and related new curriculum reforms over the past two decades have aimed to promote student-centered, active discussion in the classroom, and to reduce passive, exam-focused pedagogical approaches such as rote memorization, thereby also reducing student stress (Adams and Sargent, 2012).

Murphy (2004) illustrated ways in which the increased focus on the individual in education reform was complementary to furthering the goals of the nation-state. She

pointed out that *suzhi* (quality) discourse facilitates policy implementation by imbuing disparate policies with seeming coherence, and by painting state institutions in a favorable light as working to improve people's well-being. Also, *suzhi* discourse places the responsibility on the individual for raising their own quality, and regulating their conduct in accordance with the political drift of society. In the author's words, "by enfolding *suzhi* norms into identity formation, the education system shapes each individual's ongoing process of "becoming" in ways that parallel the nation's modernization." (Murphy, 2004, p. 1).

The shifting relationship between the individual and the nation is a central theme that emerges in the analysis to follow. I seek to situate the emergence of mental health education alongside concurrent education reforms in China, and to examine the extent to which global mental health discourse shapes the language and practice of mental health education in ways that are distinct from moral and *suzhi* education. In the next chapter, I begin at the policy level, with a close reading of Chinese national education policy documents concerning mental health education and how their language aligns with global mental health discourse over time.

CHAPTER 4. COMPARATIVE ANALYSIS OF MENTAL HEALTH DISCOURSE IN WHO AND CHINESE NATIONAL POLICY DOCUMENTS

Enhancing people's level of mental health is not only good for the whole population's physical and psychological health but also good for social and economic development.

--Vice-Premier Li Lanqing, 2001

Introduction

International organizations have the power to shape norms and influence new organizational innovations within states (Finnemore, 1993). In this chapter, I examine the discourse of the most influential international health organization, the World Health Organization (WHO), and how that discourse is encoded in Chinese national mental health education policies. I also explore how discursive changes over time compare between WHO publications and Chinese national policy documents, to trace global normative influences on national policies on mental health education. To address these objectives, I conducted comparative content analysis of 1) WHO publications addressing adolescent mental health, 2) Chinese Ministry of Education (MOE) and Ministry of Health (MOH) policy documents on mental health and mental health education.

As discussed in Chapter 2, I chose WHO to represent "global discourse" because, from an institutional perspective, powerful organizations like WHO influence governments to address mental health as a core social concern (Inoue & Drori, 2006). The Chinese government has explicitly collaborated with WHO since the 1990s on activities such as high-profile conferences and workshops about mental health, including a 1989 workshop on school mental health programs. China was also one of the participating case study countries in WHO's "Nations for Mental Health" project (WHO, 1994). Around that same time, the Child Mental Health Centre in Nanjing was designated

as a WHO Collaborating Centre for Research and Training in Child Mental Health, and WHO's Western and Pacific Region carried out a study on behavioral and emotional problems among youth in Beijing, Tokyo and Seoul.

Despite the influence of WHO in China and other countries around the world, no current study exists that closely examines the discourse around child and adolescent mental health that is presented in WHO's outward-facing publications. In this chapter, I sought to examine the paradigms of mental health put forth by WHO, and how they have evolved and changed over the past 25 years. I also sought to examine how Chinese national policy documents on mental health education map onto the WHO discourse, and identify instances of convergence, divergence and transformations over time. Understanding contrasts at the policy level helps to inform inquiry at the level of practice, and to comprehensively describe the emergence of mental health education in China.

Data and methods

WHO documents

To select WHO documents for inclusion in the sample, I performed an online search for documents in WHO's publication archive, using combinations of search terms related to mental health (see Appendix A). Because I am most interested in the discourse that WHO presents to the outside world, I limited my sample to accessible, published documents and did not include internal technical documents or "grey literature." I further reduced the resulting sample of 73 documents based on three criteria: 1) documents directly related to mental health, 2) documents that included discussions of child and adolescent mental health (CAMH) and 3) documents which included information on

mental health promotion and prevention, including mental health education (MHE). Coded documents include technical reports, bulletins, articles, advocacy tools, planning tools, capacity-building materials, guidelines, and health promotion tools. After eliminating 53 documents that did not meet the inclusion criteria, my final sample includes 20 documents ranging from the 1990s to the present, so that they followed the same time period as the Chinese national policies on mental health education. Table 1 presents the final sample of WHO documents.

TABLE 1: WHO publications on child and adolescent mental health

1990	*WHO's activities in the field of child and adolescent mental health and psychosocial development.* Division of Mental Health, World Health Organization. Geneva.
1993	*Guidelines for the primary prevention of mental, neurological and psychosocial disorders.* Division of Mental Health, World Health Organization. Geneva.
1994	Hendren, R., R.B Weisen & J. Orley. *Mental Health Programmes in Schools.* Department of Mental Health, World Health Organization. Geneva.
1995	Weare, K. & G. Gray. *Promoting mental and emotional help in the European network of Health Promoting Schools: A training manual for teachers and others working with young people.* Health Education Unit, the University of Southampton and the World Health Organization Regional Office for Europe.
1998a	Graham, P. & Orley, J. *WHO and the mental health of children.* World Health Forum, vol. 19.
2000a	*Preventing Suicide: A resource for teachers and other school staff.* Mental & Behavioural Disorders, Department of Mental Health, World Health Organization, Geneva.
2000b	*Mental disorders can begin in teenage years and go untreated for life.* Press release, Information Office, World Health Organization, Geneva.
2001	*Through children's eyes: A collection of drawings and stories from the WHO Global School Contest on Mental Health.* Department of Mental Health and Substance Dependence, World Health Organization. Geneva.
2003	*Creating an environment for emotional and social well-being: an important responsibility of a health-promoting and child friendly school.* Information Series on School Health, World Health Organization. Geneva.
2004a	*Mental health promotion : case studies from countries.* Saxena, S. and P. J. Garrison, eds. A joint publication of the World Federation for Mental Health and the World Health Organization.

2004b	*Prevention of mental disorders : effective interventions and policy options: summary report.* A report of theWorld Health Organization Dept. of Mental Health and Substance Abuse ; in collaboration with the Prevention Research Centre of the Universities of Nijmegen and Maastricht .
2005	*Mental Health Policy and Service Guidance Package : Child and Adolescent Mental Health Policies and Plans.* World Health Organization. Geneva.
2006	Stewart-Brown S (2006). *What is the evidence on school health promotion in improving health or preventing disease and, specifically, what is the effectiveness of the health promoting schools approach?* Copenhagen, WHO Regional Office for Europe (Health Evidence Network report).
2010	Stengard, E. & Appelqvist-Schmidlechner, K. *Mental Health Promotion in Young People – an Investment for the Future.* WHO Regional Office for Europe.
2011	*Regional strategy for mental health: Report of the regional director.* World Health Organization Regional Office for Africa. Windhoek, Namibia.
2012a	*The global burden of mental disorders and the need for a comprehensive, coordinated response from health and social sectors at the country level.* Report of the 9th Plenary meeting, Sixty-fifth World Health Assembly.
2012b	*Adolescent mental health: mapping actions of nongovernmental organizations and other international development organizations.* World Health Organization (WHO) and the United Nations Children's Fund (UNICEF).
2013a	*Investing in mental health: evidence for action.* World Health Organization. Geneva.
2013b	*Mental health action plan: 2013-2020.* World Health Organization. Geneva.
2014	*Social determinants of mental health:* World Health Organization and Calouste Gulbenkian Foundation. Geneva.

Chinese national policy documents

To collect the Chinese national policy documents for this analysis, I searched the Ministry of Education website, Ministry of Health websites, and China's education yearbooks[5] for lists and records of all major policies on mental health education. I then obtained the documents through the MOE and MOH websites or reprints in Chinese journals. All major Chinese national policy documents on mental health education are represented in the sample, based on systematically reviewing all policies by year in

[5] China statistical yearbooks can be accessed at http://tongji.cnki.net/overseas/brief/result.aspx

China's education yearbooks, starting in 1990 and continuing to the present. Table 2 presents he full sample of Chinese national policy documents included in the analysis.

TABLE 2: Chinese national mental health education documents

1992	Basic requirements for the mental health education in primary and secondary schools (trial)	State Education Commission (former name of Ministry of Education)
1999	Opinions on Strengthening Mental Health Education in Primary and Secondary Schools	Ministry of Education
2002	Guidelines for Mental Health Education for Primary and Secondary School Students	CCP
2004	Guidelines for mental health education for secondary vocational school students	Ministry of Education
2008	Guideline for the Development of the National Mental Health Work System 2008-2015	Ministry of Health
2012	Guidelines for School Mental Health Education	Ministry of Education

Analytic approach

Through an iterative coding procedure using NVivo 10, I analyzed the texts quantitatively and qualitatively. I began with the WHO documents and continued with the PRC documents, which reflected my hypothesis that discourse flowed from the international publications to the national policies. My analytic approach included inductive word counts and deductive coding of key phrases to identify dominant themes (Krippendorf, 2004). Furthermore, I analyzed each set of documents over time in order to allow for temporal comparisons. During the first coding pass, I identified five broad emergent themes that were salient across all documents in the WHO sample, and used them to create a coding scheme, as summarized in Table 3. The five broad themes were 1) the importance of mental health education, 2) risk factors for mental health problems

among adolescents, 3) examples of mental health problems among adolescents, 4) ideal characteristics of mental health promotion/prevention initiatives, and 5) specific goals for mental health promotion/prevention initiatives. More sample codes for each theme can be found in Appendix B.

Table 3. Coding scheme

Five themes	Sample codes
1. Importance of mental health education	Building labor force, social stability, national economic development, human rights
2. Risk factors for mental health problems among adolescents	Academic stress, violence, family structure, poverty, migration, environmental stress
3. Examples of mental health problems among adolescents	Anxiety, depression, behavioral problems, social rejection, suicidal ideation, severe disorder
4. Ideal characteristics of mental health promotion/prevention initiatives	Adaptive to developmental stages, adaptive to individual differences, inclusive, scientific, integrated
5. Specific goals for mental health promotion/prevention initiatives	Cultivating healthy behaviors, promoting resilience, skill development, promoting mental health

During the second coding pass, I used the coding scheme I had developed in the first pass and went through each WHO document, using an inductive process to create codes within each of the five broader themes. After each document was coded, I measured the coverage of each code. In order to account for variation in the length of the documents, I measured coverage by dividing the code frequency per document by the number of pages in the document, to obtain an average per-page count. I identified the top ten most covered codes within each of the 5 dimensions of the coding scheme. The full list of ten most covered codes for each dimension can be found in Appendix B. For conciseness, I collapsed codes with the highest co-occurrence and conceptual similarity

into the aggregate codes presented in the results section. I also plotted the coverage of the aggregate codes over time, in order to assess how the documents have evolved over the 25 years covered by the sample.

I then used the same coding scheme and coding approach with the sample of Chinese national policy documents. My aim was to identify instances of wholesale convergence of concepts, such as both sets of documents using the same or similar terms to describe elements of the five dimensions of my coding scheme. I also sought instances where PRC policies diverged or were transformed from the global mental health discourse, as demonstrated by a lack of overlap in coded terms and phrases. I compared changes in convergence and divergence over time within the Chinese national policy documents to changes over the same time period within the WHO documents.

In addition to my coding scheme, I also noted instances where the content of PRC mental health education policy documents aligned with the aims and objectives of *moral* education in China, because mental health education has always been considered, for policy purposes, to be part of moral education. This is illustrated by an excerpt from the Ministry of Education's 1999 *Opinions on Strengthening Mental Health Education in Primary and Secondary Schools*, which recommended that mental health education should include "integration with moral education classes, politics classes, classes on puberty, activity classes, group activities, and lectures on mental health education." Similarly, The Ministry of Education's 2002 *Guidelines for Mental Health Education for Primary and Secondary School Students* directly addressed the links between mental health education and moral education, as follows:

> In practice, attention should be paid to the close relations between mental health education and moral education, neither of which can be

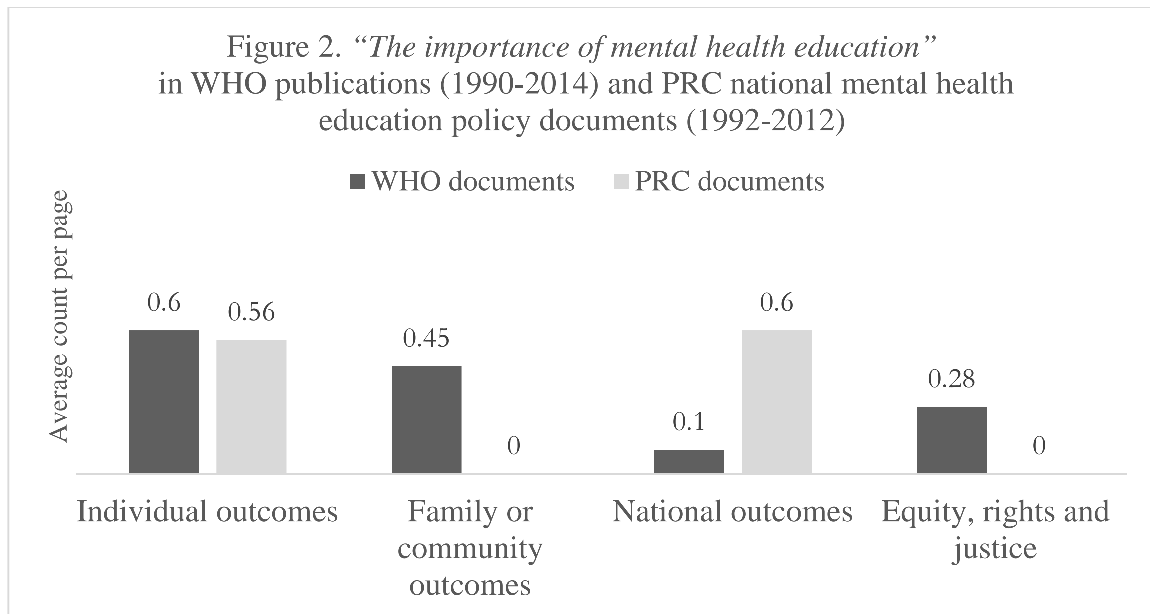
> replaced by the other. Students' mental problems should not be simply taken as moral problems. [MOE, 2002]

A corollary objective of my analysis, therefore, was to identify areas where Chinese mental health education policies aligned more closely with Chinese moral education discourse than they did with global mental health discourse.

Results

I. The importance of mental health education

The first of my five themes concerns the rationales expressed by WHO publications and PRC national policies for the importance of providing adolescents with mental health education. I aggregated the most commonly covered codes among both sets of documents into 4 major categories: the importance of MHE 1) for individual outcomes, 2) for family and community outcomes, 3) for national outcomes, and 4) for furthering broader, transnational objectives of equity, human rights and justice. Appendix B provides more detailed figures for the coverage of the most common codes in these categories.



As shown in Figure 2, both WHO documents and PRC policy documents discussed the importance of MHE for individual outcomes. In both sets of documents, this category included the importance of preventing mental health disorders in individuals, the link between mental health and physical health, and the objective of improving emotional and mental well-being of individuals. One important difference was that WHO documents tended to refer to individual outcomes using clinical terms such as "depression" or "anxiety," while PRC policy documents more often referred to non-specific problems of, for instance, "behavior" or "personality." WHO documents also tended to focus to a greater degree on improving the general quality of life for individuals, as shown in the following quotation from a 2013 WHO document:

> It is difficult, if not impossible, for a person to flourish and feel fulfilled in life when he or she is beset, whether temporarily or permanently, by health problems such as depression and anxiety. [WHO, 2013a]

Beyond a shared emphasis on the importance of MHE for individual outcomes, significant differences emerged between the two sets of documents across the other three categories. As shown in Figure 2, family and community outcomes represent the second

largest area of coverage in the WHO documents, yet references to family and community are absent in the PRC documents. Deschesnes (2003) points out that the language of global school health policy tends to emphasize the community aspect of health promotion, stressing that families and communities must share responsibility with national institutions such as schools in promoting the health of young citizens (Deschesnes, 2003). The absence of family and community references in the PRC documents does not necessarily indicate a fundamental departure from this point of view, but rather may be explained by the overlapping ideas of family, community and the nation in China. During the height of the Cultural Revolution in China, citizens (and particularly women) were encouraged by leaders to reject kin-based and gender roles and re-imagine themselves as members of the *guo* (country) over the *jia* (family) (Duara, 1996). While the tone of such rhetoric has changed considerably in the intervening decades, the idea of nation-as-family still permeates discussions of political identity in China, perhaps most apparent when evoked in campaigns for unification in greater China (Pan et al., 2001). It follows that policies put forth by the government would emphasize nation-building over other types of family and community strengthening. Indeed, the PRC documents stressed the importance of MHE for national outcomes to a much greater degree than WHO documents, as seen in Figure 2. PRC documents stressed the cultivation of behaviors, attitudes and characteristics most suitable to being a productive and high-quality Chinese citizen, therefore furthering broader nationalist and socialist causes, as demonstrated in the following quotation:

> Mental health education in primary and secondary schools is necessary both for the healthy development of students and for cultivating qualities called for by national development. [MOE, 1999]

In the PRC documents, the discussion of national outcomes included repeated references to other national education reform initiatives, such as “Education for All-Round Development” and “Quality Education.” The link between education and nation-building in China is a persistent narrative not only in mental health education discourse, but in education reform writ large, including moral education, (Zhao & Fairbrother, 2010). This is particularly true regarding rhetoric that promotes the national socialist cause, which was a recurring code in the PRC mental health policies:

> Mental health work concerns the physical and mental health of the people, social stability, ensuring social and economic development, and constructing a socialist harmonious society. [MOH, 2008]

In this sense, discourse about the importance of mental health education in China appeared to align more closely in many respects with Chinese moral education, as opposed to aligning with global paradigms in the WHO documents, which stressed the importance of community, equity, human rights, and justice over nationalism and politics.

Therein lay the most striking difference between the two sets of documents, as illustrated in Figure 2: the extent to which global mental health discourse stressed the importance of equity, justice and human rights outcomes over national development or national politics, while the rights-based aspect of mental health discourse was absent in the wording of Chinese national policies. The strong emphasis on rights in the global discourse can be illustrated by the following two quotations from WHO publications:

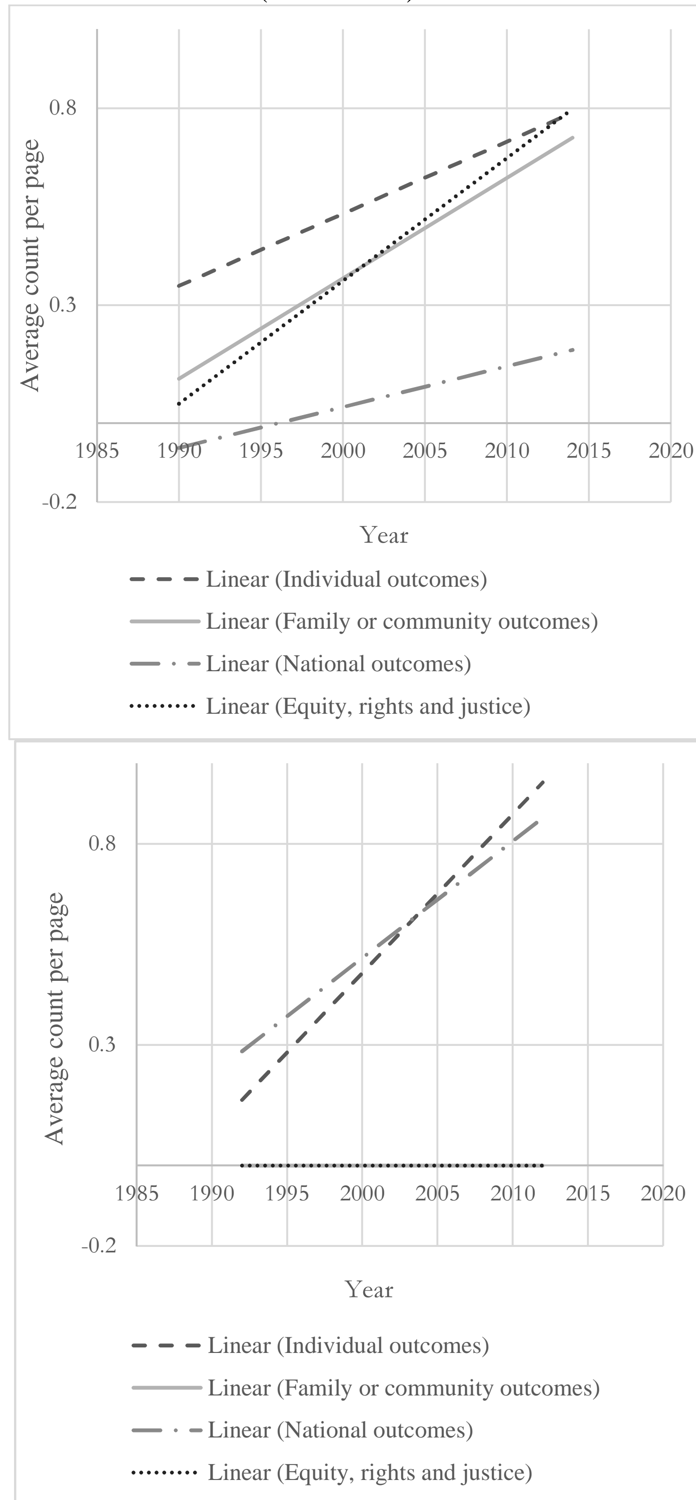
> “Access to health is a human right.” [WHO, 2013a]

> “There is a strong case to be made for investing in mental health, whether on the grounds of enhancing individual and population health and well-being, or reducing social inequalities.” [WHO, 2013b]

Indeed, turning to changes in the importance of mental health education over time, Figures 3A and 3B show how coverage of the human rights and equity paradigms increased most steeply in WHO publications, likely gaining additional political momentum as countries and agencies sought to achieve EFA and Millenium Development goals. Disadvantaged populations arguably have the most to gain from programs that improve mental health and help them access their right to learn: because children living in poverty already struggle to pursue their education in the face of delayed development and poor general health, the impact of disease and mental health disorders is much more likely to disrupt and negatively impact their learning (Jukes et al, 2008; WHO, 2012). Ensuring that the poorest children, who suffer the most ill health and risk factors for mental disorders, are able to attend and stay in school is essential to providing a basic education of good quality to every child, and to meeting universal education goals.

The increase in coverage across all codes in the WHO documents, as shown in Figures 3A and 3B, reflects that publications in the area of MHE in general became more highly detailed as mental health continued to emerge as an area of focus for WHO. In the PRC documents meanwhile, the twin streams of individual and the nation increased at an almost identically steep rate, further illustrating that these two ideas are more complementary than conflicting, as discussed in Chapter 3. Chinese mental health policy, along with other education reform policies (Murphy, 2004), has increasingly used language that promotes the development of individuals with characteristics that, in turn, benefit the nation.

Figures 3A and 3B. Changes over time in *"The importance of mental health education"* in WHO publications (1990-2014) and PRC national mental health education policy documents (1992-2012)



II. Risk factors for mental health problems among adolescents

Next, I explored how the two sets of documents addressed risk factors for adolescent mental health problems. Following my standard procedure, I created three categories based on the first coding pass: 1) Individual-level factors, 2) Family or community-level factors, and 3) Structural-level factors. A full list of all codes in these categories can be found in Appendix B.

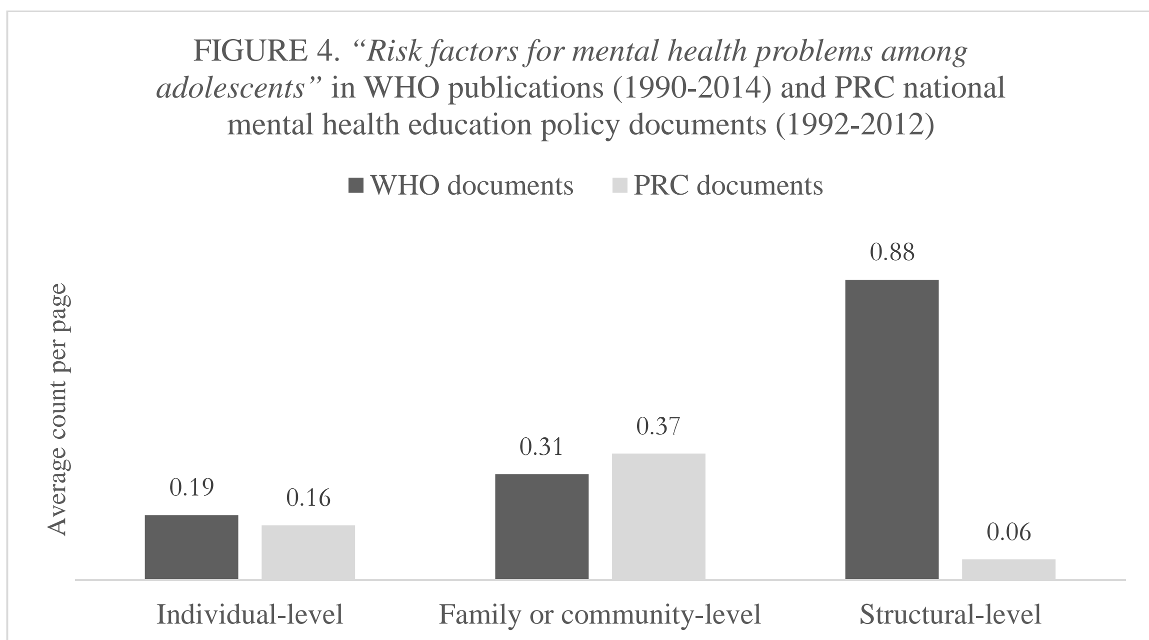


FIGURE 4. *"Risk factors for mental health problems among adolescents"* in WHO publications (1990-2014) and PRC national mental health education policy documents (1992-2012)

Generally speaking, the low average count per page across all three categories of risk factors in China reflects the fact that the PRC documents are not particularly focused on the background of mental health problems among adolescents. In the Chinese policy landscape, there appears to be little emphasis on providing context for reforms within the policy documents themselves. The PRC policy documents were more focused on providing actionable guidelines for carrying out MHE programs in schools, as will be demonstrated by higher page counts in the subsequent three coding categories.

As shown in Figure 4, both sets of documents contained roughly the same amount of references that could be coded as individual-level or family or community-level risk factors for mental illness. Individual-level factors included physical and mental development, variation in coping mechanisms, and the experience of multiple, inter-connected stressors. Family or community-level factors included conditions in the home and interpersonal relationships; in China, this category also included competition, academic pressure, and worries about future employment.

While the WHO and PRC had similar *levels* of coverage in these areas, there were differences in the way these topics were treated. For instance, regarding interpersonal relationships, the WHO documents tended to be more detailed and specific in their descriptions of the type of social challenges adolescents may face. For instance, the following quotation uses peer rejection as a specific example of a risk factor:

> There is evidence to support the view that young people with poor peer relationships or who are rejected by their peers are at risk from emotional and mental health problems later in life" [WHO, 1995]

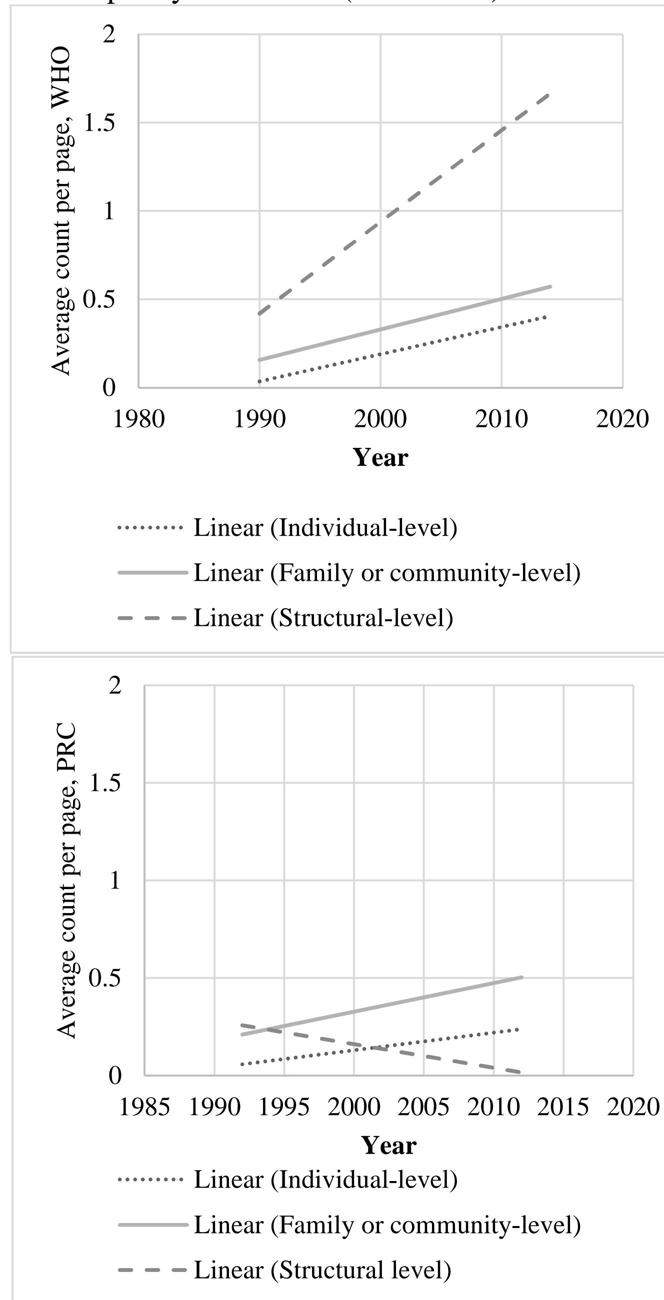
Meanwhile, the PRC documents discussed interpersonal challenges in more general terms, such as the "expansion of social experiences" (MOE, 2002). Also, academic stress and competition were commonly referenced in the PRC documents, they did not appear among the top ten risk factors present in the WHO publications. For example, 2012's "Guidelines for School Mental Health Education" stated that "students of primary and middle schools…will encounter various mental problems concerning such issues as their studying." (MOE, 2012).

