# The Influence of Discourses and Power Relations on Parents of Young People Identified as Having Mental Health Difficulties

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## Abstract

**Background:** The children and young people's mental health (CYPMH) crisis represented in media and research is highly contingent on social constructions of CYPMH. Existing research explores the experiences and feelings of parents; exhaustion, shame and parental mental health difficulties are explored in extant thematic and phenomenological qualitative studies. Looking beyond experience to discourse is a key missing factor in the social construction of parenting and CYPMH difficulties (CYPMHD). Discourse defines, structures and limits what can be known about CYPMH and power mediates how this happens.

**Systematic literature review (SLR):** 19 discourse analysis (DA) papers were reviewed and highlighted the primarily discursive and conversational literature base around CYPMH. Research has so far not conceptually connected historical and macro-discourses around parenting and CYPMHD.

**Aims:** This research aimed to extend existing DA research by interrogating macro-discourses and applying a Foucauldian conceptualisation of power to parental talk around CYPMH.

**Methods:** Four sessions were recorded from a parental peer support group facilitated by a local charity. Transcriptions were analysed using Foucauldian discourse analysis using Willig's six stages (Willig, 2021).

**Findings:** Discourses were grouped into six headings: Evidencing good parenting, blaming the parents, responsibility for removal of CYPMH symptoms, subject positions in relation to bureaucracy, authoritative discourses and education as oppressive and exclusionary.

**Discussion:** This research extended DA concepts of blame of parents illustrating that psychology, education and local authority exert more authority over the social construction of CYPMHD. Practices such as diagnosis, psychoeducation, parents demonstrating good parenting and administrating distress contributed to the development of contemporary conceptualisations of CYPMH. Parents resisted authority where possible but discourses around neoliberalism and deficit parenting persisted in tasking parents with the removal of CYPMHD symptoms and judging parents where this was not possible to evidence. Findings are explored with reference to systemic theories, broader literature and clinical/research implications.

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## List of abbreviations

**CA:** Conversation Analysis

**CBT:** Cognitive Behavioural Therapy

**CDA:** Critical Discourse Analysis

**CYP:** Children and Young People

**CYPMH:** Children and Young People's Mental Health

**CYPMHD:** Children and Young People's Mental Health Difficulties

**CYPMHS:** Children and Young People's Mental Health Services

**DA:** Discourse Analysis

**EBSA:** Emotionally Based School Avoidance

**EMHP:** Education Mental Health Practitioner

**FDA:** Foucauldian Discourse Analysis

**IAPT:** Improving Access to Psychological Therapies

**SEND:** Special Educational Needs and Disabilities

**SLR:** Systematic Literature Review

**Glossary of Key Terms**

| Key term | Definition |
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| Archaeology | Archaeology is an alternative approach to analysing discourse in its archival and historical context. Foucault's linguistic choice of the word archaeology in favour of history is deliberate and describes the nuanced difference between this and attempting to present a 'total history' consisting of overarching reductionist patterns (mainstream historical approach). Archaeology analyses an idea as it occurs in an archive, opening up specific networks and social arrangements at moments in time. Archaeology is primarily concerned with understanding how discourse creates the context for ideas to become thinkable and sayable (Kendall & Wickham, 1999; O'Farrell, 2006). |
| Child and adolescent mental health services (CAMHS) | CAMHS is referenced throughout; when I use this term, I am referring to NHS services which encompass a wide range of support for people aged 0-18 and their families. Sometimes this support is delivered in inpatient units, in schools or other settings. Typically, when I have referenced CAHMS in this thesis, I am referring to 'core' or mainstream emotional and behavioural teams who support young people aged 6-18 with distress defined as moderate in a clinic setting (NHS England, 2023). |
| Child and young person mental health | I have used the term mental health throughout to refer to psychological distress and wellness experienced by young people. I have used the term to denote a wide range of experiences and understandings of mental health that are categorical and dimensional. This is in order that all potential discourses relating to and constructing the concept of CYPMH are included. Children and young people are defined here in by the world health organisation definitions meaning children and young people are defined as 0-19 (World Health Organisation, 2025a, 2025b). |
| Education and Healthcare Plan (EHCP): | ECHPs are official documents designed to describe the special educational needs of a child and outline the adaptations necessary for the school to meet this young person's needs. They are informed by the network around the child but responsibility for the document sits primarily with the local authority (Department for Education & Department for Health, 2015). |

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| Emotionally Based School Avoidance (EBSA): | This is a term widely debated and not universally accepted. EBSA describes the behaviour of a child or young person not attending school due to emotional distress of some kind. This can include CYPMHD such as: low mood; anxiety; psychosocial factors such as familial relationships or bullying; physical/health needs; neurodevelopmental needs. Typically, EBSA is used to describe children or young people who are not attending school for 15 days or longer but there is no official determined time period associated with EBSA (Department for Education, 2023). The term has been criticised for individualising distress but it is preferred by many parents and professionals and has been used throughout this thesis to reflect this preference (Cambridgeshire County Council, 2024). |
| Discourse: | This thesis draws on Foucault's definition of discourse when using this term. It is noted that Foucault's definition of the word varied depending when and where he used it. Broadly, this thesis sees discourse as social knowledge and meaning produced through language informed by cultural and social information (Taylor, 2013). With closer reference to Foucault, discourse can be understood as "rules, divisions and systems of a particular body of knowledge" conceived as artifacts of history and constructed through relationships of power and knowledge (Arribas-Ayllon & Walkerdine, 2017, p.114). Foucault also included non-discursive elements in his definition of discourse, meaning a discourse consists of more than just language. For example, cultural repertoires associated with certain discourses dictate how we act, dress, which values, beliefs we hold and many more aspects of social life (Taylor, 2013). For example, discourses within clinical psychology will determine the structure of an assessment session, the tone of voice a psychologist uses, the layout of a therapy room and many other non-discursive elements. |
| Genealogy: | An approach Foucault developed (though originally created by Nietzsche) in many of his works (Foucault, 1991, 1998, 2003a) best understood as a history of the present (Kendall & Wickham, 1999). Genealogy aims to surface the "disreputable origins and unpalatable functions" (Rose, 1985 in Kendall & Wickham, 1999 p.29) of broad institutional bodies of knowledge such as psychiatry. Genealogy as a methodological approach tracks concepts back against the flow of time to move beyond right and wrong and instead explore contingencies within various historical contexts. For example, |

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| | the conceptual transition away from punishing those persons deemed insane towards treatment within an emergent psychiatric tradition. Foucault explores this in Madness and Civilization (2003) and demonstrates a key defining concept within genealogy which is the release of subjugated knowledge; where psychiatry may have a vested interest in maintaining that treatment was a move away from brutality towards humanity, Foucault's application of genealogy may reveal alternative interpretations of contingency by examining discourse in a historical context (Kendall & Wickham, 1999). |
| Governmentality: | Held in close connection to Foucault's concepts of power more generally, governmentality is defined as a reconceptualization of the effects of state governance. In contrast to sovereign power where authority figures control through instructing people directly what they can and cannot do, governmentality implies that power is enacted through shaping expectations. Expectations for people are understood through invented categories and practices – people then monitor themselves to ensure that they fit the expectations for themselves which overall represents a nuanced difference between the effects of power in the traditional sense and power/knowledge in the Foucauldian sense (Huff, 2020). |
| Heterotopia | This term was coined by Foucault and describes a space outside of everyday social and institutional spaces (O'Farrell, 2006). In contrast to utopias which are hypothetical perfect forms of society, heterotopias are spaces in which things are different. A heterotopia is a microcosm containing layered and nuanced juxtapositions of how things are outside of the heterotopia (Foucault, 1984). Because life inside a heterotopia is often hidden from the rest of society, Foucault felt they could offer a liberatory space to explore difference without the oppressive effects of normalising power (Johnson, 2006). |
| Neoliberalism: | A term related to economics but with broad implications to sociology, power and discourse. Neoliberalism is well defined by Ganti (2014) who delineates four definitions held within this concept, three of which have been extracted here as they encapsulate the manner in which neoliberalism is understood in this thesis: 1) Deregulation of the economy through policy to liberalize trade and privatise state-owned enterprises, 2) The ideological application of market exchange expanded beyond economic theory to guide human behaviour and serve as a replacement for obsolete ethical and moral guides, 3) |

Complete trust in the self-regulating nature of free markets which are fuelled by self-interest and competition (Ganti, 2014). The relevant implications of neoliberalism for society which underpin the use of the term in this thesis are: 1) mental health difficulties are primarily conceived as a measurable deviation from the norm which should be ameliorated to ensure that ideal mental health is achieved for optimal performance in terms of achievement and success 2) ameliorating mental health difficulties relies on individualistic hard work 3) it is important to measure the severity of mental health difficulties because this shows how well a person is performing.

Normalisation:

Foucault sought to denaturalise the concepts of norms (in particular medical norms) to problematise the ubiquitous assumption that there is a medical hegemony which prescribes norms against which everyone can be compared and degrees of abnormality can be established (O'Farrell, 2018). Foucault explored the power of normalisation with the example of the transition in the 18th century away from a system of sovereignty whereby a crime was a crime against a 'social body' towards the reconceptualization of the criminal as 'mad' and unwell in a psychological sense. This broadened out to an enmeshment between the law and medicine to rehabilitate rather than punish criminality; a primary technology employed in this purpose was the establishment of norms to which a criminal can be measured in terms of deviation from that norm (O'Farrell, 2006). This concept is not limited to criminality and has come to define modern life in terms of normalising power which influences each person's sense of their own deviation from norms in innumerable contexts.

Panopticon

Perhaps one of Foucault's best-known concepts – the Panopticon was originally a form of prison designed by Jeremy Bentham in the latter part of the 18th century as part of intended prison reforms aimed at increasing efficiency. The panopticon contains one central tower for a guard and is surrounded by the cells of the prison. The key premise was that prisoners in a panopticon are unable to see whether the guard can see them but it is known that the guard is capable of covertly watching any prisoner at any time. In this sense, prisoners are never fully sure whether they are being surveilled at any time, therefore prisoners theoretically behave in accordance with the rules as they are never sure whether they will be caught if they break the rules (Elmer, 2014; Foucault,

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| | 1991). Foucault saw this idea as a metaphorical representation of power and control; for him, the panopticon was applicable as a way of conceptualising power in many other parts of society: schools, government, psychology and many more. Foucault's genealogy in Discipline and Punish (1991) outlines the changing role of punishment in society throughout history. Initially punishment for crime took the form of public beatings, executions and other extremely violent public displays. Over time, this morphed into a more private punishment of the soul in prison. The panopticon slots into this cultural shift towards punishment of the soul and individuality. |
| Power | Power, in the Foucauldian sense is inextricably linked to knowledge. Centrally, Foucault conceives power as productive; power is not repressive i.e. the production of knowledge through social construction makes certain things knowable by erecting parameters of truth which have real world effects (Kendall & Wickham, 1999). For example, psychiatry tells us that distress is best understood as a set of highly delineated diseases which should be treated by a doctor. This means that institutions such as the NHS provide support for people who fit within this conceptualisation of distress. However, the effect of labelling distress as a health condition can create the conditions for stigma and oppression based on relationships of expertise and authority between doctors and patients. This is in stark contrast to mainstream conceptualisations of power whereby someone *wields* power, for example, a politician or sovereign leader who oppresses those seen to be less powerful |
| Psy-complex | The psy-complex is a term denaturalising the status of 'the study of psychology' in society. From one (arguably dominant mainstream) lens, psychology is a neutral study of psychological phenomena. The psy-complex refers to psychological disciplines, including but not limited to: clinical psychology, psychiatry, psychotherapy, counselling and psychoanalysis. Informed by Foucauldian and post-structuralist thought more generally, the term 'psy-complex' invokes the regulating effects of these disciplines on defining, controlling and limiting truth in a broad spectrum of aspects of social life by exerting power through the construction of knowledge and discourse. For a full exploration of the term see Rose (1985). |
| Subject position | A term describing the notion that people speak out of positions which are defined by discourse, these positions are governed by power relations that define the limits of what can be |

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| | said/known/thought (Arribas-Ayllon & Walkerdine, 2017). Subject positions limit freedom and indicate a social arrangement based on expectations constructed by discourse (Willig, 2021). |
| Special Educational Needs / Disability (SEND) | SEND is an acronym applied to young people which describes a range of needs within educational settings including behavioural, physical health, cognitive and others (HM Government, 2025). SEND can be understood from social, medical or biopsychosocial frameworks in terms of the inclusion or response to needs within schools (Rolfe, 2019). Statutory UK guidance asserts that a child or young person has SEND needs if: “they have a learning difficulty or disability which calls for special educational provision to be made for him or her. [Or] a child of compulsory school age or a young person has a learning difficulty or disability if he or she: has a significantly greater difficulty in learning than the majority of others of the same age, or has a disability which prevents or hinders him or her from making use of facilities of a kind generally provided for others of the same age in mainstream schools or mainstream post-16 institutions” (Department for Education & Department for Health, 2015, p. 15-16). |

# Chapter 1: Introduction

## 1.1 Chapter overview

This thesis recounts a systematic literature review (SLR) and empirical study investigating the social construction of children and young people's mental health (CYPMH). The SLR presents, appraises and syntheses the findings of discourse analyses on the broad topic of CYPMH. The empirical study describes a Foucauldian Discourse Analysis (FDA) investigating the social construction of CYPMH through parental talk in a peer support group for parents.

Chapter one will summarise the researcher's positionality and context before presenting an overview of relevant research and theory to situate and provide justification for the current thesis.

## 1.2 Contextualising myself

I have conducted this research from an oscillating position of insider and outsider. As a person born in the mid-90s in the UK I lived through a period marked broadly by New Labour; a time of vast investment in the NHS and creeping neoliberalism then a turn to austerity, Brexit, and a cost-of living crisis. These historical and political contexts shaped my understanding of right and wrong, rich and poor and the meaning and function of mental health. I managed to more-or-less thrive in a state provided educational setting and never accessed mental health support as a young person, yet I have provided a great deal of mental health support to young people as an adult. I have broadly been socialised into dominant theories of psychology through my university education yet personally seek out points of resistance through moves I can make as a trainee to provide ongoing critique to evidence-based practice

and our role as psychologists in society. These paradoxes and dualling identities have been applied time and again (see Appendix A for reflective diary) to increase the complexity of this thesis at every point.

I hold a variety of privileged aspects of identity being a middle-class, White British, university educated, heterosexual, cisgender man. This means that I have experienced life as someone afforded comparatively more authority to claim truth on most things. To me, this privilege is accompanied by a responsibility to reflect and always consider the power of my voice in any interaction and the reverberations of my voice beyond an interaction.

I have always been drawn to working with young people and families in various NHS and non-NHS settings. Beyond this I have built a career on working in services where 'mental health' as a phenomenon is critically debated but temporarily deployed to support clients through psychological distress. Some examples of these services include Child and Adolescent Mental Health Services (CAMHS) harmful sexual behaviour, sibling sexual abuse (King-Hill et al., 2023), forensic learning disability and researching gender identity (Butler et al., 2022).

I do not hold an insider researcher role in terms of parenting as someone who does not have children. My insider knowledge of the subjective experiences of parents is limited to working with children and families professionally and anecdotal relationships with friends and family. My gender identity is one way in which I hold a potentially 'outsider' researcher role; based on my experiences working in CAMHS, mothers are commonly expected to take on the primary role of providing emotional support to their children. Moreover, stereotypes identified in research suggest men

hold dynamic and performative gender roles in society which can shift between caretaking, leadership and action-oriented responses whereas women's roles are assumed to be essentialist and fixed to caretaking (Gustafsson Sendén et al., 2019). I cannot ever fully expect to subjectively know what it is like to be a mother in this regard, therefore I have reflected with my supervisor and colleagues identifying as women to consider potential areas of ignorance and subjective effects I may be less attuned to.

I knew from the outset that CYPMH was a topic I wanted to explore due to my previous professional experiences. My thesis research aims were informed by my experiences co-facilitating a peer group for parent/carers of children under CAMHS. Discussions within the group almost always turned to societal pressures, shame from internalised discourses for example around: health, parenthood, work, money and many others. Reflecting on this group, I felt it was a unique insight into what is seldom heard from parents; the powerful cultural forces which define CYPMH. Though the group was a useful forum to explore this issue, I felt that this could be translated into a research project with the intention of leaning into the relativity and construction of CYPMH.

### 1.3 Epistemological position statement

This research has been conducted primarily from a social constructionist stance. Social constructionism is an epistemological approach that is not attributable to any one person. I will draw on concepts outlined by one of social constructionist's key explicators; Kenneth Gergen with reference to how I have approached this research from a social constructionist stance (Gergen, 2009).

I have maintained throughout that CYPMH to the social constructionist is not formed of any natural or a priori objective basis before the process of study or description is applied to it. This means that how one understands an object of study is not necessarily informed by the thing itself (Gergen, 2009; Gergen et al., 2004). This sense of anti-essentialism is important to hold onto as a standpoint if one's aim is to build up an alternative and critical voice where there is hegemonic knowledge on a subject; in this case, mainstream psychology purports that a scientific, empirical and medical approach to distress is truthful and liberatory (Burr, 2015; Evans-Lacko et al., 2014; Hazell et al., 2022). The claim that mental health may be understood as a socially constructed phenomenon is held in contrast to a positivist, mainstream ideology which posits that CYPMH is best understood through a biomedical model based on empirical scientific principles (Morehead, 2021; Shalev, 2001). Conversely, from a social constructionist stance, I have sought to challenge the taken-for - granted dominant 'truths' of CYPMH throughout this thesis (Burr, 2015; Gergen, 2009). In this way, a social constructionist stance has a greater capacity than realist positions to take up a critical voice and de-naturalise objects of study such as concepts within mental health – this fits well with a discourse analysis (DA) approach. There is a commonsense assumption that language is a static, value-neutral representation of objective reality. DA instead interprets language as holding stories of contingent ideas subsumed into shared meanings which become dominant 'truths' (Taylor, 2013).

Drawing on social constructionism, I have foregrounded the social relational nature of truth which is presented as an imperative maxim of a social constructionist

stance (Burr, 2015; Gergen, 2009). This is one example of my rationale for taking a social constructionist stance in this research; my research questions highlight that this study's level of focus is on how broad discourses construct CYPMH in parental talk. It is therefore essential that I adopt an epistemological position capable of studying the subjective consequences of language's hegemonic effects and the process of constructing knowledge. Compared to a more pragmatic position or critical realist stance which assumes a reality external to human subjectivity, social constructionism provides greater access to the process of knowledge creation (Burr, 2015; Gergen, 2009).

## 1.4 CYPMH and parents in context

The remainder of this chapter will be dedicated to contextualising the current thesis within the empirical and theoretical literature relevant to this topic.

### *1.4.1 A CYPMH crisis*

The prevalence of child and young people's mental health difficulties (CYPMHD) in the UK is typically characterised as an epidemic – this is a characterisation favoured by news media (Adams & PA Media, 2024). In research too, journal articles will commonly begin with a representation of a CYPMH crisis in urgent need of fixing through new interventions or approaches (Hashimi, 2025; Jayman, 2024; McGorry et al., 2025). Deployment of this discourse often focuses on the pressures on NHS services to cope with an increasing CYPMHD demand resulting in long waiting lists to access support (Hashimi, 2025).

Within the CYPMH crisis discourse there are key contributing factors cited in as causes of CYPMHD, for example McGorry and colleagues (2025) explore the

impact of increased screen time, rising neoliberalism, increased exam pressures, socio-economic inequalities and many more factors in their policy review of 'the youth mental health crisis'. On one hand, a focus on social determinants is a highly useful lens from which to expand the formulation of CYPMHD beyond a potentially stigmatising, biomedical framework (Hazell et al., 2022). On the other hand, studies such as this risk leaning into a cause-and-effect argument which relies on an endorsement that CYPMHD can be clearly identified and measured through diagnosis and screening. For example, McGorry and colleagues encourage researchers to build more sophisticated mechanisms for measuring causal relationships between contributory factors and poor CYPMH. This is underscored by the assumption that more specificity will lead to clearer recommendations on how to reduce CYPMHD. What is missing from this analysis is a critical lens on hegemonic models of mental health and the relations of power and discourse which define the parameters of CYPMH.

### *1.4.2 Parenting in a CYPMH crisis*

It is important to consider the position of parents within this broad discourse of CYPMH crisis. In contrast to adults who may be held predominately responsible for managing their own distress, the responsibility for supporting CYPMH often falls solely to parents (O'Reilly et al., 2018). Martin and colleagues' qualitative meta-synthesis of parents' experiences of having a child or young person with a mental health difficulty explores the pressures parents feel and the subsequent challenges of parenting a child or young person identified as experiencing distress (Martin et al., 2025). This meta-synthesis describes parents' critical relationship with children and

young people's mental health services (CYPMHS) which can be perceived as parent-blaming and a source of stress. Moreover, the effects of stigma, blame and anxiety are described by parents as pervasive and exhausting, impacting daily life and family dynamics (Martin et al., 2025).

The extreme stresses and challenging experiences may be influenced by wider discourses such as the mental health crisis and stigma attached to biomedical frames of CYPMH. There was a clear theme highlighted by this meta-synthesis of 46 high-quality qualitative studies; parents described their experiences parenting children and young people (CYP) with identified distress as extremely stressful and isolating (Martin et al., 2025). This review summarised a comprehensive research base aiming capturing the phenomenological experiences of parents in this area combined with an acknowledgement of a changing landscape of challenges for families in the 21st century, however the synthesis of these two aspects is so far limited (Blum, 2007; Martin et al., 2024, 2025; Penzo & Harvey, 2008).

### *1.4.3 CYPMHD and service provision*

Based on 2021 census data, around 1.4 million children are reported to have a 'probable mental health disorder'. This is reported to be an increase of 17% from the previous year, and it is estimated that fewer than half of those young people had at least one contact with NHS CAMHS between 2021-2022 (Children's Commissioner, 2023; Garratt et al., 2024). There is a national recognition that CAMHS provision currently does not match the number of young people who are identified as needing mental health support. It is in this context of CYPMHS being represented as not meeting CYP needs that provision for CYPMHD is being reconceptualised in a more

holistic sense to better meet increased demand.

It should be acknowledged that the Children's Commissioner role has been criticised for a lack of meaningful impartiality from the government as well as limited powers to effect change. Current Children's Commissioner and author of the Children's Mental Health Services 2021-2022 report (cited above), Rachel De Souza arguably embodies the state's focus on 'getting children back to school' which may have influenced her interpretation of representation of CYPMHS in this report. De Souza has a long history working in senior education roles and limited experience with CYPMH meaning her priorities for CYP are likely to be framed in terms of education. Published just after COVID, discourses around poor school attendance and aftershocks of the pandemic may have influenced the representation of CYPMHS at this time in a manner which arguably may have taken the 2022 report beyond a 'neutral' retelling of the CYPMHS landscape. It is important to recognise that roles such as the Children's Commissioner are created to critique services and identify how they can improve, meaning they often highlight gaps and limitations and are unlikely to tell the full story of CYPMH.

The 2017 green paper introduced Mental Health Support Teams (MHST) and the NHS Long Term Plan actioned this approach. This was a key service delivery change to expand CYPMHS out of CAMHS clinics (Department of Health & Department for Education, 2017; NHS, 2019). MHSTs are designed to deliver evidence-based interventions for mild-to-moderate CYPMHD, provide consultation from CAMHS to educational professionals and develop Whole School Approaches to introduce psychoeducational information as a means of preventing the development

of CYPMHD (Department of Health & Department for Education, 2017; NHS England, 2025). At the time of writing there are approximately 500 MHSTs operating in the UK (NHS England, 2025). Initial mixed-methods evidence including interviews with programme implementers and service providers suggested that MHSTs were a welcome addition to the CYPMHS landscape. However, they also suggested the improving access to psychological therapies (IAPT) low-intensity model endorsed by MHST may be creating new threshold gaps between mild-moderate and moderate-severe and may not be working well for the full range of children and young people referred to MHST (Ellins et al., 2024).

Importantly, this study focused on a group of trailblazer sites, meaning data were collected during a period that could still be considered formative in the implementation of MHST in the national CYPMHS context. Hence, findings may not represent the efficacy of MHST nationally. Moreover, the authors attribute some of the challenges in focus of services to high staff turnover in the Education Mental Health Practitioner (EMHP) role. Challenges in retaining EMHP staff (as an example of broader systemic changes) may have been ameliorated by 2022 updates to Health Education England funding which now limits EMHPs from applying to any other training programmes for two years after qualifying (NHS England, 2021).