I found that most risk factors in the PRC documents were phrased as issues that were at least partially within the control of each student. For instance, instead of stating

that exams cause stress, the risk factor would be stated in terms of the student's "problems with studying." This reflects Murphy's (2004) observation that other education reforms in the 1990s, such as *suzhi* (quality) education, increasingly emphasized the role that the individual plays in actualizing the quality of his or her character. It points to a heightened emphasis on *duty* over *rights* in the Chinese discourse: each student has a duty to overcome potential risk factors and achieve positive mental health, as opposed to each student having a right to a childhood free from risk factors.

The most striking difference between the two sets of documents lay in the coverage of structural-level risk factors for mental health problems. Structural-level factors present in WHO documents included poverty, violence or warfare, lack of access to treatment or support, environmental or population stress, and displacement or migration (see Appendix B for the full list). In the PRC documents, few mentions of structural factors existed aside from a few references to environmental stress and lack of access to treatment, along with a code representing the phrase "new ways of thinking in society," which appeared in two of the six policy documents. Aside from the differing overall levels of coverage, structural-level risk factors were the most dramatically increasing factors addressed by WHO publications in recent decades, as shown in Figures 5A and 5B. Meanwhile, coverage of structural-level factors—of which there were very few to begin with--slightly declined in China.

FIGURES 5A and 5B. Changes over time in "*Risk factors for mental health problems among adolescents*" in WHO publications (1990-2014) and PRC national mental health education policy documents (1992-2012)



Structural-level factors may also be conceptualized as distal factors, meaning that they originate at a distance from a given individual's daily life, and are largely out of the individual's control, such as the effects of environmental degradation or the aftermath of war. Individual and relationship factors are, by definition, more proximal. The

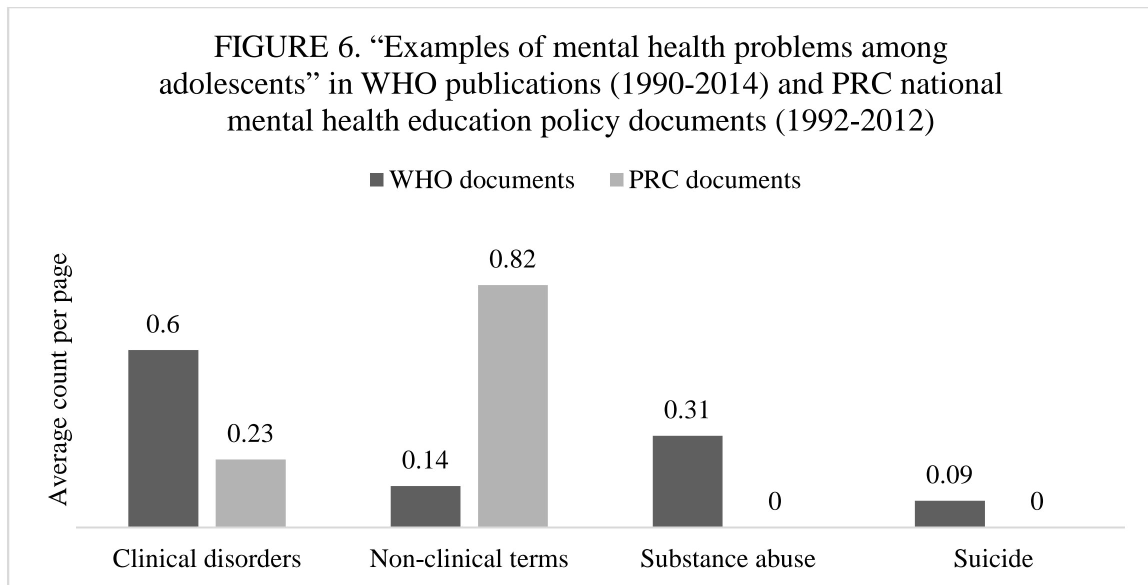
differences in coverage between the two sets of documents suggests that global organizations such as WHO place a higher premium on addressing the type of distal factors brought about by globalization and international development. In an example from 2014:

> Certain population subgroups are at higher risk of mental disorders because of greater exposure and vulnerability to unfavourable social, economic, and environmental circumstances. [WHO, 2014]

This focus on distal, structural risk factors likely relates back to WHO's emphasis on the importance of MHE for equity, justice and human-rights, as shown in Figures 5A and 5B above. By contrast, Chinese national education policy documents were almost entirely focused on proximal factors that played out within the school environment or within family dynamics, with the exception of a concern with society's "changing ways of thinking" (MOE, 1999).

III. Examples of mental health problems among adolescents

For the third of my five themes, I compare examples of adolescent mental health problems as they appear in WHO and PRC documents. The most commonly referenced examples fell within four categories: 1) Clinical disorders, 2) Non-clinical terms for problems related to mental health, 3) Substance abuse problems connected to mental health, and 4) Suicidal ideation or behavior. A full list of codes is presented in Appendix B.



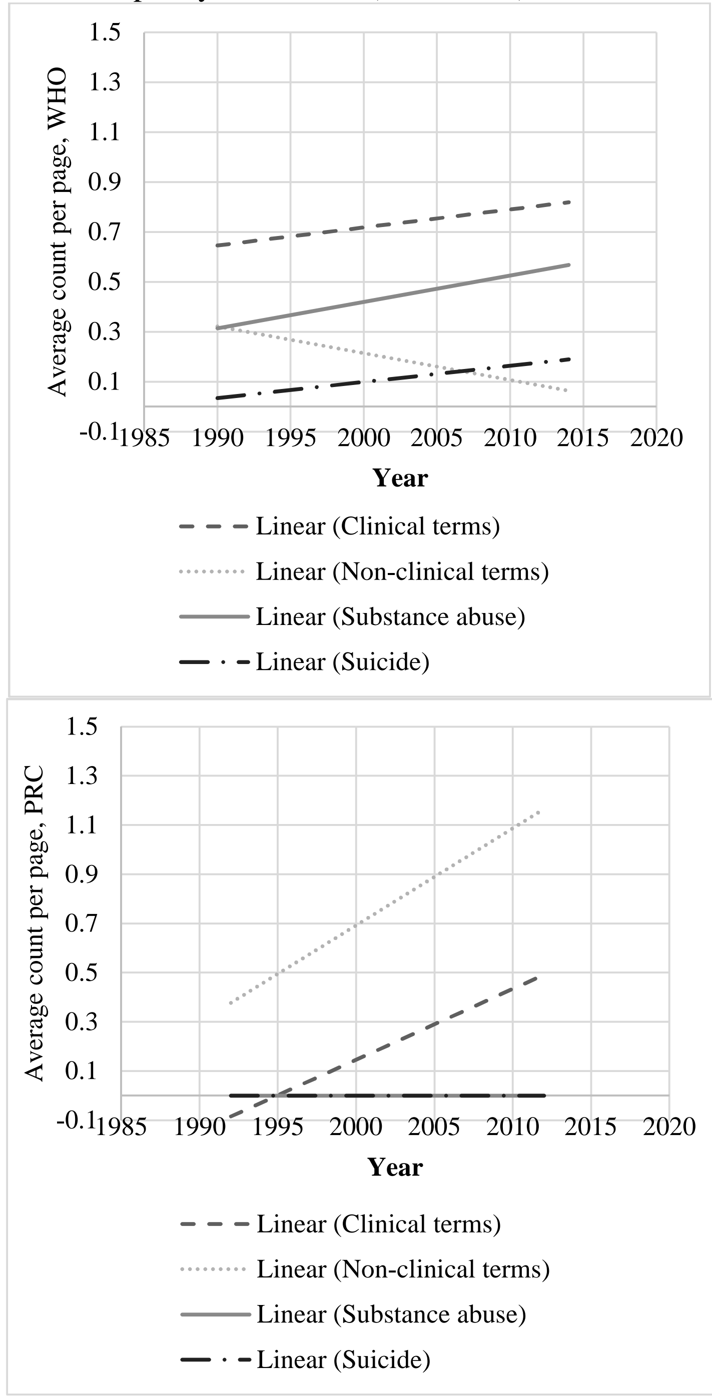
As shown in Figure 6, mentions of substance abuse and suicide were absent in PRC documents. This does not necessarily reflect the realities of Chinese society, where suicide has been on the rise in the death among young adults aged 15–34 years, and is disproportionately prevalent among young women and rural youth (Bridge et al., 2006; Zhang, 2011; Jiang, 2013). Examples of mental health problems in PRC documents, rather, tended to be referred to in non-clinical terms, such as “confusion,” “disturbance,” “mental barriers” or “self-consciousness.” Clinical disorders were mentioned only in a 2008 policy document released by the Ministry of Health, and were not discussed in the education policy documents put forth by the Ministry of Education.

Meanwhile, WHO documents were much more likely to refer to specific examples of clinical disorders such as depression, anxiety, bipolar disorder or neurological disorders. Moreover, WHO publications often provided specific descriptions of symptoms associated with disorder, as shown in this example from a 1994 publication called *Mental Health Programmes in Schools:*

> Depressed young people may experience symptoms of sadness, tearfulness, sleep and appetite disturbances, and feelings of hopelessness. [WHO, 1994]

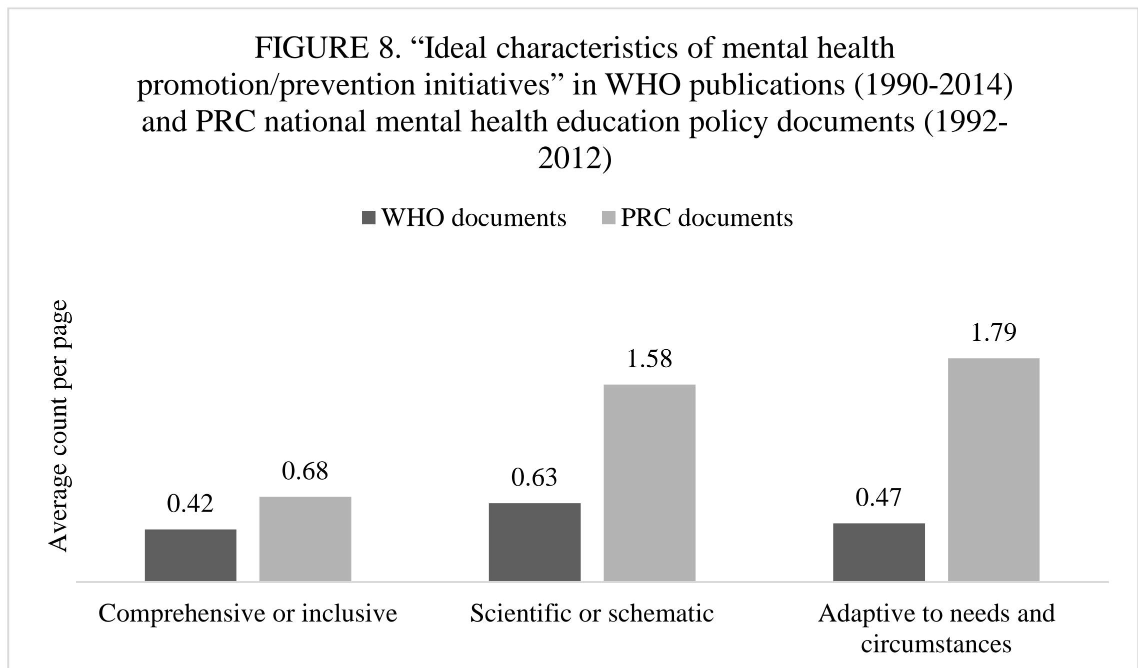
The predominance and increase of clinical terms in the WHO documents reflects a growing tendency to conceptualize mental health in scientific terms, and to provide concrete, specific examples of disorders and their associated symptoms. In accordance with world society theory, this can be linked to broader trends in global norms about science, which has arguably triumphed across social domains and around the world, due to its institutionalized cultural authority in an increasingly rationalistic global society (Chabbott & Ramirez, 2000; Drori, Meyer, Ramirez & Schofer, 2003). Looking at changes over time in Figures 7A and 7B, it is clear that non-clinical terms drove the discourse in China, whereas the use of non-clinical terms declined in WHO documents. Chinese national education policies' use of non-clinical terms possibly reflects a broader cultural reluctance to discuss mental health as a clinical subject, which extends beyond MHE to psychological counseling in China as well (Chen, 2000; Hesketh et al., 2002; Yu, 2005; Higgins & Zheng, 2008).

FIGURES 7A and 7B. Changes over time in *"Examples of mental health problems among adolescents*" in WHO publications (1990-2014) and PRC national mental health education policy documents (1992-2012)



IV. Ideal characteristics of mental health promotion/prevention initiatives

Next, I examined how the two sets of documents represent the ideal characteristics of promotion and prevention activities, including mental health education initiatives. As shown in Figure 8, the high average per-page counts in this area among the PRC documents compared to previous sections reflects the practical nature of the documents; as policy documents, they are much more concerned with describing and operationalizing MHE than they are with providing background, context or rationale for the reforms.



I aggregated the most commonly covered codes into three categories to describe ideal mental health initiatives, as shown in Figure 9: 1) Comprehensive or inclusive, 2) Scientific or schematic, and 3) Adaptive to needs and circumstances. The full list of codes can be found in Appendix B. As seen in Figure 9, both PRC and WHO documents emphasized that MHE programs should be comprehensive and inclusive, and they should

be grounded in scientific theory. The final category, "adaptive to needs and circumstances," was pervasive particularly in PRC policy documents, which stipulated that mental health education should be adaptive to individual differences, developmental stages, and local realities or culture. This category also included active participation or student voice in the education process. Examples from the PRC documents included the following excerpts:

> "Mental health education in rural and urban primary and secondary schools should be dealt with differently according to actual conditions in different areas and characteristics of different students' physical and mental development." [MOE, 2002]

> "Schools should design phase-specific contents for mental health education according to students' characteristics and needs in physical and mental development and career development at different ages." [MOE, 2004]

> "Pay attention to the whole group as well as focus on individual differences." [MOE, 2012]

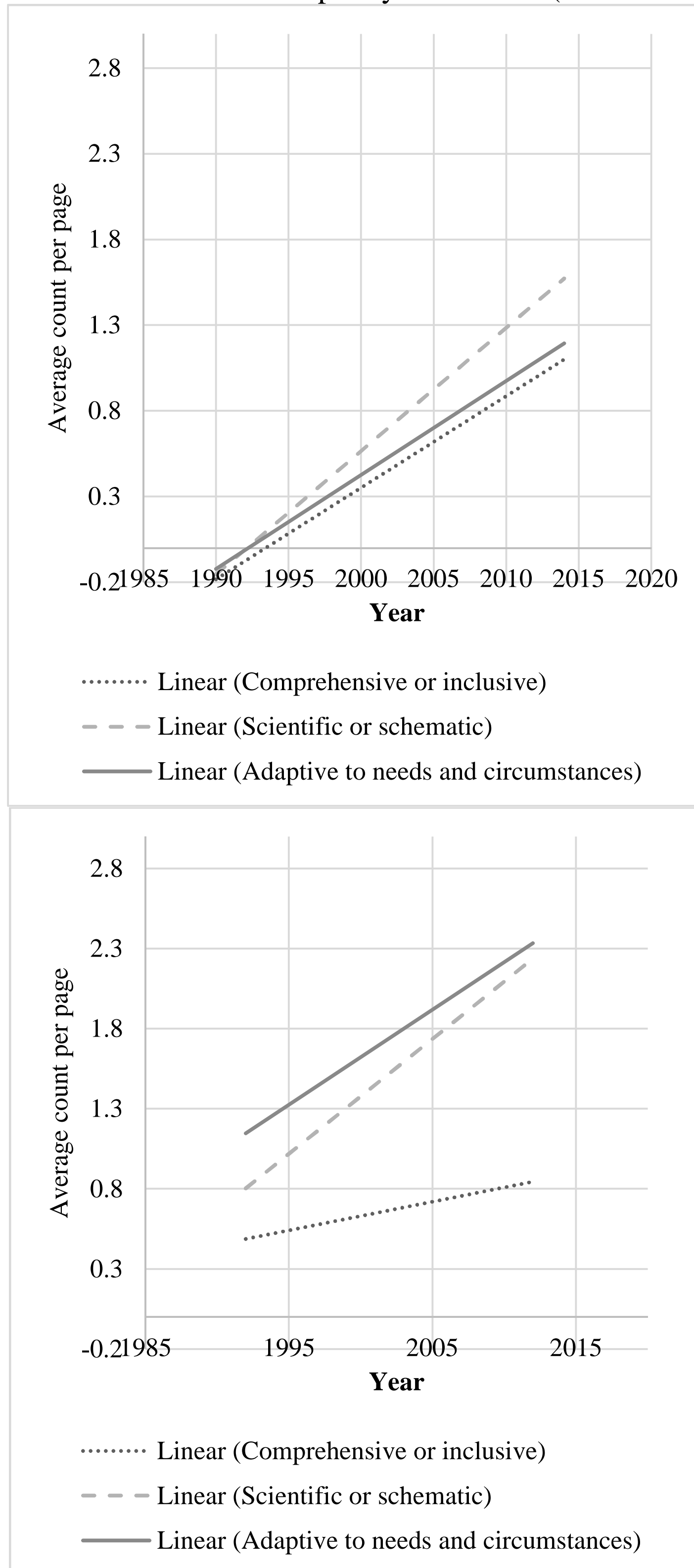
The emphasis on individual needs, characteristics and differences reflect the aim of other concurrent education reforms in China, as discussed earlier. For instance, quality *(suzhi)* education aimed to make curriculum and pedagogy more learner-centered and responsive to students (Adams and Sargent, 2012). Taken together, this phenomenon resembles what Cheung and Pan (2006) referred to as "regulated individualism," a parallel trend that was also occurring in Chinese moral education policy during the same time period. According to Cheung and Pan, regulated individualism represented a departure from the traditional aims of moral education, which were to serve political needs, train students ideologically, and produce well-educated workers imbued with a socialist consciousness. In response to economic reforms and increasing individualism in civic society, moral education was in the process of evolving from what Cheung and Pan called a "hard sell" to being more

flexible, enjoyable, and attractive to individual students. Arguably, the overall objective and content remained the same, but the method of delivery changed, and mental health education has increasingly played a role as a delivery tool to make moral education more attractive to students who are more and more curious to learn about themselves as individuals. Indeed, this is expressed quite explicitly in the 2002 Guidelines for Mental Health Education for Primary and Secondary School Students, which states:

> The main tasks of mental health education are to advance "education for all-round development" in a comprehensive way, and to make school moral education more suitable to individual cases. [MOE, 2002]

Looking at changes over time in Figures 9A and 9B, we can see that both the WHO and the PRC documents experienced the highest rate of increase in the category of "scientific or schematic." As touched upon in section III above, science has emerged as a major component of modern discourse in a globalized world (Drori, 2003). Here, Chinese national education policies' increasing emphasis on science matched the global mental health discourse put forth by WHO. Thus, when it came to describing MHE programs, PRC education policies appeared to embrace modern scientific discourse. This stands in contrast to the findings in section III above, which showed that when describing mental health problems themselves, there was a tendency in PRC education policies to avoid clinical, scientific terms for mental health problems or disorders. This discrepancy suggests "loose coupling," or adopting the rhetoric of modern discourse in broad strokes, without actually incorporating the details and mechanisms that would make it possible to enact in practice.

FIGURES 9A and 9B. Changes over time in *“Ideal characteristics of mental health promotion/prevention initiatives”* in WHO publications (1990-2014) and PRC national mental health education policy documents (1992-2012)



V. Specific goals of mental health promotion/prevention initiatives

Finally, I turn to the specific goals of mental health promotion and prevention activities. I collapsed the most commonly coded goals into four broader categories: 1) To strengthen resilience or adaptation among adolescents; 2) To promote or protect adolescent mental health; 3) To foster independence, self-esteem or individual development; and 4) to improve interpersonal skills or work ethic. The full list of codes included in each category can be found in Appendix B.

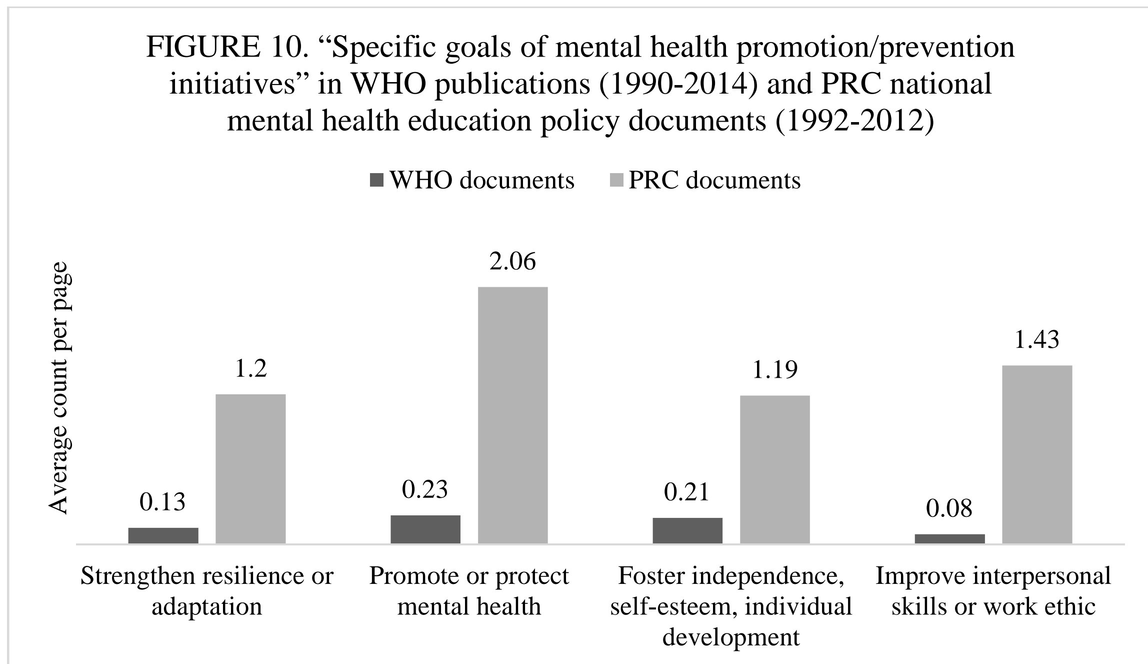


FIGURE 10. “Specific goals of mental health promotion/prevention initiatives” in WHO publications (1990-2014) and PRC national mental health education policy documents (1992-2012)

As shown in Figure 10, the coverage of these categories was fairly evenly distributed across both sets of documents, though the higher absolute coverage in the PRC documents supports the previous observation about the practical nature of these policy documents. As policies, they focused much more on the operational aspects of mental health education as opposed to the background and importance of it. The WHO sample,

on the other hand, contained a wider variety of types of publications, and thus more variety in the topics covered.

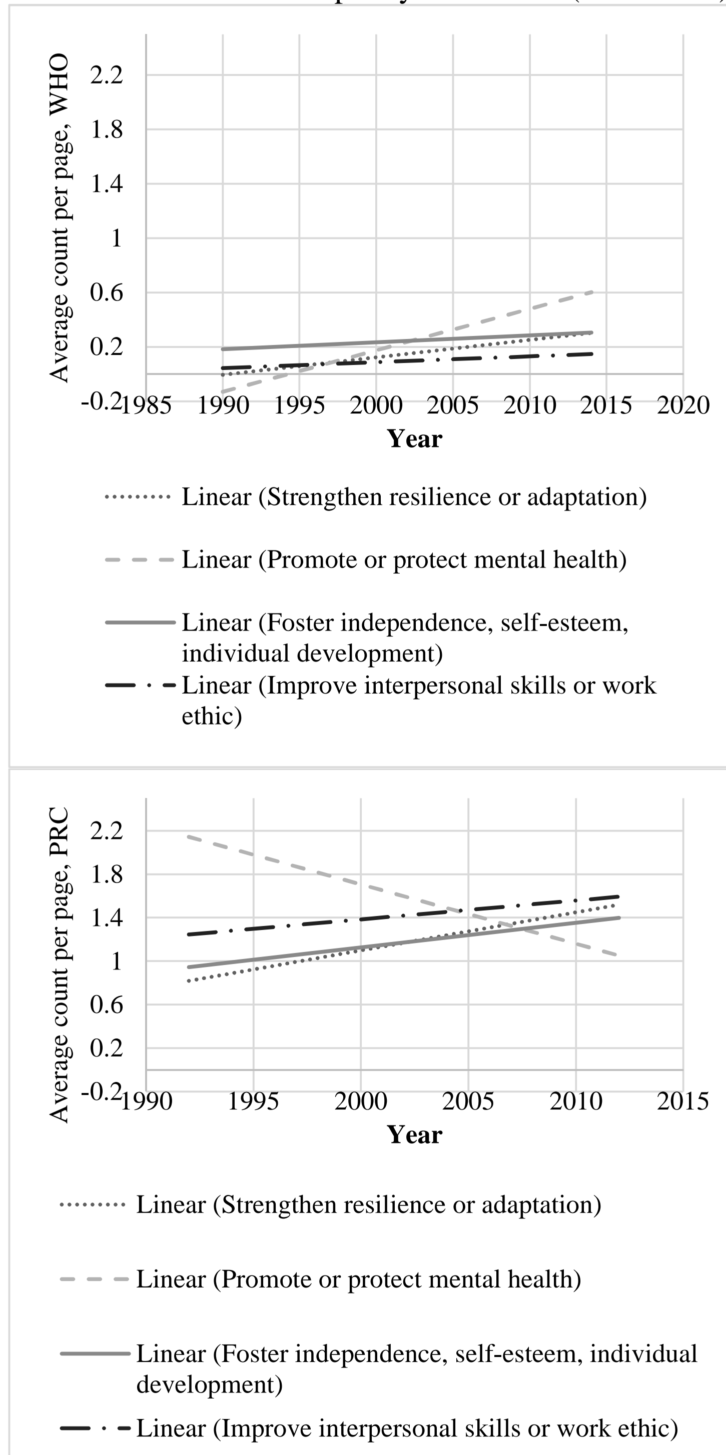
All 4 categories of “specific goals of mental health promotion/prevention activities” shown in Figure 10 relate to individual outcomes among adolescents. “Improving work ethic,” which emerged as the second most commonly discussed goal among the PRC documents, relates not only to individuals but also to the broader national objective of building a strong and healthy labor force in China. For instance, the Ministry of Education’s 2004 *Guidelines for mental health education for secondary vocational school students* states that “schools should help students prepare psychologically for employment.” The emphasis on mental health for productivity recurs throughout the PRC documents. It also appears in the following quotation from 1999’s *Opinions on Strengthening Mental Health Education in Primary and Secondary Schools:*

> “We have to work hard to cultivate hundreds of millions of laborers of high quality, and tens of thousands of professional talents that meet the demands of modernization, in order to rejuvenate the nation.” [MOE, 1999]

In the findings from section I of this content analysis, individual and national outcomes comprised all of the arguments for the importance of mental health education in the Chinese discourse. The emphasis on economic productivity as a goal for mental health education here echoes those findings, and underscores the theme of national development that permeates the Chinese policy landscape.

In both WHO and PRC documents, the most commonly covered goal was promoting or protecting the mental health of adolescents. However, when looking at changes over time in Figures 11A and 11B, we can see that while this goal increased over time in the WHO documents, it decreased in the PRC documents. This could reflect a

FIGURES 11A and 11B. Changes over time in *“Specific goals of mental health promotion/prevention initiatives”* in WHO publications (1990-2014) and PRC national mental health education policy documents (1992-2012)



strong push in the early days of MHE in China to differentiate it from moral education, but as time goes by, the emphasis on mental health is replaced by an emphasis on corollary goals such as adaptation, self-awareness, and work ethic, which apply to both MHE and moral education.

The most steeply increasing goal in PRC MHE policy documents related to resilience and adaptation, which also increased over time in the WHO documents. It is important to note some conceptual differences in the way that the WHO publications address resilience and adaptation compared to the PRC policy documents. WHO publications were much more likely to stress resilience and coping as they related to systemic inequalities and disadvantages in society, whereas the PRC policy documents were more likely to promote a youth's ability to adapt herself to her surroundings in a "right" or "correct" way. The differences are demonstrated by the following quotations:

> "The aim of school-based interventions is to provide an experience that will strengthen the children's coping abilities to counter environmental stress and disadvantages with which they have had to cope in growing up." [WHO, 1994]

> "The specific goal of mental health education is to help students look at themselves in the right way and improve their abilities of self-control, dealing with setbacks and adapting themselves to the environment." [MOE, 2002]

Again, this finding points to a heightened emphasis on *duty* over *rights* in the Chinese discourse. Students, seen through this lens, have the duty and responsibility to mold their characters to meet the demands of their society, and a goal of mental health education is to provide tools and resources for doing so.

Discussion

In this chapter, I examined how mental health discourse generated by the most influential international health organization, the World Health Organization (WHO), was encoded in Chinese national mental health education policies, and how both streams of discourse evolved over time. The goal was to trace global normative influences on Chinese national policies on mental health education. The extent to which Chinese mental health education policymakers explicitly "borrowed" or copied models from other countries was not made explicitly clear in the policies themselves. This is consistent with findings from previous research in other contexts, for instance Steiner-Khamsi's (2004) analyses demonstrating how origins disappear as ideas move through the policymaking process. But by comparing the Chinese policy documents with WHO documents, I was able to map them onto each other and identify areas of convergence, divergence and transformation.

The most striking convergence concerned the shared focus on individuality: both sets of documents stressed the importance of mental health for individual outcomes, and promoted initiatives that were adaptive to adolescents' developmental stages and individual needs. The inclusion of these ideas in China's mental health policies reflects changes in Chinese education in general, which has become increasingly liberalized and child-centered along with economic reforms and societal change (Lee & Ho, 2005; Cheung & Pan, 2006; Adams & Sargent, 2012). Chinese mental health policy, along with other education reform policies (Murphy, 2004), has increasingly used language that promotes the development of individuals with characteristics that, in turn, benefit the nation.

Despite the high coverage of individuality across both sets of documents, an important difference emerged in the *treatment* of individuality between the two sets of documents, which related to the contrasting ideas of duties and rights. In the Chinese national policy documents, mental health tended to be presented as something within the control of each individual student. The policies consistently emphasized the role that each individual youth plays in actualizing the quality of his or her character, suggesting that individuals have a duty to overcome risk factors and achieve positive mental health, using MHE as a tool. This emphasis on duty contrasted with the global discourse, which tended to emphasize individual rights over individual duties or responsibilities.

Another major area of discursive divergence emerged in the role of the nation state in mental health education. The Chinese policies placed a much higher premium on national-level outcomes compared with the global discourse, which tended to focus more on transnational goals of equity, human rights and justice, along with arguments for the individual, family- and community-related benefits of mental health promotion. The absence of family and community references in the PRC documents may be explained by the overlapping ideas of family, community and the nation in China, where the idea of nation-as-family still permeates discussions of political identity (Pan et al., 2001). Returning to the ideas of duty and rights, the PRC documents on MHE stressed that young people had a duty to develop into productive members of the labor force, and that their positive mental health development would have direct benefits to the nation as a whole.

An area that showed both convergence and divergence was the treatment of science in the two sets of documents. Chinese national policy documents did stress a

“scientized”, rationalistic approach to mental health education in terms of how MHE programs were to be carried out, which aligned closely with global discourse. This suggests evidence for institutional theory’s central premise of isomorphism and conformity over time (Meyer and Rowan, 1977). But institutional theory also contends that the reality of practices within organizations may be only loosely coupled with their outward-facing rhetoric (Meyer, 1977, Boli et al, 1985, Ramirez, 1997), and indeed, when it came to describing mental health problems and their risk factors, the Chinese policies avoided using clinical or scientific terms. A possible implication of the absence of such clinical terms at the policy level could be that it undermines the importance of hiring professional, trained mental health educators with backgrounds in psychology to work in schools. This in turn could prevent the school counseling profession from gaining a legitimate foothold at the level of practice, and from fulfilling Chinese education policy’s promise of delivering a scientific approach to mental health education in schools.

In a related finding, when discussing the risk factors for adolescent mental health problems, global discourse tended to focus on a range of individual differences, proximal family and community factors, and distal factors relating to structural disadvantages, adversity and vulnerabilities among certain groups. In Chinese mental health education policy, on the other hand, the focus was almost entirely on individual factors such as differences in coping mechanisms, and proximal factors found in the school setting, such as competition and study-related stress. This may simply reflect the fact that the policies are targeted for educators and administrators, but the absence of attention to the many diverse risk factors that adolescents face may again reduce the perception that schools

should employ professionally trained counselors and practitioners who can help students with problems that extend beyond the classroom.

In other words, global discourse on mental health education, as represented here by WHO, presents schools as an area where trained educators can address not only proximal sources of school-related stress, but can help adolescents through a vulnerable point in development that is exacerbated by structural disadvantages according to background and circumstance. Thus, mental health education can help to promote not only national development through the production of a healthy labor force, but also promote justice and human rights by helping to prevent the onset of mental disorders among the most vulnerable youth. While in many ways Chinese policy discourse aligns with the global discourse, particularly regarding the prevention of mental health problems and the resulting benefits for individuals and nations, less attention is paid in Chinese policy discourse to the clinical aspects of mental health, the diverse risk factors faced by adolescents and their communities, and the possibility of mental health education to address structural inequalities. Instead, there is an increased focus on the role of mental health education in furthering other national education reform initiatives, and in delivering moral education content. Mental health education functions as a tool for attracting students to moral education, by making room for discussion of topics that are interesting to a generation of students growing up in a changing China, including individual development and self-awareness.

This interconnection between mental health and moral education is a complete divergence from global mental health discourse. In the WHO documents reviewed,

morality was mentioned only once, in a 2005 publication entitled *Mental Health Policy and Service Guidance Package: Child and Adolescent Mental Health Policies and Plans:*

> Taking into account cognitive development, a plan for adolescents can assume a capacity to consider nuances of morality, risk-benefit ratios and causes and consequences. [WHO, 2005]

Even in this example, the global mental health discourse tended to stress mental health education as a means of helping adolescents make adaptive choices, rather than helping adolescents choose between “right” and “wrong” ways of thinking or behaving. There was a much greater emphasis in the Chinese documents about helping students to think and behave “correctly.”

For these reasons, I emerged from the comparative content analysis with a hypothesis that educators entering the profession of school counselor (*xinlilaoshi*) particularly those with formal training in psychology, face external challenges to the legitimacy of their profession, and likely must negotiate tensions between their training and knowledge of mental health and the educational climate they are preparing to enter. These tensions are explored in the following chapter, in which I present findings from interviews with 55 students training to become school counselors. My inquiry at the policy level in this chapter helps to inform my subsequent inquiry at the level of practice, and to comprehensively describe the emergence of mental health education in China.

Policies are never finished products. They continue to evolve over time, and the process of creating them is driven by iterative, collaborative, dialectic processes (Tobin et al., 2009). In this analysis, I did not delve into the processes that went into the creation of either the Chinese national policies or WHO’s publications. This was intentional, because I wanted to present a close reading of the public-facing discourse that these documents

percent. After all, the educators who are in charge of ultimately enacting discourse in the "real world" also lack access to the policymaking process. In subsequent chapters, I will explore how educators and practitioners make their own meaning of the policy-level rules and constraints that govern their work.

CHAPTER 5. CONFLICTING SCRIPTS:
TRAINING TO BE A SCHOOL COUNSELOR IN CHINA

Educators are the agents who enact policy objectives in the classrooms, offices and hallways of their schools. If mental health education (MHE) is to become an institutionalized feature of Chinese schooling, policy-level discourse must be put into practice by school counselors, called *xinlilaoshi* in China.[6] According to structuration theory (Giddens, 1979; Sewell, 1992; Barley & Tolbert, 1997) institutions arise through *scripts*, which are observable, recurrent rules or patterns characteristic of a particular setting. I suggest that China's school counselors in training must negotiate conflicting *scripts* about mental health that filter from the policy discourse level into their training and work experiences while they develop their professional identities and ideas for practice. To examine the processes by which the macro-sociological process of institutionalization occur at a micro level, I interviewed 55 students training to be school counselors at one of the top universities in the field of MHE in China.

In the previous chapter's discourse-level analysis, I found a shared focus on individuality between global and Chinese national MHE discourse, with differences in the treatment of an individual's *duties* and *rights.* Chinese policy discourse emphasized each young person's duty to develop into a productive member of the nation's labor force, which contrasted with the global discourse's emphasis on individual rights over duties or responsibilities concerning their own mental health. I also found that global mental health

[6] Because the school counseling profession is still in emerging stages in China, several names are often used to describe roughly the same school-based position. For the sake of clarity, in this chapter I will refer to the position by the most commonly used Chinese name, *xinlilaoshi*.

discourse tended to describe child and adolescent mental health problems using clinical terms such as anxiety or depression, and to focus on the societal, structural risk factors of mental health problems. By contrast, Chinese national MHE policies stressed the connection between mental health and moral education, focused on proximal family conditions, individual characteristics and school-based sources of stress as risk factors, and did not use clinical terms to describe mental health problems among youth. I emerged from the comparative content analysis with a hypothesis that educators entering the profession of school counselor (*xinlilaoshi*) particularly those with formal training in psychology drawing from western models of mental health, may find themselves entering an education system that challenges their sense of professional legitimacy.

The primary research question driving this chapter is: *How are policy-level paradigms enacted by school counselors in training as they develop their practices and professional aspirations?* To address this broad research question, I organized the inquiry process around three driving sub-questions that I developed from the results of the analysis in Chapter 4:

Sub-question I. How do school counselors in training understand adolescent mental health problems and their proximal and distal risk factors?

Sub-question II. What drives students to pursue school counseling as a career?

Sub-question III. What do students perceive as barriers to effective work as a school counselor in China?

Combining institutional and structuration frameworks

Structuration theorists contend that institutional theory, taken alone, tends to depict an institution as somehow distinct from those who comply with its rules and defining rhetoric. In this chapter, I draw from structuration theory, particularly Barley and Tolbert's (1997) model, which combines institutional theory and structuration theory to demonstrate how individuals and organizations work within institutional constraints to either enact or deliberately modify institutions through choice and action. Barley and Tolbert define institutions as "shared rules and typifications that identify categories of social actors and their appropriate activities or relationships" (Barley & Tolbert, 1997, p. 97). They emphasize that practices and patterns are not equally institutionalized, and that institutions with a relatively short history that have not yet gained the widespread acceptance of a collective are more vulnerable to challenge. Relationships between institutions and actors are described as recursive ones, in which institutionalization happens in four stages:

1) Institutional principles are *encoded* through scripts used in specific settings, which may take the form of sanctioned behaviors, formal organizational rules and procedures, or even mental models.

2) Actors then *enact* the scripts through either intention or the unconscious choice to follow established protocols.

3) Scripts are either *replicated* and become institutionalized, or *revised* to change the course of the institutionalization process.

4) Finally, if scripts become institutionalized, there is a process of *externalization* in which patterns become disassociated from particular actors and take on a normative quality.

This model provided a useful tool for examining the experiences of students training to enter the new profession of school counselor in China, because mental health education is a newly developed feature of Chinese education and lacks the degree of institutionalization of for instance, moral education. By interviewing school counselors before they entered the profession, I was able to draw inferences about the first (*encoding*) and second (*enacting)* of the four stages outlined above. Chapter 6 of this dissertation explores the third stage (*replicating or revising*), and the fourth stage (*externalization*) is outside the historical scope of this study.

Research Setting

The setting for this study was a major teaching university in Beijing, which I will call Capital Teaching University (CTU).[7] CTU consistently ranks among the top universities in China, according to the annual academic listing compiled by the Higher Education Research Center of Renmin University.[8] Both the schools of Education and Psychology at CTU are considered particularly prestigious in China. CTU is one of the first universities in China to train *xinlilaoshi,* and faculty there have engaged with partners from universities in Hong Kong, Taiwan and the U.S. to adapt curriculum and training materials for the Chinese education system (Zhou & Bray, 2002, Ye & Fang, 2010). Students from both the Education and Psychology departments at CTU are qualified to apply for jobs as *xinlilaoshi* after graduation, and students from both streams regularly choose to pursue that career path.

7 The names of the university and any student names that appear in this chapter have been changed.
8 See http://www.asiaone.com/News/Education/Story/A1Story20100630-224511.html. [Latest ranking of China's top 50 universities] Wed, Jun 30, 2010 China Daily/Asia News.

The School of Education was established in 2002 and offers 13 Doctoral programs, 17 Master's programs and 5 undergraduate programs. There is a Master of Arts degree specifically in school counseling, which falls within the Curriculum and Pedagogy division. CTU's Psychology department is distinct from the School of Education both physically and in terms of its degree programs, admission standards, curriculum and faculty. However, due to the history and structure of teaching universities in China (referred to as Normal Universities), there is no separate degree for Psychology graduate students, who technically receive a Masters or PhD in Education. Areas of concentration within the Psychology department include Developmental Psychology, Educational Psychology and Applied Psychology.

There is also an undergraduate major in Psychology, and a number of students from provinces outside of Beijing participate in a competitive national scholarship program in which they receive free tuition and a stipend of up to 800 yuan per month (about 130 USD) for living expenses. In exchange, they agree to return to their home province to serve as teachers in their field for ten years. The general understanding behind this policy is to prevent "brain drain" in the outer provinces and allow their development to benefit from the educational resources of the larger cities. At the time of my interviews, approximately 45 Psychology undergraduates at CTU were participating in this national program, with plans to return to their home provinces as *xinlilaoshi.*

Because students from both Education and Psychology compete for the same jobs as *xinlilaoshi* in schools, I asked students to describe their perceptions of the differences in preparation for the job between the two departments:

> The training in the education faculty is classroom-based, so during their three years, they learn things that are related to the classroom. People in

> the psychology faculty are not particularly trained in this area, perhaps because we have more people, and we do look for a larger variety of jobs, only some of us will end up becoming teachers…we learn more psychology-related things. We are more professional. The advantage of being in the education faculty is that they learn things that are not taught in the psychology faculty, such as education theories and education methods. [Psychology graduate student]

> When I went for an interview, a secondary school teacher asked a similar question, what's the difference between these two majors? They don't understand the difference in training. They feel that it's different but they don't know the specific differences. There are people from both faculties looking for jobs over there. [Education graduate student]

In general, students from both departments tended to concur that the Education students received more training in pedagogy, and the Psychology students focused more on content knowledge related to psychological theories. It is important to note that while both Psychology and Education are well-regarded departments at CTU, the admission requirements for Psychology are somewhat higher. Therefore, there is great prestige to being admitted into the Psychology program, leading some students to enter it despite a lack of previous interest.

> It was because of the opportunity at that time. I didn't have much understanding of psychology, but my enrollment score was quite high…so I studied this. [Psychology graduate student]

Several students in my interview sample had originally wanted to enter the Psychology program, but had tested into the Education program instead. For instance, one Education student said, "My undergraduate degree was education, and then I didn't pass the Psychology entrance examination." I encountered a number of students who, despite entering their particular programs without much initial interest, reported that their interest grew as they learned more about the field.

> I didn't consider coming to this school, and I also did not consider this major. Because my impression of psychology was that they counsel people, and it's not a very important profession, it's just a profession that helps people. My understanding was that if you wanted to counsel people, you could do so with very little knowledge. But when I sat for my senior examination my marks were not exceptionally high, I couldn't get into Tsinghua University, but they were not too low, and then I thought about it, and I ended up coming here because the school's ranking was still acceptable. After I enrolled here I realized that psychology was quite a unique profession, so I really wanted to enroll in this, and it was quite fun…it was quite scientific, and I was quite interested in counseling. [Psychology graduate student]

Regardless of their original intentions or initial levels of interest in being a *xinlilaoshi,* a stated current intention to pursue the career was a prerequisite for inclusion in my interview sample. I describe more of my methods in the following section.

Data and methods

I collected data through in-person semi-structured interviews, limiting my sample to students the Education and Psychology departments who were planning to become *xinlilaoshi* after graduation. Because students do not publicly or officially identify their specific career ambitions, I relied on a snowball approach to recruit participants. I attended seminars and presented my research in both the Education and Psychology departments, posted an announcement on a public student forum, and asked participants to refer me to other suitable participants. The final sample consisted of 55 students, as shown in Table 4. All but five of the participants (2 from the Education department and 3 from Psychology) were women.

Table 4. Interview participant overview

Department	Undergraduate	Graduate	Total
Psychology	7	25	32
Education	0	23	23

I conducted interviews using an iterative, semi-structured process guided by the principles of grounded theory (Strauss & Corbin, 1990). I began by following an interview protocol based on my research questions, and asked individualized probe questions based on responses and ideas that emerged during the course of each interview. After each day of interviews, I wrote memos in which I integrated new themes and patterns that came out of participant responses, which then became part of the subsequent interview protocols. This process allowed me to make theoretical interpretations while still grounding my findings in the empirical reality reflected by the interview materials (Strauss & Corbin, 1990; McCoy, 2006). Interviews were conducted in Mandarin, and took place in private office space within the Psychology department at CTU. In accordance with ethical standards for human subjects, students were informed about the study and signed consent forms before interviews began. With permission, I recorded the interviews using a digital audio recorder. Identifying information was removed before sending the audio recordings to a professional agency to be transcribed, and all audio and text files were stored in a password-protected computer.

Results

Because school counseling has not yet become institutionalized in Chinese education, there are no specific national standards or regulations concerning the daily responsibilities and tasks of a *xinlilaoshi*, nor is there a centrally developed curriculum for mental health education. One student's description of her future profession captures the broad range of activities that *xinlilaoshi* can organize as part of their jobs:

> The most important thing is teaching psychology classes, and then we give counseling, …I know some teachers only care about these two areas, they don't do anything else, they don't seek improvements. Some teachers give talks about students to parents, help to build psychological portfolios, they give psychological quizzes at the beginning of the year to understand students' conditions, and then they follow up and also train the class teachers, discuss how to conduct classes, and then communicate with the students, and some teachers organize activities based on their counseling, such as large-scale performances to make it like an activity-based thing. [Psychology graduate student]

The wide variation in activities and tasks that make up the job of *xinlilaoshi* reflects the many-tiered system that governs both MHE and moral education, such that schools often have flexibility in how they will implement policy directives (Ping et al., 2004, Zhao & Fairbrother, 2010).

Research Sub-question I. How do school counselors in training understand adolescent mental health problems and their risk factors?

In the comparative content analysis presented in Chapter 4, I found that Chinese national education policy used non-clinical and non-specific terms to describe child and adolescent mental health problems, despite a stated objective that MHE programs should be scientific and theory-based. Additionally, when it came to risk factors, the national policy documents primarily engaged with proximal (individual-, family- and community-level) risk factors as opposed to distal risk factors such as structural inequality, poverty, or migration. In order to investigate the extent to which *xinlilaoshi* in training enact policy-level scripts, I asked about their understandings of child and adolescent mental health in China and their associated risk factors.

Perceptions of the most common adolescent mental health problems in China

More than half of the interview participants, in roughly equal numbers between Education and Psychology students, used clinical terms to describe adolescent mental health problems. In the words of an Education graduate student:

> There are a lot of problems with the students, they have psychological problems such as depression, anxiety. These are things that normal teachers can't solve. So you need *xinlilaoshi* to help solve these problems.

Likewise, a psychology graduate student reported that the presence of youth with clinical mental disorders in schools was increasing, saying "According to my school's administration, we have more cases of depression in recent years." These expressions reflect an understanding of mental health disorders as distinct from transient, non-specific mental or emotional ailments that adolescents face in the course of their daily lives. A small number of Psychology students specifically referred to the practical clinical knowledge and skills they had acquired to address clinical disorder:

> I have met some students who really have problems, some who have obsessive compulsive disorder, social anxiety. Some who have gone through some dangerous things, like the experience of rape. … I want to use my training in Cognitive Behavioral Therapy for some problems, such as social anxiety, and obsessive compulsive disorder.

On the other hand, roughly half of students from both the Education and Psychology department used only non-scientific terms, similar to those found in the national policy, to describe adolescent mental health problems. Among the more basic non-clinical mental health challenges mentioned were "boyfriend-girlfriend problems", "problems in their studies" and "disturbances." A finding common to both policy documents and interviews was frequent use of the term "confusion," (*kùnhuò* 困惑). For instance, a Psychology graduate student said:

> Personally, I think secondary school students do not have many psychological problems, they are just confused in really basic ways. So this does not require psychology teachers to be really professional, or talk about really deep things.

Overall, compared to the language used in national policy documents, future *xinlilaoshi* employed a much greater variety of terminology to describe the mental health problems they expected to encounter in their jobs as educators in schools. As *xinlilaoshi,* their actual professional role would involve providing counseling and assistance to students whose problems fell outside of the realm of clinical disorder, while referring more serious cases to external medical practitioners (Higgins et al., 2008). The responses, in general, suggested that most future *xinlilaoshi* in my sample would make those referral decisions based on an understanding of clinical mental health disorders that aligned with the diagnostic criteria reflected in global mental health discourse.

Risk factors: Proximal or distal?

In Chapter 4's discourse analysis, proximal factors at the level of individual, family and school were the most commonly referenced risk factors for youth mental health problems, with less attention paid to distal, structural risk factors. To explore the extent to which this script was enacted by future *xinlilaoshi,* I asked them about their understanding of mental health risk factors. Their responses, on average, aligned with the policy-level discourse to the extent that they stressed individual, family- and school-level risk factors during interviews, but the resulting discussion suggested that the distinction between proximal and distal may not necessarily be so clear. For example, interpersonal

communication was one of the most commonly discussed risk factors for mental health problems among interview participants:

> There are so many only children who do not know how to talk to people, cooperate, communicate, or how to take care of others. So, in the process of interaction students will encounter some conflicts, and encounter some difficulties. [Education graduate student]

This student linked problems of interpersonal communication with being an only child. Arguably, then, issues of interpersonal communication could be considered structural as well as proximal. China's national family planning policies have led to family dynamics that affect the psycho-social well-being of only children in ways that have been documented both anecdotally and in social science research: youth in smaller families perceive more pressure and responsibility from parents and grandparents, who see them as the family's chance for future economic survival, and many find themselves struggling to adjust to changing circumstances and relate to others as they mature (see Fong, 2006). A number of participants in my study cited the one-child policy as a risk factor for mental health problems. An Education graduate student said:

> Most children in China are only children…and only children often tend to be self-centered, don't learn how to cooperate with others, or how to take others into consideration…also I think parents spoil their children too much, so the relationship between parents and children at home is sometimes contradictory…many students just do not know how to deal with these pressures, and this is coupled with a lack of ability to cope with setbacks.

Another consequence of small families mentioned frequently by future *xinlilaoshi* was the so-called "Little Emperor" syndrome: in a one-child family, each child has two parents and four grandparents showering him or her with both attention and demands.

Many participants in my study spoke of children being "spoiled" and unable to adjust to changing circumstances.

Risk factors related to families, therefore, may not be simple to categorize as either proximal or distal (structural). When family dynamics are the direct result of national policy, their roots can be traced beyond the family itself into the structure of modern Chinese society. Furthermore, young people in China can struggle with reconciling these modern demands with other aspects of family dynamics that have even deeper roots in Chinese history, such as notions of filial responsibility that have been entrenched as far back as Confucianism (King & Bond, 1985). The idea of loyalty and respect for parents emerged in a number of interviews with future *xinlilaoshi:*

> I think in western countries and other countries, students have a higher degree of… independence and autonomy. But here, we have a lot of respect for our parents' point of view, but maybe it's changing in this country. Before, it was always up to our parents what you do or where you go, so our ability to make our own decisions is not that good. [Education graduate student]

Several future xinlilaoshi mentioned during interviews that along with loyalty and respect for parents can come challenges with distinguishing one's own ambitions and developing self-awareness:

> I think [students face problems with] self-discovery, including knowing who they are, knowing their weaknesses and disadvantages…their study plans, for their own future, what they want to do, what's suitable for their personality and suitable plans for their future. [Psychology graduate student]
>
> Students nowadays are more realistic…they don't really have their own dream, and the desire to achieve their dream. They just want to look for a good job, a stable job, and have a high income. They don't really think about what they want to achieve, the kind of life that they want. They don't have their own ideas, and all these thoughts are just influenced by

> the society. So I think it's better if I help them discover what they want, so that they will not only fulfill the wishes of others. [Psychology graduate student]

In addition to family dynamics, another risk factor that I conceptualized as proximal in Chapter 4's discourse analysis was academic stress. While the direct origin of academic stress is indeed the student's immediate school environment, academic stress can also be linked to broader, distal national conditions, such as China's famously high-stakes college entrance exam. Academic competition was the most frequently mentioned risk factor in Chinese national policy documents on mental health education (see Appendix B), and was also the most common risk factor cited by the future *xinlilaoshi* during interviews at CTU. The two examples below illustrate how students linked the rise in school-related stress to structural issues in Chinese society:

> I think over here in China there is a trend of huge academic pressure. After graduating [students] can't find a job, everyone studies hard and they ignore their psychological issues. This matter is really important…mental health is being neglected, and you can't really solve it in a short period of time. [Education graduate student]

> Those students that are not successful academically, are not useful to the society. They might go to jail in the future, and things like that. They will have stunted development. [Psychology graduate student]

The structural risk factors most commonly discussed in global mental health discourse, as found in Chapter 4, included economic inequality, poverty, violence and displacement. Very few future *xinlilaoshi* mentioned such risk factors during interviews, despite the existence and relevance of these concerns in China. For instance, the urban-rural divide is widely discussed in China, because the economic, educational and social service disparities that persist between urban and rural areas condition a multitude of

disadvantaged outcomes for rural children and families (Adams & Hannum, 2005). This urban-rural economic inequality, however, was mentioned by only a small number of future *xinlilaoshi* as a mental health risk factor, including an Education graduate student who described a formative experience as follows:

> I joined a national training program last year, and when I joined this program I had to be a substitute teacher in this village's primary school…In this process, I realized a lot of things, especially the differences between rural and urban areas, and then I also realized the problems of kids at different developmental stages.

Another relevant societal issue in China is the growing phenomenon of migration from the countryside into large cities. Migrant children face particular challenges in urban schools, such as social marginalization (Yiu, forthcoming). Only one future *xinlilaoshi,* a Psychology student, referred to this specific structural-level challenge:

> The secondary school that I did my internship in was not a really good school. There were a lot of students from not very good backgrounds, parents were divorced, and parents were sick, and so the kids didn't get attention at home and their results at school were poor. A lot of their families were not in Beijing…There were a lot of students who needed help in that school. In terms of their studies, they were scolded in class and not accepted. And maybe some of them were discriminated against by their classmates, because of their families.

Interestingly, several future *xinlilaoshi* expressed a belief that mental health problems are actually the result of an *increased* economic quality of life, as opposed to the reverse:

> I think there is a higher quality of life, and so you will think about these problems when you have a better quality of life. I think…that you will only have psychological problems if you are rich. Those people that are starving will not think about whether they have psychological problems. I think maybe China has developed to this stage…the child really has problems, like internet addiction, because we have the internet. And then depression, and suicide, and stuff like that. [Education graduate student]

The sentiment above represents a way of thinking about mental health that used to be more widespread in the global mental health discourse. Mental health disorders, like other non-communicable diseases, were long considered 'diseases of the rich' (WHO, 2006). Contemporary global mental health discourse, as described in Chapter 4, now much more often tends to highlight the multiple inter-connected stressors that individuals face when living in poverty, which in turn lead to an increased risk for clinical mental health problems.

Overall, the dichotomies between proximal and distal risk factors for youth mental health, which appeared straightforward in the written discourse, were more nuanced as understood by future *xinlilaoshi.* Future *xinlilaoshi* saw both proximal and distal factors feeding into the significant challenges with interpersonal communication that they perceived among adolescents in China. Interpersonal communication among students, in turn, has implications for the career of school counseling, because students may be less likely to seek help when facing mental health challenges if they feel uncomfortable communicating about their feelings. The following examples illustrate this concern:

> Teenagers are not really willing to show their weak side to strangers. They want to pretend that they are stronger. That is a psychological characteristic of that stage, they don't talk about it when they face problems. But, if the parents or the teachers don't look into it carefully, don't pay attention to it, maybe sometime in the future, there is a problem and it will be too late to prevent it. [Psychology graduate student]

> They discover that they don't feel right, but a lot of times they don't realize that they have a psychological problem, and then the problem worsens, and then suddenly, when they go and seek help, they discover that it's a really big problem. [Education graduate student]

The future *xinlilaoshi* I interviewed saw many proximal and distal threats to the well-being of adolescents in China, and acknowledged the important role they played in

mitigating those risks through mental health education and counseling. I wanted to understand how those perceptions influenced them to pursue the career of school counseling, and what other factors were behind their career aspirations.

Research Sub-question II. What drives students to pursue school counseling as a career?

From the perspective of structuration theory, policy-level arguments for the importance of mental health would be considered *scripts.* To explore how future *xinlilaoshi* enacted the scripts identified in the discourse analysis, and to understand the extent to which these scripts influenced them to choose MHE as a career path, I asked them to describe their motivations for entering the profession and to describe their understanding of the rationales behind the importance of mental health education.