Another way in which CYPMHS provision is changing is in the expanding role of third sector organisations and charities to support young people who may be on waiting lists for CAMHS or falling between threshold gaps (Dutton et al., 2023). This introduction of third-sector commissioning is happening across CAMHS pathways, for example in crisis care (Dutton et al., 2023) but school support is perhaps a focal area

for this reorganisation. School non-attendance has become a highly politicised and central issue in the representation of CYPMH in broader society (BBC News, 2024; Busby, 2025; Maynard et al., 2015; Want & Gulliford, 2024). As such, there has been an increasing focus in drawing in a variety of sources of professional support to address this issue. Where MHSTs are situated in schools and CAMHS work almost exclusively in clinics, accessing support for CYP not able to attend school (sometimes unable to leave the house) is a need perhaps best met by charities with more flexible delivery models. For example, the Attendance Hubs programme in Middlesborough delivered by Barnardo's used a mentorship model to work with the whole family with the aim of overcoming barriers to school attendance (Gibb & Department for Education, 2023). In a broader context of long waiting lists for CAMHS support, charities are increasingly part of a vision of transformation via integration across services (Fazel et al., 2021).

#### *1.4.4 CAMHS*

CAMHS is the primary NHS organisation tasked with assessing, formulating, intervening and consulting to networks regarding CYPMHD. Broadly CAMHS is divided into four tiers to determine pathways of care: 1) General Advice and Treatment; early intervention and preventative guidance for general mental health 2) Targeted Services for more complex needs; services for mild to moderate needs such as schools teams 3) Specialist services; specialist CAMHS teams providing assessment therapy and liaison for more moderate mental health difficulties 4) Highly Specialised Services; for CYP with severe mental health difficulties services such as inpatient wards (Hertfordshire Partnership NHS Foundation Trust, 2025; NHS

England/Medical Directorate/Parity of Esteem programme, 2014; The Association for Child and Adolescent Mental Health, 2018). The NHS outlines several problem descriptions for which CAMHS is commissioned to support young people and families with. These provide an insight into the generic ways in which is CYPMHD thought to present: family issues, emotional and behavioural disorders, conduct disorders, anxiety, depression, bullying, phobias, self-harm, psychosis, eating disorders, trauma and a number of other CYPMHD (NHS England/Medical Directorate/Parity of Esteem programme, 2014).

Understanding the purposes, discourses and positions of psychologists in CAMHS is important as this is a site where CYPMH is reified. The everyday practices, language and behaviour of a psychologist in CAMHS is part of what constructs CYPMH. An average person specification for a band seven clinical psychologist in a tier three CAMHS outlines that they will be expected to 'carry out high quality assessments', 'provide evidence-based treatment', 'manage risk', 'work to relevant professional and ethical guidelines' and 'demonstrate treatment effectiveness using screening and outcome measures' (NHS South West London and St George's Mental Health Trust, 2023). Activities such as demonstrating quality and effectiveness through empirical means such as outcome measures indicate an organisational priority of standardisation and a focus on monitoring. Standardisation and homogeneity appear to be built into the NHS CAMHS system; looking at the latest available service specification for tier two/three CAMHS from NHS England, two key understandings of CYPMHD can be extrapolated to form the remit of CAMHS (paraphrased): 1) CYPMHD affect a rising number of children in standardised ways 2)

CYPMHD represent an economic and societal burden which needs to be reduced (NHS England/Medical Directorate/Parity of Esteem programme, 2014).

CAMHS is nationally implementing frameworks such as i-THRIVE which aims to alter the CAMHS system by introducing five categories of support: Getting Advice, Getting Risk Support, Getting Help, Getting More Help, and Thriving (Moore et al., 2023; Wolpert et al., 2019). I-THRIVE aims to provide an alternative to a tiered system by instituting a more responsive CAMHS system that includes the voices of CYP and families in shared decision-making and encourages interagency co-operation (Sippy et al., 2025). Initial studies have suggested that implementation of i-THRIVE leads to more equitable access to support through signposting, service-mapping and outreach. Moreover, i-THRIVE was found to improve patient flow due to a focus on endings and goal-oriented intervention according to clinicians interviewed as part of a qualitative evaluation (Farr et al., 2021). Consequently, i-THRIVE may represent a CAMHS system becoming more meaningfully integrated within the community and cognisant of epistemic inequalities in decision-making (Moore et al., 2023).

### *1.4.5 Wider cultural trends influencing CYPMH service provision*

It is notable that a contributing author to a contemporary CAMHS service specification is the Parity of Esteem programme – this programme's mandate is to ensure that the NHS values and treats mental health in same manner as physical health (Panday, 2016). Parity of Esteem captures the broad rebranding of mental health that occurred between 2000-2020 which still informs current approaches to CYPMH; this is well summarised by the Time to Change campaign (Evans-Lacko et al., 2014; Hazell et al., 2022). Time to Change (and similar campaigns) aimed to reduce

stigma by promoting a biomedical framework of distress with the intention of representing the importance of mental health as equal to physical health (Evans-Lacko et al., 2014). Unfortunately, these campaigns arguably promoted a more stigmatising discourse that distress represents a disease, a condition which should be contained and treated only by expert doctors (Hazell et al., 2022).

Time to Change is an example of a cultural discourse embedded in NHS policy which impacts the care received when accessing a service for CYPMHD. This demonstrates how cultural discourse can be imported into therapeutic services and over time contribute to hegemonic knowledges about CYPMH. Though Parity of Esteem has become a taken-for-granted way of talking about CYPMH, its potentially harmful effect on stigma indicates that these discourses require critical analysis. This would help understand the effects of services (with more authority to claim truth on CYPMH) reproducing ontologies of distress which are limiting and potentially oppressive to parents.

### *1.4.6 'Poor parenting' and CYPMH in the UK brief historical context*

The contemporary remodel of distress as predominantly biomedical is best understood in its widest possible historical context; Nikolas Rose explored the historical institutional UK context underpinning this in his book The Psychological Complex (Rose, 1985). Rose examined the introduction of public health models applied to 'mental hygiene' beginning after the First World War with theories that psychological 'abnormality' was conceptually linked with delinquent behaviour. Rose presented links between morality, criminality and mental health that appear unusual from today's formation of psy-complex which has naturalised the concept of mental

health as an illness rather than a moral defect. Yet in the early 20th century, national policy indicated that children showing symptoms of psychological distress should be identified and treated early because they lead to later criminal behaviour which would represent a drain on the economy. This mandate then led to the formation of the first Child Guidance clinic in 1927 (Rose, 1985). This purpose of intervening to solve later problems highlights similarities between 21st century and 20th century mental health policies.

Theories of causality around CYPMHD undulate across the developing CYPMHS across the 19th - 21st centuries. Rose highlighted an increase in epidemiological models identifying risk based on 'poor parenting' and/or 'moral poison' in the local community – this culminates in legislation following the 1927 first Report of the Home Office Children's Branch. The report is unambiguous in its wholesale endorsement of environmental causes (poor parenting primarily) of delinquency in children which constitutes a psychological illness (Rose, 1985). This paved the way for social regulation via treatment (not punishment) to be administered by psychological professionals in clinics, schools and the home. This service remit was underpinned by the goal of easing the judicial burden of later criminality in children who are seen effectively as innocent and vulnerable to a mental disease caused by poor parenting (Rose, 1985).

Moving forward to the early 21st century under a New Labour government, it appears that theories of causality, where CYPMHD are concerned, still cite poor parenting and moral poisoning albeit under new guises. What is different at this point in history is neoliberalism, austerity and a politics of individuality and

performance (De Benedictis, 2012). Out of this historical context, the 'feral parent' emerges as a clear subject position informed primarily by the construction of 'reflexive parenting' as a measurable competency (De Benedictis, 2012; Gillies, 2012). Ultimately, 'poor parenting' as a site for neoliberal measurement and correction subtly transformed the epidemiological and morality driven theory in the 19th century. The degree to which environmental causes are cited in CYPMHD is effectively the same and these are still informed by class politics; but the introduction of competency shifts this. The suggestion in the 21st century is that working-class models of parenting are *lacking* but can be remedied if parents are willing to learn middle class methods of parenting, thereby achieving social mobility (De Benedictis, 2012; Gillies, 2012).

This cultural promotion of a deficit parenting discourse is well exemplified by Emery in his critical discourse analysis (CDA) of interviews with policy figures in the UK government during New Labour (2016). Emery interprets the discourse of policy makers in the UK as drawing on cultural repertoires of CYPMH as measurable through performance metrics (exam results, school attendance) but also, crucially ameliorated by the psychoeducation of parents on how to parent better. There is a tone of pity in the excerpts included in the analysis and the influence of Parity of Esteem, biomedical frames and the Psy-complex is a potentially important influence on discourse around parenting within CPYMH at this time.

One limitation of Emery's work is that it does not address power in a governmentality[1] sense; by examining policy in terms of the practical impacts of including health and wellbeing in schools and introducing the deficit model of

[1]See glossary of key terms at the beginning of this thesis for a full definition of governmentality

parenting it is clear to see how professionals respond differently to CYPMHD and parents. However, the degree to which theories of deficit and working-class parenting as inherently 'feral' and wrong contribute to a normalising panopticon for parents is perhaps explored less in his article due to the focus on policy makers and the flow of power from state to governed as unidirectional.

### *1.4.7 School, CYPMHS and families: a relational perspective*

Mapping the broad social discourses in which CYPMH is constructed leads one naturally to question how these systemic relationships are enacted on a more local level. CYPMH discourses are highly relevant in the relationships between school, CYPMHS and families. I have used David Campbell's model of semantic polarities to bring meaning to this network with reference to discourse (Campbell, 2011; Campbell & Groenbeck, 2006). During my placements in CAMHS, I have noted the value of 'stepping back' in a consultation setting involving network members such as educational professionals, other psy-professionals and family members using the semantic polarities model. This can help the whole system critically consider the various positions occupied and the subjective effects of this.

Reframing relationships through semantic polarities requires the reconceptualization of everything that is said and done as informed by positions rather than personalities. The aim of this is to support change where interactions can become limited by assumptions that behaviour is informed solely by static personality factors (Campbell & Groenbeck, 2006). Reframing action as informed by positioning introduces possibility in a more tentative and moveable sense without suggesting that the person is limited to a concrete fixed role. This is particularly

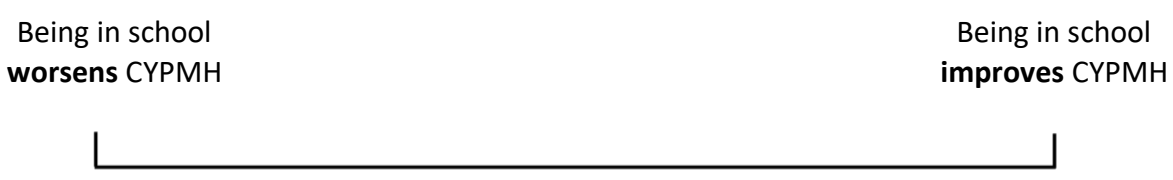
useful when formulating CYPMHD; using the Semantic Polarities model, one maps problems along Semantic Polarity lines, representing where positions sit along this spectrum and how these positions are taken up or applied to people (Campbell, 2011; Campbell & Groenbeck, 2006).

The semantic polarity model is rooted in systems theory, closely related to systemic family therapy and has been applied in a variety of organisational settings including systemic consultation in NHS settings (Campbell & Huffington, 2008; van Roosmalen et al., 2013; Van Roosmalen et al., 2024). Semantic Polarities is epistemologically aligned with social constructionism and draws on ideas around the positioning nature of language with regard to discourse, making it highly applicable to this thesis (Campbell, 2011).

Based on available literature and policy and what has been interpreted about CYPMH so far, semantic polarities can be constructed to interpret the various subject positions made available by discourse, beginning simply with an example of the relationship between attendance and CYPMH:

Figure 1

*Semantic polarity line of the relationship between attendance and CYPMH*



This initially feels a crude and binary conceptualisation of school non-attendance otherwise referred to as Emotionally Based School Avoidance (EBSA) and yet, considering where institutions may be positioned along this spectrum begins to open new ways of thinking about what is made available from within those positions. For instance, official documents decree that attending school has a positive effect on CYPMH as a fact (Department for Education, 2024). This clearly limits the available ways of being for educational staff who are legally compelled to do everything in their power to keep children in school under the assumption that every second not attending school worsens CYPMH. The semantic polarity here invokes curiosity about how educational staff position would themselves along this spectrum.

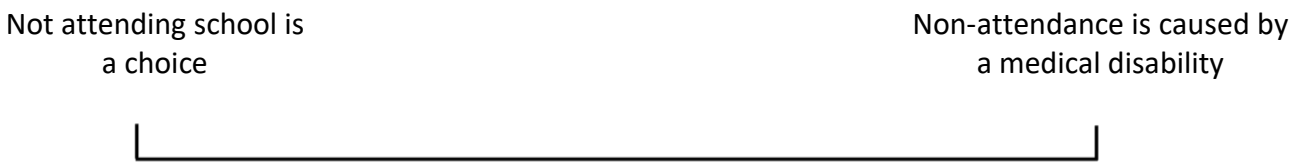
Moreover, situating CYPMHS within this polarity line adds layers of complexity to the overall picture. CYPMHS clinicians ideally should take an individualised approach guided by formulation which could mean that they position themselves anywhere on this spectrum but the interplay between CYPMHS and school dependant on positioning is of particular interest. It is well-recognised that the professional opinion of CYPMHS can often be endorsed more strongly than school or parents' perspectives (Denman et al., 2016; Rothi & Leavey, 2006). It is therefore interesting to consider the effects of CYPMHS officially positioning a young person on this spectrum and the potential undermining effect of this on a school's position.

This has wider implications when considering discourses of choice, freedom and biomedical frames in CYPMH. EBSA is a useful example as it can be positioned at

the intersection between CYPMHD and 'delinquency' as previously explored (Rose, 1985). The following semantic polarity line explores this:

Figure 2

*Semantic polarity line indicating choice within EBSA*




Considering the pressure, shame, confusion and blame explored in the parental experience of EBSA, it is possible that biomedical frames which explore EBSA as a medical disability may offer explanations which relinquish the burden of choice and responsibility in some ways, making this an appealing position to take up (Avdi et al., 2000; Martin et al., 2025). This relates strongly to the experience of parental blame in CAMHS assessment settings; where discourses of blame abound in our society, it can be interpreted that parents understandably look to psychiatry and diagnosis for an explanation which offers relief from blame at the expense of labelling a child as abnormal (Avdi et al., 2000; O'Reilly et al., 2020). Yet, this abnormality heterotopia[2] is perhaps preferable to the potential shame associated with the label of 'feral parent', 'delinquent child' or 'moral poisoner' (De Benedictis, 2012).

Previous research has established parents' experiences in CYPMHD networks, but the nuanced influence of power and discourse to position some stakeholders as

[2]See glossary of key terms at the beginning of this thesis for a full definition of heterotopia

more able to claim truth and dictate responses to CYPMH. The semantic polarities model provides a method of representing subject positions from various perspectives and is therefore highly relevant to the current thesis and builds on previous research.

### *1.4.8 Discourse analysis and language*

Positioning, language and meaning are central to my thesis due to my focus on discourse throughout. I have therefore decided to define in fine detail several terms used throughout in a glossary at the beginning of this thesis - the reader may want to refer to these throughout. Of particular note are the Foucauldian concepts: power, genealogy, normalisation and panopticon as well as the definitions provided for the psy-complex and discourse.

Michel Foucault's ideas have been central to this research throughout, explicitly in the analysis but also in terms of my epistemological stance. Foucault's work does not sit comfortably in any one particular epistemological 'school' but he was broadly defined as a poststructuralist thinker interested in power (Hook, 2007). Foucault paid particular attention to the productive power of discourse (Khan & MacEachen, 2021). Moreover, Foucault built on previous ideas of social construction by considering the productive force of power through knowledge; this is most accessibly understood through his works around prisons, sexuality and madness through the ages. This way of re-examining the production of what is known and analysing forces of power through administrative processes which reify relations of power (for example between a psychologist and a parent of a child with identified CYPMHD) within this are key epistemological tenets I have applied in this research.

I have elected to include Foucauldian concepts as an embellishment to a 'pure' social constructionist stance with acceptance that there may occur epistemological contradictions in this. I believe that the strength in this case of using Foucault's ideas (criticality, access to broad discourse and wider contexts) outweigh the potential lack of opportunities for critique were I to focus more on language from a social constructionist stance without reference to Foucault's ideas. It is precisely because Foucault was so resistant to and critical of formal methodology, science and psychology that his concepts are so useful for taking up a reflexive, de-naturalised and critical voice in qualitative analysis of discourse within mainstream psychology (Hook, 2007).

Discourse is generally highly relevant to the relationships, expectations and positionality of clinical psychology, CYPMH and parents within this. A great deal of extant research has focused on exploring the experiences of parents and young people in relation to CYPMH (Crouch et al., 2019; Harden, 2005; Mishna et al., 2020; Parry & Varese, 2021). This research has predominantly used thematic analysis and phenomenological approaches to explore the experiences of parents of young people experiencing distress. Reviews have described an evidence base of high methodological quality and consistent findings around parents experiencing shame, blame, and challenges in relating to relationships within the family and externally with professionals (Arbuthnott & Lewis, 2015; Martin et al., 2024, 2025).

Interpreting the role of discourse in constructing and defining CYPMH and parenting is a vital step in critiquing dominant models which can patronise parents and pathologise young people. This is an element lacking in extant literature around

CYPMH and parenting; there is a gap where the role of institutional bodies (healthcare, education, law, social care etc.) in establishing truth around CYPMH needs to be examined from a critical perspective. Truth and knowledge (mediated by power) are important elements to be considered in interrogating the construction of CYPMH and parenting within this. DA allows one to take up a more critical voice by investigating how language and discourse contribute to ideological dilemmas and construct truth (Taylor, 2013). Where research has predominantly sought so far to channel voices of parents to build a picture of how they experience parenting a child with identified CYPMHD, the next step is critically engaging in this at the level of discourse to better understand how discourse and discursive practices shape these experiences which is the focus of this thesis.

### *1.4.9 Conclusions based on literature*

This introduction has presented a review of extant literature and theory with a clear throughline; parents are a central figure in societal discourses around CYPMH. From the 18$^{th}$ century through to post-COVID UK, morality has been held centrally as a deciding factor in determining who is responsible for causing and responding to CYPMHD. Research has explored these discourses of delinquency and brought useful criticality into the discussion of monitoring and controlling hegemonies of CYPMH (Rose, 1985).

Moreover, school has proven to be an important site where institutional technologies of power clash with parental testimony. Research has explored narratives and testimony around the familial experiences of CYPMHD

comprehensively: a considerable amount of qualitative literature has also been published to date, the majority of which is focused on phenomenological analysis or analysis of interview/focus group data using thematic analysis. However, the potential utility of explicitly analysing discourse has not yet been fully explored. DA offers a useful analytic lens to bring critical social constructionist theory to CYPMH. The next chapter therefore presents an SLR exploring available DA research into CYPMH which aims to address the identified gaps in extant research and lay the foundation for the subsequent empirical study.

# Chapter 2: Synthesising the Discourses Relevant to Child and Adolescent Mental Health Constructed Through Discourse Analysis Studies: A Systematic Literature Review

## 2.1 Introduction

This section describes the SLR undertaken synthesising DA research in CYPMH. The objectives of this review were:

- To provide an overview of discourses related to child and adolescent mental health specifically arising from DA research
- To explore how have authors methodologically incorporated historical context in DA research on children and adolescent's mental health

Mental health was defined broadly as follows: 'mental health' conceived as either dimensional or categorical pertaining to psychological distress in broad terms as acute or chronic. Wellbeing was included within the definition of mental health. The definition was stretched to include diagnoses such as ADHD and Autism which are debated as to whether they conceptually fit within mental health, disability or neurodiversity (O'Reilly, Karim, & Lester, 2015).

## 2.2 Methods

This review was registered on Prospero on 08/10/2024 (Prospero reference: CRD42024587807).

### *2.2.1 Eligibility*

The following inclusion/exclusion criteria were applied throughout the title/abstract and full text screening process.

Inclusion criteria:

- Studies about the mental health and wellbeing of children and adolescents defined as 0–19-year-old (World Health Organisation, 2025a, 2025b)
- Studies pertaining to a primarily UK context
- English language papers only
- Peer-reviewed journal articles
- Studies must use a form of DA as method. For example: DA, discursive psychology, Foucauldian DA, CDA, conversation analysis (CA), Ethnomethodology, Political Discourse Theory, Semiotic Analysis.
- Data can consist of any data suitable for DA (textual, policy documents, interview, naturalistic etc.) and the study need not sample children/adolescents directly (e.g. via interview) per se.
- Studies which blend DA methods or combine a type of DA with another method (e.g. thematic analysis) will also be included.
- No date parameters were applied to allow for synthesis of a broad range of findings across time

Exclusion criteria:

- Grey literature (newspapers, blogs etc.)
- Studies using quantitative methods only

In cases where papers used CA, CDA and discursive analysis, this highly interactional form of analysis often produced no or very limited commentary of wider interpretive repertoires and discourses around CYPMH (Chourdaki et al., 2023; Yadlin et al.,

2022). Where papers applied methods such as CA and CDA with a clear link to macro discourses around CYPMH I chose to include these papers. Where analysis remained at the level of interaction and commented on a highly specific interaction (for example a therapeutic session, a mode of therapy) with little to no commentary on how this contributed to wider discourses of CYPMH I chose to exclude papers.

The decision to include ADHD and autism was based more on the recognition that discourse is relevant to the institution of 'mental health' and 'psychology' broadly and that I was interested in the construction of mental health in sum rather than specific categories imposed by the psy-complex. What happens 'in the clinic' in terms of power differences, rhetorical devices sheds light on broader claims to truth which transcend post-hoc psychiatric differentiations.

### *2.2.2 Search strategy*

Search terms were initially identified according to three overarching concepts structured by application of the Population Exposure Outcomes (PEO) tool (Grindlay & Karantana, 2018); 'child/young person', 'mental health' and 'discourse analysis'. A search planning tool was used to delineate a set of relevant search terms for each of these concepts (see Appendix B). The following search terms were used: "Child" OR "Kid" OR "Young person" OR "Young*" OR "Youth" OR "adolescen*" OR "Teen*" OR "Boy" OR "Girl" AND "Mental health" OR "Mental disorder" OR "mental illness" OR "mental health difficulty" OR "wellbeing" OR "mental disease" OR "child psychiatry" OR "psychiatrized" OR "psy-complex" OR "therapy" OR "intervention" OR "psychotherapy" OR "diagnos*" AND "Discourse analysis" OR "discursive psychology" OR "Foucaul*" OR "critical discourse analysis" OR "conversation

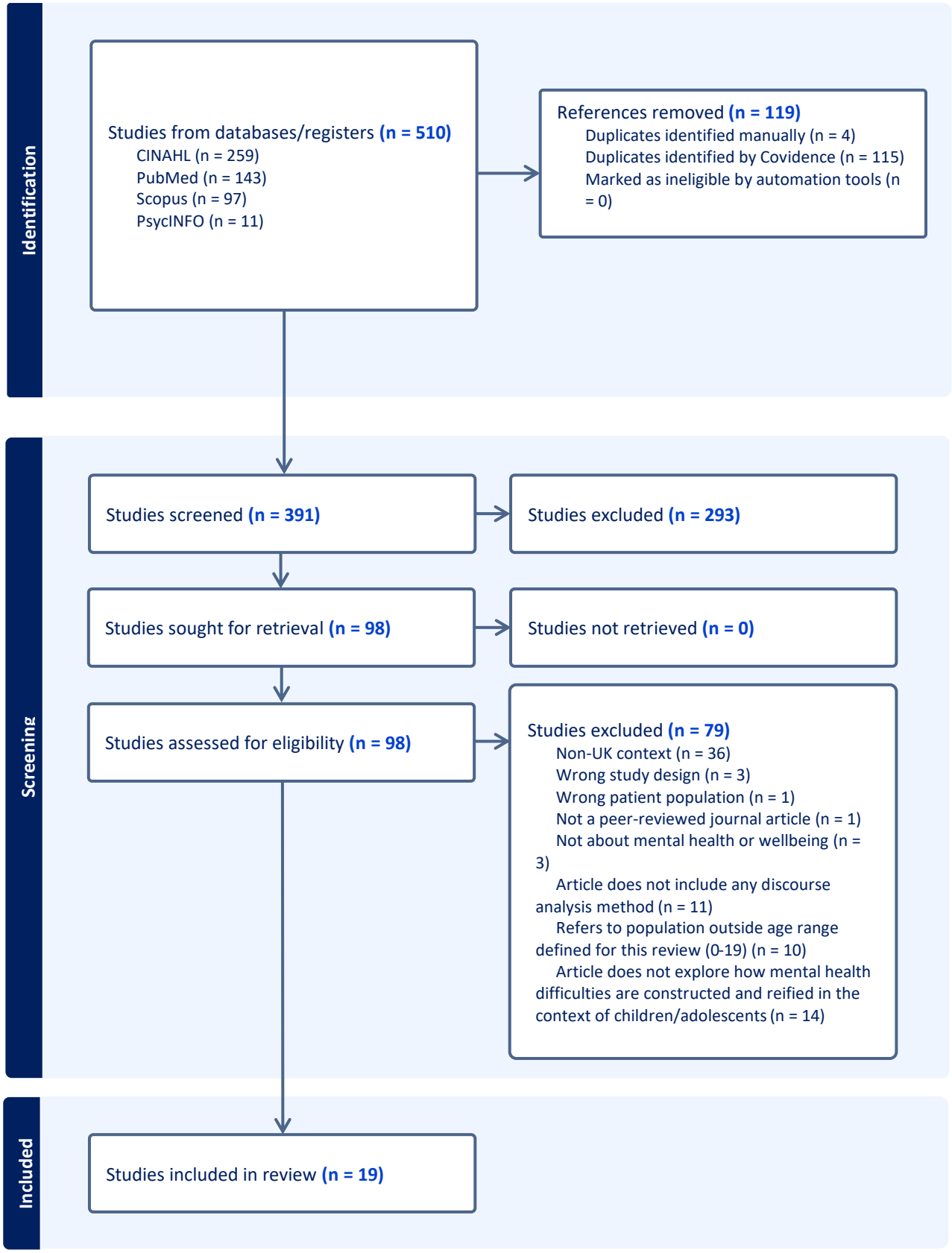
analysis” OR “Ethnomethodology” OR “Political Discourse Theory” OR “Semiotic Analysis”.