When asked about their motivations for becoming *xinlilaoshi*, many students at CTU indicated a basic personal interest in the field of psychology, sometimes stemming from positive experiences with mental health education in their past:

> When I was in college, I participated in many psychology-related activities such as group counseling and extension activities…I liked books related to psychology and found myself interested in psychology…so I chose to take examinations for the graduate program on psychology. [Psychology graduate student]
>
> It derives from an experience in my school years. I had lots of confusion, such as difficulty in concentrating, absent-mindedness, and problems in relationships and socializing...in my graduate study years, I did lots of work relevant to students and felt it was meaningful to communicate with them and that my value was realized, so I made the choice. [Psychology graduate student]

Beyond personal interest in the field of psychology, I sought to understand what drives students to pursue this career, with particular attention to the issues that emerged in Chapter 4's analysis of Chinese and global mental health discourse. My results in that

analysis showed that both Chinese policies and global discourse (represented in Chapter 4 by WHO publications on child and adolescent mental health) described MHE as equally important for both individual and national outcomes (see Figure 2 in Chapter 4). The most striking contrast that emerged in Chapter 4 was the finding that equity, social justice and human rights rationales for mental health education permeated the global discourse but were absent from the Chinese policy discourse.

Individual and national outcomes of MHE

While arguments for individual-level and national-level benefits of MHE received roughly equal coverage in China's national policy documents, my interview participants emphasized the individual-level benefits much more strongly than the benefits for national development. Participants from both the Education and Psychology department used similar language when discussing the individual-level benefits of MHE, with an emphasis on helping students with self-awareness and individual adaptive development:

> According to developmental psychology, childhood and adolescence is a critical time for psychological development, so if the school is able to seize this opportunity I think it can play a really strong role in affecting their future development. [Psychology graduate student]

The theme of individuals' duty to care for their own mental health, which emerged consistently throughout the multi-level analysis in this study, was especially central to these discussions, as illustrated by the following remarks:

> We have to believe that every student has the ability to heal themselves, to solve their own problems and treat their own wounds, so we shouldn't interfere too much in their development. [Psychology undergraduate student]

> People have the ability to solve their own problems. So I think this is particularly good. Sometimes teachers say that if you want to help this

> student, you have to change them. But in fact…each individual is responsible for his or her own development. We each have the ability to help ourselves to change and grow. I think this makes a lot of sense. [Education graduate student]

These sentiments point again to the tendency of Chinese mental health discourse to focus on the duty of individual students to care for their own mental health, as opposed to mental health being a fundamental right. Many of the future *xinlilaoshi* in my study saw themselves as having a guiding role in helping students to achieve their own self-awareness and develop their own strategies for maintaining positive mental health.

When probed about their thoughts on the link between mental health and national development, most future *xinlilaoshi* described the national-level outcomes as something that would flow naturally from the individual-level outcomes. One Education graduate student described this approach, of starting with the individual to affect larger social change, as a modern thought process in China:

> I think that helping students is the same thing as helping our country. Because many young people's questions reflect social problems. If these adolescent mental problems are not resolved, the future of our country might have a lot of problems. So if we can change some of the young people, change some individuals, some groups changed, I think that is a very great achievement. And we can indirectly change our country. I feel that there is a lot of concern for the country and society at large, but there is not enough concern for personal development services. So I think we need to focus more on individual students…I think it is relatively new [way of thinking in China]. But now there are a lot of people who realize it…Before, when things were more traditional, we would say that this kind of concern is for State-level services, such as social services. Not a lot of people paid attention to young people as individuals. I think the kinds of changes that are needed require a lot of time.

For other participants, national-level outcomes were not at the forefront of their motivation for becoming *xinlilaoshi* at all. One education student said, "I think it's not such a big deal to say that it's for the country or the society. I think as a teacher, if I can help my students grow and be healthy I will be very happy about that. I think that I don't

have such a great ability to change the society and things like that." For these future xinlilaoshi, the individual outcomes of mental health were the most important motivators of their work. However, as I explore in the next section, certain individual outcomes may be better understood as entwined with broader themes of equity and justice.

Human rights, equity and social justice

Global mental health discourse, as represented in Chapter 4 by WHO publications on child and adolescent mental health, is driven by a pervasive focus on mental health as a human right, and the importance of mental health education for promoting equity and social justice around the world. It is not surprising that Chinese policy discourse does not pay explicit attention to human rights, given China's public-facing stance on the issue. A report from the Royal Institute of International Affairs (2012) described China's "preferred understanding of human rights, according to which 'universal rights' are goals to be attained on the path to development, rather than binding legal obligations, and collective socio-economic or 'survival' rights are firmly prioritized over individual civil and political rights."

From the perspective of structuration theory, one could argue that the rights-based *script,* which is pervasive in global mental health discourse, is simply missing in Chinese mental health discourse. I wondered, however, if interviews with future *xinlilaoshi* would reveal the existence of parallel scripts that provide rationales for MHE that extend beyond the level of the individual and the nation. Asking about human rights is a sensitive undertaking in China, particularly among students. In order to respect commonly observed boundaries and avoid making my interview participants

uncomfortable, I limited my interview protocol to include one broad open-ended question to which students could easily decline to respond (see full interview protocol in Appendix C). Most participants indeed declined to speak directly about the connection between mental health and human rights, with common responses including:

> I don't get involved in these problems. [Psychology graduate student]
>
> I have never considered this. I think that for human rights, we don't really think about it in China. Our teachers think it's funny (*gǎoxiào*), and they don't really want to let us discuss it. [Psychology graduate student]
>
> I think in China it's weird to talk about human rights. No, we do not discuss this, and even if we do, probably only a little bit on paper, not really a real-life discussion. [Education graduate student]

There were, however, several students who responded to the question with their own thoughts on the connection between mental health and human rights. It is notable that when discussing human rights, participants had a tendency to emphasize the responsibility of the individual to exercise his or her own rights. In these conversations, the themes of *duty* and *rights* came into direct contrast, with interview participants consistently emphasizing duty over rights.

> Everyone should pay attention to mental health but I haven't thought much about its relation to human rights. I have the right and obligation to take good care of my mental health. [Psychology graduate student]
>
> Yes, it is a human right. I think if someone has mental problems but does not ask for help, the problem does not lie in counselors but in that he hasn't made good use of resources and is not sufficiently aware, so the government should make efforts in this regard. [Education graduate student]

While very few interview participants explicitly vocalized the idea of mental health as a human right, a number of interview participants stressed the importance of *xinlilaoshi* in working to reduce the stigma and shame about mental health in Chinese society. Arguably, the stigma faced by sufferers of mental health problems in China is an

issue of both equity and social justice (Schomerus & Angermeyer, 2008). Human rights discourse is rooted strongly in confronting the politics of exclusion that limit the participatory power of marginalized people (Niezen, 2003), and interview participants acknowledged how mental health stigma in Chinese society leads to marginalization. In the words of an Education graduate student,

> A parent would rather his child had some physical illness, such as lung problems, or maybe something in the brain, rather than admitting that there is something wrong with the child psychologically because they can't really accept it.

Other participants echoed this sentiment, pointing out that misunderstandings about mental health problems often led to students being bullied, ostracized or marginalized for their efforts to seek help. Describing her own experiences with the *xinlilaoshi* at her middle school, one Education graduate student explained:

> I never even went through the door. We knew that we had the counselor, and we walked by there every time we went for lunch, but we never thought about going. We had never studied psychology before, so we thought that if we went in we would be perceived to have psychological problems, and then everybody would laugh…so students may feel that if they seek help other students will say they are psychologically unfit.

Future *xinlilaoshi* discussed this problem in impassioned tones during interviews, expressing that it was the most serious barrier to the development of effective mental health work in China, and the most serious social problem facing people suffering from mental health disorders in both the school setting and society at large. In this sense, they were engaging more deeply with issues of equity and social justice than the education policy language might suggest. While the particular language of the human rights script may have been missing from policy discourse, related ideals of equity and justice for the marginalized were being enacted by the individuals preparing to practice mental health

education in schools, and these ideals emerged as a strong motivator for entering the profession.

Many participants felt responsible, as future mental health educators, for working to reduce stigma and shame regarding mental health problems. Others, however, expressed the limitations they perceived as individuals working towards this goal, saying things like “I can’t change society.” They described ways they needed to work around the reality of stigma in the school climate in order to help students without inducing shame. For instance:

> If the class teachers say that, maybe some students need help, you will have to use some more creative methods to make him not realize that you are there to talk to him specifically…. for example, invite him to come to class and say that we will draw a prize, and the person who wins will get to talk to the teachers privately about their feelings, to share some of the things that made them happy recently. That way, he won’t realize that he was picked to win the prize, and we have to act like we are really happy that this student won the prize.

Such “work-arounds” likely do not actually help to reduce the prevalence of stigma-related injustices, but they reflect what many future *xinlilaoshi* see as the reality of their professional capacity under current conditions. While it was not uncommon for interview participants to view entering the profession as a step in the right direction, most expressed a belief that the institutionalization of mental health education would require a much broader cultural shift than they alone could hope to induce. In the words of an Education graduate student:

> It’s like if you need some temporary psychological consulting, it’s regarded like psychosis. It’s just the same as if you had a really serious problem that required serious psychological counseling. So, there is not enough awareness in this regard, and it makes it harder to develop our work. We can’t just say, “come and see us for counseling.” If they’re not willing, they’re not willing, and there

> isn’t anything we can do about it. So this is something that needs to change.

Most interview participants echoed these sentiments, expressing the feeling that their work as *xinlilaoshi* represented only one small part of changing societal norms around mental health. However, while many agreed that the institutionalization of mental health education in China would require a much broader cultural shift, they optimistically saw themselves as part of that process. In explore this idea further in the next section, which focuses on future *xinlilaoshi’s* perceptions of barriers and challenges in their work.

Research Sub-question III. What do students perceive as barriers to effective work as a school counselor in China?

The gradual expansion of MHE in China’s schools

Many of my interview participants’ career decisions were influenced by their beliefs in the importance of mental health, as described above. For others, there were more practical and instrumental factors at play. For instance, the seven undergraduates in my sample were participating in China’s program of free tuition and living expenses for students from outer provinces who study in larger cities, granted upon the condition that they will return to their home provinces to serve as teachers for ten years. As described at the beginning of the chapter, the policy is intended to prevent brain drain and promote development in China’s more remote areas. For the individuals participating in the scholarship, it can have some very personal and profound consequences for their lives and careers.

The students in my sample who were participating in the scholarship program stressed that Psychology is different from subjects like math and language, which are

guaranteed to require teachers in middle and high schools. There is no guarantee that schools in the countryside are yet seeking to employ *xinlilaoshi*, and indeed middle- and high-school level MHE existed primarily in only the largest of Chinese cities at the time of this study. According to the MOE's 1999 *Opinions on Strengthening Mental Health Education in Primary and Secondary Schools*, "Schools in small towns and rural areas should make efforts gradually to provide mental health education based on their actual conditions." By 2012's *Guidelines for Mental Health Education in Primary and Middle Schools*, the MOE policy language on the topic had evolved, but still reflected a gap between coverage of mental health education in rural and urban areas: "According to the principles 'integrating city and villages, and city leading villages', we shall strengthen the communication and cooperation between urban and rural areas, so as to cover different areas and achieve balanced developments."

For students from rural areas, then, returning home meant seeking a job which in many cases does not yet exist in schools. For some interview participants, this created anxiety, while some others saw it as a chance to be a pioneer in the field:

> Everyone studies hard so that they can find a job in the city, so that they have a better rank socially. But because of this government policy, we have to go back to our hometown and our classmates are all from Midwestern China, it's a more rural area [with] a slower pace of development. Everyone hopes to leave their hometown and come to the east to these developmentally advanced towns, but because of the limitation of the policy, we are forced to return to their hometown. Like me, I came from a small town, to go back to the small town, some people don't really want that…[but] I think it's quite good. We don't have psychology classes in school at the moment, so if I go there, I will be the first founder. [Psychology undergraduate student from Hubei]

> I have to be a psychology teacher, and maybe it's different from what I wanted in the beginning. But after studying for a few semesters, after going back to my hometown for internship, I think

> my opinion changed a little, and I think that it's not a bad thing to be a teacher. [Psychology undergraduate student from Shanxi]

The predicament of these students illustrates that policy-level mandates can take time to be enacted at the level of practice. What happens during that process, when schools are taking steps to meet a policy mandate before a deeper process of institutionalization has taken place? An Education graduate student explained her perception of the link between policy and practice as follows:

> I know that some schools are just [hiring *xinlilaoshi*] because of national policy. Because right now our country has some requirements that every school should pay attention to students' mental health, so these schools are just trying to make a show of putting forth a lot of effort. So they set up a counseling room, but the teacher they hire ends up not exactly doing mental health education…I have discussed this with other students, we think our country has written a lot of policies that actually do not have much to do with reality. The policies are written, but teachers cannot actually put them into place in accordance with the policies. It's very problematic…Even if some schools want to hire these kinds of counselors and pay attention to these topics, they can't do it. They have no funding, or they have no time. So, the connection between policy and practice is not strong. Usually after we see these policies once, we don't look at them again. We don't see the significance of discussing how to put them into practice. We see them just as guidelines for future developments, for how to make these things stronger in the future. Right now, their practical significance is not great. [Education graduate student]

These observations paint a clear picture of the type of "loose coupling" that can occur between policy rhetoric and the reality of educational practice (Weick, 1976). The comments also point to the most commonly perceived barrier to effective mental health work in China, according to my interview participants: the lack of status that *xinlilaoshi* hold in schools.

Status in the school setting

When asked about barriers to effective work for *xinlilaoshi,* every single interview participant alluded to the problem of status. They described a number of reasons that *xinlilaoshi* may have to struggle for respect or resources. A major reason that emerged is that middle and high school students are not graded for their performance in mental health education, and the subject is not covered in the national exams:

> It's not examined in the senior examinations, [so] people will classify it as less important, you don't really have a position. [Psychology graduate student]

> In China, even if they care about other things, what they care the most is the students' results and those related to it. [Education graduate student]

National exams are critically important for determining student outcomes, and school staff are bound to focus on content that will allow students, and by extension the school itself, to succeed (Yan, 2015). For that reason, future *xinlilaoshi* reported that school leaders and administrators regarded their work as less professional than that of subject teachers, and often did not see the point in hiring a designated, trained *xinlilaoshi.* This perception was shared by both Education and Psychology students, as demonstrated by the passages below:

> I asked a headmaster in an upper secondary school, he said, we don't need *xinlilaoshi* here. If the education ministry decides to perform a check, we will just ask some teachers who teach relevant subjects like Biology, and say that's our *xinlilaoshi*. [Education graduate student]

> In some smaller towns, they will just ask the psychology teachers to do some other jobs, and psychology teachers will have a different office than other teachers, somewhere near the self-study room or counseling room…other teachers will just forget about the existence of that teacher, and they will just marginalize that teacher. [Psychology undergraduate student]

As mentioned in the comment above, *xinlilaoshi* reported facing not just a lack of respect and status, but also the expectation that they will juggle multiple demands from

school and community stakeholders without clear directives, job security, or space for safe practice. Because the MOE has no central standard for MHE curriculum and no formal regulation of its content or pedagogy at the time of this study, *xinlilaoshi* are often asked to do, in the words of an Education graduate student, "really mixed stuff, for example, maybe discipline, or to look after the class, some administrative things like giving out salaries. I think that the scope of the job is not really clear, and the school does not respect them every much." Sometimes, the perceived predicament was not a total lack of respect, but rather a mixed set of expectations and unclear directives. A Psychology student recounted the following story to demonstrate the effect that unclear expectations can have on the motivation of *xinlilaoshi:*

> I heard that there was a school where the head of school came to inspect, and he thought that the mental health department didn't really do anything, so he just closed the department. And for one year, he didn't allow them to organize any psychological activities, since he thought they cost money and didn't have a lot of effect. During that year, a few students committed suicide. After that he realized that the psychological department does have some effect. I often heard that…if the students are not fine, the blame is on the psychological teachers. The first thing that will come to [the administrators'] minds if something happens, will be that the psychology teachers did not do their job well. However, if everything is fine, nobody will see the work that psychology teachers are doing. So it's demotivating to psychology teachers. [Psychology graduate student]

In a work climate that overlooks one's successes and places undue pressure on one's shortcomings, it is difficult to develop career aspirations and a clear sense of professional worth. As a Psychology student said, "schools have too many expectations for *xinlilaoshi* and want *xinlilaoshi* to solve all the problems that head teachers and other teachers cannot cope with." Nonetheless, there was a recurring theme of optimism that ran throughout the interviews, and a sense that with time, governmental support, and

persistence on the part of themselves and their colleagues, the profession would continue to gain legitimacy and the important work of xinlilaoshi would begin to resonate in society:

> [Policymakers should] draft some policies to ensure that mental health education, to ensure that the teachers have a higher position. And this will cause China's mental health level to improve. [Education graduate student]

The connection between mental health education and moral education

Among the tasks and responsibilities that *xinlilaoshi* must juggle as a result of the emerging status of MHE in schools, one emerged as particularly salient in both policy documents and interviews: moral education. As seen in Chapter 4, policy-level discourse closely tied mental health education to moral education, a feature of Chinese schooling that has been institutionalized over many centuries of history. At the policy level, the link between mental health education and moral education was clearly a dominant script, and to understand the extent to which that script was being enacted by the future *xinlilaoshi* in my sample, I asked them to describe their understanding of the connection between mental health education and moral education, and whether or not they believed mental health education and moral education should be combined in schools.

Most interview participants expressed that they believed MHE and moral education should be treated as distinct and taught separately in school. At the same time, there was a shared perception that such a distinction would be difficult given the deep history and institutionalization of moral education in China's education system:

> [Moral education] is more respected in China. It is more important. It's historical, it's traditional. In theory, we could separate them, we could teach them separately, but at the moment to teach them separately, it's not really possible in China. [Psychology graduate student]

National education policy explicitly states that mental health education is a part of moral education, and scholars note that mental health education was introduced in part to make moral education more popular and interesting to young people (Cheung and Pan, 2006). This would make mental health education a subset of moral education. However, when asked about the connection between mental health and moral education, interview respondents did not all agree about which encompassed which, and almost all expressed a belief that some sort of separation between the two would be preferable. Some agreed with the policy-level script that moral education encompassed mental health education, as demonstrated by the responses below (emphasis added):

> In terms of Chinese culture, there must be moral education. From moral education, we can discuss mental health…*moral education is a bigger, a more ambitious thing,* it will help the student develop ideologically, while mental health education is more practical…. [Education graduate student]
>
> There's a great difference. *I think morality has a broader range,* and it is more closely related to society, with stronger social attributes. One's morality is integrated with that of the other people around him or her. Mental health education is about the individual, and only if one is in good mental health can he or she have better morality. [Education graduate student]
>
> *Most mental health education is under the scope of moral education*, so it's under the responsibility of moral teachers, moral principles, but I think they are different. Moral education is about right or wrong, like we encourage students to do things like love the country, be brave, always help people and things like that. But mental health education will focus more on the student's personal needs…It's better if they could [separate them], but it's difficult at the moment. [Psychology graduate student]

The responses above reflect moral education's historical precedence and deeper level of institutionalization in Chinese education. Generations of students in China have been raised with moral education, while mental health education was only introduced in the

1990s. Interestingly, however, a handful of interview participants saw mental health education as encompassing moral education, as demonstrated by the quotations below (emphasis added):

> *I think moral education can be used as a part of mental health education.* It can teach students to become a moral person…however, the range of mental health education should be larger than moral education. [Education graduate student]

> *Moral education should be a part of mental health education.* Moral education emphasizes behaviors towards other people: kindness, acceptable public behavior, good behavior. And then mental health education emphasizes more behaviors towards oneself, a person's own development. [Education graduate student]

I wanted to understand what participants viewed as the most crucial difference between mental health education and moral education. In general, the most common answer appeared to lie in the distinction between moral education's focus on "right and wrong" and mental health education's focus on adaptive decision-making. Interview participants stressed that behaving "correctly" was not the same thing as behaving in a way that promotes well-being and prevents the development of pathology. This difference was illustrated by an example from an Education graduate student:

> We have beauty in Chinese traditional culture, such as respecting the old and loving the young, but this is different from mental health…if a person doesn't respect the old and love the young, does it mean that he has a psychological problem?

This student used respecting one's elders as an example of "correct behavior" that aligns with the goals of moral education. Other examples cited by interview participants included patriotism, filial piety, hard work and avoiding temptations. One future *xinlilaoshi* from the Education department suggested that moral education's definitions of

correct behavior might be formulated to further certain political agendas and maintain social hierarchies:

> I think that moral education preserves certain class structures. Moral education in China can be for political purposes, such as to preserve the Communist party. But mental health education should purely be for the development of the child, it's for personal development. It should be completely separated. It's not the same.

Given the high degree of perceived differences between mental health education and moral education, how do future *xinlilaoshi* plan to reconcile them in their future practice? As a probe question, I asked a number of interview participants how they would respond if asked to perform the duties of a moral education teacher alongside mental health education when they began their jobs. One of the Psychology graduate students, who had expressed a strong preference for separating mental health and moral education, said right away, "I can accept that." Given the lack of institutionalized MHE in Chinese schools compared to moral education, her sentiment was a common one. A Psychology undergraduate student gave a slightly more nuanced response, demonstrating the realities of job-seeking in a field where jobs are scarce:

> It depends on the situation. If the school is one that I really hope to get into, a school that I really like and the school really wants to employ me I will consider it. However, if the school is not one of my top choices, I wouldn't because I think it's embarrassing to my position, and it makes it difficult for me to do my work [Psychology undergraduate student]

Professional capacity and resources

Another significant barrier to effective mental health education work cited by interview participants concerned the development of professional capacity. Many

participants expressed that their university training prepared them very well in terms of theoretical background and knowledge, but that they felt underprepared in their practical skills. When asked how they would respond to a student in crisis, responses included a certain amount of improvisation and uncertainty:

> If [a student] approaches me, I will try my best to help him. If I can't do it, I will seek help somewhere else. How to do it practically, I don't really have much of a concept in my head right now, maybe I need to ask some lecturers. If he really needs help, he definitely has to be referred to some professionals. [Education graduate student]

Some participants felt that their lack of practical preparation was exacerbated by a shortage of centrally developed MHE curricula, leading them to search for their own materials and teaching plans on the internet. Concerns about the resources available to *xinlilaoshi* ranged from curricular materials to physical classroom space to having enough time in the schedule for their activities. Even the layout of classrooms was mentioned as a potential obstacle by a Psychology graduate student who said, "China mandates that each class have rows of tables…when everyone wants to sit in a circle, it's limiting." An Education graduate student described the process of navigating school resource shortages as follows:

> It's one thing to say every school needs a school counselor, but if the conditions are no good…they need to formulate some rules about how other teachers must collaborate with the school counselor. Then they need to determine whether or not there is a good environment for this kind of counseling, and whether or not the facilities are good. For example, if you want to do a game, are there materials available to support you? Perhaps there are no such materials, and not enough funding to provide them, and also not enough time for you to go and do these things, so this is a big challenge. You just stand there by yourself, and there's a helpless feeling, there's just no way to do things. [Education graduate student]

This student related the dearth of resources available to *xinlilaoshi* back to issues of status and legitimacy described earlier. Several other future *xinlilaoshi* echoed this expression: school leaders are more likely to dedicate time and resources to a position that they value, meaning that *xinlilaoshi* must often go without the resources they need and make the best of what's available.

Discussion

Discourse-level paradigms in practice

Multi-level analysis allows for a richer description of emergent phenomena than possible through single-level analysis alone. In this chapter, I built upon the comparative content analysis presented in Chapter 4, which used a macro-sociological framework to elucidate patterns, or *scripts,* in global mental health discourse and Chinese national policy discourse about mental health education. Through speaking to the actors who will actually be responsible for enacting those scripts in school settings, I was able to better understand not only the nuances of the scripts themselves, but also how the paradigms encoded in policy-level discourse are either enacted, transformed to fit the realities of practice, or in some cases disregarded.

My interviews with future *xinlilaoshi* demonstrated that the way they understood adolescent mental health problems and their risk factors differed from the way that mental health problems were portrayed in the national policy documents. The national policies on mental health education put forth by the Ministry of Education since the 1990s tended to describe mental health problems as manifestations of vague syndromes such as "confusion" or "disturbance," without referring to specific clinical disorders by

name. However, many of the future *xinlilaoshi* that I interviewed were highly trained in the same psychological theories and methods that inform the global mental health discourse. Although their future profession as *xinlilaoshi* will likely not require them to diagnose or treat youth with clinical disorder, formal training and background in psychological theory is what sets school counselors apart from other teachers in their ability to effectively counsel and refer troubled youth, as well as to prevent the onset of disorder in the larger school population through education and support. As one Education student put it, “Psychology is a branch of science, so there is a technique to it. If it can be utilized well, it can be used to reduce pressure.” To put this finding in terms of institutional theory, the future *xinlilaoshi's* engagement with clinical psychological terms to describe mental health demonstrated their participation global scientific norms, which have gained the status of institutionalized authority in multiple social and intellectual domains around the world (Chabbott & Ramirez, 2000; Drori, Meyer, Ramirez & Schofer, 2003).

Conversations with future *xinlilaoshi* painted a more nuanced picture of the risk factors for adolescent mental health problems in China. The national policies on MHE mostly focused on proximal risk factors at the level of individual, family and school, in contrast to the global mental health discourse which tended to focus on structural risk factors due to poverty, displacement, war and environmental issues. When interview participants were asked about their understanding of risk factors in China, their responses suggested that the dichotomies between proximal and distal risk factors may not be so clear cut. Most notably, the problems of interpersonal communication that they witnessed among young people could be traced to changing family dynamics under the China's

one-child policy, and academic stress arguably has its origins in the pressure-cooker environment engendered by the national entrance examination. These factors are felt by students most immediately in their home and school environments, but are products of structural societal-level conditions in China.

A recurring theme that emerged in both the policy analysis and the interviews was that of individual duty versus individual rights. In Chinese mental health discourse, there is a tendency to stress the individual's duty to care for her own mental health, and by extension to cultivate herself into a productive and contributing member of society. Positive mental health is not portrayed as an inalienable right, but rather a responsibility shared by all individuals in society. The future *xinlilaoshi* that I interviewed saw their role, in general, as mostly a resource to help students do what they ultimately had to do for themselves, which was to develop and maintain a healthy mind, body and character.

This is not to say that the paradigms associated with human rights were absent in the Chinese discourse. Policy-level analysis alone might have suggested that mental health educators in China are concerned only with the benefits of MHE for individuals and the Socialist nation-state, while issues of rights, equity and justice were simply missing from both the language and practice of the field. I found, however, that while the students I interviewed did not use the same rights-based vocabulary that pervades the global discourse (and certainly avoided speaking explicitly about human rights), many were deeply engaged with issues of equity and social justice as they related to the problems of stigma and shame that surround mental health in Chinese society. They saw themselves as having an important role in working to reduce the marginalization of young people who struggle with mental health problems, although most agreed that their

individual efforts were only a small part of a movement that would require broader cultural change.

The future school counselors in my sample perceived considerable professional barriers as they prepared to enter their field, particularly concerning their professional status in school settings, and the difficulty of reconciling their psychological training with the inevitable carrying out of moral education instructional tasks. The conflation of mental health education and moral education was a particularly vexing challenge for many of the future xinlilaoshi with whom I spoke, because they recognized the deep roots and institutional power of moral education and the relationship between morality and mental health, while at the same time struggling to distinguish the "right and wrong" focus of moral education with MHE's focus on adaptive development. Given the lack of jobs in MHE, particularly in the more remote provinces to which some students were preparing to return, most of the students I interviewed were prepared to accept performing the tasks of moral education as at least part of their job as *xinlilaoshi.*

Despite the perceived barriers to performing the work for which they were trained, most interview participants were enthusiastic about prospects for the growth of their profession in the future. For instance, an undergraduate student in Psychology expressed optimism about the chance for mental health education to make a significant contribution to society at large:

> More people are paying attention to this field. In that school where I've done my internship, during a parent teacher meeting, the parents were more concerned about the child's mental health…Now they think that, a healthy child will also need to have good mental health besides good academic results.

The mechanisms of paradigm transfer

Understanding how policy-level discourse is enacted by educators requires exploring the mechanisms by which paradigms travel from discourse to practice. I asked participants to describe their understandings of the national policies on mental health put forth by the Ministry of Education. Most had been exposed to the policies at certain points, but had not engaged with them directly on a deep level. In the words of a Psychology graduate student:

> How does [policy] affect our studies? I don't think it has an obvious effect, but I think our jobs will be affected by these policies. Such policies are first received by the city's Education Ministry, and after that they are passed down to the Education Department below them, and then to the school. And the headmaster will receive the policies and use them to determine the work that they will do for the year to fulfill the policy requirements. But I think it shouldn't affect us as students, we don't notice it much, I don't think it affects our studies.

Likewise, an Education graduate student described her encounters with recent national education policies on mental health as follows:

> To be frank, I did not finish reading the whole policy. I know, China does not have a national standard for mental health courses. So my mentor wants to compile such a standard and has asked us to read more from the literature so we can give some suggestions.

The policy-level discourse, then, largely operated in the background of the training that future xinlilaoshi were receiving. Their professors and advisors were apparently more directly engaged with policy work, and they knew that their own work would be inexorably linked with policy mandates in the future. In the meantime, paradigms from the level of discourse appeared to be transmitted indirectly through their course curricula and training activities. Importantly, most of the theories they were learning in their coursework were psychological theories imported from foreign contexts.