The four databases accessed were: Scopus, CINAHL Plus & Medline, PubMed and APA PsycArticles. Filters were used where available to filter out non-English language papers and widen the search results to disciplines other than psychology. Searches of all four databases took place on 08/10/2024. Searches produced 510 studies which were uploaded to Covidence (*Covidence Systematic Review Software*, 2024). 119 duplicates were automatically removed. 391 titles and abstracts were screened by the researcher resulting in 293 excluded. Finally, the researcher read full texts of 98 full articles and excluded 79 studies. A final 19 studies were included in the review. Full details of reasons for exclusion and full breakdown of the procedure are displayed in the PRISMA diagram (Figure 3).

A google scholar alert including the key overarching concept words was set up to reveal any papers published after the initial search, yet none have been at time of writing (June 2025).

Figure 3

*PRISMA flow chart depicting SLR process*



A random 10% sample of the overall article titles and abstract (after deduplication) were screened by the primary researcher and an independent peer trainee clinical psychologist (O'Connor & Joffe, 2020). Cohen's κ found there was substantial agreement between the two coders' judgements, $\kappa = .733$, $p < .001$, 90% agreement. Discrepancies were discussed until full agreement was reached between raters.

### *2.2.3 Quality Assessment*

Tracy's "big tent" criteria (Tracy, 2010) was applied as a quality assessment in this review. The eight big tent criteria is a tool specifically designed to assess quality in qualitative research based on the following elements: worthy topic (relevant, timely, significant and interesting); rich rigour (uses appropriately complex constructs, sample, data collection/analysis); sincerity (study includes self-reflexivity and transparency); credibility (thick descriptions, triangulation, multivocality); resonance (affects the reader through evocative representation, naturalistically transferable findings); significant contribution (conceptually, practically, methodologically); ethical (procedural, relational and situational ethics); meaningful coherence (achieves aims, uses coherent methods and theory) (Tracy, 2010).

SLR guidance suggests that the quality appraisal tool selected depends on the epistemological assumptions of the reviewer and the purpose of the review (Carroll & Booth, 2015). As this review explored DA, a broad and flexible approach capable of evaluating quality in terms outside of realist validity and reliability was required. Compared to other approaches such as the critical appraisal skills programme (CASP) (CASP, 2025), the big tent criteria tool offers a more relevant approach to evaluation in DA. The big tent framework is highly applicable to DA as it views takes a meta

perspective on the construction of knowledge through the qualitative research approach with a critical view – this replicates the epistemological stance of DA in which the production of truth and meaning is the target of study (Arribas-Ayllon & Walkerdine, 2017; Finlay, 2024; Parker, 2013).

Studies were assessed on whether they met each of the eight criteria. As is typical (Hoare et al., 2017; Lewin et al., 2018), studies were categorised into either high, medium or low quality according to the number of criteria they met out of eight (low = 0-3, medium = 4-6, high = 6-8). All papers were deemed high quality aside from Bennett (2007) which was deemed medium quality (Appendix C).

To check reliability, all papers were also independently assessed by a peer researcher with experience in qualitative research methodology. Five out of 152 yes/no decisions on each of the criteria for all 19 papers were different between independent reviewers. Each disagreement was discussed in detail until agreement was reached.

Table 1

*Brief summary of quality assessment across all papers included in SLR*

| Eight big tent category | Summary of quality |
|---|---|
| Worthy topic | All papers were written about a topic that was either timely or significant in some way. DA should question taken-for-granted truths. In this way topics which re-examined the therapeutic setting from a social and linguistic lens offered the potential to surprise (Avdi et al., 2000; O'Reilly, 2007; O'Reilly, Karim, Stafford, et al., 2015). |
| Rich rigour | Variable and complex datasets marked the evidence included in all studies (except Bennett (2007)). Richness of description and explanation were achieved either through data gathered across more than one timepoint (Avdi et al., 2000; McQueen & Henwood, 2002) or varied data collection methods which spanned years (Callaghan et al., 2017; Emery, 2016). |
| Sincerity | 14 papers were deemed to lack sincerity in their research. Most papers were found to lack self-reflexivity, often this meant no exploration of the researchers' contexts and the relationship between self and the research process. Not contextualising oneself often read as an antithesis of intimate discursive and ethnographic methodologies (O'Reilly, 2015a; O'Reilly et al., 2020; O'Reilly, Karim, Stafford, et al., 2015; O'Reilly & Lester, 2016; Stentiford et al., 2023, 2024). One clear exception was Emery's (2016) CDA which sensitively weaved self-reflexivity throughout the research embellishing the findings with an insider perspective. |

| Eight big tent category | Summary of quality |
|---|---|
| Credibility | Almost all studies received a positive rating for their plausibility, trustworthiness and overall credibility. Studies that included multiple forms of data were of particular note for excellent triangulation such as Stentiford et al., (2023, 2024) resulting in greater verisimilitude. Contrastingly, some authors received poor appraisals on credibility mostly due to extrapolating a great deal from highly decontextualised limited data. |
| Resonance | All studies received a positive rating for resonance, meaning that the studies were written with 'aesthetic merit', had the capacity to emotionally affect the reader and reverberate transferable/naturalistically generalisable findings. Where papers exploring policy documents struggled more to present naturally evocative findings, initial discrepancy between independent raters was resolved due to the paper's interpretation (Hardley et al., 2021). |
| Significant contribution | Many articles included in this review made significant contributions to knowledge theory and practice. Bennett (2007)'s empowerment of mothers of children with ADHD oppressed by wider society engendered a sense of catalytic validity by reconceptualising internalised blame associated with the medical model. Moreover, the reworking of social capital afforded by disability within specific contexts in Stentiford et al. (2023) was practically useful in its reframing of a previously taken-for-granted truth about disability. |

| Eight big tent category | Summary of quality |
|---|---|
| Ethical | Several articles received negative ratings on the ethics criterion (Avdi et al., 2000; Bennett, 2007; Callaghan et al., 2017; Emery, 2016; McQueen & Henwood, 2002; Peter, 2021). The primary reason for this was that a high number of articles did not mention whether the study had an ethical approval. In contrast, studies such as Mac An Ghaill & Haywood (2010) and Kristen and colleagues (2024) provided clear evidence of the influence of relational ethics on their approach by considering how to ethically include the voices of young people. |
| Meaningful coherence | Studies which had research aims more closely aligned with the influence of micro language and communication on meaning tended to use conversation analysis, CDA and discursive analysis (Avdi et al., 2000; Denman et al., 2016; Lester et al., 2023; O'Reilly, 2007; O'Reilly, Karim, Stafford, et al., 2015; O'Reilly et al., 2023; O'Reilly & Lester, 2016). These discursive analyses generally did not overstep the assumptions of their method to conceptualise power and discourse in broader which made for more coherent research. |

### *2.2.4 Analysis methods*

Thematic synthesis was applied as a method of synthesising findings. In line with guidance from Thomas & Harden (2008) three stages of thematic synthesis were followed (coding text, developing descriptive themes and generating analytical themes). In stage one, all findings and discussion sections from studies were read

and re-read to increase familiarisation with the data. Then, line-by-line coding was conducted on all findings and discussion sections. Data were annotated with the codes which were recorded onto a large table. Stage two involved organising codes under temporary descriptive themes. Finally, analytical themes were developed based on the interpretations of the researcher with reference to the codes across the dataset. Through synthesis across the dataset, analytical themes grouped the findings which took the analysis 'beyond' the original texts.

**2.3 Findings**

19 papers were included in the final review. Three papers were critical discourse analyses focusing on policy, eight were either discursive or conversational articles of naturalistic clinic data, five were discourse analyses (some Foucauldian, some narrative) of interview data with stakeholders including parents, young people and professionals, the remaining two were ethnographic studies of schools which involved collecting data from policy documents, interviews and other sources.

Seven of the 19 papers featured O'Reilly as main or co-author (Lester et al., 2023; O'Reilly, 2007, 2015; O'Reilly et al., 2015, 2020, 2023; O'Reilly & Lester, 2016). Epistemologically, it is argued that this does not represent a limitation of this review. A key theoretical assumption of DA is that it is never complete; in contrast to research underpinned by realist epistemology, social constructionist DA does not aim to capture an objective, true or complete analysis of the data. Instead, discourse analysts are cognizant of the fact that their analyses are guided by the research question, researcher and context more broadly. In this manner, different researcher teams, research questions, methods of discourse analyses and research foci can

produce different analyses when applied to the same dataset, whilst retaining methodological rigour and quality (Taylor, 2013; Willig, 2008). Consequently, this review understands each paper by O'Reilly to contribute something unique about the landscape of discourse analysis research in this area and upholds the decision to include them. Papers are summarised in the below table:

Table 2

*Summary of all papers included in SLR*

| Author(s) & date | Study Title | Aims | Participants/setting | Type of data | Type of DA | Key findings | Strengths and limitations |
|---|---|---|---|---|---|---|---|
| Avdi, E., Griffin, C. & Brough, S. (2000) | Parents' Constructions of the 'Problem' during Assessment and Diagnosis of their Child for an Autistic Spectrum Disorder | To investigate how available discourses both allow and constrain ways of talking about children who are diagnosed as failing to conform to a 'normal' developmental pathway.<br>To identify key discourses in the parents' talk, and to investigate how these related to one another and how they were used in constructions of the 'problem'. | Three sets of parents who were undergoing assessment of their sons for 'communication difficulties' at a child development centre in the West Midlands. | Eleven semi-structured interviews | Discourse analysis informed by post-structuralism | A discourse of normal development invoking developmental psychology, healthcare and education to construct an image of a genderless, cultureless perfectly normal child is deployed. Development is linked to competence of parents. Medical discourses around 'autism' constructed it as a terrifying mental problem, relating to cultural representations of madness, medicine, diagnosis. Diagnosis represented a ticket to services, the child as an object of monitoring and scrutiny, and generated a plethora of rules about 'how life should be'. Diagnosis used to externalise to resolve guilt and internalise problem within child. Medicine framed the parent–child relationship in terms of teaching or curing.<br>Discourse of disability: deviance and differentness - otherness. Needing people to 'pass' for normal. | Strengths: discourse analysis was found to provide a useful approach to examining the complex and multiple meanings that parents employ around the diagnosis of their child.<br><br>Limitations: Authors cite common criticism of constructionist analyses around over-interpretation of talk. In response, authors acknowledge the influence of their interpretation with reference to their positions and the aims of the research. |

| Author(s) & date | Study Title | Aims | Participants/setting | Type of data | Type of DA | Key findings | Strengths and limitations |
|---|---|---|---|---|---|---|---|
| Bennett, J. (2007) | (Dis)ordering Motherhood: Mothering a Child with Attention-Deficit/ Hyperactivity Disorder | To explore the extent to which medical knowledge discourses featured in the accounts of mothers of ADHD children. | Six mothers aged between 35 and 45. Participants were all white and British. Recruited via a local paper in the south of England to take part in the study | Two interviews conducted in one year. The first interview explored participants' experiences of raising a child with ADHD and the second interview explored emerging themes. | Foucauldian discourse analysis and discursive psychology | Researcher explores how a medical discourse allows resistance to bad mother narratives. Also explores the 'mother blame' discourse's interaction with biology, medicine and other discourses. Blame remains even against all of these other discourses. There were variations in the application of mother blaming. Researcher explored how socially constructed knowledge can control behaviour and regulate thoughts and feelings from within for these mothers. | Strength: Researcher provided rich descriptions of their positionality and the power relations extant within the researcher-participant relationship. Explored hermeneutic effects of their aims in the research with reference to bracketing.<br><br>Limitations: None listed |

| Author(s) & date | Study Title | Aims | Participants/setting | Type of data | Type of DA | Key findings | Strengths and limitations |
|---|---|---|---|---|---|---|---|
| Callaghan, J., Chiara Fellin, L., & Warner-Gale, F. (2016) | A critical analysis of Child and Adolescent Mental Health Services policy in England | To critically explore changes in discursive construction of children and young people, of mental health and of CAMHS in policy documents. | Textual: UK Child and Adolescent Mental Health Services policy documents (15 policy documents, 9 pre-2010, and 6 post 2010) | Textual: UK Child and Adolescent Mental Health Services policy documents (15 policy documents, 9 pre-2010, and 6 post 2010) | Corpus analysis and critical discourse analysis | Great contrast in framing of psychological distress as a biomedical illness post-2010 and linked to social context pre-2010. Pre-2010s policy documents invoked discourse around the universality of CYP mental health being 'everybody's business' in community. Post 2010s policy shifts to reducing crises to prevent ongoing drags on the economy into adulthood. CYPMHD are no longer framed as a product of socio-economic difficulties but as a socio-economic burden. Over time towards post 2010 policies discourse of 'troubled families causing CYPMHD' is found. Parenting skills deployed as means to fix this. | None listed |

| Author(s) & date | Study Title | Aims | Participants/setting | Type of data | Type of DA | Key findings | Strengths and limitations |
|---|---|---|---|---|---|---|---|
| Denman, K., Smart, C., Dallos, R., & Levett, P. (2016) | How Families Make Sense of Their Child's Behaviour When on an Autism Assessment and Diagnosis Waiting List | To understand difficulties families experience in sense making through accounts of the behaviour of a child waiting for an autism assessment. | Five families took part. All families described their ethnicity as White British. Participants were recruited from a UK autism assessment team waiting list, commissioned to assess children between the ages of 6 and 18. | Each family participated in one family interview. Interview questions encouraged families to discuss how they understood the behaviour of their young member who was waiting for an autism diagnosis, to provide conversational material. | Discursive psychology and conversation analysis | Four different forms of trouble sources identified within the study: interruptions by the focal child, problematizing behaviour, disagreements, and not using the word autism. Face saving is discussed as managing positive identities and ensuring all members of family could take part in discussion. Researchers explore how not having a diagnosis meant people searched for it and worked together as a family. | Limitations: Researchers state that the sample is 'small' and heterogenous and report that this casts doubt on generalisability of findings. Researchers further discuss challenges of completing interviews quickly may have affected richness of discussions. Also discussed overrepresentation of White British families in research and referrals for autism.<br><br>Strengths: none listed |

| Author(s) & date | Study Title | Aims | Participants/setting | Type of data | Type of DA | Key findings | Strengths and limitations |
|---|---|---|---|---|---|---|---|
| Emery, C. (2016) | A Critical Discourse Analysis of the New Labour Discourse of Social and Emotional Learning (SEL) Across Schools in England and Wales: Conversations With Policymakers | The study was driven by three research questions: how was the development of SEL policy in England and Wales framed by New Labour? What was the experience of policymakers who sought to develop and deliver SEL policy in England and Wales and how did national tradition, history and identity (including versions of childhood wellbeing) influence the discourse and policy of Welsh and English SEL under New Labour? | Policy makers in England & Wales recruited according to following criteria: 1) Had been a senior national level policy actor/leader of a policy network that was instrumental to the SEL discourse in England or Wales during the New Labour period 1997-2010. 2) Researcher had either a previous working relationship with them or they were aware of researcher's work in England and Wales and could be contacted through networked relationships | Eight interviews lasting two hours each | Critical discourse analysis through Fairclough's Three Dimensional Model (1992) | Stark differences between England and Wales in terms of foregrounding social justice, unity and collaboration in Wales and deficit normalisation model in England policy makers. Post 2008 policies introducing outcome measurement showed mix of neoliberal thought and unity. Overall policy is done through discourse driven ideas of social change. The discursive practice of neoliberal, self-managing, entrepreneur in England, and social democratic, collaborative, citizenship in Wales, intimately entwined language, knowledge and power, in the service of the dominant state actors. | Limitations: Researcher acknowledges potential negative impact of ambitious theoretical model within time constraints. Strengths: Including the three dimensional approach and particularly the detailed analytical procedure presents a level of analytical depth and reflexivity sometimes absent (or unreported) in previous CDA studies |

| Author(s) & date | Study Title | Aims | Participants/setting | Type of data | Type of DA | Key findings | Strengths and limitations |
|---|---|---|---|---|---|---|---|
| Hardley, S., Gray, S. & McQuillan, R. (2020) | A critical discourse analysis of Curriculum for Excellence implementation in four Scottish secondary school case studies | To understand how health and wellbeing policy discourse was interpreted and enacted at the local level, and what effects this might have had on the actions of school staff and teachers. | Four secondary schools serving students aged 12–18 in different Local Authorities in Scotland. Two schools from areas with high levels of deprivation. The other two are from areas with low levels of deprivation. | Four secondary school case studies produced by an external consulting firm at the behest of Education Scotland (ES), the national body in Scotland for supporting quality and improvement in learning/teaching | Critical discourse analysis underpinned by Foucauldian-inspired theoretical framework (adapted from Willig, 2008) | Construction 1: health and wellbeing as teaching for outcome achievement:<br>Pedagogic outcomes approach to 'teaching' health and wellbeing.<br>Doing care to children as per the imbalance of power between children and teachers; an example of this was schools paying for training workshops when self-harm occurs<br>Technologies of power:<br>'monitoring' and 'identifying' (surveillance) those students 'vulnerable' or 'at risk' (classification) for decreased health and wellbeing (normalisation) in order to 'tackle the situation' and 'improve outcomes' (regulation) i.e. co-opting outcomes in health and wellbeing for success of school<br>Construction 2: health and wellbeing as a process for character development:<br>Some balance of responsibility between children and adults<br>Exception of deprived areas where children 'at risk' receive more intervention and exclusion from participatory forms of learning relationships. | Limitations: Relied upon pre-produced case studies which limited the study authors' ability to solicit further clarification from school participants.<br><br>Strengths:<br>None listed |

| Author(s) & date | Study Title | Aims | Participants/setting | Type of data | Type of DA | Key findings | Strengths and limitations |
|---|---|---|---|---|---|---|---|
| Kristen, A., Lecchi, T., Loades, M. & Midgley, N. (2024) | "I can't escape my scars, even if I do get better": A qualitative exploration of how adolescents talk about their self-harm and self-harm scars during cognitive behavioural therapy for depression. | To explore the sociocultural discourses that adolescents draw on in talk about their self-harm (SH) and how various descriptions of self-harm scars might be situated within such discourses during CBT sessions | Six participants female (aged 14-17) who mentioned self-harm during participation in wider CBT IMPACT trial. | Transcribed extracts from 2-10 audio recorded sessions mentioning recorded for each participant. | Synthesized versions of Discursive Psychology and Foucauldian Discourse Analysis, particularly the approach outlined by Willig (2008). | Stigma discourse working its way into ways SH spoken about; moral deficit. Public ideas about self-harm equated with weakness/moral failings. Western ideals of undamaged being akin to beauty or perfection. Attention seeking discourses brought into the speech of clients in how they mark responsibility in their self-harm behaviours. The 'why try' effect - when they are 'bad' and aware of this public perception; this becomes internalised | Limitations: Small sample, and limited demographic range. The study did not consider the ways therapists talk and introduction of discourses which may have influenced adolescent talk Study was a secondary analysis, and data was limited due to session focus on depression<br><br>Strengths: The analysis of therapy sessions permitted the study of naturally occurring talk mitigating some of the social desirability bias that an interview setting might evoke. |

| Author(s) & date | Study Title | Aims | Participants/setting | Type of data | Type of DA | Key findings | Strengths and limitations |
|---|---|---|---|---|---|---|---|
| Mac an Ghaill, M. & Haywood, C. (2010) | Understanding boys': Thinking through boys, masculinity and suicide | To explore boys' understandings and experiences of schooling in Northeast England, examining relationships between pupils and teachers, pupils and pupils and the wider schooling environment. This study was part of a broader intellectual project exploring the formation and practice of masculinities with boys, adolescents and older men. | Middle school in Northeast of England providing education for over 400 pupils aged between nine and 13 with a catchment area of pupils from a diversity of social and economic backgrounds. | Semi-structured interviews with 28 children in the class (12 male and 16 female). Further four interviews with boys and three interviews with girls were undertaken by student request. A further eight male and eight female focus groups were carried out. The interviews and focus groups lasted from 20 min to an hour. Twelve members of staff, primarily those who were their subject and form tutors, were also interviewed. | Discourse analysis | Institutional anxiety production - the school itself gendered the behaviour of the children as opposed to the individual subjectivities. In connection to broader changes in schooling, modern schools create self-disciplining students (panopticon) rather than external power. Maturity was an important factor in this school. Adult maturity code and a femininity code connected discourses. Boys' identities were seen by researchers as controlled and regulated. Sexualities in school controlled to be heterosexual which creates discomfort in homosexual students. Intimacy and emotionality not an individualised psychological dynamic but a contextual institutional dynamic. Friendship seen as a protective factor against suicide but how friendship is gendered seldom considered. | None listed |

| Author(s) & date | Study Title | Aims | Participants/setting | Type of data | Type of DA | Key findings | Strengths and limitations |
|---|---|---|---|---|---|---|---|
| McQueen a, C. & Henwood, K. (2002) | Young men in 'crisis': attending to the language of teenage boys' distress. | To explore how two young men who have experienced mental health difficulties view themselves and their experience, and which cultural concepts they use to describe their experiences. | Part of wider study sampling five boys. Their ages ranged from 14 to 17 years. All attended an adolescent unit in Wales. The unit was part of the tertiary mental health services for the region which received referrals from young men and women with mental health or behaviour problems. Of these five only two boys were focused on for this current study. | Two interviews with each participant (n=2). In the second interview the researcher showed the participant the transcript and explored identified gaps and contradictions. | Narrative analysis followed by thematic analysis and discourse analysis | Discourse of passivity connected to speech of participant meaning he has lost intention and agency. Identifying aggression, control and power within wider masculine identity. Indifference towards this potentially challenges the legitimacy of aggressive male dominance. Intersection of aggression and class specific discourses. Drawing on normalisation-pathologisation discourses with desire to live and be normal. Male as stability and toughness. Contradictions within subject positions internally mean that participants are young men struggling to find a place in available social and cultural context.<br>Naughty used to justify behaviour in relation to weak authority. Aggression and identification with male aggressor seen as problematic so managed carefully. | Limitations:<br>none listed<br><br>Strengths:<br>A strength of the analyses is the sensitivity to cultural context, life-histories and language. Researchers consider strength of applicability to therapeutic settings with reference to language and discourse. |

| Author(s) & date | Study Title | Aims | Participants/setting | Type of data | Type of DA | Key findings | Strengths and limitations |
|---|---|---|---|---|---|---|---|
| O'Reilly, M. (2007) | Who's a naughty boy then? Accountability, family therapy, and the "naughty" child | To examine the issue of how parents label their child as naughty as a way of managing their accountability as good parents. | A family therapy service that specializes in families who have children with specific disorders and special needs. | Twenty-two hours of recorded therapy session data for this article come from four available families. A small number of examples for each point were randomly selected for inclusion in final analysis. | Discursive psychology | Naughty child discourses (dispositional and within/fundamental aspect of the child) and naughty behaviour discourses (not part of the child, external consequence - separate from child to manage accountability and possibility of change) both deployed by participants.<br>Categorising a child as a naughty child is done by associating them with existing identified types and examples. Various ideas about the cause of naughtiness cited by family- when constructed as a disorder it is deemed more serious. Capacity for change achieved by defining behaviour as naughty rather than child. | Limitations: none listed<br><br>Strengths: Researchers suggest that the article provides evidence that discursive psychology is useful for unpacking labels, categories, and concepts that are frequently applied to children in modern society. |

| Author(s) & date | Study Title | Aims | Participants/setting | Type of data | Type of DA | Key findings | Strengths and limitations |
|---|---|---|---|---|---|---|---|
| O'Reilly, M. (2015) | 'We're here to get you sorted': parental perceptions of the purpose, progression and outcomes of family therapy | To investigate language employed in family therapy sessions to understand families in therapy and their expectations. The focus for analysis is how families construct their reasons for attending therapy, how they construct their problems, what outcomes they feel are important and how progress is considered. | Data were provided by a family therapy centre in the UK. Four families with the pseudonyms of Clamp, Bremner, Niles and Webber (demographics above). All the families represented were White British, from the Midlands of England, and had low socioeconomic indices. | Transcribed videotapes of therapy sessions from four families, totalling approximately 22 hours of therapy. | Discourse analytic (DA) approach advocated by Edwards and Potter (1992) influenced by conversation analysis | Common for parents to locate problem in child - child likely to accept this. Goals around improving the child as a whole or helping whole family to be more positive (congruent with family therapy). Blaming children may inhibit progress in therapy – children view themselves as problematic. Commentary on relationship with family therapy goals and outcome measurement in services - difficult to quantify and both incongruent and congruent with family therapy in different ways. | Limitations: Reported that DA is not a hard science and therefore analytic claims offer insight rather than objective facts. Researchers mention that the analysis does not measure actual outcomes or levels of progression. Also discuss small sample size in terms of transferability to other therapy settings.<br><br>Strengths: Applications of DA to therapy explore the micro-processes of power and discourse. |

| Author(s) & date | Study Title | Aims | Participants/setting | Type of data | Type of DA | Key findings | Strengths and limitations |
|---|---|---|---|---|---|---|---|
| O'Reilly, M. & Lester, J. (2016) | Building a case for good parenting in a family therapy systemic environment: resisting blame and accounting for children's behaviour | To demonstrate some of the ways in which parents display their 'good parenting' in a systemic therapy environment and explores how blame is managed. | Data were provided by two CAMHS systemic family therapists and four families with the pseudonyms of Clamp, Bremner, Niles and Webber (demographics above). All the families represented were White British, from the Midlands of England, and had low socioeconomic indices. | Transcriptions of video/audio recorded family therapy sessions. These therapeutic interactions totalled approximately 22 hours of therapy. Several sessions from each family obtained, which always included their first session. | Conversation analysis and discursive psychology | Strategy one: Directly claiming to be a good parent: parents taking responsibility for moral behaviour of children, parents try to persuade therapists they are good parents<br>Strategy two: acting in the child's best interests: self-sacrifice as an example of parents showing they are doing what's best for child, putting child's needs ahead of their own.<br>Strategy three: coping with the child's behaviour in appropriate ways. Using contrasting bad parenting to show how culturally appropriate their own parenting was.<br>Strategy four: appeals to science: pointing to something outside of their parenting to minimise their responsibility - using biology for this.<br>Family therapists try to reconceptualise problem in systemic terms shifting focus from individual to collective. | Limitations:<br>Researchers report they drew upon only the basic principles of the CA methodology rather than developing a full sequential analysis associated with the approach<br><br>Strengths:<br>CA evidence is tangible, empirical, and a justifiable form of outcomes evidence that is useful for the examination of therapeutic process and change<br>Reported potential negative hermeneutic impact of the positionality of researchers. |

| Author(s) & date | Study Title | Aims | Participants/setting | Type of data | Type of DA | Key findings | Strengths and limitations |
|---|---|---|---|---|---|---|---|
| O'Reilly, M., Muskett, T., Karim, K. & Lester, J. (2020) | Parents' constructions of normality and pathology in child mental health assessments. | To demonstrate how parents/carers draw on notions of 'normality' and 'abnormality' in the child mental health assessment. | Data were collected through a CAMH Service (UK) and focused on initial assessment meetings in the generic outpatient setting. 28 families participated. All families were referred by the General Practitioner. Referred children attended with one/both parents (27 with mothers and 8 with fathers – one was father only). The children were 64% boys and 36% girls. | Transcriptions of recorded initial assessment meetings | Discursive psychology informed by the Discursive Action Model | Parents used contrast structures to create 'abnormal' within child compared to those performing social rules. Achieved through evidencing 'objectivity'. Creating identity within category on abnormal can lead to less accountability put on parents or child. Normality begins as a myth and becomes medicalised through talk. Contrasts within the child's life through historically 'normal' behaviour. Both parents and professionals drew on medicalised /normative notions of childhood and development. Parents uphold critiques of diagnosis which claim diagnosis is undermined by presence or absence of symptoms. CAMHS setting fraught with danger for parents' identity: Ever-present is the possibility they will be constructed as 'over-anxious parent'. Parents have to balance needing the professional to make the diagnosis and the possibility that they will blame the parents for the cause. | Limitations: Researchers reflect on limited sample in terms of size and gender diversity leading to potential lack of transferability.<br><br>Strengths: Professionals represented a range of disciplines and training backgrounds and all 29 working in that team did participate the data corpus does represent a close-to typical intake in terms of age and problem presentation. |

| Author(s) & date | Study Title | Aims | Participants/setting | Type of data | Type of DA | Key findings | Strengths and limitations |
|---|---|---|---|---|---|---|---|
| O'Reilly, M., Kiyimba, N., Lee, V. & Hutchby, I. (2023) | Give My Child a Label: Strategies of Epistemic Corroboration in Case-Building within Child Mental Health Assessments | To use conversation analysis to examine techniques by which family members seek to introduce externally sourced information into their narratives of concern over a child's behaviour or development. | 28 families were included. The demographic profile of the children was 64% boys (N=18) and 36% girls (N=10) aged from six to 17 years. | Data corpus of initial assessment meetings recorded as part of the routine work of a child and adolescent mental health clinic in a large UK city. Each assessment lasted approximately 90 minutes. | Conversation analysis | Tends to be parents who describe problem even when children are asked to describe the problem. Parents invoked the opinions of others who know the person well to undermine previous assessments. Parent constructs third party expert status to build case for other people's contrasting diagnosis. Parents work hard discursively to establish need for mental health diagnosis. Not only explanatory but also acts as gateway for accessing other resources. Practitioners are cast as gatekeepers. Parents are cast in role of 'convincers'. No parental discursive references to stigma. Power differentials mean that parents lean into expertise of others to tip power in their direction and use medicalisation expertise for this. Epistemic privilege associated with medicine and medical terminology. | Limitations: None listed<br><br>Strengths: Advantages of using naturally occurring data of actual mental health assessments is that it is possible to identify the social actions that occur within diagnostic negotiation. Conversation analysis provides a powerful analytic tool to examine language as a vehicle for the management of power dynamics between lay persons and medical professionals. |

| Author(s) & date | Study Title | Aims | Participants/setting | Type of data | Type of DA | Key findings | Strengths and limitations |
|---|---|---|---|---|---|---|---|
| Peter, S. (2021) | An (un)happy marriage: child psychotherapy with children who are medicated for ADHD | To gain further empirical understanding of how child psychotherapists work with children who are medicated for ADHD. To unpack what this minimal description does and how it works in this institutional setting. | Six psychoanalytic child psychotherapists were interviewed | Semi-structured interviews | Initial thematic analysis followed by discursive psychology approach and Foucauldian discourse analysis | ADHD as a biomedical explanation afforded a lot of power. Due to its legitimising power, a well-functioning partnership between psychotherapy and medication is treated as desirable, while expression of critical views towards medical approach is treated as sensitive or problematic.<br>Dilemma is navigated by interpretative repertoires named with marriage metaphor: (1) Marriage of convenience: there is a need for psychotherapy to be compatible with medication to lend it status and authority/legitimacy. (2) Separate lives: conveys an open-mindedness but disclaiming possible attributions of automatic or unconsidered rejection of the medical intervention. Speakers as agnostic about mediation. Not directly criticising despite serious reservations. (3) For the sake of the children. Medication is positioned as desperate and last resort response which is potentially harmful. | Limitations:<br>The participants in this study were a self-selecting, all female group with an interest in child psychotherapy and ADHD.<br>Researchers discussed potential limitation of the children featured in this study were of a specific background which may make findings difficult to generalise.<br><br>Strengths:<br>none listed |

| Author(s) & date | Study Title | Aims | Participants/setting | Type of data | Type of DA | Key findings | Strengths and limitations |
|---|---|---|---|---|---|---|---|
| Stentiford, L., Koutsouris, G. & Allan, A. (2023) | 'They think it's trendy to have a disability/mental illness': disability, capital and desire in elite education | To investigate: students' understandings of disability, and how they experience this; the normative expectations of students in this educational context (college); how these are negotiated and/or challenged by young people with disabilities | This paper is based on data collected in an ethnographic study conducted in one sixth-form college in England. Studied site is selective and students must undertake entrance exams and an interview before an offer of a place is made. It is a state-funded institution. | Data collection was undertaken by the three authors with various methods. Researchers visited the college multiple times and met with senior leadership. Researchers examined policies. Researchers conducted sixteen semi-structured interviews with students and six interviews with staff. Also completed participant observation in classrooms and social spaces over a term. | Reflexive thematic and discursive analysis | Disability as an identity marker in this school represented prestige in contrast to previous stigmatising attitudes. This is linked by authors to wider patterns in specific strata of middle class as more accepting of disability.<br>Students reworked disability as a form of social capital. Not feigned as some nod to the disadvantages of disability.<br>Family and wider discourses of disability and mental health still negatively affected pupils' experiences in relation to disability/mental health<br>There is still a subcategory of non-visible impairments (mental health, neurodiversity) as being superior to physical impairment. This non-visible type still fits within normalcy within education institution. | None listed |

| Author(s) & date | Study Title | Aims | Participants/setting | Type of data | Type of DA | Key findings | Strengths and limitations |
|---|---|---|---|---|---|---|---|
| Stentiford, L., Koutsouris, G., Nash, T. & Allan, A. (2024) | Mental health and gender discourses in school: "Emotional" girls and boys "at risk" | To critically interrogate the discourses espoused by students and staff members during semi-structured interviews, focusing specifically on their responses to the following question: "Do you think that girls and boys experience mental health in the same way?" | Purposively recruited two South England secondary schools: a mixed grammar school in a White, middle-class rural catchment (n=22) and a mixed comprehensive school in a White, working-class urban catchment (n=12). Participants aged between 12 and 17 years. 29 = White-British or British-European heritage, four = British-Asian heritage, one = British-African heritage. 17 female students, 12 male. Five students non-binary, gender fluid or something other than their "birth gender" students. Mix of SEND support. 19 self-identified as experiencing, or having previously experienced some form of mental health difficulty. | Individual semi-structured interviews with staff and students at both school sites | Foucauldian discursive analysis | Some people reported that gender does not make a difference, and girls and boys will both experience mental health difficulties because of internal and external reasons. Sentiment that "girls are open about their emotions, but boys will hide them" abounded. Clear links with how mental health is gendered in women to subjugate through medicine. Male strength and mental toughness meant that boys still felt mental health problems should not be spoken about by them. A double bind was located in the boys' opinion that girls (as ideal neoliberal healthism subjects) hoard access to mental health support which they feel they are entitled to. | None listed |

| Author(s) & date | Study Title | Aims | Participants/setting | Type of data | Type of DA | Key findings | Strengths and limitations |
|---|---|---|---|---|---|---|---|
| Lester, J., O'Reilly, M., Smoliak, O., Muntigl, P. & Tseliou, E. (2023) | Soliciting children's views on other-perspectives in child mental health assessments. | To investigate how child mental health assessments are conducted in specialist services focused on circular questions directed at the child participants. | 28 families whose child was assessed to determine mental health needs and treatment possibilities. The YP ranged in age from 6 - 17 and were 36% female and 64% male. Children and their family members participated in an assessment, referred to one specific community-based Child and Adolescent Mental Health Service in England | Transcriptions of 37.5 hours of interactional video/audio data from child mental health initial assessments | Conversation analysis | Circular questions (CQs) appear to mitigate upcoming questions about having a problem. CQs are deployed to gather diagnostic information that reveals the child's insight into their behaviour, and whether they view it as problematic. CQs used to manage resistance and check understanding by perspective taking. CQs have a role in 'doing diagnosis' practitioner is oriented to determining a diagnosis. CQs are therefore about child's awareness of their problem. Receiving a diagnosis can be seen as threatening – CQs help to manage how threatening the question of 'why are you here' is. | Limitations:<br>Sample were of variable backgrounds.<br>Also reported that method prevented them from exploring other question types beyond circular questions. Also reflected on the impact of video recording sessions as potentially impacting interactions during the sessions.<br><br>Strengths:<br>none listed |
| O'Reilly, M., Karim, K., Stafford, V. & Hutchby, I (2015) | Identifying the interactional processes in the first assessments in child mental health. | To contribute to the limited literature on initial child mental health assessments by exploring the process in practice through conversation analysis. | Recruited the 28 families, attending their first child mental health assessment appointment at a CAMHS in the UK. The 28 children consisted of 64% males and 36% females, with a mean age of 11 years old ranging from six to 17. | Triage appointments of 1.30 hrs were video recorded for their. Families were seen by a minimum of two professionals (except one family) of a range of different professionals. | Conversation analysis | Adults acted as primary historians children have limited role in the assessment. Overall rejection or acceptance of possible ideas tended to be subtle and performed over time. Family relationships explored often alone, then school life explored. Less formal approach taken overall - perhaps in line with more child friendly practices. | Limitations:<br>None listed<br><br>Strengths:<br>In qualitative terms, the data corpus is substantial and there were certain themes that were consistent. |

### *2.3.1 Histories*

In line with objective two, papers were re-read with the purpose of understanding how authors incorporated historical context, archaeology, genealogy and other methods sensitive to situating discourse and power in time (Arribas-Ayllon & Walkerdine, 2017; Foucault, 1998; Kendall & Wickham, 1999; Visker & Visker, 1995). This objective was informed by my intention to include Foucault's methodological treatment of history within my own empirical research and therefore generate a better understanding of how this is managed in the papers highlighted by this review as relevant to the topic of CYPMH.

Not all papers included in this review centred history, archaeology or genealogy and were therefore not read with this objective in mind. The papers which meaningfully incorporated these concepts into their analysis are summarised below:

Table 3

*Extraction and brief analysis of the methods by which history, archaeology and genealogy are incorporated into DA in the relevant papers from this review.*

| Author(s) | Study Title | History |
|---|---|---|
| Bennett, J. (2007) | (Dis)ordering Motherhood: Mothering a Child with Attention-Deficit/ Hyperactivity Disorder | Author includes formal Foucauldian methods of archaeology and genealogy of ADHD. This sets a theoretical standpoint for the article which acknowledges concepts such as ADHD as being conceived in contexts of contingencies and multiple competing forces of power. Author begins with a brief general archaeology of ADHD then specifically explores genealogy of ADHD and mothering which occurs more organically throughout the study write up. This approach supports the researcher to embed the discourses held in data within networks of relations (manoeuvres, tactics, techniques and functionings). The researcher applies Foucault's theories with reference to genealogy to analyse excerpts from interviews; this helps to explain the specific networks of relations identified in each quotation. |

| Author(s) | Study Title | History |
|---|---|---|
| Callaghan, J., Chiara Fellin, L., & Warner-Gale, F. (2016) | A critical analysis of Child and Adolescent Mental Health Services policy in England | Setting the scene with a short history of what was happening in policy and generally in the UK at the time the analysis is interested in. This is not a formal genealogy per se and is rooted in a more realist telling of what was happening at this time, compared with more explicitly genealogical approaches, this approach is more distant from a Foucauldian treatment of history. Though it allows for a critical approach and has a point of view, it is perhaps more challenging to analyse taken-for-granted truths within datasets because they are set against a background of history presented as an objective and set collection of things that have happened before. |
| Emery, C. (2016) | A Critical Discourse Analysis of the New Labour Discourse of Social and Emotional Learning (SEL) Across Schools in England and Wales: Conversations With Policymakers | Tracking the course of SEL, English and Welsh policies through time is part of the critical discourse analysis method in this study. This method allows the researcher to elucidate the competing forces and moves within which new understandings emerge. Focusing on these times points allowed for a useful story of how discourse shapes and reifies zeitgeists of CYPMH. Also, how institutions (government and schools) can act as sites of normalisation, reifying dominant conceptualisations of CYPMH. This highlights transitions within macro discourses as a useful point of analysis. However, in moving through time chronologically, it can be argued that this method is not in keeping with Foucault's methods of exploring time's interplay with truth (Kendall & Wickham, 1999). |

| Author(s) | Study Title | History |
|---|---|---|
| Mac an Ghaill, M. & Haywood, C. (2010) | Understanding boys': Thinking through boys, masculinity and suicide | Researchers here used macro ideas to situate excerpts from interviews within historical contexts, in line with a discourse analysis approach. This problematises the basic concept that there is a 'right' way to educate. This also highlights that naturalised ideas have historical bases punctuated by power dynamics in society. However, this was closer to a standard discourse analysis in practice as opposed to an explicit inclusion of a genealogy, archaeology or other application of time and/or history. |
| McQueena, C. & Henwood, K. (2010) | Young men in 'crisis': attending to the language of teenage boys' distress. | In the introduction, authors explore changes to the political and social landscape over time to offer a sociological formulation of a current issue. This can then be embellished by the empirical study's findings and offers a useful point of comparison and broader context. As stated for previous papers, this does allow for some contextualisation but still represents meaning through the passage of time as irrefutable and is less sensitive to the contingencies and dialectics that form dominance and hegemony. |
| Stentiford, L., Koutsouris, G. & Allan, A. (2023) | 'They think it's trendy to have a disability/mental illness': disability, capital and desire in elite education | This paper begins with the exploration of discourses around disability in different time points, cultures and situated against different power relations and socio-political landscapes. In this manner, the smaller site for analysis in the research is clearly recognisable within the larger historical and cultural context provided by the authors. In this manner, the analysis is truly embellished and problematised usefully. Though this is predominantly an introduction and is less coherently included throughout. |

| Author(s) | Study Title | History |
|---|---|---|
| Stentiford, L., Koutsouris, G., Nash, T. & Allan, A. (2024) | Mental health and gender discourses in school: “Emotional” girls and boys “at risk” | Including a very brief outline of historical perspectives of academic work on health and wellbeing as something that initially feels too broad but in reality shapes how the reader comes to the topic as more open. Understanding that these conceptualisations have a story underneath them shaped by power relations within institutional knowledges opens the reader to potentially controversial and new understandings of current practice. Meaningful explanations for current discourses by looking back through history of psychology/psychiatry e.g. why does gender play a role in conceptualising CYPMH? This approach is valued in the context of a relatively broad discourse such as gender. |

It was apparent from these papers that a standard re-telling of history as a collection of facts moving forward was often the method of choice by authors to contextualise their DA in time. Papers such as: Callaghan et al. (2017); McQueen & Henwood (2002) & Stentiford et al. (2024) were examples of this; the authors commonly used introductory sections to tell the story of how a concept such as 'health and wellbeing' has been typically applied until contemporary time. This approach is beneficial and goes some way to generating a critical awareness in the reader that ideas such as CYPMH categories and definitions have historical bases. However, by not paying close attention to the dialectics and 'networks of relationships' these introductions often worked against the authors' intentions by solidifying a set sequence of events leading up to the moment of analysis which felt immovable and not open to reinterpretation.

In contrast, where researchers paid more explicit attention to the interplay of culture, macro discourses and contingencies, a more Foucauldian and CDA often followed which felt richer and less embedded in positivism or moral judgement from a single standpoint. Bennett's (2007) DA benefitted from this approach, she organically weaved ideas of genealogy and archaeology throughout this paper at various points. This alternative approach to DA may make more room for the inclusion of history than introductory 'setting the scene' sections. As another example, Stentiford and colleagues' (2023) exploration of discourses of disability highlight how working against the flow of time - as suggested by Foucault (Kendall & Wickham, 1999; Visker & Visker, 1995) - can create a clearer standpoint that the social construction of concepts such as CYPMH is not a straight line from

'unknowable' to 'known'. This means tracking problems through time (in the classic genealogical sense) (Kendall & Wickham, 1999; Visker & Visker, 1995) without specifying a period of history and being more interested in this concept's context and relationship to discourse (Kendall & Wickham, 1999). Based on the excellent examples extracted from the current SLR, combined with guidance such as Kendall & Wickham (1999) some highly applicable notes on including history have been gleaned and are presented here:

- DA aiming to meaningfully incorporate Foucauldian conceptualisations of history, archaeology and genealogy need not focus on presenting a full picture of historical context
- Those using FDA and DA methods should seek to fluidly weave genealogical interpretations throughout a paper whilst paying close explicit attention to contingencies rather than causes and at all costs resist a realist 'setting of the scene'.

### *2.3.2 Synthesis of Key Findings*

The following themes were developed to group and synthesise findings across all papers under objective one:

- Construction of CYPMHD as an individualistic, internalised phenomenon caused by parents
- Biomedical positivistic models of CYPMH are assumed and oppressive
- Shifts in CYPMH frameworks across time: oscillating between social and biomedical

- Medical frames for CYPMHD support strict ab/normality binaries driven by wider systemic neoliberal pressures
- Marginalised identities recursively interact with production of CYPMH

### *2.3.3 Construction of CYPMHD as an individualistic, internalised phenomenon caused by parents*

This theme explored the degree to which processes of assessment, treatment and wider discourse of CYPMH reified psychological problems as existing inside young people. This also explored how CYP attending a CYPMHS were characterised as 'the problem' (Avdi et al., 2000; Lester et al., 2023; O'Reilly, 2007, 2015). This individualistic conceptualisation of CYPMHD was often presented in papers such as O'Reilly (2015) as driven by the language used by parents:

*"Much of the parents' discourse relating to the purpose of therapy and outcomes focuses on the child, as the child is constructed as the central problem"* (O'Reilly, 2015)

This was presented in some papers as a deliberate and concerted effort from parents to divert attention away from themselves and towards some internal, powerful problem inside the child (Bennett, 2007; O'Reilly, 2007, 2015). CA papers highlighted the linguistic means by which parents focused on individualising distress within children and young people (O'Reilly & Lester, 2016). The motivations and threats of parental blame which may have influenced this were outlined in Bennett (2007); O'Reilly (2015); O'Reilly et al. (2023). Researchers were able to explore wider

conceptualisations of CYPMH available to parents informed by aspects of context, power and authority which motivated their move to shift to a more medicalised conceptualisation of CYPMHD rather than assume the role of 'underperforming parent' (Emery, 2016; O'Reilly et al., 2020). CYPMHD was commonly located in transmission from parents to children, in some cases this was a literal explanation of CYPMHD as a disease passed on genetically:

"*The following participant successfully uses a discourse of biology to construct ADHD as a genetic inheritance passed from mother to child.*" (Bennett, 2007)

Medicalisation was one of the available discourses drawn on by parents to create an abnormal image of a child distorted by a pathological disease of the mind. The confirmation of this ontology of CYPMH was mediated by the authority of psy-professionals (Bennett, 2007; Callaghan et al., 2017). In some cases, young people even 'acknowledged' in front of professionals and family members that they were the problem (Lester et al., 2023).

In other cases, fear and responsibility for CYPMHD was instilled in parents in more general ways. For example, in clinic spaces, parents often turned up with expectations that they would be blamed for causing the CYP's distress (O'Reilly & Lester, 2016). This links with examples of policy CDA which tracked the increasingly neoliberal representation of poor mental health and wellbeing of children being a direct result of unlearned skills that (predominantly poor, working class) parents generally lack (Callaghan et al., 2017; Emery, 2016; Hardley et al., 2021). In these

cases, researchers posited that parents unsurprisingly turned to a culturally available biomedical, individualistic explanation of distress which allowed them to take up a favourable subject position and resist being blamed for causing CYPMHD (Bennett, 2007; O'Reilly, 2015; O'Reilly & Lester, 2016).