When asked where most of the theories they were learning came from, many students did not immediately understand why that question would be important or interesting. To a certain extent, it was taken for granted that they were learning theories from Western countries, most commonly the United States. A few students, however, discussed the challenges of learning external models of mental health education that they will need to implement in the Chinese context:

> There are differences between Asian culture and western culture. In Asia, we had very closed development for 5000 years, and so we will be different from Western countries where they emphasize freedom, and individuality. China emphasizes more collectivism, so since there is such great difference, in terms of theory there are things that are less applicable…we do talk about these differences and when we do research we will also consider these reasons, but we still do pay more attention to Western theories, since most of what we know in psychology is from western countries. So we have to understand them before changing them, we spend most of our time understanding them, only then we will have the ability to change them to suit us more. [Psychology graduate student]

> We need to look at the combined characteristics of our country, including some of the policies we have now, and there are some realities that we need to specifically acknowledge as differences. Right now, our own theories are very few. We don't really have a complete system in this country that has these different aspects, we only have these high-level psychology and educational theories that scholars have produced…I feel like our own country is doing very little in the relationship between theory and practice. [Education graduate student]

Aside from the two comments above, and one Education student who said "We should make our own theories," most students in my sample appeared to assume that imported theories and educational models represented universal "best practices" for mental health education regardless of their origins. This reflects a phenomenon that Steiner-Khamsi described as pervasive in policy reform, saying "Once a critical mass of late adopters has borrowed a particular reform, the geographical and cultural origins vanish, making it

easier for decontextualized and deterritorialized versions to spread rapidly" (Steiner-Khamsi, 2010). Although Steiner-Khamsi was referring to the policy world, a similar process could arguably be seen happening with the transmission of theoretical knowledge: in this case, students did not think much about the original context of the theories they were learning, only that they were widely adopted and widely tested theories.

Adopting foreign models wholesale in different contexts can lead to a multitude of problems and solutions. In the next chapter, I present results from a mini-case study of a middle school that was introduced to an unfamiliar model of mental health education, and tasked with putting it into practice. By looking at a real-world example of mental health education in practice, I add a third level to the analysis, shedding light on how educators replicate and revise paradigms of mental health in a school setting.

CHAPTER 6. MINI-CASE STUDY AT A BEIJING MIDDLE SCHOOL

Introduction

Understanding the emergence of mental health education in China requires exploring processes at multiple levels, from policy discourse to activities taking place in schools. For the third phase of my dissertation, I conducted a mini-case study at a Beijing middle school to observe the introduction of a progressive model of mental health education. Going into a school and speaking with teachers and counselors allowed me to describe the challenges they faced while working together to integrate new and institutionalized practices in mental health education (MHE).

My case study took place at Beijing Z Middle School,[9] a well-known middle school in a working-class neighborhood of Beijing, which was seeking to maintain its distinction as a high-quality school through innovative student programming. In partnership with education faculty at CTU, the same university where I conducted the interviews described in Chapter 5, Beijing Z Middle School had introduced a pilot project of 13 themed classroom meetings (*zhutibanhui*) to address mental health, which I observed (8) or watched on video (5). I also observed meetings with the head teachers in charge of designing and facilitating the *zhutibanhui,* and conducted individual interviews and video-cued group discussions with teachers, school counselors and moral education administrators.

To frame the case study in terms of structuration theory, it is helpful to return to the four stages of structuration proposed by Barley & Tolbert (1997), as presented in Figure 1 of Chapter 1. Structuration theory suggests that individuals can modify or

[9] The name of the school, the CTU professor, and all teachers have been changed.

eliminate institutions through choice and action, which happens through a four-step process:

1) Institutional principles are *encoded* through scripts used in specific settings, such as policy documents or curricula.

2) Actors *enact* the scripts through either intention or the unconscious choice to follow established protocols.

3) Actors either *replicate* the scripts and institutionalize them, or *revise* them to change the course of the institutionalization process.

4) The scripts become *externalized* and normative.

In this case study, I focus on the third stage, the revision and replication of scripts. The teachers at Beijing Z Middle School were presented with a pilot mental health education project in which they were given two major directives, or scripts: 1) to engage with a mental health topic, and 2) to make the activity interactive and student-centered. The primary research question driving this chapter is *to what extent did teachers at Beijing Z Middle School replicate or revise newly introduced paradigms of MHE content and pedagogy in the classroom setting?* Sub-questions guiding the inquiry included: what were the challenges of introducing a new form of learning into the institution? How did teachers and school staff distinguish a new model of mental health education from more traditional, institutionalized educational models? I concentrated on educators' own interpretations of the process of the *zhutibanhui,* because actors' interpretations are crucial for revealing whether or not they consciously considered alternative courses of action and the costs and benefits associated with such choices (Barley & Tolbert, 1997).

Research Setting

Beijing Z Middle School is located in a working-class neighborhood in Beijing's third ring (Beijing has six major ring roads radiating from the Forbidden City and Tiananmen Square). It is near one of Beijing's well-known Muslim neighborhoods, and many migrant families from other areas of China have made their home nearby. The school campus consists of two main buildings, one for grades Junior 1, 2 and 3 (roughly the equivalent of grades 7, 8 and 9 in the US), and one for grades Senior 1, 2 and 3 (comparable to grades 10, 11 and 12 in the US). The campus is guarded by a gate and a wall which has been painted with cheerful cartoon animals. The school's slogan, "Endless Learning, Endless Development" appears in both Chinese and English at the front gate and on walls throughout the school buildings. The buildings are clean and modern, and the courtyard between them has a series of large abstract sculptures. Students wear navy-blue and white tracksuits to school, and members of the Young Pioneers wear red neckerchiefs.[10]

Established in 1950 by the newly formed government of the People's Republic of China, Beijing Z Middle School was intended to be a showcase of high-quality Communist education for underprivileged pupils. In recent years, its student scores on the national college entrance exam had been slipping, and it was in danger of losing its status as a "key" school. The head of school reached out to faculty at CTU to develop innovative student programming in an effort to boost student performance. The school's primary contact at CTU is a professor named Zou, who has maintained a consulting relationship with the school for over six years. Professor Zou is well-known and well-

[10] Most elementary schools require their students to participate in China's national Young Pioneers youth organization, and Young Pioneers are between the ages of six and fourteen. At fourteen, they may choose to join the Communist Youth League.

respected by the school's administration and faculty. She works closely with the head of school, the school's CCP secretary, and staff in the moral education department, which occupies two offices on the second floor of the junior school building and also includes the school's *xinlilaoshi* (school counselor).

A pilot mental health education initiative: the *zhutibanhui*

At the time of data collection, the school was piloting a new initiative developed in partnership with Professor Zou from CTU. The intention was to hold a series of themed class meetings, or *zhutibanhui,* focused on mental health topics. Classes from Junior 1, Junior 2, Senior 1, and Senior 2 participated in the pilot (Junior 3 and Senior 3 students were considered too busy preparing for their upcoming examinations). The topics of the *zhutibanhui* were developed by Professor Zou in partnership with the school administration and a "reform team" of teachers. Table 5 presents the topics of the thirteen *zhutibanhui.* The topics were intended to be developmentally appropriate for each grade level, and to reflect the challenges that youth face at these different points in their lives. Aside from Professor Zou, the reform team included the head of the school, the head of the moral education department, several head teachers *(banzhuren)* and the school's CCP Secretary[11]. The school employed one *xinlilaoshi* (school counselor), a female graduate of CTU in her twenties. She was present at reform team meetings, but did not assume a leadership position or speak during meetings about the *zhutibanhui* project.

A series of planning sessions were held to prepare the participating teachers, who were given a great deal of leeway in designing the specific details and elements of the *zhutibanhui*. Aside from the title of the topic, teachers were responsible for developing

[11] Schools in China are assigned such a secretary to serve as a representative of the Communist party within the school leadership.

content for the meeting. In terms of pedagogy, teachers were instructed to follow current trends in student-centered education reform (see Chapter 3) to create an interactive, student-driven atmosphere in the classroom, allowing students to engage naturally and organically with topics relating to mental health, adaptive development, and habits of learning. The *zhutibanhui* took place at various times throughout the school year, and often had to be rescheduled because of last-minute changes in the timing of tests and school events. [12] Teachers were not given designated school time to prepare for the *zhutibanhui*, and were asked to find time to plan them around their other classroom commitments. The presentations of the *zhutibanhui* were structured like a competition. Each one was video-recorded and observed by other teachers and administrators, who sat in a row of low chairs at the back of the classroom and watched. The observers had score cards, and awarded winners at the end of the project. This form of competition in the classroom is extremely common in China, where competitions in just about every subject area are often held within classrooms, between classrooms, and between schools, starting as early as preschool (Lam et al., 2004; Tobin et al, 2009).

[12] Such last-minute scheduling changes are common in China, but posed challenges for data collection.

Table 5. *Zhutibanhui* topics

Junior 1 Class 3	Regulating my own study habits
Junior 1 Class 4	Deciding my own fate
Junior 1 Class 6	Not one less
Junior 1 Class 8	Shaping collective solidarity
Junior 2 Class 4	Being in control of my emotions
Junior 2 Class 7	Being Popular
Junior 2 Class 8	Being in control of my emotions (repeated)
Senior 1 Class 1	Recalling the past, considering the future
Senior 1 Class 2	Who am I?
Senior 1 Class 7	Organization
Senior 2 Class 3	Maintaining a positive mood
Senior 2 Class 5	Faith and reason
Senior 2 Class 8	Collective unconscious

Methods

At the invitation of Professor Zou and with permission from school leaders, I observed eight of the thirteen *zhutibanhui* in person, and viewed the other five on video when I was unable to attend in person due to last-minute changes in schedule.[13] I also observed and recorded, with permission, a series of meetings with the reform team responsible for carrying out the *zhutibanhui* project. Finally, I conducted individual

[13]Videotaping the *zhutibanhui* was part of the school's original plan for the project, and was not connected directly to my research. The school leaders shared the videotapes with me after the *zhutibanhui* project had concluded.

interviews and video-cued reflective group discussions with teachers, the school counselor, the moral education director and Professor Zou.

For the individual interviews, I followed a process similar to the interview method in Chapter 5. I began each interview with basic questions about the goals and challenges associated with planning and implementing the *zhutibanhui* project. Based on the principles of grounded theory, I allowed themes and patterns to emerge during the course of the interviews, and integrated those themes into subsequent interviews through a process of memo-writing and revising my questions (Strauss & Corbin, 1990). Interviews took place in classrooms and were audio-recorded after obtaining informed consent.

My use of video-cued reflective group discussions was inspired by the "*Preschool in Three Cultures*" method developed by Tobin, Davidson and Wu (1989) and Tobin, Hsueh, and Mayumi (2009). In those studies, the authors used "video-cued multivocal ethnography" (Tobin et al., 2009, pg. 5), which involved videotaping preschool classrooms in three different countries, and showing an edited 20-minute clip of classroom footage to teachers, school staff, and early childhood educators at their own school and at schools in all three countries of the study. The videos were used to stimulate discussion about classroom events and practices. A strength of this method over simple observation is that it empowers informants to speak about the activities observed, and encourages a diversity of perspectives through "polyvocality," thereby challenging the authority of the researcher by transferring power back to the researched. I attempted to avoid one of the risks associated with the method, which is the tendency to generalize each video-taped occurrence as representative of much broader phenomena, by

presenting each clip as a discrete moment in a classroom to serve as a springboard for the teachers in the group to share their own experiences.

My approach to the video-cued reflective group discussions was a reduced version of Tobin and colleagues' PS3C method. Because I was not drawing comparisons across schools but rather asking educators to reflect on their own practices, I only showed clips to teachers and staff at their own school. In consultation with two of Professor Zou's graduate students, I selected one clip from each *zhutibanhui,* so that the presentation as a whole would reflect a variety of different teaching styles and approaches to the task. The final collection of clips included 4-5 examples of each of the following types of classroom activities observed during the *zhutibanhui:* 1) A student-directed interactive activity; 2) a performance-based activity, and 3) A teacher-directed activity.

The participating teachers, along with school administrators, the moral education director, and the school counselor watched the clips in a large group, facilitated by myself, Professor Zou and the graduate students. Teachers were encouraged to take notes during the video presentation. After watching the clips, we broke teachers into smaller discussion groups, without the administrators or Professor Zou present. We based the discussions loosely around a protocol of broad questions concerning the goals and challenges of the *zhutibanhui* (see Appendix D).

Descriptions of example *zhutibanhui*

Below, I present two examples of the types of activities observed during the *zhutibanhui* project. This are samples of the varied approaches that different classes used for the tasks, and should not be taken to represent grade-level differences.

Junior 1: Regulating my own study habits

Two students, serving as MCs, introduced themselves and led the class in an exercise involving a series of hand gestures to demonstrate the concept of changing a pattern. Next, a group of students performed a skit that took place in a school. In the first scene, a student forgot a piece of homework and was criticized by the teacher (played by another student). The other players in the skit went on to demonstrate various maladaptive study behaviors, which were met with criticism by the teacher character, who said things like "aren't you 12 years old?" and "you're smart, but your bad study habits are holding you back in life."

After the skit ended, the student MCs returned and asked students to break into small groups to discuss the following question: *Did the skit make you think about your own study habits?* Instrumental music by Kenny G played on speakers in the background while students discussed the question in groups that they formed according to where they were seated. After a few minutes, the MCs reconvened the class, and a representative from each group shared out. For instance, a girl shared that she has trouble studying when she gets home from school. After the sharing, the MCs lead the other students in a call-and-repeat chant about the danger of bad habits.

Next, another student used slides on the classroom projector to present an allegory called 钉子 (nail). The allegory described how losing a single nail began a chain reaction that led to losing a weapon, which led to losing a horse, and so on until an entire war for the country had been lost. The students broke into their groups again to discuss how the story applied to the importance of breaking bad habits early, and to discuss what they could do to change their ow/n bad habits.

The share-out after the second group discussion session was somewhat different from the first, in that responses appeared to have been prepared in advance and were read aloud from notecards. The first student to share was the *banzhang*, or class monitor. She and the other students talked about how to change bad habits, ("If you are always late, you should come earlier.")

Next, the students in the original skit returned for another skit, in which they demonstrated how they had changed their *huai xiguan* (bad habits) into *hao xiguan* (good habits), and as a result, obtained higher scores in school. At the end of the skit, a student came to the front of the class and played a song on his saxophone while his classmates clapped along. When the song finished, the student MCs gave an emotional, highly dramatized speech about the importance of good habits. Finally, the teacher, a young female *banzhuren* (head teacher) came to the front of the class and responded to the students' work during the class, telling them how proud she was of everything they had learned.

Senior 2: Collective Unconscious

The class began with the teacher welcoming the students and the other faculty and staff who had come to observe the *zhutibanhui.* Next she played a video on the projector, which was a news story about a young Japanese woman who committed suicide in Hong Kong. The news story went on to describe how Facebook has been home to "suicide groups" that young people can join to discuss planning suicide attempts. At the end of the video, students broke into small group discussions about how the news story relates to the topic of collective unconscious.

After a few minutes of discussion, a representative from each group of students shared out. Each representative stood to speak, and delivered the group's insights in an oratorical manner more suggestive of a formal public speech than an impromptu sharing. At first I believed the responses had been prepared in advance, but Professor Zou's graduate students later suggested that the responses were not pre-prepared but rather reflected the type of training in public speaking that all students in China receive as part of their education.

As point of clarification, the class was using the term "collective unconscious" (集体 无意识) not in the original Jungian sense of the term, but rather to describe a type of "group-think" that happens when individuals become swept up and lose the ability to make their own decisions.

The teacher played a second video, this one describing how pyramid schemes work. The second video was followed by a second discussion following the same pattern as the first. Most items of discussion centered around the role that other people—teachers, friends—play in noticing problematic behaviors in others, and stepping in to intervene before tragedy could occur. The overall tone of the *zhutibanhui* was serious and solemn. At the end of the class, the teacher summarized the points that the students had made, and thanked everyone for their participation.

Results

Research sub-question I) What were the challenges of introducing a new form of learning into the institution?

Overall, teachers were enthusiastic about the ideas behind the *zhutibanhui* project, but faced challenges related to content knowledge, time, resources and pedagogical approach. There appeared to be a great deal of initial buy-in, with teachers expressing

belief in the importance of mental health education for their students. In an interview, a Senior 2 teacher described an incident that happened after a recent examination, which made her realize the depth of the anxiety some of her students were experiencing:

> Just as before, I simply posted the results in the classroom. When I came back to the classroom in the afternoon, I realized that the results from the worst students were blackened out with a pen. A girl came to me and said that she did not want other people to see her score on the examination and that she had blackened out the results...by afternoon almost all of the students had blackened their score, especially those with bad results. I went to look for the student whose results were the worst, and asked him why did he do that. He said that he used to attend [redacted] middle school and that he was always among the best five students in that school. Now he puts photos of the best three students up in his kitchen. When he said that, I realized that...they require teachers' guidance.

Despite buying into the motivation behind the program, some teachers felt that they would have been able to carry out more successful *zhutibanhui* if they had a greater depth of knowledge and training in psychology. While teachers were able to choose from a list of pre-designed topics for the activities, the selection was limited, and teachers were not given any additional training in content knowledge. When asked what school leaders could do to better support the *zhutibanhui,* a Junior 2 teacher said, "I wish that they could give us some professional guidance, and also sufficient time to prepare, offer them some staff support or help... the information on Baidu[14] is not always reliable." This comment demonstrates that teachers were left to search for their own information on the internet, in their own time, to develop content for the activities. The following quotations demonstrate how teachers felt unequipped to lead activities around unfamiliar topics:

> After we choose a theme, we need to master some psychological knowledge. Then, after we have gained some understanding of this new knowledge, there is the problem of transferring it into designing a session. We are more familiar with academic subjects, so the crucial thing is that

[14] Baidu is the most commonly used search engine in China, comparable to Google in the United States.

> this is all new for us – how to master the thinking and the ideas and then design a session. It is all rather difficult. [Senior 2 teacher]

> If they could provide us with some theoretical models or some advanced cases of psychological guidance of the students in foreign countries, this could give us some ideas. Teachers...have studied a bit of psychology and pedagogy, but it was mostly superficial. [Junior 2 teacher]

In addition to a lack of support in developing content knowledge, another barrier mentioned was the lack of time and resources. Most teachers reported keeping students after school into the evening to work on preparing their activities, or sacrificing time that would have been spent on other teaching activities. The small amount of time and resources devoted to the *zhutibanhui* project arguably reflected a broader lack of importance attached to mental health education activities in the school. This relates to the issues of status discussed by the future school counselors interviewed in Chapter 5, who felt that the legitimacy of their work was undermined by MHE's position in the list of school priorities compared to academic subjects. At Beijing Z Middle School, this was not necessarily the intention of school leaders, who were motivated, actively involved and supportive during the process. The salient fact, pointed out by the interview participants in Chapter 5 and reiterated by teachers in this case study, was that mental health education is not ultimately included in any national examinations, and schools have a responsibility to focus on instruction that will help students improve their scores on those tests.

In addition to challenges with content knowledge, time and resources, teachers also felt challenged by the unfamiliarity of the pedagogical approach associated with the activity. Professor Zou's original intent was for th*e zhutibanhui* to be interactive, student-driven activities in which students communicated with each other in an organic,

unrehearsed way. Teachers accepted the concept to varying degrees. A Junior 2 teacher said, “I think letting students initiate it can motivate students, and have a greater and more impactful effect on students.” Likewise, a Senior 1 teacher said, “In the end it is all about inspiration and moving students... If there is inspiration for them, they will become more active in this process, and the classroom will be more lively.”

The interactive nature of the *zhutibanhui,* however, was also the main point of contention between members of the teaching reform team. While many teachers saw the merit of the student-driven approach, it represented a departure from the teaching methods to which they were accustomed. In the words of a Junior 2 teacher, “Teaching is like infusion of pure knowledge…however, the *zhutibanhui* is psychological guidance…it might easily go the wrong way.”

This concern about the activity “going the wrong way” was a common refrain. Many teachers expressed concern over losing control of the class if students led the discussion. Some teachers felt that students would not take the activity seriously enough, as demonstrated by the following thoughts from a Junior 1 teacher:

> I am afraid that this educational performance might end up as a laugh. if you really want it to have an impact on the students, you should...be more attentive of details when writing it, or use other ways...for example, students that are good at acting could be given the acting roles.

Other teachers doubted that their students had developed the intellectual capacity or self-awareness needed to effectively engage the topics raised during the *zhutibanhui* if left to their own devices, saying that students “are not able to deeply analyze themselves.”

The most conservative response to both the content and pedagogical approach of the *zhutibanhui* project came from the school’s CCP secretary. While generally supportive of the project as a whole, her role during reform team meetings was clearly to

safeguard the more traditional educational mission of the school and to ensure that the newly introduced activity was complementary to the CCP's objectives. At one point during a meeting when teachers were discussing the Senior 1 topic of "Who Am I?" she exclaimed "this sounds like capitalism!" When discussing teaching styles, she expressed a strong opinion that teachers should retain some control of the classroom during the *zhutibanhui:*

> I saw some group discussions, and the group discussions had no meaning at all. Students were just blabbing. This kind of approach is not the necessary one! I will say it like this, if a discussion approach is useful based on the content of the discussion, that is if discussion is necessary to develop reasoning in our students or address the issues, then it is all right. But in the absence of this, we get a meaningless, noisy discussion. Discuss for five minutes, ten minutes, fifteen minutes… In reality it is just waste of students' life and time. I think the *zhutibanhui* are like that too. If the form does not serve the content, if it does not serve the educational purpose, then it does not have a purpose at all.

The *zhutibanhui* process clearly brought to the forefront some of the issues that teachers increasingly face as educational practices in China move away from traditional didactic, authoritative models (Murphy, 2004; Adams & Sargent, 2012). Central to the discussion was the question of whether teachers should try promote a more democratic climate in the classroom and relate to students as equals. The two comments below, which surfaced during the video-cued reflective discussions, demonstrated conflicting opinions on the matter. On the one hand, some teachers admired examples of democratic classroom climates:

> I think what [name redacted] did was good. She got familiar and sincerely and respectfully talked with students. I think I will learn from her strengths in the future. Standing together with students and communicating with them as equals made students feel more accepted, and that the teacher is not someone who just talks to them from above, but

> is instead a part of the class, and guides them just like a friend. [Junior 1 teacher]

On the other hand, other teachers expressed uncertainty about the results of interacting with students as equals, or sharing too much of their personal experiences in the classroom. Some felt that such an exchange would detract from the teacher's authority, with negative outcomes that tended to be expressed in somewhat ambiguous terms, as below:

> I remember clearly [name redacted] sharing his experiences with the students, when he talked about his first year of teaching after graduation. But I am not sure if this kind of communication will reassure students or make them suspicious. This *zhutibanhui* might have created an atmosphere of contrasts and that was the point of the *zhutibanhui*, but afterwards, did it lead to some negative impacts on class management? [Senior 1 teacher]

Teachers spoke openly about their struggles to reconcile what they considered new and progressive modes of teaching mental health education with their training and experience in traditional pedagogy. According to structuration theory, a newly introduced educational practice must be replicated in practice in order for it to gain traction and become institutionalized. In the next section, I explore Beijing Z Middle School teachers' process of navigating which educational practices to replicate and which to revise.

Research sub-question II) How did teachers and school staff distinguish a new model of MHE from more traditional, institutionalized educational models?

Teachers' reluctance to relinquish control of the classroom was likely rooted in their prior experiences with other types of teaching evaluations that are institutionalized in Chinese education. For instance, there is a common practice known as an "open classes," in which teachers prepare a lesson on a certain topic. The lesson is observed by

teachers from both within and outside of the school (many open classes are available on-line). Depending on the years of experience that the teacher has, there are several types of open classes with distinct purposes: to evaluate a new teacher's performance, to serve as a model lesson for other teachers, or simply to receive feedback and improve teaching quality (Liang, 2011). In general, teaching competitions are common in China, and novice teachers are encouraged to participate in order to win honors for their school and as a form of in-service teacher training.

Several teachers mentioned that when presented with the *zhutibanhui* project, they approached it as they would an open class or other type of teaching competition. Indeed, the *zhutibanhui* were observed and scored by school leaders and other teachers, which made them feel as if they needed to expend a great deal of effort to prepare a successful activity by which their performance as teachers would be judged. The teacher in charge of the Junior 2 lesson on "Regulating my own study habits" described above confessed during the group discussion:

> We rehearsed in three evening self-study sessions. That is, after they finished classes, the students stayed in school and rehearsed it. It had three acts. I wrote the script.

This approach conflicted with the intention of the project, which was to have teachers facilitate a less formal, interactive, student-driven activity. To put it in terms of structuration theory, the teachers were presented with conflicting "scripts" about what the *zhutibanhui* should entail.

It is important to note that while competition for both teachers and students in China is a common component of traditional schooling research suggests that even in China competitiveness can lead to performance goals, in which the appearance of success

is valued over learning or mastery, and more severe self-evaluation after failure (Lam, 2004). Professor Zou suggested that the competition aspect was also making teachers feel unnecessarily exhausted, because they were expending too much effort preparing the activities in advance instead of allowing the activities to progress in a more impromptu fashion. At one point during a meeting of the teaching reform team, Professor Zou expressed frustration that teachers felt constrained in their abilities to let students speak honestly and openly during the *zhutibanhui:*

> The *zhutibanhui* that I observed were too formal. This is not necessary. Everybody should be able to discuss a problem, reflect upon it…for example, me. I used to study Physics. The first time I took a mid-term examination it was in Physics. I was filled with anger because based on my previous scores I did not qualify for the prestigious universities in the country. I was angry. As a result, I was one of ten students who did not pass their exam. So, our tutor found us and talked to us. I felt so much better once I knew I was in that group of people. So, everybody should talk more about their experiences and teachers should show more of their "human", "weak" side. It is not that big of a deal. …Let us ask ourselves if there is possibility to have these *zhutibanhui* with honest and sincere discussions? In today's society, president Xi Jinping, when he visits Shenzhen he does not use a red carpet. Today's society is more benevolent, relaxed, it allows people to make mistakes, to be faulty.

If the competitive, evaluative elements of the *zhutibanhui* project were holding teachers back from achieving one of the project's main objectives, why did the school leaders persist in structuring the initiative that way? According to the moral education director, who was clearly one of the leading figures in charge of the project, having an evaluative element was the only way to get teachers to take it seriously. Furthermore, he expressed the belief that following the model of the open class and judging teachers on their performance would increase the overall quality of the project and lead to more lasting impacts. He said:

> Everybody feels that this is very tedious thing. I thought about it, why is it so tedious, so strenuous? Maybe this is the nature of it. For example, we have district open classes and municipal open classes. Naturally, whoever participates will feel tired. You need to prepare, lecture, it is tedious indeed. But because of this preparation, the effect is good. You put in the effort and you get a good result. Educational experts give you good marks, you can even get a certificate at the end of semester for municipal open classes. Also, everybody emerges with the feeling that they are worth something, whether as an expert or as an individual. So, in the *zhutibanhui*…there are also people to appraise, observe, and so on...teachers might feel tired, but it leads to results for our classes. It is tedious, tiring, but who cares, it has an effect and it is worth it.

In addition to pedagogical approaches, there was also a tension between progressive and traditional content in the *zhutibanhui.* As discussed in previous chapters, a feature of the global mental health discourse is that it focuses less on questions of what is "right vs. wrong," and more on how to foster adaptive decision-making and resilience among young people. Moral education in China, meanwhile, tends to focus more on "correct" choices behavior, which future *xinlilaoshi* mentioned as a concern for their professional legitimacy during interviews (see Chapter 5). Looking at the titles of the *zhutibanhui* presented in Table 5, some seem to lend themselves more to the individualized, adaptive framework of MHE discourse ("Being in control of my emotions") while other imply more of the value-laden discourse of moral education ("Shaping collective solidarity.") Indeed, the head of the moral education department held one of the most prominent roles on the reform team in charge of the project, while the school's *xinlilaoshi* did not appear to take an active role. Professor Zou expressed towards the end of the project that the content of the *zhutibanhui* resembled the content of moral education more than she had intended.

Discussion: to replicate, revise or integrate?

Teachers and staff at Beijing Z Middle School were introduced to a model of mental health education that consisted of two broad directives 1) to engage with a mental health topic, and 2) to make the activity interactive and student-centered. Faced with these directives about content and pedagogy that, in some ways, conflicted with more traditional "scripts" about how and what to teach in Chinese schools, the teachers involved in the task responded in different ways. Some preferred to maintain teacher-as-leader pedagogical approaches that resembled the more familiar teaching activities such as the "open class," or preferred to deliver content that reflected the objectives of moral education more so than MHE. For a few of these teachers, the *zhutibanhui* became somewhat of an empty exercise; for example, a Senior 1 teacher said, "students learn how to lie when they are writing essays. So during the rehearsals for the *zhutibanhui*, they were lying, they were putting on a show." Other teachers chose to replicate the new directives about open, interactive pedagogy, leading to some new experiences:

> These children always teach me new things. I did not think they would do so well….however, the students' capabilities, including writing of the script, rehearsing and so on, each session brought out some new ability in the students. It also helped them discover their strong points. I think this activity inspired me in different ways too. [Senior 1 teacher]

For most teachers, the project ended up being a combination of new and familiar content and instructional practices. For instance, one teacher described a combined approach in which students wrote a script for their performance under the guidance and direction of the teacher, saying "before students make the final draft, the teacher should look at it and after each session present a summary. After the performance, teacher can

present a short summary, a transition, so as to make students think even more deeply." Other teachers found creative approaches to interactive pedagogy that reduced the threat of the activity "going the wrong way," such as a Junior 1 teacher who led her class in a *zhutibanhui* on "Shaping Collective Solidarity." Her students were given an activity in which they had to work together as a team to construct a shape out of paper without speaking to each other. This way, they were interacting, but the teacher did not have to worry about the students taking the class off-message or saying something unexpected that would reflect poorly on the teacher or other students. The activity was well-received by the observing teachers, one of whom commented:

> I liked the class meeting by [name redacted], which made students cooperate in completing an assignment without talking. This activity made students rather interested in participating, and with the teacher's guidance they made progress. I think, as long as the students are interested and are participating, the impact on them will be bigger. So, I was impressed by this session. [Senior 2 teacher]

In another example, a teacher took the traditional idea of competition and turned it into an opportunity for students to praise each other in an unrehearsed manner. Her Junior 2 class *zhutibanhui* on "Being well-liked" concluded with an activity in which students were given rabbit-shaped stickers, and asked to walk around the class and stick the rabbit onto the classmate that they liked the most. The boy and girl with the most rabbit stickers then came to the front of the classroom to be interviewed, game-show style, by the student MCs, who asked them about their secrets for popularity. The activity was student-driven and the outcome was not determined in advance; the teacher later reflected on her surprise at the results:

> [The boy who won] is not really dilligent, but he is good to the teachers. When we designed this activity, never did we believe that he would be chosen, nor did we think it would be that girl. We all thought it would be

> the best students or class monitors [*banzhang*]. The girl's results are pretty good, but among all the choices, we didn't think these students would be chosen.