### *2.3.4 Biomedical positivistic models of CYPMH are assumed and oppressive*

The social construction of biomedical ontologies of distress in young people was ubiquitous across all studies but the deployment of biomedical frames was presented as slightly different between papers. The relative power and authority of the medical model was explored from a professional perspective by Peter (2021). The unique position of psychoanalysts working in an increasingly totalitarian and homogenous healthcare system which values psychiatric frames of distress above all else was represented as an inevitable surrender to a powerful force. Even where participants may be wary of the potential harm of medicalising distress, their livelihoods and professional integrity appeared to limit the opinions they could express (Peter, 2021). From this position, the participants in this study acquiesced to a biomedical model without fully believing in it by outwardly expressing agnostic positions:

*"Deborah's account establishes the impossibility of the situation, therefore justifying the acceptance of desperate measures, while also questioning the efficacy of medicating the child"* (Peter, 2021)

The status and power of diagnosis as a technology of biomedical models was explored as a changing and complex phenomenon. This problematises the earlier subject positions taken up by parents; in some cases, parents worked discursively to resist a stigmatising psychiatric label (Denman et al., 2016). In other cases, they were presented as battling to convince withholding professionals that a diagnosis was warranted for their child (O'Reilly, Karim, Stafford, et al., 2015). In some instances, young people claimed membership within a 'diagnosed with mental health condition' group as a means of gaining status and respect within highly unique contexts (Stentiford et al., 2023).

Following this idea of the encroaching power and hegemony of psychiatric or biomedical conceptualisations of distress, the role of positivist epistemologies and rationalist philosophies was explored in particular by O'Reilly and colleagues (2020). They investigated how normality and pathology were constructed by parents using a discursive psychology approach. Often parents reframed anecdotal evidence in terms of objective observation, appealing to forms of evidence which they believed carried the most authority in clinical settings. This was demonstrated in parental accounts of CYPMH in assessment spaces:

*"to present an authoritative version of events and to construct the membership to such a category as factual, the speaker must demonstrate that the facts are objectively known and based on direct observation; that is, reporting to mitigate against any potential accusation of stake or interest in the outcome"* (O'Reilly et al., 2020)

Synthesising the dominant positivistic discourses of professional understandings of distress (Peter, 2021) with the 'micro' conversational applications of psy-language (Lester et al., 2023; O'Reilly, 2015; O'Reilly et al., 2020) creates a landscape of childhood distress recursively reified as a biomedical phenomenon. Trust and power were imbued into biomedical frames of CYPMH through modern colonial practices of establishing positivistic truth such as: experiments, rationalism and policies:

*"The 'evidence-based' discourse, which Holmes et al. (2006) argue has 'colonised' the health sciences over the last three decades, accords power and trustworthiness to clinical interventions for which links between actions and outcomes can be demonstrated via large-scale experimental design, most commonly the randomised control trial"* (O'Reilly et al., 2015)

Reflecting on the landscape of clinical psychology more broadly, the oppression and dominance of colonial, rational and empirical epistemologies appear storied through various practices such as: 1) Psychoanalysts' abdication to favoured, positivistic approaches (Peter, 2021); 2) Parents' appeals to psychiatric categories and use of psy-language (Avdi et al., 2000; Bennett, 2007; O'Reilly & Lester, 2016); 3) Professional pragmatism in differentiating and categorising different expressions of distress like codified diseases (Stentiford et al., 2024).

### *2.3.5 Shifts in CYPMH frameworks across time: oscillating between social and biomedical*

Many articles explored changing discourses and taken-for-granted truths about the production and manifestation of CYPMH in social terms (Callaghan et al., 2017; Emery, 2016; Hardley et al., 2021). Some authors focused on discourse within policy through time to give some insight into how CYPMH was conceptualised. Hardley, Gray & McQuillan (2021) tracked the increasing deployment of 'health and wellbeing' in schools' policies as a method to ensure good academic attainment.

*"schools predominantly seemed to conceptualise HWB [health and wellbeing] as a pedagogic approach for teaching skills to achieve specified outcomes [.] and appeared to view HWB as teachable skills required for learning and attainment"* (Hardley et al., 2021)

More explicitly, CDAs such as Emery (2016) explored the effects of emerging neoliberalist political agendas through the 2000s on discourses around 'health and wellbeing'. Emery explored the erasure of community thinking and social determinants in Welsh policy as it gave way to English individualistic, neoliberal discourses of CYPMH:

*"Behind this higher level of English interdiscursivity sits a range of lesser but still powerful discourses combining the individualistic, promotional discourse of New Labours' third way alongside a discourse of moral panic (Humphrey, 2013) whereby*

*children are at risk or damaged (a deficit model of childhood (Watson et al., 2012)) and in danger of losing (economic) opportunity when understood in a neo liberal achievement agenda."* (Emery, 2016).

This pattern is elucidated in the context of specialist mental health support; Callaghan and colleagues highlighted community driven policies such as the *Every Child Matters* 2003 green paper which aimed to transform specialist CAMHS to be meaningfully embedded within the wider community. These policies were then replaced in the latter part of the 2000s with increasingly medicalised discourses of CYPMH:

*"This signals both a shift to a biological framing of psychological distress as 'an illness like other illnesses' and a concomitant loss of focus on social context and concerns about inequalities in the production of psychological distress"* (Callaghan et al., 2017)

Yet resistance to this discourse was evident in emergent studies from later periods of the 2000s. COVID-19 appeared to represent changing hegemony towards social determinants. School staff in Stentiford (2024) reflected on the potential social elements contributing to students' self-harm:

*"When asked their thoughts as to possible causes, several staff members attributed the rise to the Covid-19 pandemic and school closures which meant that young*

*people spent an increased amount of time isolated at home and were thought to have been greater influenced by social media."* (Stentiford et al., 2024)

This excerpt evidences the potential for adults to persist in finding a social reasons for CYPMHD (outside of innate, individualistic frames for distress) in the context of decades of powerful discourses promoting a predominantly biomedical view of CYPMH (Emery, 2016; O'Reilly et al., 2020; Peter, 2021).

### *2.3.6 Medical frames for CYPMHD support strict ab/normality binaries driven by wider systemic neoliberal pressures*

This was the most comprehensive theme which captured the coalescence of medical and neoliberalist frames of CYPMH. On one hand, the pressures to achieve and be a productive citizen/child/parent resulted in a construction of CYPMHD being an explanation for deficits in the child themselves, parenting skills or the skills of professionals (O'Reilly et al., 2020; O'Reilly & Lester, 2016). On the other hand, this theme captured the co-opting of psy-language to characterise children and young people as extremes and deviating from 'normality' in an effort to access CYPMHS (O'Reilly et al., 2020). Not only this but once CYPMHD was constructed - either by staff or parents – the responsibility for creating this abnormality was attributed either back into the child or the parents (Callaghan et al., 2017; Emery, 2016). This is despite alternative evidence that the production of CYPMHD could be linked to the impossible expectations to perform within the expected image of 'well-adjusted young person' available within institutional contexts:

*"It is suggested that being male in schools is subject to contradictory institutionally-led emotional expectations. Work with Lesbian and Gay students in schools has highlighted how the institutional regulation and control of sexual identities produces emotional distress and discomfort"* (Callaghan et al., 2017)

This pattern of individualistic frames of CYPMHD becoming dominant extended to parents, educational professionals, psychological professionals and young people themselves. In this manner, these papers highlighted that the function of individualising distress to psychiatric labels appears not to be driven by a search for truth or causation (Avdi et al., 2000). Instead, contemporary deployment of CYPMHD represents a tool to gain access to CYPMHS because neoliberal discourses construct an ideal which encourages parents and CYP to want to be 'mentally well' (Avdi et al., 2000; Callaghan et al., 2017; Emery, 2016).

The assessment/clinic context is the primary route to assign diagnostic labels and has therefore been the subject of study in many of the papers included in this review (Avdi et al., 2000; Lester et al., 2023; O'Reilly, 2015; O'Reilly et al., 2020, 2023). These studies outlined the mental health assessment as a carefully constructed social encounter with rules and expectations that overwhelmingly favoured the professional facilitating the encounter:

*"To achieve this goal* [accessing treatment] *requires a professional to align with the case a parent makes in crafting their child as in need of additional care (Escudero et*

*al. 2008), while positioning the professional to be the ultimate arbitrator of this."* (O'Reilly et al., 2020)

This idea that the mental health professional was the key to accessing treatment positioned them as an expert afforded power and authority over naming rights of distress. This power also extended to professional workers in other institutional settings such as schools (Emery, 2016; Stentiford et al., 2024). In some cases, where parents' efforts to convince professionals of the reality of their child's CYPMHD diagnosis were deemed ineffectual, they cited other professionals such as nursery staff and teachers as a means of bolstering their own claims (O'Reilly et al., 2023).

The function of CYPMH can also be understood within a neoliberal context in which CYPMHD is conceptualised as a deficit for which parents and professionals are responsible. The inability to protect children from being able to 'fully excel' by failing to prevent CYPMHD was increasingly constructed as a matter of professional responsibility in educational policy (Emery, 2016; Hardley et al., 2021). This links with previous responsibility and causation themes but also has the effect of reifying CYPMHD as an obstacle of some kind. This discourse promotes a vision of wellbeing in schools that with enough intervention from professionals, this obstacle can be removed and children will flourish (Hardley et al., 2021).

This conceptualisation creates a context in which professionals are allowed increasing powers of surveillance and control over the lives of young people because without it the risks are conceived as dangerous to life and success. In fact, these papers suggested that the 'benevolent caretaker' role created by this discourse

contributes to a lack of autonomy in young people's decision-making in their lives (Mac An Ghaill & Haywood, 2010).

### *2.3.7 Marginalised identities recursively interact with production of CYPMH*

This final theme augmented all other themes with the notion that discourses of blame, responsibility and colonial epistemologies disproportionately affect those from marginalised or oppressed identities by virtue of gender, race or class. This was explored explicitly in some papers (Bennett, 2007; McQueen & Henwood, 2002; Stentiford et al., 2023, 2024) whereas Hardley and colleagues (2021) explored the stigmatising and disempowering effects of dominant Western discourses around CYPMH as a secondary finding.

Gender was explored as a limiting or oppressive frame alongside CYPMH. For instance, Bennett (2007) explored the notion of 'mother-blaming'; essentially the idea that mothers are revered as care takers in Western societies and therefore exuberantly praised for rearing a child who does not exhibit distress or show behavioural signs of CYPMHD. Yet when a child is diagnosed with a mental health condition, it is the mother who is disproportionately blamed for having caused CYPMHD. This sense of responsibility was described as internalised by the participants in Bennett's research; the mothers labelled causes, even biomedical causes of mental health conditions as inherently female (Bennett, 2007). This augmented the existing processes of stigma and ostracization that occurs when a parent is identified as parenting a child diagnosed with a mental health condition; the mothers in this study described the deepened internalised shame and alienation

felt at having failed as a mother because their child had received a diagnosis of ADHD:

*"I saw other mums and their children and they were not like us, we were like aliens. Nobody liked Andrew at toddler group er I could tell they never said they just looked or tutted and it makes you feel so bad, um it wasn't as if I wasn't trying because I was [So I always felt on the outside, and you just know that the other mothers in the group blamed you]"* (Bennett, 2007)

Outside of the experience of parents, gender was also argued to shape the limits of what can be experienced or expressed about distress in young people. Stentiford and colleagues (2024) explored this amongst staff and students in two secondary schools. They found that staff and students firmly expressed that the binary of possible manifestations ('girls talk about their difficult emotions and boys hide their emotions') was firmly divided and completely separate:

*"What was notable was that this binary discourse appeared totalising, and was the only way in which students and staff appeared able to articulate any perceived relationship or connection between girls' and boys' experiences of mental health" (Stentiford et al., 2024)*

Boys felt they were less likely to receive support due to their gendered expressions of distress being 'naturally' suppressed which created a sense that girls were

disproportionately accessing support which the boys felt they were entitled to. The 'poor boys' discourse highlighted here was understood by the researchers in the context of white middle-class boys feeling dominated by a rising wave of feminism within the 21st century (Stentiford et al., 2024).

Class interacted with the production of CYPMH discourse in highly nuanced ways in Stentiford's (2023) DA of an elite sixth form setting. Stentiford described that disability and CYPMHD in this sixth form had been reconceptualised as desirable membership groups. Researchers postulated that middle/upper-class identities may have been crucial in forming a nurturing and accepting atmosphere within this specific context:

*"private and selective schools can often 'buy out' of traditional models of education and—in somewhat contradictory and paradoxical ways—proclaim the virtues of egalitarian, liberal and progressive values and anti-elitist sentiments"* (Stentiford et al., 2023)

Researchers highlighted that this sense of acceptability and outward expressions of tolerance for those experiencing CYPMHD was highly specific to this environment and was not transferable outside of the confines of students at the sixth form. The conditions of the students' specific class background were defined by the authors as a "specific strata of the middle-class which highly valued liberal values" (Stentiford et al., 2023, p. 1079). This identity appeared to rework their normalisation tactics in contradiction to dominant discourses outside of this 'institutional habitus'. In this

heterotopia (separate space in which difference is freely explored), those who did not outwardly support adaptations for and tolerance of CYPMHD and disability became the ostracised 'othered' students.

A counter example to the above is McQueen & Henwood (2002) who described the power of gender and class-specific rules which dictated the behaviours expressed by working-class teenage boys:

*"Admitting emotional distress would be seen not as an asset but as a liability to masculine identity within such a class-specific discourse."* (McQueen & Henwood, 2002)

This intersection of gender and class meant the participants appeared to find it challenging to make sense of traumatic life events and reframe this in any way except expressions of violence, power and authority:

*"Dominant class-specific discourses aligning power and achievement with physical prowess and dominance can also construct emotions as the antithesis of what it is to be male, so that men's experience of emotions is prohibited by fear of intimidation and violence"* (McQueen & Henwood, 2002)

Further intersections by virtue of cultural background also appear to interact with available expressions of emotional distress:

*"Camila articulated that she was a student of mixed ethnic heritage and felt that her parents' views could be a product of her family background: 'I think from my own personal experience in the families of colour from my mum's side disability gets ignored, it's something that's swept under the rug, it's considered something you should be ashamed of and should not talk about.'"* (Stentiford et al., 2023)

Stentiford's (2023) identification of intersectionality and nuanced influences on how CYPMH can be constructed is vital to consider against the backdrop of rising neoliberal, individualistic biomedical models which have become dominant in the UK discussed by Callaghan et al., (2017) and Emery (2016). The contradictions and limits of these warring discourses are well exposed by Callaghan and colleagues' CDA of CAMHS policy which ultimately revealed that the dominant model of CYPMH left no space to consider anything not held within the Western disease framework of CYPMH:

*"Because the 'mental illness' model with its attendant notion of 'best practice' is essentially universalising, there is little space for the conceptualisation of a service that is not rooted in western models of illness and psychological disorder and their treatment"* (Callaghan et al., 2017)

**2.4 Discussion**

This SLR explored the findings of DA methodology within the field of CYPMH. Examining the discourses explored within this review, I interpreted a common thread around the effects of normalisation enacted through institutional practices of power.

The relevant institutional practices contributing to these normalising effects were: labelling, clinical assessments, health and wellbeing psychoeducation in educational policy and dominance of the biomedical psychiatric frame. Generally, researchers included history in DA by 'setting the scene' or more fluidly considering various, nonchronological aspects of a concept's interaction with discourse and power.

Papers in this review discussed the well-established power dynamic between institutional representatives (commonly CYPMH professionals) and parents/CYP. This was evidenced by papers exploring the social rules within CYPMH assessments (Lester et al., 2023; O'Reilly et al., 2020; O'Reilly & Lester, 2016). Clearly, this dynamic has changed over time but its roots can still be traced to the asylum with the violent punishment and later societal control of madness through Freud's reimagination of the meaning and causation of distress (Foucault, 2003a).

Contemporary models of therapy outlined in this review highlight the sidelining of psychoanalytic explanations and a return to the application of positivism to distress (Foucault, 2003a). Though most explicitly enacted in assessment and clinic spaces, this omnipotence and naming rights over distress extended beyond the clinic. At this point, Foucault's theories of normalisation could be drawn upon to understand the recursive effects of hegemony across culture and within clinical/scientific knowledges (Kelly, 2019). In this conceptualisation of power self-surveillance abounds; a psy-panopticon is erected in which professional opinions are indistinguishable from hegemonic epistemologies of distress. This serves the function of defining divisions, abnormality and social norms for behaviour (Foucault, 1998, 2003b; Kelly, 2019).

Parents, young people and professionals cited within the papers appeared to frame CYPMH through an increasingly positivistic, biomedical lens across the beginning of the 21st century. This was enacted through language and discourse which resulted in the transmission of naturalised categories, deficit models and thresholds for distress from professional and political framings to internalised lay frames for what is means to be abnormal or experiencing a psychological condition. This can be witnessed in the synthesis of CDA tracking the co-opting of categorical psychiatric models of distress to fit increasingly neoliberal aims in the beginning of the century (Callaghan et al., 2017; Emery, 2016; Hardley et al., 2021; Peter, 2021). These knowledges were then replicated through practices in local clinic and educational institutional spaces (Avdi et al., 2000; Denman et al., 2016; O'Reilly, 2007; Stentiford et al., 2023, 2024).

Ultimately the normalisation process could be framed as follows: 1) distress occurs but manifestations of this are limited to the confines of prescribed categories; (e.g. accepted gender norms or diagnostic labels) (McQueen & Henwood, 2002; O'Reilly et al., 2023; Stentiford et al., 2024); 2) behaviour is monitored and adjusted (sometimes with input from professionals) to fit within established norms or return to these norms where abnormality is perceived as a block to effective contribution and success (Emery, 2016). This entire process elucidates a Foucauldian interpretation of the reifying effects of institutional power normalising understandings. DA research therefore contributes to a conceptualisation of CYPMH through its offer of micro-discursive effects deployed through institutional means to create limits and frameworks for how CYPMHD is understood. This primarily

manifests as a deficit attributable to naturalised, biological factors which prevent acceptable achievement in society.

In understanding CYPMH's contemporary theoretical presentation, DA research is an invaluable resource for looking critically at the broader discourses which exist in relationship to one another. For example, CYPMHD is constructed through discourse as an obstacle that needs to be removed so a child or young person is better able to flourish at school (neoliberalism). This is combined with biomedical frames of CYPMH and the synthesis of these discourses ultimately serves a broader political aim of individualism (Timimi, 2010).

The papers neatly tracked a story through time towards contemporary CYPMH discourse. This SLR evidenced a move away from community and socially contextualised understandings of distress towards individualisation throughout the beginning of the 21st century (Callaghan et al., 2017; Emery, 2016). Where previously societies and communities could broadly be held culpable for creating conditions in which CYP may express distress, the image of an unfit, low class, 'feral parenting' system became synonymous with CYPMHD aetiologies in the early 21st century (De Benedictis, 2012; Timimi, 2010). This sociological phenomenon of holding individual parents (disproportionately working-class mothers (Barnes & Power, 2012)) to blame for CYPMHD intersects with paradigmatic shifts within clinical psychology. This review takes a meta-perspective which understands the combination of 'austerity parenting' and objective, colonial forms of therapy as a dangerous mixture for a wholesale rebranding of CYPMHD as a predominantly individualistic phenomenon. Though the contextualisation between more discourses identified in the SLR within

broader power/knowledge effects has been somewhat achieved in this section, further empirical work is required to critically situate CYPMH discourses within the power effects of discourse.

The move towards presenting expressions of psychological distress as irrefutable, objective symptoms is understandable in a national context where a Western conceptualisation of distress is a prerequisite for accessing support even if it is not a useful lens through which to make sense of the problem (Lamb et al., 2012). This pattern in itself can be conceived as a feedback loop: the more tightly protected resources are, the stricter entry requirements are for accessing care, the more desperately parents and young people demonstrate their need within the language and discourse of objective truth, observable signs of abnormality and decreased functioning (Avdi et al., 2000; O'Reilly et al., 2020; O'Reilly & Lester, 2016).

The findings suggest it may be important to consider the dominant model of CYPMH being of Western origin and maintained by colonisation. Colonisation speaks more widely to the wholesale exportation of Eurocentric, rationalist understandings of psychology and distress which it is argued have been historically applied as tools to defend colonialism and today individualise, medicalise and ultimately stigmatise distress in non-western or marginalised peoples (Fellows, 2023; Opara et al., 2022; Papadopoullos et al., 2022; Shaw & Proctor, 2005; Timimi, 2014). Even where medicalisation is not a good explanation of distress, it is felt by professionals and parents to be the way in which distress must be presented and understood as per the hegemony of CYPMH in the early 21st century (Emery, 2016; Lamb et al., 2012). This was well evidenced by Peter's exploration of psychoanalysts' conceptualisation

of psychiatry; though rationalist and positivistic epistemologies would appear to contradict psychoanalytic ways of making sense of distress, professionals appear to have limited capacity to advocate for their preferred epistemologies in favour of a dominant biomedical frame (Peter, 2021).

### *2.4.1 Strengths*

This review took a novel approach to exploring the CYPMH evidence base where previous reviews have summarised qualitative research without focusing on the level of discourse meaning that this SLR demonstrated important methodological significance. This review is also novel because it included an examination of how DA research has incorporated historical context in their analyses. Despite this being an important part of FDA in particular, it has not yet been addressed in extant literature reviews to the best of my knowledge. Establishing inter-rater reliability was also a strength of this review due to second reviewers screening and assessing quality.

Another strength of the SLR was adopting a broad definition of CYPMH where previous research has focused on specific disorders or categories. Had a specific disorder been applied in this review, the potential to synthesise rich qualitative information across papers may have been limited. The decision to include these foci together was conscious and thoughtful as it noted through the papers that intersecting discourses of disability, medicine, social determinants and more are fluidly applied and therefore require merging to analyse.

### *2.4.2 Limitations*

This review was limited by the decision to exclude grey literature sources. Despite newspapers, online sources and other grey literature being a useful source of cultural

discourses around CYPMH, the researcher deemed that this was outside the scope of the current review due to limited resources.

Similarly, only research articles published in English and focusing on UK contexts were included. Discourses outside of this context were not captured and interpretive repertoires from non-English languages may have been imported differently. Not all participants may have had exclusively English heritage and ideas or discourses may have histories beyond the UK context that were not considered here. Interpretations and generalisations should therefore be made with caution and consideration of cultural and linguistic context.

**2.5 Conclusion**

This review brings together a wealth of high-quality theoretical DA research to elucidate the multifaceted way CYPMH is socially constructed by discourse. The macro level of neoliberalism, colonialism, gender norms, positivism and more are clearly crucial discourses which people at all levels (parents, professionals, policy makers and CYP themselves) replicate through their normalising behaviours, language and practice.

Any hope of understanding further how CYPMH is socially constructed should synthesise both the local normalising enactments of power and the macro discourses which mutate over time according to a plethora of power priorities.

**2.6 Aims and rationale for the empirical study**

This review identified numerous discursive and conversational forms of DA which addressed the micro-level of parental social construction of CYPMH (Avdi et al., 2000; O'Reilly et al., 2020; O'Reilly & Lester, 2016) alongside broader practices such as

educational and healthcare policy (Callaghan et al., 2017; Emery, 2016).

Discourses which blamed parents for CYPMHD were identified time and again throughout the papers. The nature and application of these discourses appeared to vary depending on the context. What is clear is that power appeared to play a key role in this for example in the deployment of powerful scientific, medical and neoliberal discourses. Where resistance to blame was interactionally analysed in CA, subject positions of 'good parent' seemed highly relevant (O'Reilly & Lester, 2016).

The following study targeted the parental perspective but sought to analyse how cultural and societal discourses constructed parental talk and practices within networks around CYP. Also, how parents and professionals are positioned within these discourses, and how these are sometimes resisted. This study also had the capacity through the FDA method to move beyond the micro level to analyse discourse and power in a more Foucauldian sense. This study was therefore positioned between the foci of existing studies identified in the review.

FDA as a method is highly useful for exploring the influence of power on claims to truth around CYPMH. FDA can also bring in ideas such as normalisation, panoptical power, governmentality and abnormality from a broader lens to better understand the influence of power and discourse on socially constructing CPYMH. This offers a way to move past a meta-blaming of parents which has occurred in CA's spotlight on parental methods to resist blame (i.e. rhetorical appeals to expertise and objective evidence). Where this more discursive approach to DA is less interested in the wider discourses underpinning their language, FDA has more capacity to move beyond the parent-child-psy-professional relationship. This aims to build a

formulation which more broadly contextualises parental social constructions of CYPMH.

The biomedical discourse frequently cited in the review papers is highly relevant to contemporary practice working with families and young people in clinical psychology. As Peter (2021) identified, there can be competing forces of power at play in determining how to conceptualise 'best practice'. Based on the findings of the review, much of psychological practice can unintentionally oppress, scapegoat and stigmatise the people supported by services.

In the following study, it was aimed that stepping away from the assessment or research interview context to analyse parental talk could allow access to more naturalistic applications of macro discourses. This review has highlighted that parental positioning within discourse constructs truth around CYPMH in a manner so far not captured by extant research. This will naturally have clinical implications for how services could adapt practices or invite the perspective of parents in less oppressive ways.

**Research questions:**

1. How do contemporary discourses around mental health structure parents' understandings of CYPMH?
    a. *How do discourses such as neoliberalism, 'good parenting', medicine and the 'psy-complex' position parents in relation to wider society?*
    b. *How do the aforementioned discourses define parents' relationships to therapeutic support and mental health professionals?*

Additionally, the objectives of this research were:

- To highlight points of difference, resistance to and collusion with dominant discourses around CYP within parents' talk to understand how these discourses position parents' understanding of CYPMH
- To discuss the implications of parents' understandings of their own position and their child's MH experiences on the work of mental health professionals
- To trace shifts in dominant discourses identified in the analysis through their historical context to better understand how power is exerted through discourse to scaffold parents' understanding of themselves and CYPMH

# Chapter 3: Methodology

## 3.1 Chapter overview

The previous chapter provided a rationale for this study and this chapter begins with a description of my epistemological position, followed by a detailed breakdown of the research methods including recruitment and participant demographics. Then ethical issues relevant to the project are discussed, and the crucial role that experts by experience played in shaping this research. The chapter ends with outlining in detail the approach I took to analysis, and how I ensured and assessed quality of my research methods.

## 3.2 Epistemological position

This research was conducted from a social constructionist epistemological position, meaning that in designing and conducting the research, the following principle underpinned the entire body of research and findings: social/psychological reality is collaboratively formed by interaction through language and social meaning (Losantos et al., 2016). As the researcher, my interpretations form part of the creation and recreation of meaning through my application of methods and research study – this means that I must be transparent about my own social and historical contexts as this informs my lens of analysis (Losantos et al., 2016).

A critical voice and de-naturalising taken-for-granted truths are indispensable tools for questioning socially constructed dominant discourse to reimagine what may be (Gergen, 2009). This departure from essentialist, positivist aims requires a social constructionist epistemology with the capacity to include culture, history, social context, language, process rather than content and the researcher themselves as

objects of analysis (Losantos et al., 2016). The SLR suggested that broader discourse may be linked to how parents socially construct CYPMH and a de-naturalising stance is vital in critically re-examining practices around CYPMH which are reproduced in parental talk.

For the purposes of the current study Michel Foucault's theories of knowledge and power have been foregrounded in the analysis and discussion phases of this research. There are a series of key concepts and processes that characterise Foucault's work which are outlined in the glossary of key terms. These ideas support de-naturalisation and a truly critical analysis in the current study by bringing ideas across knowledge bodies in application to psychology. Moreover, the theme of power (in the Foucauldian sense) allows for a more explicit analysis of technologies that oppress and normalise which would be otherwise tangential to qualitative methods. One way in which this is better achieved in FDA rather than other qualitative methods from within the social constructionist tradition is Foucault's more nuanced epistemology. Foucault paid particular attention to the productive power of discourses in socio-political discourses (Khan & MacEachen, 2021). FDA therefore pays more attention to how power constructs knowledge, and who is afforded authority to claim truth as well as historical contexts. FDA's focus on macro processes mean that it is perhaps one step away from a social constructionist stance that would pay less attention to broad discourse and forces of power as this begins to drift from a 'pure' social constructionist relativist position (Willig, 2021).

A strength of a Foucauldian approach is a move away from an assumption of progression. As demonstrated in the previous chapter, by genealogically analysing

ideas through time a more de-naturalised conceptualisation of an idea such as diagnosis becomes more available. The analysis does not end at this point because the idea is constantly subject to recreation, replication, subjugation and other effects occurring through everyday social interactions (Foucault, 1998; Hook, 2007; Kendall & Wickham, 1999). Therefore, a Foucauldian social constructionist position allows for the synthesis of a critical voice, inclusion of broader discourse and an analysis of how language, discourse and power constructs CYPMH in parental talk which is why it is the most appropriate approach for this study.

**3.3 Design**

This is a qualitative study which applied FDA to naturalistic recordings of transcribed parent peer support groups.

**3.4 Participants**

Data were collected through FamilyFirst (pseudonym); an independent charity organisation in southeast England. FamilyFirst provide free and paid-for support for children and families experiencing mental health difficulties through individual, group, and consultation work. Their charity status and psychotherapeutic approach has positioned them as an accessible alternative to NHS CYPMHS which struggle with capacity (Children's Commissioner, 2023).

I came into contact with FamilyFirst through the University of Hertfordshire doctoral research fair. I began talks with FamilyFirst in May 2023 with the intention of arranging to collect naturalistic data by recording peer support groups. I began meeting with a senior member of the FamilyFirst leadership team to understand the nature of their organisation and whether their support sessions would be suitable to

collect data from. This proved to be very important as establishing the parameters of the research and clarifying the aims and methods of my research was a sensitive part of the research process. FamilyFirst were understandably apprehensive about allowing a researcher to have access to confidential therapeutic data; their highest level of context was the best interests of the families they work with. As FDA and collecting naturalistic data were novel research methods for the organisation to consider, it was imperative to be transparent with participants and FamilyFirst to gain informed consent to work with them on this project. To ensure mutual benefit for supporting the study, we decided that the findings of this study could be disseminated directly to FamilyFirst in support of recommissioning services.

I applied pseudonyms for parents and facilitators in the group throughout the transcripts to ensure anonymity.

Table 4

*Table indicating the pseudonyms assigned and the role of each person*

| Pseudonym | Role |
|---|---|
| Jessica | Parent |
| Arwen | Parent |
| Denise | Parent |
| Erica | Parent |
| Lilly | Parent |
| Sally | Facilitator |
| Lucy | Facilitator |
| Sharon | Facilitator |

### *3.4.1 Demographics*

The region from which participants were recruited is a vast and diverse area of southeast England in terms of socioeconomic status and provision; there are isolated areas of deprivation set against wider areas of affluence. In terms of provision, the counties in this area have a good range of non-specialist mental health support (Crenna-Jennings et al., 2024). Specialist support for young people is covered by multiple CAMHS teams and charities across the region.

Participant demographic information including gender identity, age and ethnicity was collected through a Qualtrics survey. Not all participants responded to the Qualtrics survey; hence some information was taken from FamilyFirst registration data and some from the Qualtrics survey.

Table 5

*Demographic data for each participant in the group. Cells in grey represent data gathered from FamilyFirst.*

| Participant Pseudonym | Ethnicity | Gender | Age |
|---|---|---|---|
| Jessica | White British | Woman | 49 |
| Arwen | White other | Woman | 49 |
| Denise | Mixed race – black Caribbean/white | Woman | 54 |
| Erica | White other | Woman | Unknown |
| Lilly | White British | Woman | Unknown |

It is immediately clear from this demographic data that the entire group of participants identified as women. Moreover, though their demographic information was not collected, the facilitators in these groups all made references to being a 'mum', 'wife' or 'woman' potentially indicating their gender identity. In terms of quality assessment of the methodological approach, this homogeneity with regards to gender identity does not weaken findings; FDA has differing epistemological assumptions to other empirical methods which may require adequate representation of a group to make reliable or valid claims about a wider group. The discursive constructions may be layered by different discursive contexts which could embellish the analysis but may also be understood by shared identity markers such as 'special educational needs and disabilities (SEND) parent' or 'child schooled in the 70s'.

Consequently, a variety of discourses linked to the backgrounds of these participants are explored in the analysis but are not seen as limited by those who took part; as Parker describes wherever meaning is present, FDA can be conducted (Parker, 1999).

**3.5 Ethical considerations**

Ethical approval was originally granted by University of Hertfordshire on 29/07/2024 (protocol number: LMS/PGR/UH/05771) (Appendix D). Following approval, amendments were applied for and approval was granted due to modifications following consultation with the steering group and a change in demographic information data collection methods (protocol number: 0735 2025 Feb HSET) (Appendix E).

This study involved recording private peer support sessions discussing highly sensitive information around parenting and CYPMHD. To ensure participants felt safe and comfortable, I joined for the initial ten minutes of three sessions but then left to ensure that this research did not impede their access to support. I also agreed with consultation from my steering group (discussed below), that if one participant did not want to take part in the study, that group session would not be recorded at all.

I have stayed firmly within the BPS Code of Human Research Ethics (Oates et al., 2021) by respecting the integrity, autonomy and expertise of the participants in this study. By taking a naturalistic approach, participants had space to speak freely and use their peer support group as they typically would with relatively little impact from me as a researcher.

### *3.5.1 Informed consent*

Participants were provided an information sheet (Appendix F and G) via email one week before the group was scheduled to take place to ensure they received ample information and time to consider participation (Oates et al., 2021). This sheet contained the researcher's contact details should participants wish to ask any questions or discuss the study beforehand. I also joined the initial ten minutes of three groups to explain the purpose and nature of the study and field any questions participants may have. Following this, participants signed an informed consent form (Appendix H). Participants were informed through the information sheet and during the beginning of groups that they were able to withdraw up to the point of transcription because at this point names would not be included and it would be challenging to remove one participant's data. Transcription was therefore not undertaken until the full course of the peer groups was finished (seven consecutive weeks).

### *3.5.2 Data storage*

Video and audio recordings of the groups were taken via Microsoft Teams by one of the family support workers facilitating the groups, this meant that confidential data was stored securely on online servers at all times in compliance with general data protection regulations (GPDR) according to the BPS guidelines (Oates et al., 2021). Signed consent documents were password protected and stored on secure University of Hertfordshire OneDrive. Transcripts were created without identifiable details (names were changed to initials before saving).

### 3.6 Experts by Experience Steering Group

A steering group was formed consisting of people identifying as parent/carers of CYP with identified CYPMHD. These group members were recruited through FamilyFirst, they were primarily family support workers who worked for FamilyFirst and held a dual identity as worker within a mental health service for young people and a parent/carer who had shared experiences with the participant group for this study. Family support workers are recruited to this position purposively by FamilyFirst meaning they were willing and experienced to reflect on their parenting experiences to inform their practice, making them ideal steering group members.

Initially I met with the group in July 2024 for one hour. I introduced the group members to the study, gave some background about my own experiences and my interest in the topic. In August 2024 I met with the steering group again to present some of the resources such as participant information forms and consent forms. During the first meeting the group provided useful reflections on the formatting and contents of these documents. Additional consent items and understandable information was added to the documents following this.

Moreover, advice was sought from the group around how to introduce myself as the researcher and what parents may want to know about me and the study prior to participation. The group suggested that sharing some of my previous experiences working in CAMHS and what interests me about working with CYP and families would be valuable. I therefore prioritised ten-minute slots at the beginning of meetings to answer any questions and be as transparent as possible (Oates et al., 2021). The steering group were invited to provide ideas and feedback by email as well as during

these scheduled meetings which was taken up by some of the experts by experience.

Meeting with the steering group informed various reflections about the hermeneutic framework of the study and how this fit with a DA approach. In explaining the study to the group, I was internally drawn to promise that I could transmit the voice of parents up to create better services to validate their contributions (though I did not make this promise to the group). Through my reflexive research diary (Appendix A) and in conversation with my research supervisor I reflected on this pull and established a way in which I could hold onto the desire to create positive social action from this research but also be realistic about the extent to which experts by experience could contribute to this research. I reached a conclusion around the steering group being well-placed to represent the voice of parents and participants and shape the research in terms of research procedures but have less involvement in the analysis phases of the research. The nature of DA is highly interpretative and FDA in particular requires the researcher to use their own perspective more than other methods, in this manner, it is more challenging to include experts by experience in this stage of the research generally in DA research.

**3.7 Selection of naturalistic data**

Part of FamilyFirst's current provision is free peer support groups for parents/carers of children not attending school. These groups are facilitated by specialist family support workers or psychotherapists working within various modalities. The purpose of these groups is advertised as offering parent/carers a chance to discuss current difficulties and connect with others in similar situations as well as support and

guidance from the family support workers. These groups mainly happen online with some limited provision for in person groups in certain areas.

Guidance on FDA suggests selecting data for analysis informed by the research question (Willig, 2021). Data should also either "constitute or problematise an object" (Arribas-Ayllon & Walkerdine, 2017 p. 115). In this case, the research question was 'how do contemporary discourses around mental health structure parents' understandings of CYPMH?' – naturalistic talk in parental peer groups constitutes an object in this sense as it is a context in which parents naturally bring in wider social discourse to scaffold meaning around CYPMH. As well as this, the interaction between parents and professionals invites expertise as a mediator of truth which makes this context highly interesting (Arribas-Ayllon & Walkerdine, 2017).

One potential challenge in the design of this study is that naturalistic data prevents probing of particular topics that may have proven more fertile for analysis. Knowledge that sessions were being recorded for research purposes may have altered the manner in which participants presented themselves and topics discussed. From a social constructionist, FDA perspective, this does not weaken the findings due to differences in generalisability assumptions. However, it is important that I attend to the potential added artificiality of this dataset due to knowledge of being recorded.

I was aware from my prior experience facilitating parental peer groups from within an NHS CAMHS setting that parents commonly draw on broad cultural discourse and operate in systems where they commonly navigate relatively

powerless positions. Further, parents often navigate healthcare systems for several years and a peer group can be a space in which parents reflect on changes which occur through time. I therefore decided that a parental peer group with psy-professionals present would likely be a highly useful example of institutional and naturally occurring talk, from a power, knowledge and genealogical perspective to answer my research questions (Arribas-Ayllon & Walkerdine, 2017; Kendall & Wickham, 1999; Taylor, 2013).

**3.8 Data collection**

Initially, seven peer groups were recorded for this research (Appendix I). The groups were recorded through Microsoft Teams by FamilyFirst facilitators and saved directly to the FamilyFirst Microsoft OneDrive account. One participant who attended the first three groups did not reply to invitations to participate in the research, consequently these initial three sessions were not listened to by the researcher or included in the research. The final four included recorded sessions are outlined in Appendix I.

Verbatim transcription was undertaken by the primary researcher in line with the understanding that interpretation and analysis commences at this stage (Taylor, 2013). The transcription method followed was the Jefferson system of transcription symbols (Jefferson, 2004). In keeping with published FDA research, there is a greater focus on concepts and discourse alluded to or mentioned in texts as opposed to CA which may pay greater attention to the minutia of interaction in conversation. For the purposes of this study, it was decided that only a selection of Jefferson symbols

would be used (Appendix J). A random excerpt of transcript has been included in the appendix for exemplary purposes (Appendix K).

### 3.9 Data analysis: DA and FDA

DA is highly related to the social constructionist imperative outlined in the beginning of this section. Where data have primarily been analysed from the perspective of interpretative phenomenological analysis or thematic analysis in this topic of child and young people's mental health (Martin et al., 2025), this limits the capacity to which a critical voice can be held in the analysis. DA is analytically positioned at the level of language and communication and aims to investigate how discourse produces social realities (Taylor, 2013). This analytical focus is contrasted with other qualitative methods which may aim to channel experience or testimony as products of analyses (Harper, 1995). It is important in any qualitative study that the method and findings logically match the research aims as per the big eight's category of meaningful coherence, which will be used throughout this thesis to assess the quality of research (Tracy, 2010).

#### *3.9.1 The added benefit of FDA in distinction to DA*

FDA is a form of DA informed by the theories of Michel Foucault. It was introduced by American researchers first applying Foucault's ideas to DA methods (Arribas-Ayllon & Walkerdine, 2017). FDA is highly contingent on poststructuralist thinking and the 'turn to language' (Arribas-Ayllon & Walkerdine, 2017). Michel Foucault's ideas which are of relevance to an FDA in particular is his reconceptualization of the relationship between people and society as mediated through discourses which normalise and enact boundaries around what can be thought (Kelly, 2019). In this

way, Foucault emphasised the possibilities and subjective effects that discourses open up for life, thought and behaviour (Foucault, 1991, 1998, 2003a).

FDA's primary distinction from 'pure' DA is in its aims and assumptions. FDA aims to map discursive contexts in terms of knowledge and power and the subjective *effects* of this on people for example in terms of creating subject positions such as 'mentally ill child' which may limit and define people and behaviour (Willig, 2021). This is highly specific to Foucault's theories of power which are not as relevant to other forms of DA. For the purposes of this study, FDA's inclusion of genealogy and the productive nature of power to open up ways of thinking about CYPMH for parents make it a highly useful frame from which to critique taken-for-granted hegemonies of CYPMH.

Foucault was not in favour of formulaic methodology and was keen to resist this characterisation of his approach (Arribas-Ayllon & Walkerdine, 2017). The method of FDA has been primarily informed by researchers who have sought to apply knowledges and concepts from Foucault's work in DA approaches. There have been moves towards formalising the FDA method (Kendall & Wickham, 1999; Willig, 2021). This would arguably have been an anathema to Foucault who famously represented some of his ideas in a deliberately ambiguous manner to prevent attempts to formalise or standardise approaches (Arribas-Ayllon & Walkerdine, 2017).

The comparative focus on the power of discourse to construct objects and constrain possible ways-of-being, meant that I, as a researcher using FDA, chose to represent this analysis using relatively less tentative language than may be typical in

qualitative research using different methods. The result of this is that my presentation of findings appears, at times, emphatic and strong to indicate the constriction and definitional power of discourse. In some ways this is informed by Foucault's ontology being challenging to pinpoint exactly; his writing style and representation of reality were understood as oscillating between social constructionist and critical realist at times (Joseph, 2004). FDA's inclusion of non-discursive practices, the role of institutions, ideology, subjectivity and power means that it is, by nature, more ambitious and less postmodern or tentative than other DA methods; just as Foucault was (Hook, 2007; Joseph, 2004; Taylor, 2013; Willig, 2008). Therefore, my use of less tentative language is intended to reveal 'truth-effects' or 'games of truth' in the Foucauldian sense (Hook, 2007) and believe I have remained within the methodological guidelines of FDA in my presentation of this research.

Though I am familiar with Foucault's ideas, as a doctoral student using this method for the first time, it was important to take a pragmatic approach to following methodological guidance so as not to unwittingly break epistemological assumptions or stray too far away into methodological practices which could not be contained within FDA. Consequently, the formalised approach of Willig's six steps (Willig, 2021) has been applied in this study but not applied mechanically at the expense of the more fluid and unstandardised approach endorsed by authors such as Arribas-Ayllon and Walkerdine, (2017) and Derek Hook (2007). My approach to FDA has therefore amalgamated several guidance resources and incorporated elements of DA which are epistemologically portable to the FDA approach. I have outlined this below.

### *3.9.2 Coding*

Following guidance on DA I began by transcribing the audio myself, listening back to ensure accuracy and then reading and re-reading the transcripts to familiarise myself with the entire dataset (Taylor, 2013). During this process I read through the entire dataset multiple times considering possible connections between ideas, references to (latent and explicit) discourses and other interesting moments in the transcripts where I felt effects of power, normalisation or other Foucauldian ideas could support interpretation (Taylor, 2013). When noticed, I coded these instances by hand (Appendix L) and made a digital record (Appendix M) to make finding quotes and codes easier later on. Coding is iterative and exploratory in FDA and does not align simply with concepts of data saturation to indicate when this phase is complete. Indeed, coding in this manner is not explicitly prescribed by other methodological guidelines such as Arribas-Ayllon and Walkerdine (2017). I decided to code to have a clear corpus to then apply Willig's six stages, this allowed me to break down the large transcripts into workable sections marked by codes and corresponding quotations to achieve the analysis within the timeframe.

### *3.9.3 Willig's six stages*

The next step was to systematically work through my record of codes with reference to each of Willig's six stages (see Appendix N for an example). Initially, I worked through the stages in order beginning with discursive constructions but as I progressed this process became much more recursive. For example, where I had constructed a new example of practices relating to discourse, this often inspired me to describe new subject positions, discursive constructions and so forth.

On reflection, I commonly found that inspiration around a possible discourse, practice or other element of analysis would strike me at times when I was not 'working on' the analysis i.e. on placement or in discussion about something seemingly unrelated. It is for this reason that discourse analysts commonly bring in additional researchers to discuss possible interpretations of data (Taylor, 2013). Throughout the data collection, analysis and write up phases I therefore engaged in a group with two peers also conducting DA theses and an expert facilitator who supported our learning of DA: the advanced methods workshop. We met as a group five times over the course of this study. I used the advanced methods workshops to discuss possible interpretations and discourse ideas I was developing. I did not share the transcript fully here but reflected on my process in generating ideas to understand how they landed with other people with different lenses. This informed the way in which I approached analysis, supported me in generating ideas and affected how I represented discourses in the write up.

FDA assumes that the researcher cannot be fully extricated or neutral within the analysis process; their claims about the data are themselves discursive constructions which require interpretation and critique – seeing oneself as an author as opposed to researcher can be a more helpful lens through which to understand this relationship between data and analyst (Willig, 2021). Being a trainee in placement on CAMHS whilst I was conducting this research, I found that my analysis was embellished and problematised by my continuing assessments and community psychology informed work in an NHS setting with young people and parents/carers. I did not shy away from this realisation that there was a symbiotic relationship

between the two acts of research and practice; instead, I brought these discussions into my advanced methods workshops to understand how best to bring these interpretations into my analysis. In some ways, acculturation to FDA is best achieved through reflexive practice and group discussion as outlined in Kendall and Wickham's testimony of orientating students to FDA (1999). My use of the reflective advanced methods workshops was therefore a strength of this analysis.

**1. Discursive constructions**

In this initial stage, I searched quotations to construct an account of how discursive objects were constructed in the transcripts. As Willig advises, the relevant discursive objects depend on the research question (Willig, 2021). For example, in the current study, I was interested in direct references to aspects of CYPMH such as using psychological jargon or concrete references to mental health categories. I also looked for ways in which discursive construction occurred outside of explicit reference which is a key feature distinguishing FDA from DA for example through the use of sarcasm or euphemism (Arribas-Ayllon & Walkerdine, 2017; Khan & MacEachen, 2021).

**2. Discourses**

This next stage involves identifying broader discourses such as medicine or capitalism which are invoked in the transcript. This was highly informed by the discursive constructions stage but also by the practices and subjectivity stages described below (Willig, 2021). For instance, discourses may become identifiable in language through the subject positions they make available. For example, a subject position of 'good

mother' is made available through the discursive formation of a wider discourse such as 'traditional family life'.

**3. Action Orientation**

The action orientation stage is highly contingent on the construction of other stages, once discursive contexts are built up, this stage invites an exploration of 'so what' or 'what does this mean' or 'what is the discourse doing?'. Essentially this stage asks the researcher to consider the function of invoking certain discourses which is part of the 'effects of discourse' element of FDA referenced earlier (Willig, 2021).

**4. Positionings**

Subject positions imply a repertoire for being in the world and they construct roles and expectations within this structure (Willig, 2021). I created pithy labels for identified subject positions which are made available through the invoked discourses in the transcripts. Subject positions are naturally limiting and can therefore seem judgmental which I reflected on in my self-reflexive diary (Appendix A). I noted that constructing these harsh and limiting-sounding identity labels for people felt judgemental. However, as the researcher I found that the more succinct the label, the more I was able to take up a critical voice and be unwavering in my reconceptualization of institutional practices and discourses often labelling and limiting possibilities for people.

**5. Practices**

In this stage, I highlighted the non-linguistic ways in which discourse can limit or permit certain ways of being. Practices as actions within discourse were highlighted as not only effects of discourse but equally as formative in the reification of expected

norms (Willig, 2021). Assessment is one example of a key practice in clinical psychology; the acts of psy-professionals assessing through psychometric tools, interview and so forth have become normalised social acts but the practice of assessment is steeped in power which functions to confirm the authority to claim truth.

**6 Subjectivity**

The final stage involved hypothesising around the psychological and social consequences of discourse. This step involved active construction and interpretation by me in terms of how discourses, subject positions and practices may *feel* to participants (Willig, 2021). Commonly, this involves considering how feelings such as shame, hope, fear, relief may have been evoked by the subject positions, practices and other elements identified within an FDA.

### *3.9.4 Grouping*

Once all six stages were complete, the next phase was to organise the identified information into a coherent narrative. The six stages process produced an extremely comprehensive set of findings divided by discourses which was too unwieldy to present in one single findings section as it was. This phase of FDA is not clearly explicated in available guidance; therefore I drew on generic guidance from DA (Taylor, 2013) and my own sense of the dataset and findings to group the identified discourses into a presentable 'story' of the findings based on theoretical similarities and counter discourses (Taylor, 2013). I used a map of the discourses which I manipulated in various configurations to reach a presentation of the data that I felt

represented my interpretation of the findings well. I have indicated in the appendix this process of building a coherent map of the discourses (Appendix O).