To an outside Western perspective, this activity stood out as one that would rarely be seen in a Western classroom, where students are less accustomed to competing directly with each other, or to giving and receiving assessments and criticisms from each other, including self-assessments and self-criticisms. At Beijing Z Middle School, teachers responded positively to the rabbit sticker activity, as the following comments illustrate:

> "Popular person" impressed me the most. Everybody put a sticker on their shoulders and people could make comments about them. The children could learn something about themselves, and I believe that interaction between students was also very good. [Senior 1 teacher]
>
> I was also most impressed by this one. The fact that the person involved did not know that he would be chosen as the most popular person, might have a deep impact on him. I am sure that this class meeting had a big influence on this student. [Junior 1 teacher]

The integration of new and traditional content and pedagogy could be viewed as a variation of what Tobin and colleagues (1989, 2009) observed in China's preschools, referred to as *bentuhua* (Tobin et al., 2009, pg. 89-90). *Bentuhua* is a conscious process of combining ideas from the West with features of the local context in China. When presented with a set of directives, or what structuration theory would call *scripts*, the teachers at Beijing Z Middle School chose to replicate some and revise others based on their understanding and beliefs about teaching practice. Arguable, this practice could ultimately lead to the development of "hybrid" models of MHE that honor traditional elements of Chinese schooling while introducing new elements that harmonize with other streams of education reform in China and around the world. The process of integrating educational paradigms, though, can leave educators feeling confused about the results

and unsatisfied with their level of success. A Senior 2 teacher shared an anecdote that illustrated her struggle to find the right balance between teacher-centered and learner-centered approach during the *zhutibanhui:*

> During rehearsal, I told a student that he should stop and reconsider what he was saying. This method of mine might have hurt his self-respect. But his experience was not ample enough, and I felt like during the performance, he needed to say something different. So he took my suggested line and said it, but he did not understand the meaning of the sentence. As a result, I think that the discussion was not as good, and that we did not achieve the results I expected.

Observing the experiences of the teachers and staff at Beijing Z Middle school allowed for a glimpse into the experience of implementing a progressive model of mental health education in a school setting. Similar processes are happening at schools throughout China's major cities, and even into the provinces as graduates from programs like CTU's return to their home cities to become *xinlilaoshi.* Undoubtedly, each school will have a unique approach to implementing MHE alongside institutionalized features of schooling such as teaching competitions and moral education, and each approach will include varying degrees of adoption, rejection and transformation of global paradigms of mental health. In the final chapter, I discuss some implications of this study's findings for other schools where MHE is emergent, in China and beyond.

CHAPTER 7: CONCLUSIONS, LIMITATIONS AND DIRECTIONS FOR FUTURE RESEARCH

I once spent a year teaching English at a school in rural Hunan province, and there was an office with a sign on the door reading, in both English and Chinese, "Psychological Office." Although my students' lives were fraught with personal struggles and risk factors ranging from poverty to chronic illness, I never during my time at the school saw anyone enter or leave that office. This made me wonder how a school in rural Hunan province decided to open a psychological counseling office, and why it was never used. I decided to explore those questions in my dissertation, which was intended as an exploration of the emergence of mental health education at multiple levels of the education system, using China as a case study of how global paradigms of mental health are adapted, rejected or transformed in policy and practice.

Mental health continues to gain prominence as a worldwide health concern, particularly in developing countries where the global transformations of our era have arguably increased the prevalence of economic inequality, unemployment, poverty, discrimination, unhealthy lifestyles, displacement, and human rights violations. In response, many developing countries are in the process of doing what China is doing: establishing means of preventing mental health problems in childhood before they escalate. Other countries, then, are likely to face challenges similar to China's in adapting imported models of mental health education and service delivery to meet local needs. Schools continue to emerge as a cost-efficient and appropriate setting for supporting child and adolescent mental health, and mental health education has increasingly become part of the globally legitimated "recipe" for mass schooling. Research is needed to strengthen

international collaboration and develop shared understanding of the challenges of mental health education in different contexts. Moreover, because forces that influence psychological well-being are as much local as they are national or international, research must seek to elucidate the socio-cultural factors at both macro and micro-levels that determine whose needs are ultimately being served by school-based mental health programming. This way, countries might be able to better develop "hybrid" models of mental health service delivery and prevention that do not rely the assumption that imported models are best.

In this study, I considered China as an example to illustrate these challenges. I employed mixed methods along with a combination of complementary theoretical approaches, with the aim of linking the macro-sociological processes described by institutional theory with the micro-level processes described by structuration theory (Giddens, 197; Sewell, 1992; Barley & Tolbert, 1997). This combined model frames institutionalization as a process of structuration, carried out by individuals as they interact with paradigms, or *scripts*, that are encoded in the rules and policies that govern their work. Because it allowed for exploring the micro-level mechanisms by which macro-level institutions are created, altered and reproduced, this approach served as a valuable tool with which to explore the ongoing institutionalization of mental health education in China.

In Chapters 1 through 3, I introduced the role that organizations such as WHO have played in promoting global discourse about mental health, along with the background and context of mental health, moral education, and student-centered educational reforms in China. In Chapter 4, I approached the emergence of mental health

education in China from an institutional perspective, examining the extent to which the language of national education policy in China aligned with “scripts” put forth by WHO, a prominent organization that influences global mental health discourse. In Chapter 5, I pulled out the most salient patterns of discursive tension that emerged from my macro-level policy analysis and explored how they were navigated by actual agents of educational change: a sample of students training to become school counselors in China. Finally, in Chapter 6, I used a mini-case study at a Beijing school to illustrate the challenges that teachers faced when introduced to new content knowledge and asked to adapt their instructional methods to carry out a pilot project in mental health education.

Conclusions

I found that certain global paradigms of mental health were also pervasive in Chinese education policy and practice. This included an emphasis on individual adaptive development, which mirrors broader movements in Chinese education reform that reshape the traditional collective focus of Chinese educational and political discourse, re-conceptualizing education as a means to equip individuals to manage themselves, develop their personalities, and make independent moral judgments in an increasingly pluralist and open society (Lee & Ho, 2005; Cheung & Pan, 2006). Chinese policy documents were also similar to WHO publications in their descriptions of what mental health education programs should look like: both streams of discourse emphasized that school-based programs should be comprehensive and inclusive, they should be grounded in scientific theory, and they should be adaptive to individual needs and circumstances.

In other areas, China’s policy discourse diverged from global paradigms. For instance, global discourse relies heavily on a science-based approach to conceptualizing

child and adolescent mental health disorders. While Chinese policy documents espoused an approach grounded in scientific theory, clinical terms were rarely used to describe mental health problems among adolescents. The absence of scientific language at the policy level echoed a tendency for schools to overlook the importance of hiring professional, trained mental health educators with backgrounds in psychology, which emerged during interviews with school counselors in training. Highly trained school counselors, therefore, struggled with managing their career aspirations in an educational climate that challenged the professional legitimacy of their occupational status. Likewise, in my case study, ordinary teachers were asked to carry out mental health education activities for which they lacked training or content knowledge, which hindered their ability to succeed in their task.

In addition to areas of discursive convergence and divergence, instances of discursive transformation also emerged. For example, while global mental health discourse stressed equity, social justice and human rights, Chinese national policy documents avoided those terms and focused more on the importance of mental health for individual outcomes and national development objectives. However, during interviews, I found that school counselors actually engaged deeply with themes of equity and social justice as they discussed the issues of stigma, shame and exclusion that surround mental health problems in Chinese society. They saw their role as critical for reducing the marginalization of young people who suffer from mental health problems.

The idea of morality was absent from the global mental health discourse, but emerged as a particularly complicated feature of mental health education in China. National education policies promote integrating MHE into existing moral education

departments and curricula, but the school counselors I interviewed struggled to reconcile the principles of moral education with their professional training in mental health. Many expressed the feeling that moral education was more suitable for teaching "right and wrong" as opposed to helping students make individual adaptive choices, while at the same time expressing the belief that separating mental health and moral education would be impossible in China. Meanwhile, I found in my school case study that when challenged to implement a progressive MHE model, many teachers embraced the innovative subject matter while simultaneously enacting more traditional forms of pedagogy that resembled those of moral education.

A persistent theme that emerged throughout the study was the conceptual struggle between *rights* and *duties*. While global mental health discourse is driven by the concept of rights, the Chinese educational landscape retains a historically rich tradition of emphasizing duty, which pervades both mental health and moral education discourse. I suggest that for mental health education to become an institutionalized feature of Chinese schooling, moral education and the notion of *duty* must be negotiated as an entry point. Moral education is a long-established component of Chinese schooling, and enacting mental health policy recommendations will likely depend on delineating the objectives of mental health and moral education, while establishing ways for the two types of education to coexist effectively in schools. This process appears to happen organically to a certain extent in school settings, where I observed educators finding ways to adapt externally imposed models of mental health education. In this way, they were performing a natural process of *bentuhua*, or localization of an external model to make it work within their setting (Tobin et al., 2009). To use the language of structuration theory, by doing so

they were replicating some features of mental health education while revising others. The process, however, left some counselors and educators feeling confused about the results and unsatisfied with their level of success.

The possibility of developing hybrid educational models in China was touched upon by Tobin and colleagues (2009) in relation to preschool. Similar to the case study at Beijing Z middle school in my study, Tobin and colleagues observed preschool teachers and administrators in China selectively adopting features of imported models that met their needs, while rejecting other features that contradicted their objectives or were misaligned with traditional Chinese values. A hybrid system of mental health and moral education in China would allow room to acknowledge that imported psychological models do not necessarily represent universal best practices. For instance, imported models from Western countries that rely on students to proactively seek help from a school counselor are likely to fail in China if imported wholesale. Likewise, mental health professionals in China and other countries might disagree with the use of psychotropic drugs and other medicines to treat mental health problems among youth. It should not be assumed that all features of an imported model will serve the needs of diverse populations, particularly considering that imported "solutions" are often decontextualized, and mismatched with local problems (Steiner-Khamsi, 2010).

There are significant challenges associated with developing an effective hybrid system of mental health and moral education in China. The school counselors in my study that were trained in psychology felt marginalized and undervalued when asked to perform the duties of a moral education teacher at the expense of their mental health-related work. The teachers at Beijing Z middle school felt that they were unable to

succeed at the task they were given without having the right background and training. The challenge is to combine mental health and moral education in a way that draws upon the strengths of different types of educators, and does not "dilute" the professional identity of practitioners in either field. Developing a more effective way to combine mental health and moral education would require cross-sectoral collaboration between policy, curriculum, teacher education and mental health specialists.

In China and on a global scale, mental health continues to grow as an urgent public health concern, as individuals with mental health problems struggle to maintain their physical health, relationships, dignity, and capacity to contribute productively to the work force. It seems certain that policymakers and professionals in diverse settings will increasingly face the challenges of adapting global paradigms of mental health to develop educational policy and models that work in local contexts. Because disorders are disproportionately represented among members of disadvantaged social groups, mental health education is an urgent issue of equity and social justice. Schools will continue to be important settings for this work, so understanding the processes by which actors at different levels of the education system reject, adapt, transform or harmonize conflicting features of the discursive terrain can help practitioners in China and elsewhere develop mental health education programs that embrace innovation while honoring educational traditions.

Limitations

My status as an outsider is both a limitation and a strength of this study. I was not raised in the context of the Chinese education system, and therefore lack the deep

understanding that comes with personal experience. Furthermore, while I was rigorous with checking my translations and sharing my notes with native speakers of Mandarin, the language barrier prevented complete comprehension of all observed activities and nuances in language. However, any researcher, whether an outsider or an "insider," necessarily approaches a research question from a particular point of view and brings a unique set of biases to the inquiry. I tried to use my outsider status to situate China's emerging field of mental health education within a larger global context, considering China as a case study illustrating the type of processes that many countries are facing in the process of developing mental health education programming. Also, my outsider status may have allowed me to engage in types of inquiry that would be challenging for a native researcher due to political and normative constraints, such as the inclusion of human rights as a feature of the discursive analysis.

Another limitation is that due to time and budget restraints, I was not able to conduct as many "member checks" (Maxwell, 2012) as would have been ideal. Because I was bringing my own particular set of experiences and biases to the inquiry, it would have been better to continually share initial findings with the participants of my interviews and case studies. During my case study (Chapter 6), I shared initial findings with Professor Zou and in informal conversations with school staff, but because of the teachers' schedules and my intermittent contact with them, I was not able to consistently confirm my interpretations with all of them throughout the process.

Finally, my study would have benefitted from including the voices of CTU faculty during the interviews, because it is likely that they engaged more with mental health policy discourse than their students. In fact, more than one student mentioned that

their professors were collaborating with officials from the Ministry of Education to develop policy. If policy discourse is transmitted to students not only directly from the policies but also filtered through their interactions with faculty, this study would have benefitted from including those processes. Likewise, interviewing more *xinlilaoshi* who had already graduated and were actively working in the field would have added cohesion to my analysis of mental health education at different levels of policy and practice.

Directions for future research

Multi-level analysis allows for understanding how actions at each level of policy and practice relate to the others in turn, but the current study still draws heavily from snapshots of particular moments in time. While there was a temporal component to the policy discourse analysis in Chapter 4, the interviews and case studies did not traces processes over time. An idea for a future study would be to follow a group of *xinlilaoshi* through different phases of their education, internship and employment processes. Detailed case studies of their experiences over time would help to shed further light on the conditions that promote successful mental health education practices in Chinese schools. Beyond China, a multi-country study of school counselors might demonstrate how educators in different settings go through the process of localizing paradigms of global mental health discourse in their work.

From a policy and practice perspective, more evaluation is needed of mental health education programs, both in China and in other countries. In the current Chinese and English-language literature, there do not appear to be either formative or impact evaluation studies of MHE policies or programs in China, and there is a need for

scientific evidence to help determine effective practices. For example, the findings from my case study suggested that most teachers felt they needed more pedagogical content knowledge to carry out the *zhutibanhui.* A possible research design could be to give one group of randomly selected teachers additional support and professional development to accompany the *zhutibanhui* directive, and compare their experiences to a control group of teachers who received no additional support. The results of such a study could shed light on the extent to which instrumental support matters, or whether the challenges of negotiating tensions between new and institutionalized educational features require more than technical assistance to overcome. Also, as suggested above, the development of hybrid programs that merge MHE with moral education would need to be developed through cross-sectoral collaboration, and rigorously evaluated.

Finally, incorporating student outcomes in the study of mental health education is critical, because students are the ultimate beneficiaries of programs that promote resilience and prevent the onset of disorder. In addition to linking the expansion of school-based mental health education programs with larger-scale data on adolescent mental health disorders in the population, qualitative studies are also needed that show how students experience mental health education as part of their schooling. Some important research questions to consider include: what are the factors that contribute to help-seeking behavior? How is the notion of individual control over health being changed by the greater availability of information?

As globalization continues to introduce new lifestyle behaviors, opportunities, pressures and expectations that engender risk factors for adolescent mental health, protective factors are likely to become more globalized in nature as well. For instance,

the internet, while arguably a risk factor for gaming addiction and related problems, also allows more people to access information and online support for mental health. Powerful and influential organizations shape not only the online discourse but, as I argue here, also shape how mental health education is taught in schools around the world. Future research should further elucidate how actors at different levels of local education systems embrace, push back, and transform the influence of global mental health discourse, as they work to help youth develop into adults who are ready to face the challenges of living in the world.

APPENDIX A. SEARCH TERMS FOR WHO PUBLICATION SAMPLE

I searched the WHO publication archive using iterations of the following search terms:

Mental health
Child
Adolescent
Youth
School
Education
Counseling (counselor)
Teaching (teacher)
Curriculum
Psycho-(social)
Psychological
Depression (-ive)
Anxiety (-ous)
Stress
Well-being
Disorder
Emotion(al)
Health

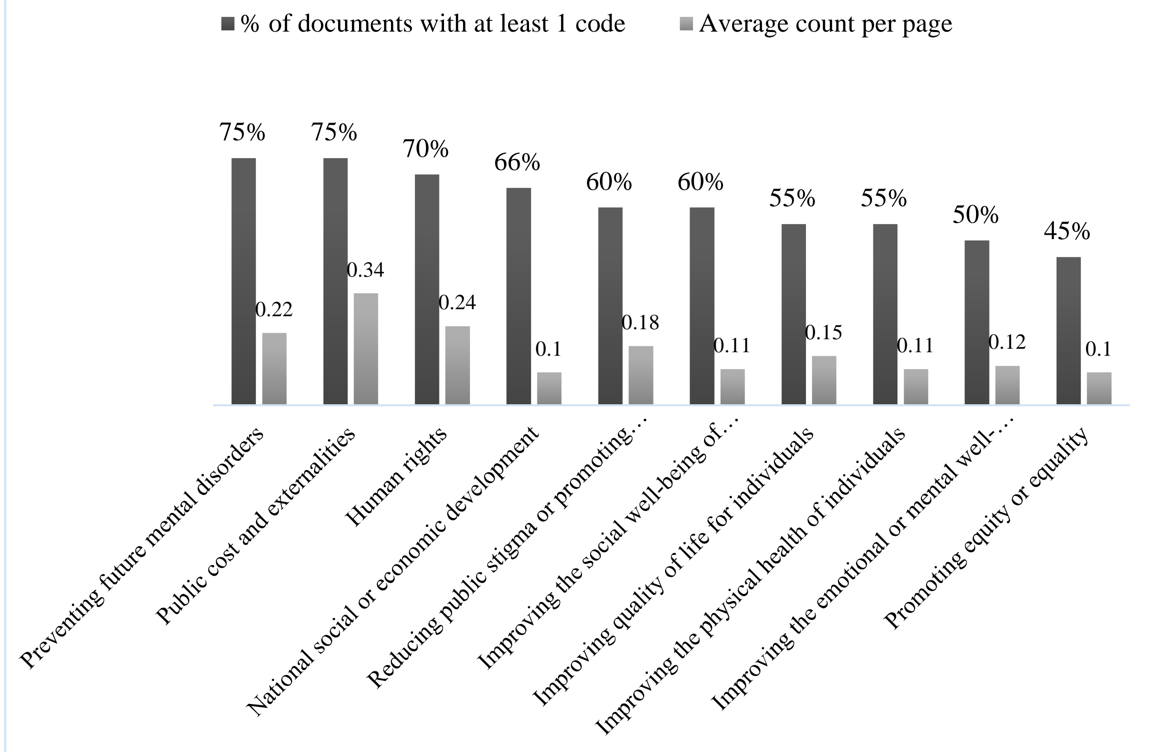
APPENDIX B. DETAILED CODING FOR COMPARATIVE CONTENT ANALYSIS

1) The importance of mental health education

Ten most frequently and densely covered codes for *“the importance of mental health education”* in WHO publications from 1990-2014

Aggregate code	Code	% of WHO documents with at least one reference	Average count per page in WHO documents	Example
Individual outcomes	Preventing mental disorders	75%	.22	“Throughout this document, primary prevention is used in a strict sense…and refers to methods designed to avoid the occurrence of a specific disorder or groups of disorders.” (1993)
	Improving quality of life for individuals	55%	.15	“It is difficult, if not impossible, for a person to flourish and feel fulfilled in life when he or she is beset, whether temporarily or permanently, by health problems such as depression and anxiety.” (2013a)
	Improving the physical health of individuals	55%	.11	“The onset or presence of a mental disorder also increases the risk of disability and premature mortality from other diseases.” (2013a)
	Improving the emotional or mental well-being of individuals	50%	.12	“We cannot hope to teach young people to be physically healthy without considering their emotional and social needs” (1995)
Family or community outcomes	Public cost and externalities	75%	.34	“Effective interventions reduce the burden of mental health disorders on the individual and the family, and they reduce

				the costs to health systems and communities." (2005)
	Improving the social well-being of individuals	60%	.11	"Health is more than physical; it has mental and social dimensions too." (1995)
National outcomes	National social or economic development	66%	.10	"The good mental health of children and adolescents is crucial for their active social and economic participation." (2005)
Equity, rights and justice	Human rights	70%	.24	"Access to health is a human right." (2013a)
	Reducing public stigma or promoting tolerance	60%	.18	"Students who are treated as equals and believe that the chance of success is as accessible to them as to the next person, are not only more likely to reach their intellectual potential but will value their school for its friendly and supportive environment and be more tolerant of others who are 'different'." (2003)
	Promoting equity or equality	45%	.10	"There is a strong case to be made for investing in mental health, whether on the grounds of enhancing individual and population health and well-being, or reducing social inequalities." (2013b)

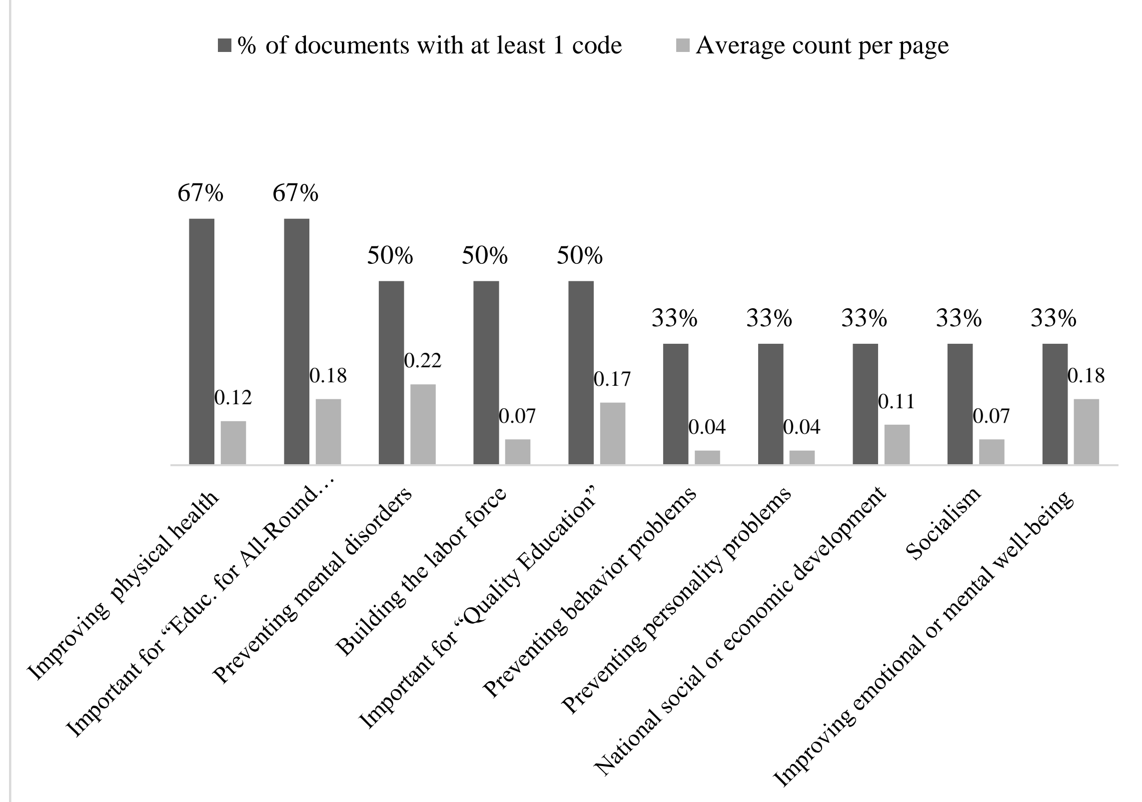


Ten most frequently covered codes for *"the importance of mental health education"* in PRC national mental health education policy documents from 1992-2012

Aggregate code	**Code**	**% of policy documents with at least 1 reference**	**Average count per page**	**Example**
Individual outcomes	Improving the physical health of individuals	67%	0.12	"Mental health education in primary and middle schools is essential for the improvement of students' health." (MOE, 2012)
	Preventing mental disorders	50%	0.22	"Primary importance is attached to prevention." (MOH, 2008)
	Preventing behavior problems	33%	0.04	"It should be utilized to guide the healthy development of students' mental health and personality, so as to avoid as much as possible

				mental and behavioral problems in their life." (MOE, 2012)
	Preventing personality problems	33%	0.04	"If some problems are not solved in time, they will exert negative influence on students' healthy development and even result in behavioral obstacles or personality defects." (MOE, 1999)
	Improving the emotional or mental well-being of individuals	33%	0.18	"We shall improve the quality and effectiveness of primary and middle school mental health education and to achieve the overall development of students' mental quality and moral, intellectual, mental, aesthetic development." (MOE, 2012)
National outcomes	Important component of "Education for All-Round Development"	67%	0.18	"Mental health education in primary and secondary schools is highly necessary for students to grow up healthily and for the promotion of "education for all-round development." (MOE, 2002)
	Important component of "Quality Education"	50%	0.17	"To carry out mental health education in secondary vocational schools is necessary for Education for All-Round Development, for Quality Education, and for improving students' overall vocational competence." (MOE, 2004)
	Building the labor force	50%	0.07	"We have to work hard to cultivate hundreds of millions of laborers of high quality, and tens of thousands of professional talents that meet the demands of modernization, in order to

				rejuvenate the nation." (MOE, 1999)
	National social or economic development	33%	0.11	"Mental health education in primary and secondary schools is necessary both for the healthy development of students and for cultivating qualities called for by social development." (MOE, 1999)
	Socialism	33%	0.07	"Mental health work concerns the physical and mental health of the people, social stability, ensuring social and economic development, and constructing a socialist harmonious society." (MOH, 2008)

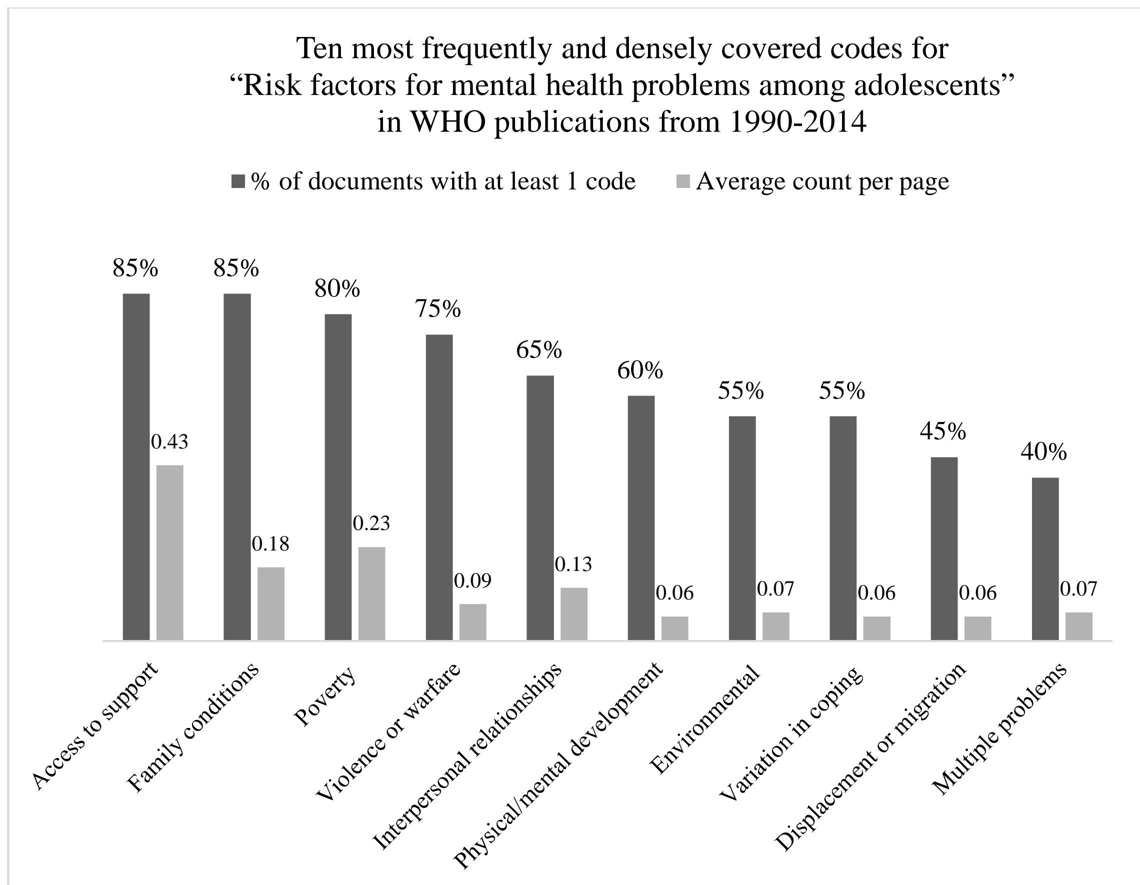


2) Risk factors for mental health problems among adolescents

Ten most frequently and densely covered for *"risk factors for mental health problems among adolescents"* in WHO publications from 1990-2014

Aggregate code	**Code**	**% of WHO documents with at least one reference**	**Average count per page in WHO documents**	**Example**
Individual-level	Physical and mental development	60%	.06	"Most mental and neurological disorders have multiple and interacting causes, with biological, psychological, and socio-cultural components." (1993)
	Variation in coping mechanisms	55%	.06	"Not all individuals with similar exposures have the same vulnerabilities; some are more resilient." (2014)
	Multiple interconnected problems	40%	.07	"The more risks young people experience, the worse their developmental outcomes are likely to be and the higher the probability of experiencing psychological distress or mental health disorders." (2012b)
Family or community-level	Family conditions	85%	.18	"Family conditions and quality of parenting have a significant impact on risk of mental and physical health." (2014)
	Interpersonal relationships	65%	.13	"There is evidence to support the view that young people with poor peer relationships or who are rejected by their peers are at risk from emotional and mental health problems later in life." (1995)
Structural-level	Poverty	80%	.23	"Factors contributing to depression include genetics, socioeconomic problems and insecurity."

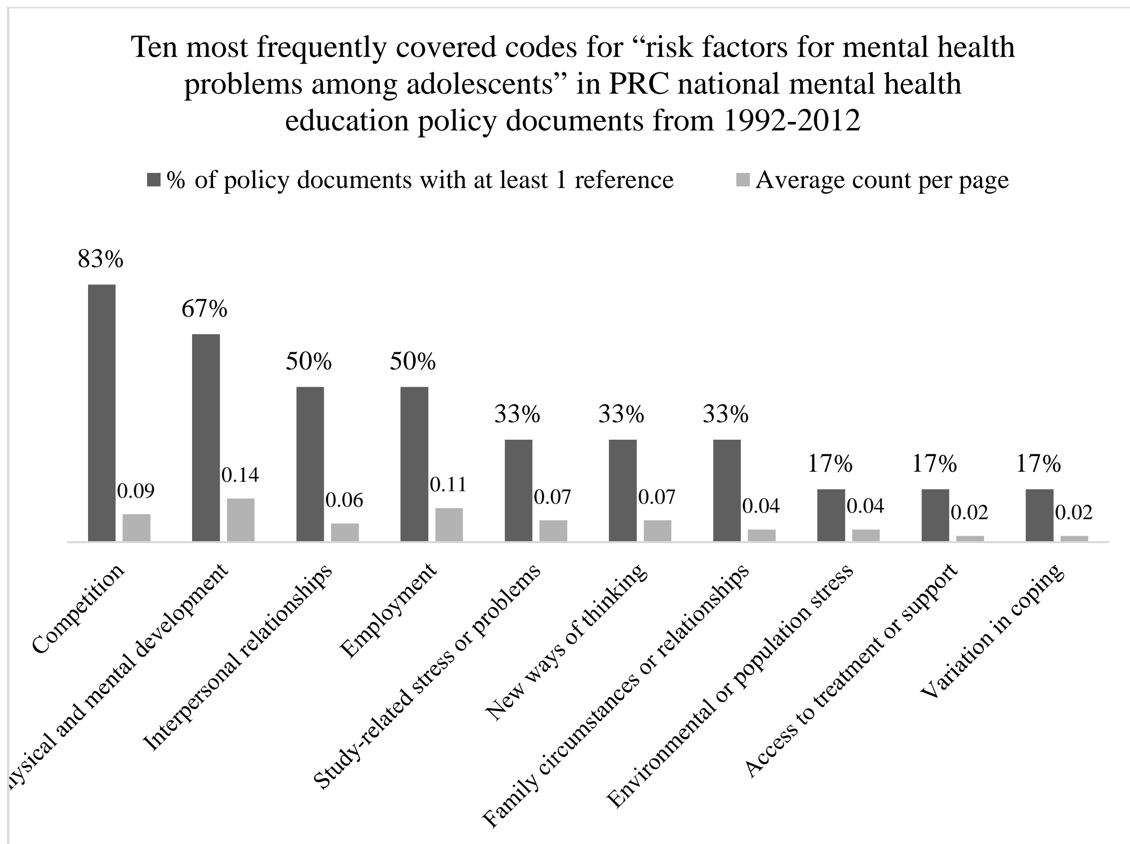
				(2011)
	Violence or warfare	75%	.09	“Conflict and violence, both between individuals and between communities and countries.” (2004b)
	Lack of access to treatment or support	85%	.43	“In the rural areas, there were few child and adolescent mental health services.” (2005a)
	Environmental or population stress	55%	.07	“Certain population subgroups are at higher risk of mental disorders because of greater exposure and vulnerability to unfavourable social, economic, and environmental circumstances, interrelated with gender.” (2014)
	Displacement or migration	45%	.06	“Migrating from rural to urban areas.” (2005)



Ten most frequently covered codes for *"risk factors for mental health problems among adolescents"* in PRC national mental health education policy documents from 1992-2012

Aggregate code	Code	% of policy documents with at least 1 reference	Average count per page	Example
Individual-level	Physical and mental development	67%	0.14	"Students of primary and middle schools are going through a critical period of physical and mental development." (MOE, 2012)
	Variation in coping	17%	.02	"They will encounter such problems as…emotional adjustment." (MOE, 2012)
Family or community-level	Competition	83%	0.09	"They have to face challenges from the job market and competition in society." (MOE, 2004)
	Interpersonal relationships	50%	0.06	"Expansion of social experiences." (MOE, 2002)
	Worries about employment	50%	0.11	"Their focus changes from study to employment." (MOE, 2004)
	Study-related stress or problems	33%	0.07	"Students of primary and middle schools…will encounter various mental problems concerning such issues as their studying." (MOE, 2012)
	Family circumstances or relationships	33%	0.04	"Most of them are the "only child" in the family." (MOE, 1999)
Structural-level	New ways of thinking in society	33%	0.07	"Changing ways of thinking." (MOE, 1999)
	Environmental or population stress	17%	.04	"Prevention of diseases and health care, environmental

				sanitation, mental health, safety measures and the latter's influence on the former." (MOE, 1992).
	Access to treatment or support	17%	.02	"China is still confronted with such problems in mental health work as lack of efforts in preventing, recognizing and handing mental illnesses and psychological problems, overall insufficient service resources and diffused management, distinctive regional differences, lack of prevention and control institutions and staff, absence of effective cross-institution interplay mechanisms, etc." (MOH, 2008)



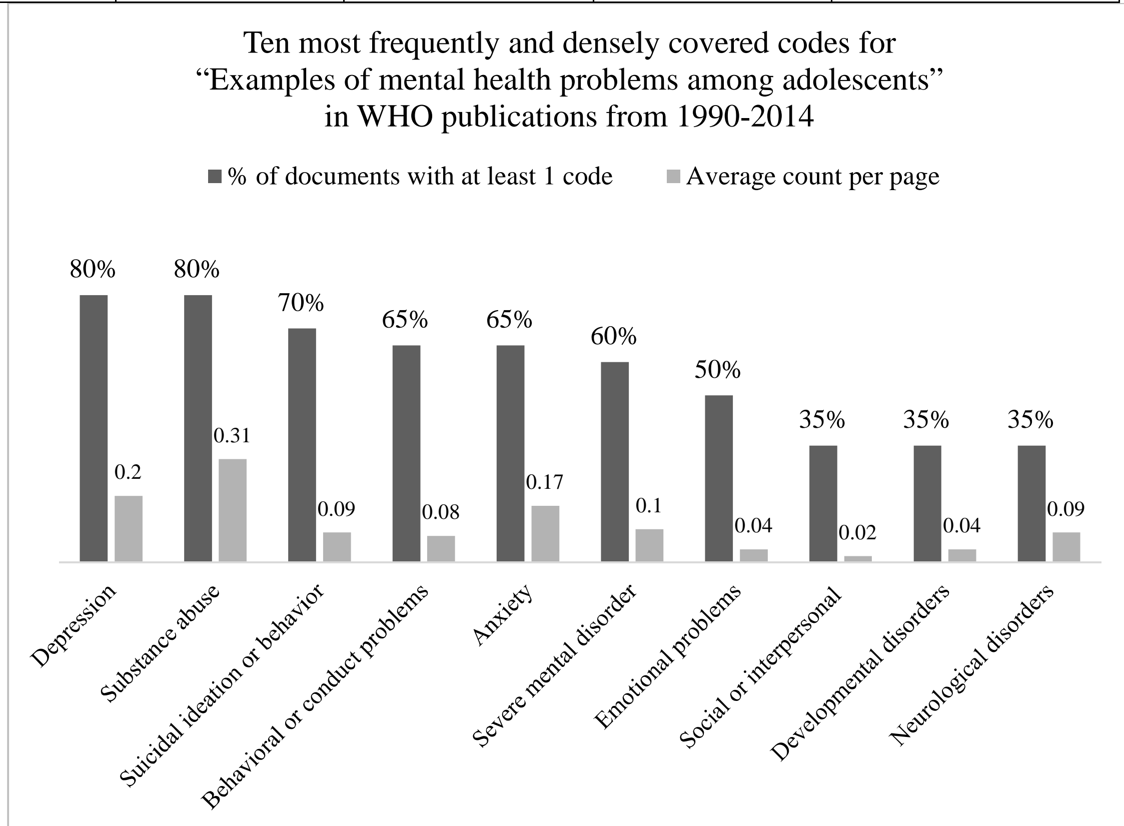
3) Examples of mental health problems among adolescents

Ten most frequently and densely covered codes for *“Examples of mental health problems among adolescents”* in WHO publications from 1990-2014

	Code	**% of WHO documents with at least one reference**	**Average count per page in WHO documents**	**Example**
Clinical terms	Depression	80%	.2	“Depressed young people may experience symptoms of sadness, tearfulness, sleep and appetite disturbances, and feelings of hopelessness.” (1994)
	Anxiety	65%	.17	“The median age of onset for anxiety disorders was just 15 years.” (2000b)
	Severe mental disorder	60%	.10	“Although few children and adolescents suffer

				from severe psychiatric disorders such as schizophrenia or manic-depressive disorder, suicide risk is very high in those affected." (2000a)
	Developmental disorders	35%	.04	"Developmental and behavioural disorders with onset usually occurring in childhood and adolescence, including autism." (2013b)
	Neurological disorders	35%	.09	"It is quite common for children and young adults to have epilepsy." (2001)
Substance abuse	Substance abuse	80%	.31	"Responses include alcohol and drug abuse, which are classified as mental disorders when they lead to alcohol or drug dependency." (2014)
Suicide	Suicidal ideation or behavior	70%	.09	"Young people and the elderly are among the most susceptible age groups to suicidal ideation and self-harm." (2013b)
Non-clinical terms	Behavioral or conduct problems	65%	.08	"Conduct disorder refers to a repetitive and persistent pattern of destructive or hostile behavior that violates the rights of others or deviates significantly from age-appropriate norms and rules." (1994)
	Emotional problems	50%	.04	"The frequency of presentations of negative emotion increases with the age of the students." (2004a)

	Social problems or interpersonal communication	35%	.02	“Children with emotional disturbances…may also have difficulties in relating to peers or adults.” (1994)



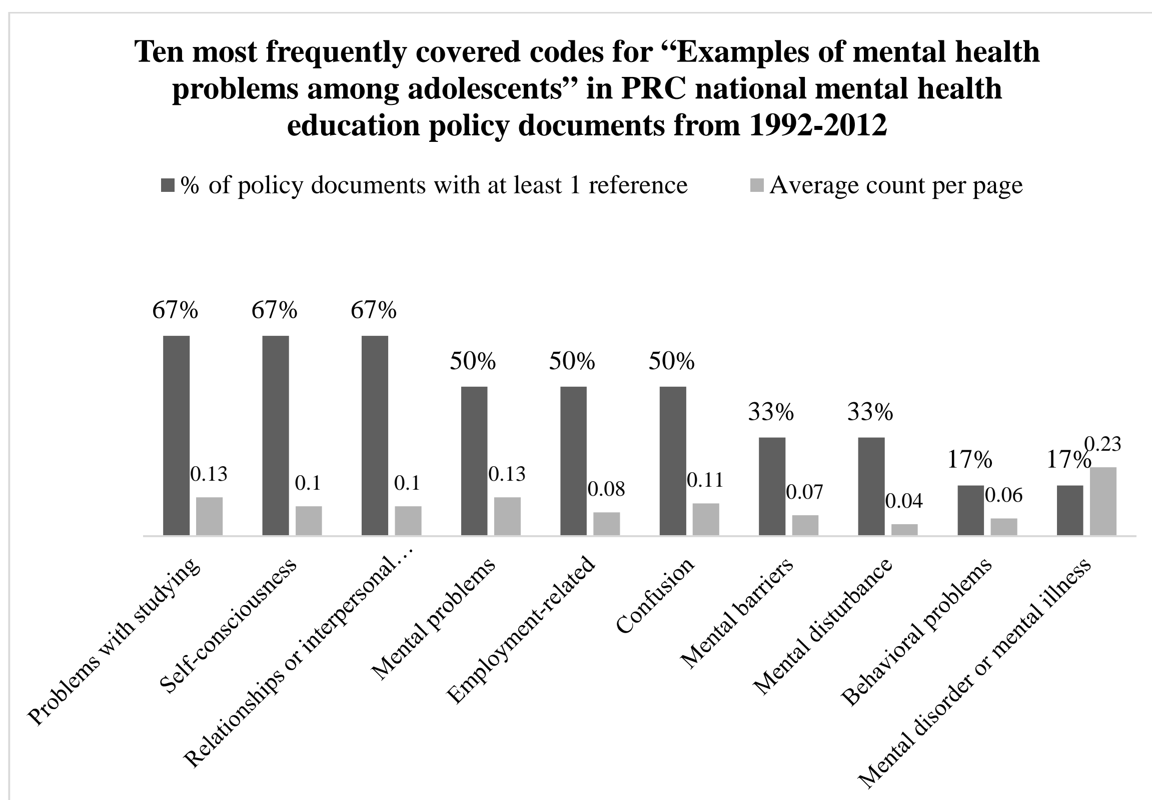
Ten most frequently covered codes for *“Examples of mental health problems among adolescents”* in PRC national mental health education policy documents from 1992-2012

Aggregate code	**Code**	**% of policy documents with at least 1 reference**	**Average count per page**	**Example**
Non-clinical terms	Problems with studying	67%	0.13	“They may come across all kinds of mental problems in their study.” (MOE, 1999)
	Self-consciousness	67%	0.10	“They will encounter confusion and problems

				with …self-consciousness.” (MOE, 2002)
	Relationship problems or interpersonal communication	67%	0.10	“They will encounter confusion and problems with…interpersonal communication.” (MOE, 2004)
	Mental problems	50%	0.13	“Mental counseling offices should be built so as to play a significant role in preventing and solving mental behavioral problems of students.” (MOE, 2012)
	Problems relating to future employment	50%	0.08	“Primary and secondary school students are confronted with various kinds of confusion or psychological problems in terms of…pursuing further study and job-hunting.” (MOE, 2002)
	Confusion	50%	0.11	“Schools should actively establish psychological consultation centers and offer both group and individual counseling and training…to help them clear up

				psychological confusion." (MOE, 2004)
	Mental barriers	33%	0.07	"The main tasks of mental health education include...providing scientific and effective counseling and tutoring for students with mental disturbance or mental barriers." (MOE, 1999)
	Mental disturbance	33%	0.04	"Provide the small group of students suffering from mental disturbance or mental barriers with scientific and effective mental counseling and tutoring." (MOE, 2002)
	Behavioral problems	17%	0.06	"Mental health education should...be utilized to guide the healthy development of students' mentality and personality, so as to avoid as much as possible the mental and behavioral problems in their life." (MOE, 2012)
Clinical disorders	Mental disorder or mental illness	17%	0.23	"The occurrence rate of mental illnesses and psychological problems among

				children and teenagers is reduced." (MOE, 2008)



4) Ideal characteristics of mental health promotion/prevention initiatives

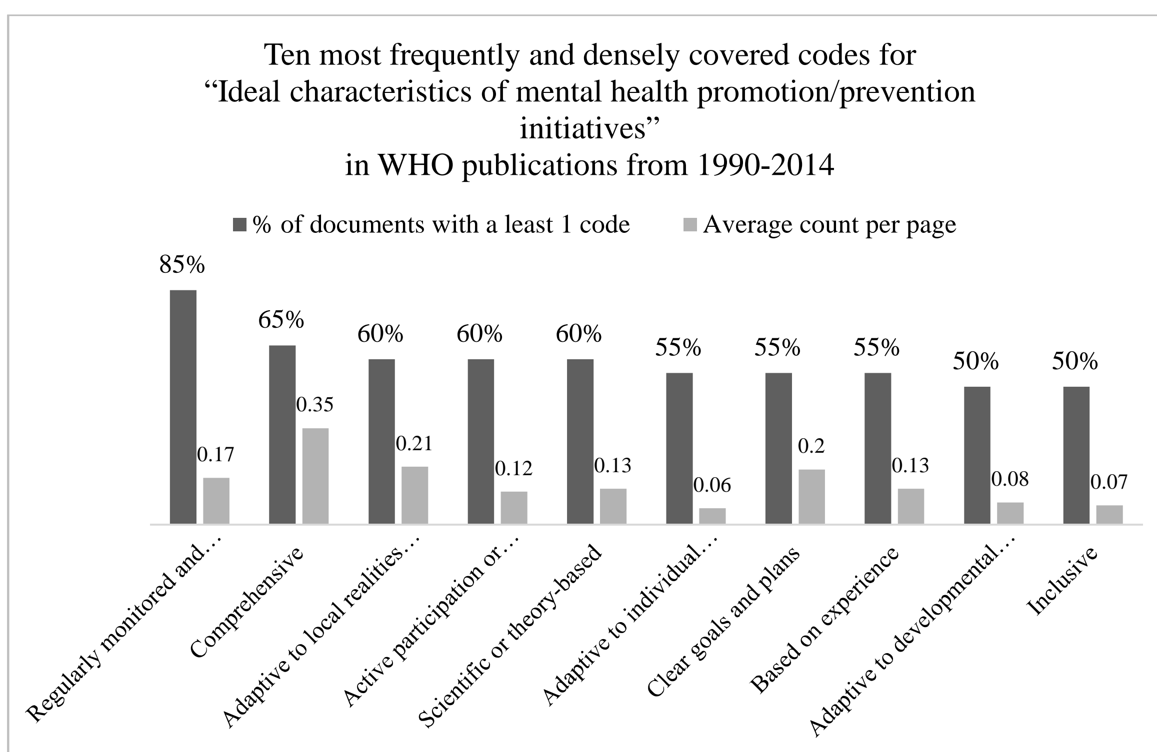
Ten most frequently and densely covered codes for *"Ideal characteristics of mental health promotion/prevention initiatives"* in WHO publications from 1990-2014

Aggregate code	**Code**	**% of WHO documents with at least one reference**	**Average count per page in WHO documents**	**Example**
Scientific or schematic	Regularly monitored and evaluated	85%	.17	"Schools will be encouraged to evaluate the programmes each year and provide feedback to the Mental Health

				Promotion Coordinator, who will report these findings to the regional committees." (2004a)
	Scientific or theory-based	60%	.13	"Generate scientific evidence on effective interventions in the field of adolescent mental health in low-resource settings and promote the dissemination of best practices." (2012b)
	Clear goals and plans	55%	.20	"Clear goals and precise limits as defined in manuals on suicide prevention are important tools in this work." (2000a)
	Based on experience	55%	.13	"In the future, experience born of the anticipated activities will serve as ref-erential evidence for correcting or consolidating the literature; meanwhile it can function as a traditional mechanism that helps deal with adolescent melancholic emotions." (2004a)

Comprehensive or inclusive	Comprehensive	65%	.35	“The purpose of this monograph is to familiarize the reader with a model framework for a comprehensive approach to mental health promotion, prevention, and treatment in schools.” (1994)
	Inclusive	50%	.07	“The promotion of mental and emotional health is not just for those students who have obvious 'problems'. It is for all.” (1995)
Adaptive to needs and circumstances	Adaptive to local realities or culture	60%	.21	“Cultural applicability makes the task of dissemination of evidence-based interventions complicated and slow; however, given the complexity of prevention programmes, this is to be expected.” (2004b)
	Active participation or student voice	60%	.12	“Adolescents can be important advocates of their own interests and concerns. They need to be recognized with respect and given a voice when developing policies and

				plans." (2005)
	Adaptive to individual differences	55%	.06	"The experience and impact of social determinants varies across life, and influence people at different ages, gender and stages of life in particular ways." (2014)
	Adaptive to developmental stages	50%	.08	"Relevant, interesting content aimed at the target age group." (2004a)

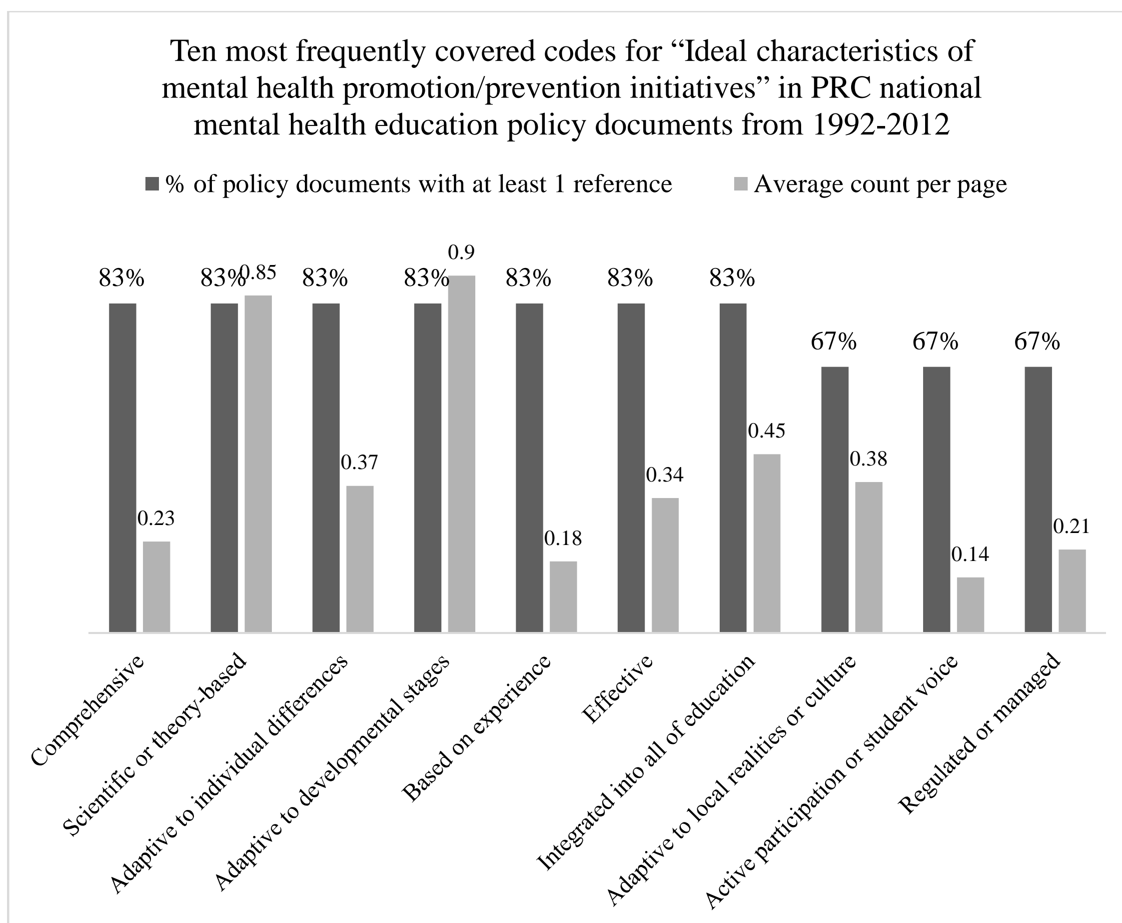


Ten most frequently covered codes for *""Ideal characteristics of mental health promotion/prevention initiatives""* in PRC national mental health education policy documents from 1992-2012

Aggregate code	Code	% of policy documents with at least 1	Average count per page	Example

		reference		
Comprehensive or inclusive	Comprehensive	83%	0.23	“Under the working policy of "comprehensive implementation, emphasizing focus, classification guidance and coordinated development.” (MOE, 2012)
	Integrated into all of education	83%	0.45	“Mental health education is integrated into the entire process of school education.” (MOE, 1999)
Scientific or schematic	Scientific or theory-based	83%	0.85	“Mental health counseling is a scientific and highly professional job and is an important means of mental health education.” (MOE, 2002)
	Based on experience	83%	0.18	“Based on experience, promotion of local mental health education as a whole should be strengthened.” (MOE, 2002)
	Effective	83%	0.34	“Provide effective mental health service for teenagers” (MOE, 2008)
	Regulated or managed	67%	0.21	“These guidelines were drawn up…to better direct and regulate mental health education for primary and secondary school students.” (MOE, 2002)
Adaptive to needs and circumstances	Adaptive to individual differences	83%	0.37	“Pay attention to the whole group as well as focus on individual differences.” (MOE,

				2012)
	Adaptive to developmental stages	83%	0.90	"Schools should design phase-specific contents for mental health education according to students' characteristics and needs in physical and mental development and career development at different ages." (MOE, 2004)
	Adaptive to local realities or culture	67%	0.38	"Mental health education in rural and urban primary and secondary schools should be dealt with differently according to actual conditions in different areas and characteristics of different students' physical and mental development." (MOE, 2002)
	Active participation or student voice	67%	0.14	"A combination of teachers' scientific guidance, students' active participation, and parents' collaboration." (MOE, 2004)



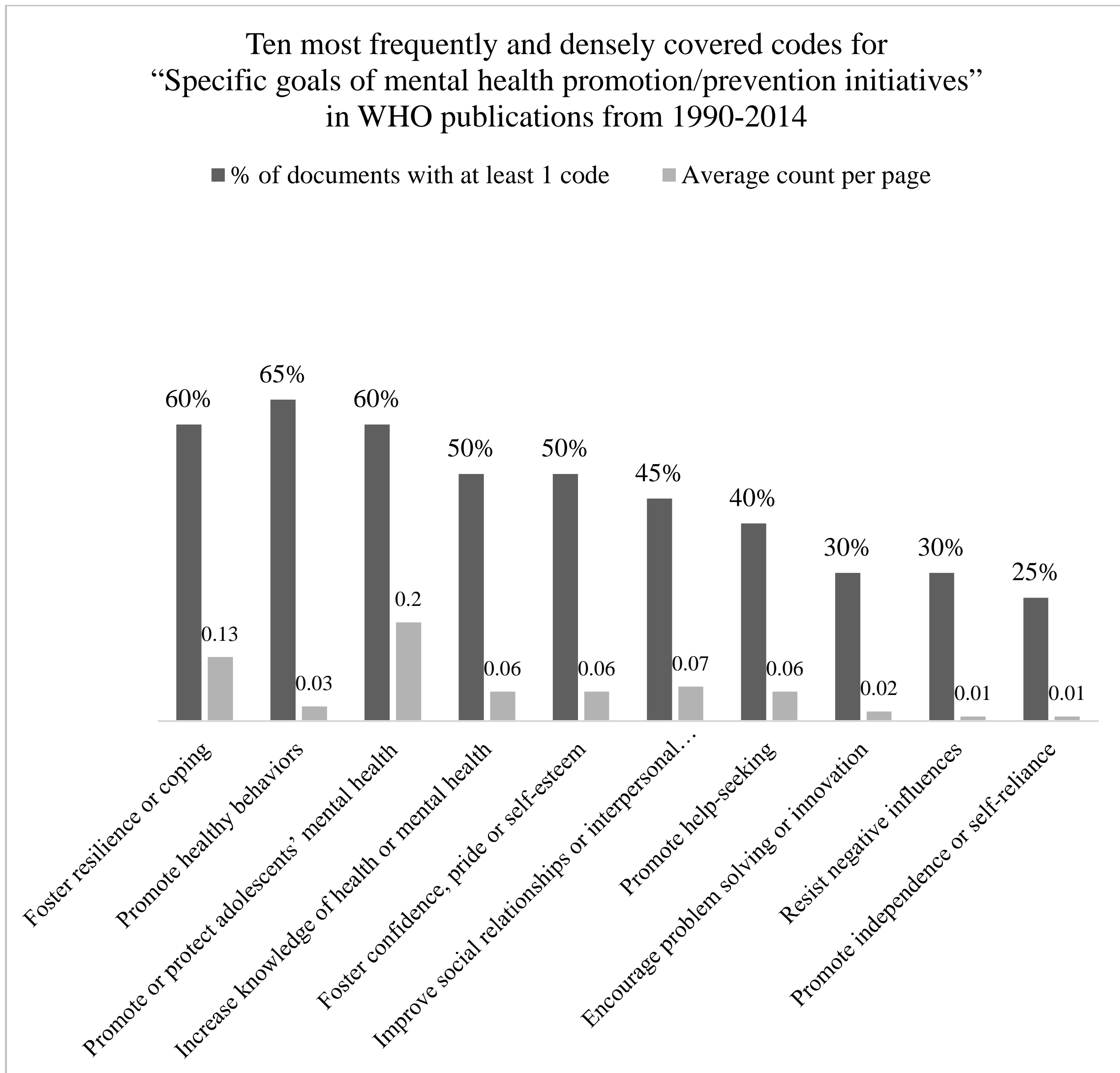
5) Specific goals of mental health promotion/prevention initiatives