## 3.10 Quality validity and self-reflexivity

### *3.10.1 Quality considerations*

A reflexive and well-defined approach to quality is required in qualitative research due to the myriad of ways in which researchers have conceptualised traditional markers of quality in scientific research; namely reliability and validity (Bryman et al., 2008). Bryman's research exploring the range of ways in which social policy researchers conceptualise quality has been extremely helpful. In particular, foregrounding the concept of dependability of the research method and reflexivity in relative importance to ensuring quality in qualitative research as opposed to reliability through concepts such as external validity (Bryman et al., 2008). I have synthesised this with the approach used throughout the SLR and remaining thesis: Tracy's Eight Big-Tent criteria for quality assessment in qualitative research (Tracy, 2010).

Tracy's Eight Big-Tent criteria offers a language and concrete framework through which to enact the valued markers of quality highlighted in Bryman's research (2008). For example, Tracy's category of meaningful coherence aligns closely to the concept of methodological dependability in terms of coherence between problem, approach and findings. I have attended to this during this chapter and throughout the discussion section as well as highlighting the epistemological, methodological coherence of approach in sections where I provide a solid rationale for the FDA approach.

As mentioned, I have sought to weave quality assurance throughout this thesis instead of demarcating exclusive sections for critique of my own work. A brief overview is provided here also.

The way I have designed this study ensures credibility through recording several 90-minute-long peer-support sessions. This allows for thick descriptions from naturalistic data which will 'show, not tell' in the findings section (Tracy, 2010). Similarly, multivocality was sought through recording multiple, different sessions. This allows for various perspectives to be represented in the research.

In this chapter I have justified why FDA and naturalistic data are well suited to address my research question, demonstrating meaningful coherence and methodological dependability (Bryman et al., 2008). Similarly, I have described above relational and procedural ethical considerations. Finally, this project represents a significant contribution through a novel conceptual and methodological approach in this topic area. It is hoped that this means the project will have resonance by being influential and evocative (Tracy, 2010).

### *3.10.2 Self-reflexivity*

Reflexivity is another core component in qualitative research (Bryman et al., 2008; Taylor, 2013; Tracy, 2010). Throughout this thesis I have endeavoured to contextualise methodological decisions, practical aspects of conducting this research and analysis with reference to my own positionality, experiences and identity. My reasoning is that reflexivity is highly valued as a route to achieving quality in qualitative research (Bryman et al., 2008) and also highlighted by Tracy as an important way of achieving sincerity in high quality qualitative research. I have

outlined how I came to research this topic in the introduction, giving an important initial insight into my active role in shaping and constructing the research from proposal to dissemination.

I have specifically explored self-reflexivity with my supervisor regularly but also engaged in an in-depth 'bracketing' meeting. Bracketing to ensure that one's identity does not unduly affect the findings of a study is a common research practice (Tufford & Newman, 2012). However, this conceptualisation of bracketing would undermine the epistemological assumptions of FDA (Arribas-Ayllon & Walkerdine, 2017; Dwyer & Buckle, 2009; Kendall & Wickham, 1999; Tufford & Newman, 2012; Willig, 2021). Consequently, I entered into the bracketing meeting with my supervisor (and continued my reflexive research diary) with the aim of exploring aspects of my identity for the purpose of embellishing and understanding my role as author of interpretations in this research. I was clear that my intention with bracketing was not to compartmentalise and erase findings attributable to my own lens. In the knowledge that bracketing is not a 'one time' exercise, I have kept a reflexive research diary throughout the project, noting memos of how I have made decisions, issues that have arisen and my own thought process with reference to my own knowledges (Tufford & Newman, 2012) (Appendix A).

During the bracketing meeting in the summer of 2024 I explored aspects of my identity in this research using the social mapping exercise (Jacobson & Mustafa, 2019). My supervisor also completed this exercise for the purpose of understanding their influence on the project. This exercise helped me to understand my role as 'parented' but not a parent in the sense that my participants might experience

subjectivities from within certain subject positions that are unlikely to be applied to me.

Moreover, this exercise (alongside my subsequent reflections in the research diary) illuminated my potential motivations in moving to a discourse level when proposing this research. Though DA is a valid approach from the perspective of gaps in the literature, the social mapping exercise identified a tension between my status as insider through working in CAMHS and outsider in terms of not being a parent. This tension may have influenced my decision to distance myself from a more parent-focused project in favour of broad discourse. The assumption being that I may have more right to comment on broad discourses around CYPMH through professional and academic experiences.

Had I used a method such as interpretative phenomenological analysis, I felt I may have been exposed as a fraud by parents for not truly being able to understand their felt experiences. FDA allowed me instead to analyse from a more distant perspective without the same pressure to accurately represent the phenomenology of parents.

Moreover, my privilege as a white middle-class man has often led me to feel fraudulent in allyship, aware that my identity may feel oppressive to others. In response to this I often take up highly critical approaches explicitly to demonstrate my commitment to hold fair critique to dominant and oppressive structures. FDA has allowed me unparalleled access to a critical voice methodologically. The social identity mapping exercise allowed me to see that throughout writing the proposal, data collection and analysis, this critical voice in relation to my privileged status was

loud and unapologetic. In response to this, I have sought to mitigate this by soliciting the views of my supervisor and advanced methods workshops peers to ensure that my critical voice does not stray from my remit as researcher.

### *3.11 Chapter summary*

This chapter has outlined key considerations and detail around the methodology including rationale for the project, quality appraisal approach and self-reflexivity. The following chapter outlines the key findings of the study.

# Chapter 4: Findings

## 4.1 Summary of findings

Based on the FDA I have represented the key discourses in six main groups: evidencing good parenting, blaming the parents, responsibility for removal of CYPMHD symptoms, subject positions in relation to bureaucracy, authoritative discourses and education as oppressive and exclusionary.

## 4.2 Evidencing good parenting

A discourse of good parenting as linked to technical, expert conceptualisations of CYPMH was focal; the discourse was constituted through talk around institutions requiring parents to evidence learning, recording or attending to CYPMHD. This discourse was constructed through parents listing the multitude of monitoring requirements which were directed at them:

> *"I've put in an email right I've just signed up to this I'm doing this on such a date at this time and everything I literally write everything that I'm doing so no one can come back and say I'm not doing enough"* Lilly Transcript 4

What Lilly captured here is the function of officially documenting her efforts to psycho-educate herself through registering to attend psychoeducational workshops on parenting and other psychological topics. This discursive construction seemed to position parents in a way which leaves them feeling the need to defend their parenting. The degree to which parents are required to demonstrate their humility and efforts to improve their parenting competencies through education were

constructed as stressful, arduous and time-consuming. Though parents built the consequences of this administrative burden as stressful, their language implied a fear and control underlying the drive to record efforts to improve parenting:

*"yeah when you're under the spotlight you feel that you've got to do got to do to prove that you're doing something"* Lilly Transcript 1

A subject position of 'good parent' as conflated with 'psycho-educated' parent was constructed in the talk wherein gaining knowledge of psychology was a justifiable and expected route to ameliorating CYPMHD. This was demonstrated by the facilitator's agreement with parents that this stressful practice of administrating distress every day was a warranted means of demonstrating the 'good parent' subject position:

*"these courses or groups being things you are doing to prove something to things you can you're doing because you want to learn"* Lucy (facilitator) Transcript 1

Here we begin to see the conflation of education and psychology; Lucy's talk constructed a deficit which could be addressed through learning. Yet deeper than this is the phrase "*want to learn*"; this relates to the 'humble parent' subject position – a good parent is constructed as someone who accepts their lack of knowledge and works hard to fix themselves through the absorption of facts and strategies about good parenting. This combined with the forced activity of documenting a child's

absence every day (as a symptom of CYPMHD) which confronts parents with the fact that they have not yet 'learned enough' to fix their children.

As a counter-discourse to the disempowerment of the humble parent, parents in the current transcripts invoked a discourse of instinctual parenting and protection.

*"it's fine she doesn't need to do GCSEs it's more important that she's alive and she's here with us"* Denise Transcript 1

Leaning into this discourse allowed parents to resist professional practices of authority such as using deficit conceptualisations which blame parents for causing CYPMHD. Deployment of the instinctual parenting protection discourse allowed parents to construct an alternative image of 'good mother' which was not based solely on addressing deficits through psychoeducation and instead promoted direct resistance to powerful institutional representatives from education and the local authority. This discourse was further developed by parental talk which undermined the credibility of institutional practices of giving advice which has not been gained through lived experience:

*"like schools and different people that you see and say oh you know try this this and this you know like everyone says they've probably never been through it in their life and some people that have even written books yeah it's all factual it's not real life (2.0) you know they've not actually been through it like us"* Lilly Transcript 2

**4.3 Blaming the parents**

A key discourse drawn on and utilised by the parents in these groups was a sense that members of a system around them attributed the cause of a young person's difficulties to the parents directly – blaming parents. Parents cited challenges made to their parenting in relation to understanding the reason for a young person's distress:

*"mine and my husband's parenting was literally called into question you know and if oh if you let her stay in her room she'll become completely isolated if you don't make her come down and make her eat dinner with you you know it'll get to the point when she won't leave her room"* Denise Transcript 2

Parents cited the local authority and attendance officers intruding on their space as a practice which unfairly implicated the parents as culpable for causing the distress in their young people. Parents built these practices up as genuinely frightening, implying a misuse of power and an unjustifiable act of blame:

"*it is sad what the school put you through I remember them sending children services round to us and us being investigated"* Lilly Transcript 4

Due to their relative lack of power and an invocation that parents may be held solely responsible for their child's distress, parents and professionals constructed a contrast figure: the 'truant-permissive parent' this subject position was a caricature of an

imaginary parent who can be justifiably investigated by social care, where a young person's non-attendance is discursively constructed as genuinely caused by parental neglect, laziness or harm:

*"yeah it's just that you know what some people are like some parents are like you know when they take their children out of school and all of that lot you just feel that if it's you can now have like a day off for anxiety you just dunno oh I can't be bothered to get up today I'll just say they've got anxiety some parents are like that aren't they"*

Lilly Transcript 4

*"yeah and there are other cases obviously where we have children wandering the streets where parents really don't care less and in those circumstances it's a totally different scenario"* Sally (facilitator) Transcript 1

Based on this subject position, the targeting of statutory surveillance towards parents of children not attending school due to distress was constructed as immoral, unjustifiable and a misuse of valuable time. There was a strong sense that the implied criminalisation of parenting through local authority monitoring was subjectively experienced as humiliating, as though submitting 'humble SEND parents' to the same statutory processes as the 'truant-permissive parent' represented a waste of resources:

*"it just upsets me like how do they not know that like (name of Lilly's child) is covered in bruises or he's got a broken leg or they're doing this welfare check I say it all the time (.) they're doing a welfare check but they're not actually checking (.) it's just a tick thing and it just makes me so angry cuz I mean I'd never hurt a hair on (name of Lilly's child)'s head but you just don't know other parents (.) yeah that child could be in danger"* Lilly Transcript 4

In contrast, a subject position of 'humble parent' was constructed in the parents' talk; in this manner internalisation and acceptance of blame were positioned as important qualities of a good parent. This is connected to earlier discourses constructing a subject position of a 'good parent' as someone who acknowledges their deficits and actively works to improve the deficits through psychoeducation. By demonstrating that they were now earnestly working hard to ameliorate their child's distress by improving their psy-knowledge, the discourse of parental blame was sustained but the demonstration of these efforts would perhaps shield them from further judgement:

"*I'm constantly reading constantly I can't sleep at night so I end up reading books about PDA and books about gut health and (h) books about family dynamics"* Arwen Transcript 3

Importantly, within the parental blame discourse, there is a more operationalised form of blame targeted exclusively to mothers. The manner in which the mothering

role was constructed as innate, expected and accepted was built up through the construction of the 'good mother' subject position. Out of this subject position, parents demonstrated pride and determination in their acceptance of a greater parenting burden relative to male partners:

*"when you've got SEND children I mean tell me if I'm wrong but it's the mum that does everything it's the mum that keeps the house together and you know has to look after the child still do the cooking the cleaning the housework and everything I mean I'm when I was ill I'm still picking things up that I didn't do for three weeks cuz I just didn't have the energy to do it I was doing the bare minimum of still cooking and feeding for everybody d'you know what I mean and that's not putting my husband down but it is all left down to the woman"* Lilly Transcript 2

Within this discourse, the subject of 'good mother' was constructed as acceptance of pain and inequality and especially good mothering as persisting within this context with determination. All but one of the participants were co-parenting with a male partner yet the discursive construction of parental blame was built up almost entirely in the first person, implying they were solely accountable for responding to distress 'wrongly':

*"I never realised how much (name of Lilly's child) was struggling in school and you know I made him go into school every single day it must have been torture"* Lilly Transcript 4

**4.4 Responsibility for removal of CYPMHD symptoms**

Mental wellness was discursively framed by participants in terms of achievement and taking responsibility to work hard to remove symptoms of an individualised characterisation of poor mental health. The institutional contexts of school and psychology are important to consider here; experts and figures of authority were constructed as dominant speakers of truth on theories of how to improve poor CYPMH. Firstly, pressure to achieve mental wellness was represented through the practices of school using data and statistics to construct an image of failure to improve CYPMH:

*"yeah and the school keeps showing us they they- they've showed me and they've showed (name of Jessica's child) so many times the stats of like if you look at the stats you see that [those kids with] […] the low [attendance don't get GCSEs and I'm like what can I do]"* Jessica Transcript 1

Here education contributed to a construction of wellness conflated with improvement and success through the practice of co-opting statistics to motivate parents to improve CYPMHD. The fact that the effects of 'low effort' having a detrimental effect on CYPMH and broader capitalistic success in life can be charted and presented to parents replicated blame of parents.

Where school non-attendance was marked as a symptom of CYPMHD, removal of this symptom to return to a state of 'mental wellness' became an

attainable goal. In contrast, the mere notion of not maintaining a constant driving pace towards success was represented as a terrifying prospect:

*"you're terrified of looking back as well in case you haven't made any improvement or it hasn't got any better"* Sharon (facilitator) Transcript 3

'Success' for children's lives was constructed as evidenced through practices such as achievement of GCSEs, A-levels, a degree and finally securing a job. This was discursively constructed through the extreme bottom end of the success scale:

*"[and the] school are telling you their life chances are affected and they won't do this they can't do that and basically they'll be on the dole they'll be homeless (.) and you know their lives over if they don't take their GCSEs (.) […]"* Denise Transcript 1

This image of success was also constructed through parental testimony of children who have experienced distress in the past and gone on to succeed according to neoliberal markers of success, such as obtaining qualifications:

*"my daughter didn't go to school she's now got her health and social care […] and everything and she's she's doing amazing so (.) honestly school is nothing that's why I'm not really too bothered […] now my daughter's got so many qualifications under her belt"* Lilly Transcript 1

This construction was nuanced, though parents expressed resistance to what was presented as oppressively standardised neoliberal markers of success in terms of school attendance and GCSEs, they discursively constructed an orbit back towards success firmly prescribed by mainstream neoliberal definitions of 'successful contributor to society' i.e. attending university or securing a job:

*"there's plenty of people go to college […] go in their late teens in their early twenties [cuz] […] they've worked out what they wanna do it's their time and they just go (.) you know and it's their terms (.) […] and in their own time they they will learn and if she wants to go to university as a mature student you don't need all of these a levels and all of these other things to get in because it's it's a different it's different when you're older"* Denise Transcript 1

Money was framed as a solution through wider discourses of attainment, effort and access to resources resulted in better health. In the parents' speech money was framed as a potential way of ameliorating CYPMHD and an escape from stress. Moreover, class differences in the possibility to avoid CYPMHD were invoked:

*"I don't just have money to throw at things I'm really limited in what I can do so I'm yeah I feel I feel I feel the frustration today"* Arwen Transcript 3

*"I have to pay the ed psych to attend and the speech and language therapist to attend and the occupational therapist to attend and they charge like a grand each so*

*I (h) am praying that it it gets sorted before that otherwise [yeah otherwise I'll be yeah I I I] […] I just can't afford it so I'm I'm playi- I'm gambling massively here"*

Arwen Transcript 4

Elsewhere in the transcripts, Lilly outlined how money became part of an attempted treatment of a behavioural problem:

*"we're gonna get him a* [young person's banking scheme] *or go to a bank and set him up an account so that he can earn his own money and it's gonna be like silly things but like make your bed and we're gonna give him ten P just ten P bec- just so he can earn his own money and he can see the money building in im um- and um hopefully he'll want to do more to want to earn more money"* Lilly Transcript 2

Here the ubiquity of money and status is brought to life. Money as a measurable yardstick against which success is judged was proposed as a way of relinquishing young people from their poor mental health, which was conceived in terms of the earlier discursive construction of low effort/responsibility resulting in CYPMHD not being ameliorated.

**4.5 Subject positions in relation to bureaucracy**

This group of discourses can be thought of as the consequences of the institutional requirements of evidencing good parenting. Participants' talk constructed a resistance against an ever-shifting, amorphous body of shared power between local authority, education and CYPMHS. These bodies are given more authority to claim

truth on the matter of CYPMHD. The experience of surrendering to or resisting the requirements of this bureaucratic system was constructed as exhausting and maddening in itself. An example of this was the requirement to fill in a form to gain access to support but not understanding the technical language required to fill in the form:

*"Lilly: the thing is as well when you're filling in all these forms it's the wording that you use I dunno about you but [I'm not very good]*

*Denise: [yeah]*

*Arwen: [yeah]*

*Lilly: with wording it's you just you try and explain things*

*Arwen: yeah*

*Lilly: if you know what I mean and then you don't word it right*

*Denise: yeah*

*Lilly: and then yeah it is it is so stressful [it's like]*

*Arwen: [it's like] a secret language that nobody and English isn't my first language so I struggle I'm there with the dictionary and on google"* Lilly, Denise and Arwen Transcript 4

The consequence of this marginalisation through the deployment of expert technical language was an epistemic injustice but how parents responded to this bureaucratic landscape of CYPMH contributed to the construction of the bureaucratic system as hegemonic. Though parents recognised that rules and thresholds created by

institutions were exclusionary and, to some extent, scare tactics: *"forget about the fine cos they're not gonna fine you so don't worry about it they're not gonna fine you"* (Denise Transcript 1), their recognition of the bureaucracy did not necessarily result in resistance. Parents described an acquiescence to this exclusionary, bureaucratic threshold system *despite* knowing it was arbitrary and unjust. This was constructed through the parents and facilitators instructing one another on how to 'play the game':

*"(h) yeah so it's about knowing how to play the game and the game is you need as much evidence as possible which you've got yeah"* Sally (facilitator) Transcript 1

*"[so if there's] an email or anything that they've said to you you know if it was over the phone that they said that to you get back to them and ask them to put it in an email that they won't take you on"* Denise Transcript 1

*"and that's the crucial bit that's what Lilly I think you were getting at is if you have got a paper trail (2.0) demonstrating that from your point of view you were maintaining an open communication with school that you are willing to engage with them that you are willing to attending necessary courses that you are part of this peer support group what you are demonstrating is that it's to do with your daughter's mental health difficulties it isn't that you can't be bothered and she's playing truant (2.0)"* Sally (facilitator) transcript 1

These acts of demonstrating to powerful forces that one is performing good parenting strongly invoked the 'humble parent' subject position and 'evidencing good parenting' discourses presented earlier.

Alternatively, these acts of administration could be represented as acts of resistance. In some parts of their talk, parents framed their responses to burdensome requests for proof of absence from school as ironic administrative acts of retribution:

*"[I normally write what I think and then just send] all the documents everything I've got I just send all his diagnosis everything else just send the whole lot and then I'm like yep you can file through that (h)"* Lilly Transcript 4

From a position of almost complete submission, Lilly demonstrated that resistance could still be enacted; by sending a cumbersome, inordinate stack of jargon-filled technical documents back to school (following a request to defend her child's absence) Lilly shifted the burden straight back to school where epistemic dominance was enacted out of. In real terms, this meant an administrator had to sift through an awkward amount of paperwork thereby suffering some of the daily stress experienced by these parents.

**4.6 Authoritative discourses**

These discourses describe the forms of evidence which are deployed by schools, local authority, psychology and parents to claim authority and truth over the construction of CYPMH. Evidence rooted in rationalism, empiricism and logic were discursively

constructed as more authoritative claims to truth. Often a biomedical discourse was invoked by parents and professionals through the use of technical and medical language to construct a real, objective physically realist description of distress:

*"because people when they're stressed or they're depressed they just work out a lot and you know when you do sport it's like your body create endorphins and the ( ) it's really work (h)"* Erica Transcript 2

*"it's too much information but my tummy was upset I was so stressed on Friday you know I couldn't breathe my blood oxygen levels dropped"* Arwen Transcript 4

This assumption that distress has a physical, objective and diagnoseable pattern to it then provided a discursive framework from which parents could construct CYPMHD as empirically medical:

*"he had a complete meltdown then he was screaming shouting trying to hit me he was completely dysregulated it was heartbreaking cuz I would never stop him midway of his of what he needs to do to regulate himself but I had no choice"* Arwen Transcript 3

The use of the word 'dysregulation' in the above quote evidences the deployment of technical language typically used by psy-professionals. This objective 'symptom-like' description allowed for authority to claim truth about the experience of CYPMHD

here.

In later extracts, parents use of humour and sarcasm compounded this construction of CYPMHD as so firmly real in a positivistic, empirical sense that to question the stable existence of a diagnosis would be so unfathomable as to be surreal:

*"Lilly: and [we were told] […] that his diagnoses were out of date (.) that's what they tried to say to us and I was like how can they be out of date they're a diagnosis […] Arwen: (sarcastic) oh yay I just woke up this morning and I'm no longer dyslexic (h)"*

Lilly and Arwen Transcript 4

Positivistic, rational and empirical frameworks of reasoning were also deployed to construct a binary of lawful/unlawful which supported their holding the school accountable for not recognising CYPMH needs:

*"I said well does that mean you have an unlawful blanket policy because according to the mental health act or whatever you know it's classed as a disability"* Arwen Transcript 4

In this extract, Arwen demonstrates the discursive construction of lawful/unlawful. Discursively, the law was constructed as irrefutable truth by parents here. In this sense the law relies on an illness model of CYPMHD to refer to a definable and stable identity marker to then mandate how people must legally act in relation to this

reified state of CYPMH. From this theoretical perspective, parents drew on authoritative discourse as a way of 'truth-telling', in the context of particular relations of power vis-a-vis the school. Here parents drew on juridical truth to evidence wrongdoing on the part of schools:

*"it's just you know ah an eight year old having autistic burnout and being in crisis how is that okay how is that okay"* Arwen Transcript 4

The law as a rational and irrefutable barometer for morality was constructed elsewhere when parents were debating the ethics of covertly recording meetings with professionals:

*"Lilly: [d'you know what my friend does] she records the whole call on her phone she puts her phone down on the table without anyone knowing and records everything*

*Sally: brilliant brilliant*

*Lilly: they the school don't know but yeah she she does it for all meetings and everything so that she knows everything that's said so that she can go back on it well you said this this and this"* Lilly and Sally (facilitator) Transcript 4

Where initially this disclosure elicited conflicting opinions as to whether this behaviour was justifiable or not, notions and ideas drawn on to ultimately absolve this behaviour were the corruption and epistemic injustice of schools and the finality/irrefutable decree of law:

*"I was just saying […] that I agree with Arwen that you know I don't like being sneaky I like to kind of be honest […] but school don't in my experience […] will absolutely backtrack on what they've said and outright deny saying it to the point of doctoring minutes and doing inaccurate minutes or not giving you minutes and just giving you hand written notes that someone made in a meeting which are absolutely inaccurate so unfortunately if you can't trust them and recording a meeting I think is the only way and I would do it secretly personally"* Denise transcript 4

Here, Denise talked about discourses of corruption and experts misusing power to construct the parental position as relatively powerless when truth can be warped and defined in practices such as doctoring minutes. From this position, acts of resistance such as covert recording were constructed as a justifiable form of self-defence. This was then confirmed further by the act of online searching the law's exact parameters of illegal behaviour with regard to secret recordings:

*"Lucy: and I've just had a quick google and*

*Sally: yeah what's the law*

*Lucy: yeah so recording*

*Sally: go for it*

*Lucy: recording a conversation in secret is not a criminal offence and is not prohibited as long as the recording is for personal use"* Lucy and Sally (facilitators) Transcript 4

This extract demonstrates the power of employing rational forms of logic; as long as a recognised and recorded law could be cited, behaviour was represented as irrefutably ethical. This links to the rights-based discourse synthesised here with deployment of rationality and law; where an injustice has occurred, parents and professionals deferred to recorded and officially documented forms of proof to guide behaviour.