Ten most commonly and densely covered codes for *"Specific goals of mental health promotion/prevention initiatives"* in WHO publications from 1990-2014

Aggregate code	Code	% of WHO documents with at least one reference	Average count per page in WHO documents	Example
Strengthen resilience or adaptation	Foster resilience or coping	60%	.13	"The aim of school-based interventions is to provide an experience that will strengthen the children's coping abilities to counter environmental stress and disadvantages with

				which they have had to cope in growing up." (1994)
Promote or protect mental health	Promote healthy behaviors	65%	.03	"To improve academic outputs among adolescents by reducing the prevalence of risk behaviours and increasing the prevalence of health promoting behaviours." (2005)
	Promote or protect adolescents' mental health	60%	.2	"While children need to be encouraged to take responsibility for themselves and their community, at the same time they have a right to a period of their lives when they can be physically and environmentally dependent on others and protected from physical, social and emotional harm." (2003)
Foster independence, self-esteem, individual development	Increase knowledge of health or mental health	50%	.06	"The project seeks to address the social and economic determinants of health and includes actions to improve participants' knowledge about mental health issues." (2014)
	Foster confidence, pride or self-esteem	50%	.06	"Helping students to believe in themselves is empowering and encourages them to

				stand up for their rights." (2003)
	Encourage problem solving or innovation	30%	.02	"Thinking about ways of doing things leads children to attempt more novel solutions to their problems." (2003)
	Promote independence or self-reliance	25%	.01	"Like adults, children seek self-determination." (2003)
	Promote help-seeking	40%	.06	"Young people often underestimate the need for outside help and attempt to deal with their problems on their own." (2010)
Improve interpersonal skills or work ethic	Improve social relationships or interpersonal communication	45%	.07	"Working on relationships and improving our communication skills can help us maintain these vital links with people." (1995)
	Resist negative influences	30%	.01	"Young people need to be taught to resist pressure." (1995)

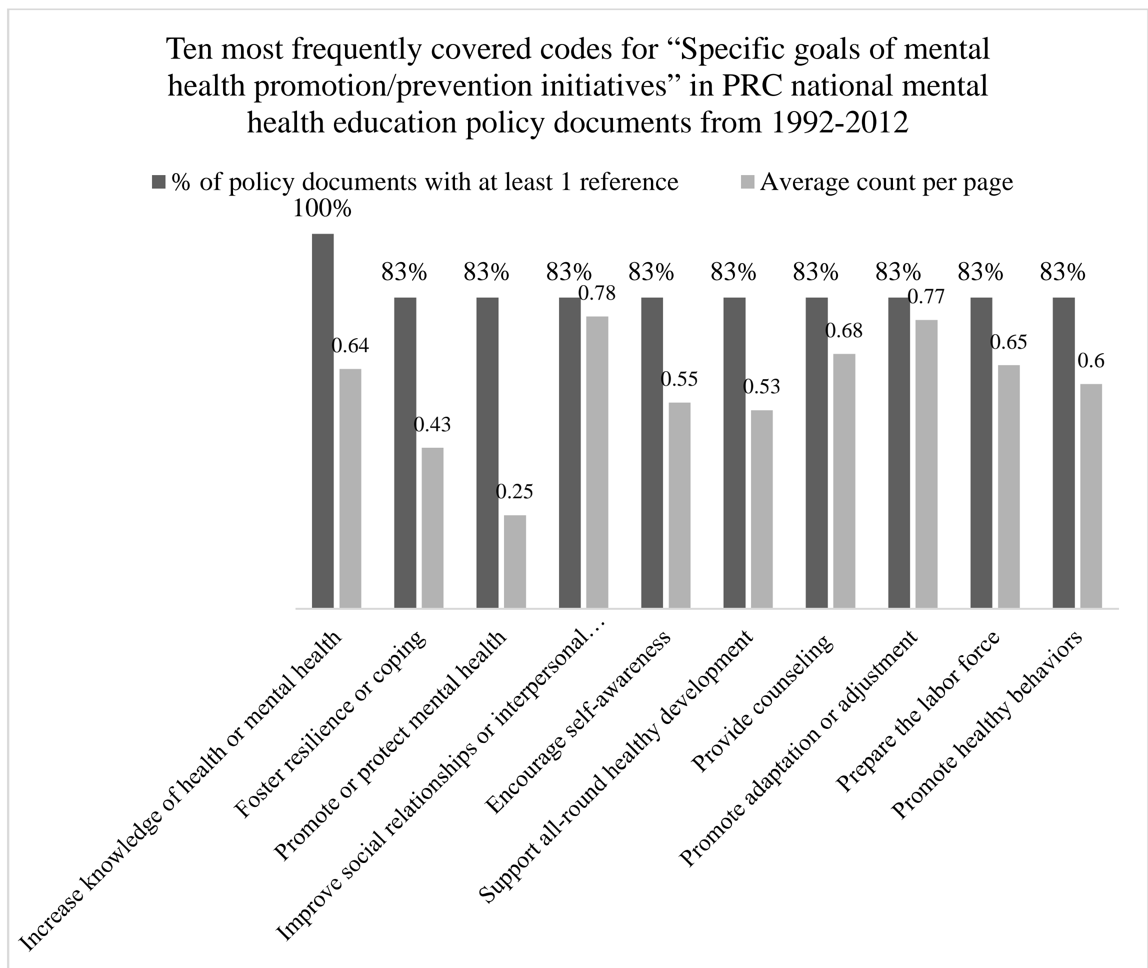


Ten most frequently covered codes for *"Specific goals of mental health promotion/prevention initiatives"* in PRC national mental health education policy documents from 1992-2012

Aggregate code	Code	% of policy documents with at least 1 reference	Average count per page	Example
Foster independence, self-esteem, individual development	Increase knowledge of health or mental health	100%	0.64	"Mental health education includes popularizing basic knowledge of mental health, fostering awareness of mental health, helping students learn about simple methods of adjusting oneself mentally and realizing abnormal mental

				phenomena, and providing a preliminary command of mental health protection knowledge.” (MOE, 2002)
	Encourage self-awareness	83%	0.55	“Emphasis is placed on content that helps students to know about themselves.” (MOE, 2012)
Strengthen resilience or adaptation	Foster resilience or coping	83%	0.43	“Encourage students to…progressively adapt to changes in life and society and pay more attention to the ability of facing failures and setbacks.”(MOE, 2012)
	Promote adaptation or adjustment	83%	0.77	“The specific goal of mental health education is to help students look at themselves in the right way and improve their abilities of self-control, dealing with setbacks and adapting themselves to the environment.” (MOE, 2002)
Improve interpersonal skills or work ethic	Improve social relationships or interpersonal communication	83%	0.78	“Schools should help students integrate to the group by cultivating their sense of responsibility, honor and friendship. Schools should also help students understand adolescent sexuality, learn to control their emotions and to form proper relationships with friends of the opposite sex.” (MOE, 2004)
	Prepare the labor force	83%	0.65	“Schools should help students prepare psychologically for employment.” (MOE, 2004)
Promote or protect mental health	Promote healthy behaviors	83%	0.60	“To cultivate children and teenagers’ health habits and healthy mental states.” (MOE, 1992)

	Promote or protect mental health	83%	0.25	“Greater efforts are made in prevention of mental problems and intervention of mental crises to safeguard people’s mental health.” (MOE, 2008)
	Support all-round healthy development	83%	0.53	“Therefore better mental quality could be cultivated and all-round development be achieved.” (MOE, 2012)
	Provide counseling	83%	0.68	“Secondary schools in large and medium-sized cities should gradually set up and perfect mental counseling rooms.” (MOE, 1999)



Additional examples of codes for *"the importance of mental health education"* in WHO publications from 1990-2014

Code	**Examples of coded phrases**
Public cost and externalities	"Cost-benefit analyses have had a major importance for the assessment of the efficiency of many health activities, including prevention." (1993) "The big unresolved question is, who should pay for prevention?" (2004a) "Effective interventions reduce the burden of mental health disorders on the individual and the family, and they reduce the costs to health systems and communities." (2005) "Mental health problems of young people affect the whole society." (2010)
Human rights	"Protecting human rights is a major strategy to prevent mental disorders." (2004b) "Child and adolescent mental health policy is most effective when it encompasses a framework that relates child and adolescent development to an understanding of the rights of the child or adolescent." (2005) "Access to health is a human right." (2013a)
Preventing future mental disorders	"Throughout this document, primary prevention is used in a strict sense…and refers to methods designed to avoid the occurrence of a specific disorder or groups of disorders." (1993) "Open discussion is a necessary part of prevention." (2001). "Prevention of these disorders is obviously one of the most effective ways to reduce the burden." (2004b). "There are close links between child and adult mental illness." (2010).
Reducing public stigma or promoting tolerance	"Students who are treated as equals and believe that the chance of success is as accessible to them as to the next person, are not only more likely to reach their intellectual potential but will value their school for its friendly and supportive environment and be more tolerant of others who are 'different'." (2003) "Disorders are often stigmatized, underlining the need for health authorities to work with relevant groups to change attitudes to mental disorders." (2012a)
Improving quality of life for individuals	"We can help young people live more productive and fulfilling lives." (1994) "Mental disorders often have a devastating effect on role functioning and quality of life." (2000) "It is difficult, if not impossible, for a person to flourish and feel fulfilled in life when he or she is beset, whether temporarily or permanently, by health problems such as depression and anxiety." (2013a)
Improving the emotional or mental well-being of individuals	"We cannot hope to teach young people to be physically healthy without considering their emotional and social needs" (1995) "Participation fosters physical, mental and social well-being within the learning environment." (2003) "Many factors have an impact on adolescents' mental ability to achieve and sustain a state of mental well-being." (2012a)
Improving the social well-being of individuals	"Health is more than physical; it has mental and social dimensions too." (1995) "An important function of schooling is to assist families to help their young become emotionally and socially secure and productive members

	of the community." (2003) "The term 'psychosocial' denotes the inter-connection between psychological and social processes and the fact that each continually interacts with and influences the other." (2012b)
Physical health and development	"Between 15 and 25 percent of children presenting at health centres had psychosocial problems or disorders contributing to the reason for attendance." (1990) "Mental health as a distinct concept integral to daily life, the maintenance of which is vital to physical health." (2004b) "The onset or presence of a mental disorder also increases the risk of disability and premature mortality from other diseases." (2013a)
Promoting equity or equality	"Ensuring equity of all services for children and adolescents with mental disorders." (2005) "There is a strong case to be made for investing in mental health, whether on the grounds of enhancing individual and population health and well-being, or reducing social inequalities." (2013b) "Mental disorders are heavily associated with social inequalities, whereby the greater the inequality the higher the inequality in risk." (2014)
National social or economic development	"The good mental health of children and adolescents is crucial for their active social and economic participation." (2005) "Mental health reduce labor productivity and economic growth." (2013a)

Additional examples of codes for *"risk factors for mental health problems among adolescents"* in WHO publications from 1990-2014

Code	**Examples of coded phrases**
Access to treatment or support	"Almost half of those who are ill don't seek help, most are not treated at all, and often the treatment is inadequate." (2000b) "Despite the need for early intervention in childhood, most treatments are geared towards adults." (2001) "In the rural areas, there were few child and adolescent mental health services." (2005a)
Family circumstances or relationships	"Aspects of family dysfunction and instability and negative life events are often found in suicidal children and adolescents." (2000b) "The Gaining Ground Adolescent Program brings together young people aged between 12 and 18 years living with a parent affected by a mental health problem." (2004b) "Family conditions and quality of parenting have a significant impact on risk of mental and physical health." (2014)
Poverty	"Low socioeconomic status, poor education and unemployment in the family are risk factors." (2000a) "Lack of money for basic family needs." (2001) "Factors contributing to depression include genetics, socioeconomic problems and insecurity." (2011) "There is ample international evidence that mental disorders are disproportionately present among the poor." (2013a)
Violence or warfare	"Mental health problems can result from intense and/or prolonged stress associated with...war. Symptoms include anxiety, depression, flashbacks of horrifying experiences, recurring nightmares and sleep disorders."

	(1994) "In many cases, these factors are combined with the psychological impact of torture, war injuries and isolation." (2000b) "Conflict and violence, both between individuals and between communities and countries." (2004b)
Interpersonal relationships	"There is evidence to support the view that young people with poor peer relationships or who are rejected by their peers are at risk from emotional and mental health problems later in life." (1995) Young people are particularly vulnerable to social exclusion, notably in the transition stage between education and employment. (2010) "Loneliness, social isolation and difficulties with communication all heighten the risk of developing or prolonging mental illness." (2013a)
Physical and mental development	"Most mental and neurological disorders have multiple and interacting causes, with biological, psychological, and socio-cultural components." (1993) "Efforts designed to boost physical health that have profound implications for the mental well-being of children and adolescents." (2005) "Reducing inequalities in mental health cannot be achieved without reducing inequalities in physical health." (2014)
Environmental or population stress	"Rapid population growth." (1994) "The term 'vulnerable groups' is used in the action plan to refer to individuals or groups of individuals who are made vulnerable by the situations and environments that they are exposed to (as opposed to any inherent weakness or lack of capacity)." (2013b) "Certain population subgroups are at higher risk of mental disorders because of greater exposure and vulnerability to unfavourable social, economic, and environmental circumstances, interrelated with gender." (2014)
Variation in coping mechanisms	"Just as different people have different tolerance levels, so we all react to stress slightly differently." (1995) "Internal factors, related to the individual's own nature." (2004a) "Not all individuals with similar exposures have the same vulnerabilities; some are more resilient." (2014)
Displacement or migration	"Children and adolescents who lack cultural roots have marked identity problems and lack a model for conflict resolution." (2000a) "Migrating from rural to urban areas." (2005) "Leaving the parental home." (2010)
Multiple interconnected problems	"Difficult circumstances and mental health problems can be interrelated in a number of ways." (2005) "The more risks young people experience, the worse their developmental outcomes are likely to be and the higher the probability of experiencing psychological distress or mental health disorders." (2012b) "Cumulative exposure to stressors over time causes alterations in stress responses that have physio- logical effects on the immune system, cardiovascular function, respiratory system, and other systems, including the brain." (2014)

Additional examples of codes for *“Examples of mental health problems among adolescents”* in WHO publications from 1990-2014

Code	**Examples of coded phrases**
Depression	“Depressed young people may experience symptoms of sadness, tearfulness, sleep and appetite disturbances, and feelings of hopelessness.” (1994) “Surveys have established that up to three-quarters of those who eventually take their own lives show one or more symptoms of depression.” (2000a) “This is a period when risk for adolescent depression increases.” (2004a) “Depression is currently one of the leading causes of disability in the world.” (2013a)
Substance abuse	“Some will try to rid themselves of the depression by using alcohol or drugs, but these usually only make the feelings worse.” (2001) “Substance use refers to the harmful or hazardous use of psychoactive substances, including alcohol and illicit drugs.” (2012b) “Responses include alcohol and drug abuse, which are classified as mental disorders when they lead to alcohol or drug dependency.” (2014)
Suicidal ideation or behavior	“Suicide can occur more frequently in depressed youth.” (2001) “Suicide is one of the three leading causes of death in young people.” (2010) “Young people and the elderly are among the most susceptible age groups to suicidal ideation and self-harm.” (2013b)
Behavioral or conduct problems	“Conduct disorder refers to a repetitive and persistent pattern of destructive or hostile behavior that violates the rights of others or deviates significantly from age-appropriate norms and rules.” (1994) “Violence and aggression are mentally unhealthy, may be manifestations of a mental health problem, are conducive to disorder, and have a well recognized effect on the mental health of others.” (2006)
Anxiety	“The median age of onset for anxiety disorders was just 15 years.” (2000b) “The Friends Programme is a leading school-based anxiety prevention programme.” (2010) “Adolescents are generally perceived as a healthy age group, and yet 20% of them, in any given year, experience a mental health problem, most commonly depression or anxiety.” (2012a)
Severe mental disorder	“Although few children and adolescents suffer from severe psychiatric disorders such as schizophrenia or manic-depressive disorder, suicide risk is very high in those affected.” (2000a) “Schizophrenia, although not common, may often begin during teenage years.” (2001) “Disorders that cause a high burden of disease such as depression, bipolar affective disorder, schizophrenia, anxiety disorders, dementia, substance use disorders, intellectual disabilities, and developmental and behavioural disorders with onset usually occurring in childhood and adolescence.” (2000b)
Emotional problems	“Emotional outbursts.” (1995) “Emotional trauma.” (2003) “The frequency of presentations of negative emotion increases with the age of the students.” (2004a)

Social problems or interpersonal communication	“Children with emotional disturbances…may also have difficulties in relating to peers or adults.” (1994) “Problems in relations with classmates were the most recurrent psycho-social factor.” (2003) “Mental disorders...are generally characterized by some combination of abnormal thoughts, emotions, behaviour and relationships with others.” (2013b)
Developmental disorders	“WHO works closely with the Joint Commission for International Aspects of Mental Retardation.” (1990) “Many potential interventions exist for the prevention of developmental disorders in children.” (2013a) “Developmental and behavioural disorders with onset usually occurring in childhood and adolescence, including autism.” (2013b)
Neurological disorders	“It is quite common for children and young adults to have epilepsy.” (2001) “Populations in the African Region are beset by numerous mental and neurological disorders that are' a major cause of disability.” (2011) “Mental, neurological and substance use disorders are major contributors to morbidity and premature mortality throughout the world.” (2013b)

Additional examples of codes for *“Ideal characteristics of mental health promotion/prevention initiatives”* in WHO publications from 1990-2014

Code	**Examples of coded phrases**
Regularly monitored and evaluated	“The results of this will be evaluated in terms of its use in reducing health-damaging behavior.” (1990) “Schools will be encouraged to evaluate the programmes each year and provide feedback to the Mental Health Promotion Coordinator, who will report these findings to the regional committees.” (2004a) “Evaluate the outcome of interventions that aim to reduce the extent of risk behaviours or increase the extent of promotive behaviours.” (2005) “Make available a set of indicators to facilitate M&E of programmes contributing to the psychosocial well-being and mental health of adolescents.” (2012b)
Comprehensive	“The purpose of this monograph is to familiarize the reader with a model framework for a comprehensive approach to mental health promotion, prevention, and treatment in schools.” (1994) “The promotion of mental and emotional health is not just for those students who have obvious 'problems'. It is for all.” (1995) “Support coordinated and integrated programming for adolescent mental health promotion and care at all levels.” (2012a) “Targeting resources at the most disadvantaged groups alone runs the risk of detracting from the overall goal of reducing the steepness of the social gradient in health.” (2014)
Adaptive to local realities or culture	“Comprehensive but culturally-sensitive prevention plans must be tailored to a specific cause and effect.” (1993) “The values of certain cultural and ethnic groups may prove quite

	difficult for some teachers to understand." (1995) "Cultural applicability makes the task of dissemination of evidence-based inter- ventions complicated and slow; however, given the complexity of prevention programmes, this is to be expected." (2004b)
Active participation or student voice	"Telling people what to do is unlikely to be effective. Students need to be actively involved and to feel that what they are learning is relevant to their own experiences." (1995) "It is important to involve students in discussions about the findings, and to include students in the implementation of any changes that may arise from the result." (2003) "Adolescents can be important advocates of their own interests and concerns. They need to be recognized with respect and given a voice when developing policies and plans." (2005)
Scientific or theory-based	"The survey provided baseline data on public knowledge and misconceptions about depression, in order to facilitate a cost-effective education programme which would address the specific training needs of the community." (2004a) "Priority areas of research should be identified in Member States and research findings should be widely disseminated and used for appropriate reprogramming." (2011) "Generate scientific evidence on effective interventions in the field of adolescent mental health in low-resource settings and promote the dissemination of best practices." (2012b)
Adaptive to individual differences	"The content of teaching is in the present and is relevant to the students' own life." (1994) "In some homes conversation, particularly of the supportive and non-judgmental kind, may not be the norm, and some students may literally have no-one in whom they can confide. For these students, 'a listening school' may literally be a lifeline." (1995) "The experience and impact of social determinants varies across life, and influence people at different ages, gender and stages of life in particular ways." (2014)
Clear goals and plans	"The next task is to develop a specific plan of action including clearly stated objectives, assignment of responsibilities, a time-line and a coordinating mechanism." (1994) "Clear goals and precise limits as defined in manuals on suicide prevention are important tools in this work." (2000a) "The absence of an overarching framework for adolescent mental health hinders systematic programming." (2012a)
Based on experience	"Several of the activities contain leaders' notes and other illustrations based directly on the responses of participants at the workshops in the countries in which they were tried." (1995) "In the future, experience born of the anticipated activities will serve as referential evidence for correcting or consolidating the literature; meanwhile it can function as a traditional mechanism that helps deal with adolescent melancholic emotions." (2004a) "Pilot projects can provide information about successful interventions as well as why certain programmes may have failed." (2005)
Adaptive to developmental	"The materials are organized in an order which suggests an increasing understanding with age of the various concepts." (2001)

stages	“Relevant, interesting content aimed at the target age group.” (2004a) “Taking a life-course perspective recognizes that the influences that operate at each stage of life can change the vulnerability and exposure to harmful processes, or stressors.” (2014)
Inclusive	“We cannot, at the outset, identify exactly who will manifest this or that disorder, if any. Therefore, any recommendations for prevention have to be quoted within the context of a broadly based conceptual model.” (1993) “The universal approach, in accordance with population-based perspectives, provides potential public health benefits by tar- geting not only teenagers at immediate high risk but also adolescents who may, without the intervention, subsequently become at-risk.” (2004a) “Interventions that included all pupils.” (2006)

Additional examples of codes for *“Specific goals of mental health promotion/prevention initiatives”* in WHO publications from 1990-2014

Code	**Examples of coded phrases**
Foster resilience or coping	“The aim of school-based interventions is to provide an experience that will strengthen the children’s coping abilities to counter environmental stress and disadvantages with which they have had to cope in growing up.” (1994) “Be creative in helping them cope with the tremendous pressures and challenges they face in today’s world.” (2001) “The majority of students themselves enjoyed the programme and reported perceived gains in many areas, in particular an increased ability to cope with problems and emotions.” (2004a)
Promote healthy behaviors	“Pilot projects to explore adolescents’ own concepts of health and healthy behaviors have been carried out in a number of countries.” (1990) “To improve academic outputs among adolescents by reducing the prevalence of risk behaviours and increasing the prevalence of health promoting behaviours.” (2005) “Health promotion in schools can improve children’s health and well-being. Among the most effective programmes are those that promote mental health, healthy eating and physical activity.” (2006)
Promote or protect adolescents’ mental health	“While children need to be encouraged to take responsibility for themselves and their community, at the same time they have a right to a period of their lives when they can be physically and environmentally dependent on others and protected from physical, social and emotional harm.” (2003) “This module emphasizes the need to promote the mental health of all children and adolescents, whether or not they are suffering from mental health problems.” (2005) “Scaling up interventions with the aim of improving adolescent psychosocial well-being.” (2012a)
Increase knowledge of health or mental health	“Each pupil receives a booklet containing the most important facts, and teachers receive a map with extra information.” (2004a) “In many situations, mental disorders are poorly understood, and affected children are mistakenly viewed as “not trying hard enough”

	or as troublemakers." (2005) "The project seeks to address the social and economic determinants of health and includes actions to improve participants' knowledge about men- tal health issues." (2014)
Foster confidence, pride or self-esteem	"To foster positive self-esteem in children and adolescents a variety of techniques can be used." (2000a) "Helping students to believe in themselves is empowering and encourages them to stand up for their rights." (2003) "Most have regained confidence and self-esteem slowly but surely/" (2004a)
Improve social relationships or interpersonal communication	"Working on relationships and improving our communication skills can help us maintain these vital links with people." (1995) "The Program also provides participants with an opportunity to expand their peer support and social network." (2004a) "The training works by improving social competences." (2010)
Promote help-seeking	"The programme should convey knowledge to peers on how to be supportive and, if necessary, seek adult help." (2000a) "Students are confident that they will get help and support when they need it. How much is this like your school?" (2003) "Young people often underestimate the need for outside help and attempt to deal with their problems on their own." (2010)
Encourage problem solving or innovation	"It is often useful to base the lesson on a series of steps that have been mapped out…this is particularly important for the teaching of problem solving and decision-making skills. (1994) "Thinking about ways of doing things leads children to attempt more novel solutions to their problems." (2003) "A table game for students and adults, where players consider options and alternative solutions to hypothetical life adversities." (2004a)
Resist negative influences	"Young people need to be taught to resist pressure." (1995) "A good sense of mental well-being...helps them rebound from any setbacks that might occur, thrive in the face of poor circumstances, avoid risk-taking behaviour and generally continue a productive life." (2012b)
Promote independence or self-reliance	"Like adults, children seek self- determination." (2003) "The capacity of individuals to manage their thoughts, feelings and behaviour, as well as their interactions with others, is a pivotal element of the human condition." (2013a) "Incorporation of human rights principles, respect for individual autonomy and the protection of people's dignity." (2014)

Appendix C. CTU student interview protocol

First I will ask some basic questions about your background and education.

1) Please tell me your age, and where you are from.
2) Where did you do your undergraduate (bachelor’s) degree and what was your major?
3) What kind of degree are you studying for now? (Psychology or Education?)? How did you choose your degree program?
4) What motivated you to pursue a career as a 心理老师?
(Probes: Do you definitely want to work as a 心理健康教师 /心理老师 in a school after you graduate? If you haven’t made up your mind yet, what are some reasons why or why not? What do you think you might do instead?)

The next set of questions are about your views on adolescent mental health in China.

5) In your opinion, what are the most serious mental health challenges that adolescents in china face today? (Probe for risk factors)
6) Describe your understanding of the role of 心理老师 (probe for daily tasks & responsibilities, how it compares to other teachers/counselors, anything believed to be outside of the scope of 心理老师’s work)
7) What do you think are the main challenges faced by 心理老师 in their daily work?
8) How do you understand the relationship between “mental health education” and “moral education”?

The final set of questions are about your education and training.

9) Can you identify two or three particular theories or philosophies that have been influential to you in your training? (Probe about adapting foreign theories into Chinese context)
10) Do you ever discuss national mental health or education policies in your classes or with your classmates, for example 1999’s <<关于加强中小学心理健康教育的若干意见>>? (Probe for level of familiarity with policies and opinions about them)
11) Do you ever discuss the role of international organizations such as WHO? (Probe for human rights: organizations like WHO often talk about mental health in terms of human rights. Is this something you have ever discussed or would like to discuss?)
12) Which aspects of your training do you feel have been the most helpful? What kind of additional training, courses or activities during your master’s/doctoral degree program do you think would be beneficial?

Appendix D. Video-cued reflective questions for teachers at Beijing Z Middle School

Introduction: Explain our 3 categories. Explain that we chose one or more examples of these categories in every class based on the characteristic of the activity itself.

General questions:

--In your opinion, what is the purpose of the *zhutibanhui*? How did this *zhutibanhui* compare to other special events in your classroom, e.g. *gongkaike* or previous *zhutibanhui?*

-- What was the most challenging part of planning the *zhutibanhui*? *(Possible probes: did you have enough time? How clear were the instructions?)*

Interactive activity clips

Group question: Which of these interactive activities seem especially successful to you and why? *(Probe for specific examples).*

> *Teacher follow-up: Can you explain how this activity was designed? What were you trying to accomplish and do you think it was successful?*

Group question: What are the challenges of including an interactive activity?

[optional question: Do you include interactive activities in your everyday teaching? How is this kind of activity similar or different from your usual teaching practices?]

Performance activity clips

Group question: Which of these performance activities seem especially successful to you and why? *(Probe for specific examples).*

> *Teacher follow-up: Can you explain how this activity was designed? What were you trying to accomplish and do you think it was successful?*

Group question: Which performance activities do you think could be improved? *(Probe for specific examples).*

> *Teacher follow-up: Can you explain how this activity was designed? What were you trying to accomplish and do you think it could be improved?*

Group question: What are the challenges of including a performance activity?

[optional question: Do you include performance in your everyday teaching? How is this kind of activity similar or different from your usual teaching practices?]

Teacher-directed activity clips

> What is the role of the teacher's comments during the *zhutibanhui*?

[optional question: How are these kinds of comments similar or different from your usual teaching practices?]

General questions:

--Based on the videos, what do you think is a successful *zhutibanhui*? Can you give us some words to describe a successful one, and some words to describe an unsuccessful one?

--What kinds of things will you do differently next time you have a *zhutibanhui*? How can the school leaders help you?

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