**4.7 Education as oppressive and exclusionary**

In their talk, parents constructed schools as sites of oppression and exclusion. Their construction of 'school' included the school buildings, teachers, SEND professionals and the many practices which constitute the daily practice of education. This discourse encompassed the abuse of power, injustices, incompetence and inflexibility constructed as inherent, inevitable and inescapable.

Two distinct subject positions within this discourse were constructed through the parents' speech: withholding teachers who wield power unjustly to the detriment of parents and incompetent teachers who are so overwhelmed by the system and limited in their knowledge that they cannot help. The 'withholding teacher' was discursively constructed in part through the practice of educational staff deliberately not providing support in school:

*"d'you know it's because the school don't wanna be overrun by SEND children"* Lilly

*"Lilly: d'you know what the annoying thing like you say your son's got an EHCP same as my son and they haven't been to school so what are they doing with all the*

*funding they actually get for our children and it really really really aggravates me that they're not doing anything so where is this money going*

*Denise: yeah*

*Lilly: cuz they have still got EHCPs even though they're not in school*

*Denise: yeah*

*Lilly: but you ask the school for help (.) and they go oh no we haven't got the funding well yes you have"* Denise and Lilly Transcript 4

Lilly here presented educational staff as being equipped to support children but deliberately choosing not to. In some ways this position of 'withholding teacher' was also built up through imperviousness to direct criticism. These constructions drew on the earlier subject position of 'humble parent' which extended to their relative powerlessness in relation to educational staff as well as local authority and psychology:

*"Denise: it's so true that annual reviews I think we've had three this I think this might be the third one third annual review for my son since he's had his EHCP and I remember the first one I was just an absolute mess and there was there was nowhere near as involved or as much going on as yours Arwen and it was absolutely I ju- cuz I didn't know it what what it was gonna be like*

*Arwen: yeah*

*Denise: who was gonna be there I was thinking are we gonna be you know am I gonna be interrogated and you've gotta fill the form in about you know his views and my views and I find those forms almost impossible to fill in I mean what do you say*

*Arwen: yeah what do you say*

*Denise: I think my son is getting a shit education he's getting a raw deal he's not being taught properly you know I don- I dunno what to say"* Denise and Arwen

Transcript 4

The oppressive status of education was constructed here through the defined practices of EHCP application rejecting authentic criticism. Though EHCP assessments are an apparently objective process that invites parents in to share honestly what is difficult (even if that includes educational professionals) the oppression of the parent was constructed through evoked fear to directly cite education as a contributor to distress. The subject position of incompetent teacher was represented in relation to a frantic and unprofessional education machine:

*"Lilly: the SEND officers change so much [cuz]*

*Denise: [yeah]*

*Lilly: no one sticks at the job cuz it's a joke*

*Denise: [yeah]*

*Sally: [yeah that's very true]*

*Arwen: [yeah]*

*Lilly: like you'll have one SEND officer you'll phone up to speak to her and she's gone and you've got somebody else [that's why]*

*Arwen: [yeah]*

*Lilly: I can never remember who (name of Lilly's child)'s SEND officer was he must have had about ten"* Lilly, Sally (facilitator), Denise and Arwen Transcript 4

*"Arwen: it will go to panel to see if he qualifies for a specialist setting so we'll see we'll see how that goes I was a bit the SEN officer didn't even show up last minute for the review just last minute cancellation which was pretty bad*

*Sally: very bad [very unprofessional]*

*Arwen: [cuz um] yeah cuz I cuz I'm going through a lot I have […] a lady who helps me who does this for her living and bless her her mother passed away […] last week and she still showed up for the review to support me […] you know I said to her don't do it it's you know I totally get it you know but she felt so strongly about supporting me and this other woman couldn't even be arsed to show up"* Arwen and Sally (facilitator) Transcript 4[3]

Here, the school institution was constructed as powerful but chaotic and not in a position to make important decisions. This incompetence at times extended to inflexibility which began to bring in the exclusionary element of this discourse; parents constructed an image of education as stuffy, stuck in out-of-date practices:

*"Lucy: sitting in English reading these novels from a hundred years ago*

[3]Highly specific details in this quotation have been altered to retain original meaning but protect the anonymity of the participant

*Jessica: (h)*

*Lucy: or you know trying to work out algebra or things like that and realistically they aren't going to use that in their life"* Lucy (facilitator) and Jessica Transcript 1

Against a backdrop of a biomedical disease model of CYPMH, sophistication and targeting were constructed as vital to ameliorating distress. In this context, education was positioned as unfairly exclusionary. Moreover, parents discursively represented the expertise of schools to wield powers of exclusion as undermined by their inaccuracies and unsophisticated methods:

*"how accurate is that information that they are not functioning at their age but they're functioning educationally at the age of a seven-year-old when they are not able to fully access the education system anyway I would be questioning that as a parent"* Sally (facilitator) Transcript 4

*"Denise: the school this isn't helping (.) […] my daughter is struggling I am struggling trying to support her (.) I don't need you (.) showing us doom and gloom I need you to be positive for us and supportive of us*

*Jessica: mm*

*Denise: and if you can't direct me to where I can get support please (.) and just (.) it's really hard but at some point you have to say to them- a teacher even said to me well what if I come round to the house and get her in and I said [no]*

*Sally: [terrifying]*

*Denise: you're not coming to my home and and he said to me well why not (.) I said because that's her safe place you're not coming into our home trying to force her into school it's not happening (2.0)"* Denise, Jessica and Sally (facilitator) Transcript 1

This constructed an overall image of education as simultaneously incompetent and withholding. In relation to this position, psychological discourse and practices were represented as a source of relief through the capacity of psy-professionals' to validate distress through labelling. Even in cases where the diagnosis does not result in less distress, Lilly demonstrated here that the act of labelling the problem was constructed as vanquishing a threat of punishment by local authority:

*"we went to see a doctor at CAMHS yesterday and umm after everything we've been going through […] um he's decided to say that (name of Lilly's child)'s unfit for school at the moment and he's getting ESMA involved so he will [no longer]*

*Sally: [excited sigh]*

*Lilly: be under the threat by the attendance officer"* Lilly and Sally (facilitator) Transcript 1

**4.8 Chapter summary**

This section has presented findings from the parental peer group data to address my research question of how broad discourse positions parents and how these discourses define parents' relationships to support and psy-professionals. The following chapter explores these findings in relation to wider literature, theory and considers the wider implications of the study.

# Chapter 5: Discussion

## 5.1 Chapter overview

This final section presents an overview of the findings section before contextualising a selection of these discourses in synthesis with one another, wider literature and theory. The project is critically appraised according to strengths, limitations with reference to Tracy's eight big tent criteria. Finally, clinical implications of the findings and further research are considered before final conclusions.

## 5.2 Summary of findings

This project aimed to explore how broad discourse structures parents' understandings of CYPMH. Additionally, within this research question the study investigated how these discourses position parents in relation to wider society. The study also aimed to explore how the discourses define parents' relationships to therapeutic support and mental health professionals.

The findings of this study suggest the psy-complex acts as a productive force of power in positioning parents as humble and defining a 'good parent' as willing to learn psychological parenting competencies. Moreover, the role of stressful and arduous administration with regard to neoliberal competition and self-actualisation is explored throughout. Finally, the oppressive power of education is reconceptualised including the promotion of psy-professionals as arbiters of truth against educational professionals positioned as incompetent and withholding.

## 5.3 Findings in theoretical/empirical context

### *5.3.1 Blaming the parents*

Within the 'blaming the parents' discourse, a subtle and complex web of power was interpreted. There was a rich complexity to how parents drew on available CYPMH discourses, and how they positioned themselves in relation to questions of blame and responsibility within these.

DA papers explored in the SLR presented a process whereby parents would turn to biomedical discourses of CYPMH due to the amorphous threat of blame felt in an assessment setting. By characterising young people's distress in a more natural, static and organic way, researchers theorised that parents were attempting to shift attention away from theories of distress which may blame them for causing the CYPMHD presenting in the clinic (Bennett, 2007; O'Reilly, 2007, 2015). The findings of this FDA suggested that this may be a reductionist interpretation of the role of power in constructing CYPMH where parents are concerned. Power in the Foucauldian sense is always productive; applying this to the ways in which parents negotiated blame in the peer groups in the current study, it could instead be argued that the psy-complex generates knowledge that positions parents as blameworthy. Parents worked hard discursively and through demonstrated practices of attending psychoeducational 'courses' to evidence that they were willing to accept their blameworthy status. This appears to contrast with the more active, concerted interpretation provided by O'Reilly (2007, 2015) that parents are frightened to accept blame, meaning they turn to an alternative CYPMH construction which would shift the blame away from themselves.

Instead, one can conceive the production of a type of psychology starting from a conceptual assumption that parents are not psychological experts and

therefore lack the competency to parent properly, and that their deficits 'need addressing' with the provision of psychological knowledge (Callaghan et al., 2017; De Benedictis, 2012; Emery, 2016). This forms a version of truth deployed by the parents that 'good parenting' is rooted in humility and learning a highly psychologized model of parenting as per the 'humble parent' position outlined in the current findings. Hence, far from resisting blame, in some sense, blame is tacitly accepted by parents with the assumption that they are learning and improving on this constantly to demonstrate a subject position of good parent.

It is important to consider the role of psychology generally here; though talk within the peer groups on face value appeared mainly to focus on relationships between school, parents and young people, the latent role of psychology was consistently setting parameters of truth throughout.

This conceptualisation of psychology can be situated in historical context in an archaeological sense before proceeding. The role of psychoeducation in therapy has its own story (Hatfield, 1988) but the highly didactic form of psychoeducation delivered via 'webinar style courses' is perhaps best contextualised in introduction of IAPT to NHS therapies. The IAPT model was built on an pragmatic economic purposes; in order to provide everyone with therapy in a timely fashion to save the NHS money and get people back to work, cognitive behavioural therapy (CBT) skills can be taught in psychoeducation delivered in manualised low-intensity interventions (Beck et al., 2019; Binnie, 2015, 2015; Bruun, 2023; Painter, 2019).

IAPT has become a monolith in mental health provision in the UK and as such is heralded as the primary way to provide therapy to many people (Bruun, 2023).

Within this model, the transmission of strategies, tools and knowledges has become synonymous with the culturally accepted model of improving one's mental health through therapy (Bruun, 2023). This contrasts with the approach of other modalities preceding the ubiquity of CBT in the 'therapy marketplace'. The changing social discourse around psychology and distress which is inextricably linked to the evolving popular modes of therapy in the UK could be seen in the talk of the parents in this study.

In the late 19th century to the early 20th century therapy may have been understood as a mysterious force with paternal authority positioned more explicitly with Charcot as hypnotist or Freud as psychoanalyst holding epistemic control over the route to wellness (Cromby, 2013; Foucault, 2003a). Through the 20th – 21st century, the route from behavioural therapy to CBT to IAPT could be seen as a form of democratisation; no longer does one need to fearfully enter a room and lie on a sofa in receipt of techniques that the client is not privy to, now clients are given worksheets, computerised programmes and have free access to selected core concepts from CBT which are designed to be self-administered (Binnie, 2015). The promise of attending an hour-long skills webinar to improve one's parenting in a context of perpetual blame is understandably taken up by many parents. The important factor here is that psychology promises wellness and produces the cultural discourses around guided self-help and psychoeducation; discourses which are now invoked by parents to demonstrate their own humility.

### *5.3.2 Evidencing good parenting*

Building on this notion of power, the current findings illustrate a function of power in this relationship through juridical discourse to structure thought and limits to truth. Discourses around the law and justice socially constructed ethics and morality around CYPMH, for example in the debate around covert recording which was ultimately resolved with reference to the law.

Juridical and rationalist discourses were also deployed where parents acknowledged the arbitrary nature and stressful nature of 'the game'. 'The game' here referred to representing distress in forms of evidence requested by institutional bodies such as school. Parents 'played the game' because the practice of officiating absence through documented, diagnostic CYPMHD was positioned as mandatory by the law. Parents engaged in this 'game' despite declarations by the parents that forcing them to email school with evidence justifying absence was arbitrary and unfair. Through this practice of painstakingly administrating CYPMH, the absolute *definitional power* of a system was reified. Through the process of mandating categorical data of distress to be input to avoid criminalisation, authority is weighted in favour of the systems which set these parameters. Consequently, the value of administration and official recording of CYPMHD is promoted to a higher level of context than the experience of that distress.

This pattern is mirrored in the families who attend assessment clinics as explored in various articles in the earlier SLR, in particular O'Reilly and colleagues (2023) who explored strategies of epistemic corroboration in case-building within child mental health assessments using applied CA. O'Reilly and colleagues presented

a conceptualisation of power unequally distributed in the process of parents lacking epistemic authority to claim validity of their child's distress. O'Reilly found that parents used a variety of rhetorical means to claim truth in a CAMHS assessment setting where they were subjugated by the social practice of assessment. Expertise is constructed as a crucial currency within mental health assessments with parents often drawing on a third-party perspective of someone with greater authority to recognise and label distress (usually a professional of any kind in the system). The current findings extend and reframe O'Reilly's findings. Parents continue to engage in 'the game' which constructs epistemic power differences. Parents shared knowledge with one another on the best methods of maintaining 'paper trails' and the exact forms of evidence to use to validate CYPMHD according to institutional requirements. Continually engaging in this process, as with the blame-of-parents mechanism, constructs a truth around CYPMHD that distress *can* be categorised, diagnosed and labels can provide useful evidence to explain non-attendance.

Moreover, the identified forms of resistance add an interesting layer to the epistemic imbalance of power identified by O'Reilly and other studies included in the SLR examining the construction of normality in clinics (Avdi et al., 2000; O'Reilly, 2015; O'Reilly et al., 2023). Parents in the current study represented schools as unjustly, arbitrarily requesting daily administrative chores of parents; this practice constructed the role of educational professionals as having greater capacity to claim truth and authority over CYPMHD. However, one parent demonstrated a form of administrative retribution by sending a cumbersome stack of reports and official diagnostic letters to deliberately overwhelm the educational system which was

overburdening her. This indicates that parents, perhaps conceptualised as completely powerless in the discourse analyses presented in the SLR, can enact resistance to power through non-discursive methods.

### *5.3.3 Responsibility for removal of CYPMHD symptoms*

A discourse of neoliberalism informed the construction of CYPMH in relation to recovery, self-actualisation and success in the findings. In this neoliberal frame, achieving wellness and removing CYPMHD becomes an individualised practice of absorbing as much psychoeducation as possible with the ultimate goal of complete recovery as measured by engagement with society (getting GCSES, going to university or getting a job).

Parents constructed the role of education as offering a singular and limiting vision of success based on CYP mental wellness being required to achieve good grades and reported that schools engaged in scare tactics relying on statistics to frighten parents into taking responsibility for ameliorating CYPMHD. This construction of the network relationship around CYPMH links strongly to the CDA of health and wellbeing policies in education conducted by Hardley and colleagues (2021). Hardley and co-authors situated educational policy in societal expectations that a vision of the healthy child free from CYPMHD is achievable through psychoeducation around health and wellbeing in school. Moreover, health and wellbeing (constructed as the removal of CYPMHD) is co-opted in educational policy to ensure that children achieve more (e.g. GCSEs). From this standpoint, educational policy encourages monitoring and surveillance by educational staff to indicate when children may be ‘at risk’ of CYPMHD. These policy recommendations rely on the

neoliberal notion that removal of distress is an individual responsibility (or the responsibility of parents) and has some bearing on the performance of a child in competitive terms – a strongly neoliberal conceptualisation of CYPMH (De Benedictis, 2012; Emery, 2016).

This is supported by contemporary Department of Education policies encouraging monitoring and surveillance in cases when schools may be concerned that CYPMHD is affecting attendance (Department for Education, 2023, 2024). The assumption in these policy documents appears to be that monitoring children, families and CYPMHD severity with the intention of improving a child's performance is value-neutral. It perhaps even purports that by remaining in an 'assessment and monitoring' phase for a longer period before fining parents, the local authority should be commended for humanitarian and compassionate efforts. The findings of this study indicate precisely the opposite; the subjective effects of power exerted through panoptical assessment and administrative processes are patronising, restrictive, shame-inducing and the most confronting aspect of the blame applied to parents. This is demonstrated most clearly in the interpretation of findings built up in the parents' resistance to the 'truant-permissive parent' subject position. This can be theoretically connected to literature around the 'feral parent' subject position described in research around neoliberal policies which demonise working class parenting as causing CYPMHD (De Benedictis, 2012). Parents discursively constructed the contrast figure of (what can be alluded to with reference to research as) 'feral parent' as someone actually deserving of the intrusion of local authority into their homes because *their* children's non-attendance was best understood through a

frame of laziness, neglect and abuse. Conversely, to subject 'SEND parents' to local authority home assessment processes is humiliating and a misuse of resources.

The division of 'feral parent' versus 'SEND parent' is a curious historical contingency and indicates something of a full circle moment in Foucault and Rose's concepts around the normalising power of psychology. Rose draws on Foucault's concept of normalisation to argue that psychology's invention of the normal and healthy individual underscored the formation of child guidance clinics in the UK (Kelly, 2019; Rose, 1985). This reframed the conception of CYPMHD as no longer delinquency (or connected to parental moral poisoning) but as representative of a psychological illness that could be understood as deviation from the norm and psychologically 'treated' (O'Farrell, 2006; Rose, 1985).

Applying this genealogical lens to the current findings is highly relevant to the subject positions of 'humble parent' and 'feral parent' constructed in parental talk. This perhaps could be understood as a persistence of the parental 'moral poisoning' aetiology which Rose speaks to. The findings of this FDA indicate that where Rose suggests that delinquency models of CYPMHD were subsumed into psychological normalisation, here the parental talk suggests that 'feral parents' are better understood through a criminal/delinquent lens than a psychological framework.

This could also be understood through the earlier semantic polarity around choice and school attendance (Figure 1). Positioning the different types of parent at opposite ends of the spectrum implies a degree of choice or lack of choice which builds a logical argument that monitoring practices of local authority are wrongly applied to 'humble/SEND parents' but correctly applied to 'feral parents'. These

subject positions indicate a division where Rose previously represented the collapse of delinquency into psychological normalisation.

Figure 4

*Semantic polarity line indicating how parent subject positions relate to frames of psychological normalisation*

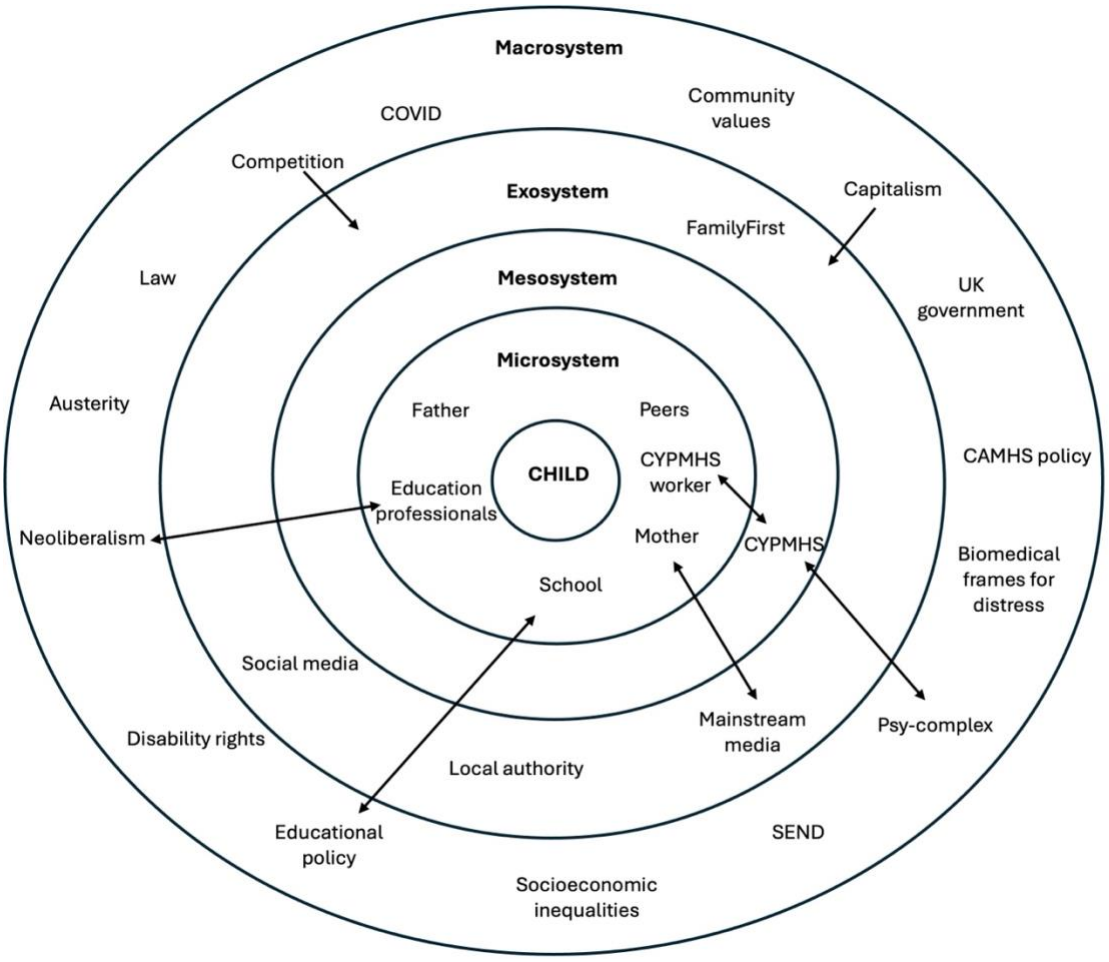

A useful contextual frame for this discursive strategy is competition for resources in austerity informed by neoliberalism. Carl Emery's (2016) CDA of interviews with policymakers in England and Wales during New Labour governments interprets the influence of neoliberal models on schooling and the effects of this on parents. Emery's findings explore how individualistic, competitive, performance-driven discourses characterise New Labour policy makers' constructions of parents of children 'at risk' of poverty or CYPMHD as objectified, 'feral' and unskilled. The antidote to this is the provision of skills building aimed at importing middle-class parenting models to working-class parents. This is clarified in the brief genealogy supplied by Emery around the transition in Welsh policy away from 'nation-building', community-oriented ontologies of family challenges towards an individualistic deficit model with the introduction of New Labour neoliberal ideologies (Emery, 2016).

Holding the influence of policy in mind with a Foucauldian notion of power,

one can interpret the parent's rejection of the subject position of 'feral parent' as occurring in parallel to educational staff and psy-professionals perseverance with an objectified model of parenting based on competency building. I have mapped these systemic relationships in Bronfenbrenner's socioecological model (Bronfenbrenner, 1996). I have interpreted that this wider neoliberal, individualistic, competitive frame may recursively interact with parental approaches to demonstrate need.

Figure 5

*Representation of the various socioecological levels of influence around a child mapped onto Bronfenbrenner's ecological systems theory*[4]




[4]n.b. Macrosystem (social and cultural values), exosystem (indirect environments), mesosystems (connections between environments), microsystems (immediate environment).

Parents may be deploying the 'feral parent' subject position in a broader societal context of austerity creating competition for resources. The adoption of a biomedical framework for distress and the construction of oneself as a SEND parent of a child with an official diagnostic label may further explain the parent's need to separate the 'feral parent' from the humble SEND parent on a waiting list competing for access to a public healthcare support with limited capacity. This interacts closely with CYPMHS policy increasingly constructing CYPMHD as a biomedical phenomenon to be assessed, described, treated in the service of removing distress to allow maximum economic contribution from children and families (Callaghan et al., 2017; NHS England/Medical Directorate/Parity of Esteem programme, 2014; Rothi & Leavey, 2006).

### *5.3.4 Education as oppressive and exclusionary*

Building on the resistance of parents, one further discursive method by which parents attempted to reconstruct the hegemonic, deficit parenting discourse was to build up a discourse of instinctual parenting. Parents drew on a counter-discourse of instinctual parenting and protection which was reliant on biomedical frames of distress and recovery. This talk contrasted the abilities of professional staff with knowledge gained through parental lived experience. The link between biomedical models and incompetency here played out through parents implying that educational professionals were incompetent because they did not recognise a CYPMHD diagnosis as fixed and unchangeable. It is useful to consider a new semantic polarity conceptualisation of these relationships:

Figure 6

*Semantic polarity line depicting the positioning of psychology professionals, school professionals along a spectrum of CYPMH knowledge accuracy*


Applying the findings to this systemic sematic polarity line, it could be suggested that parents may position educational professionals at the extreme 'inaccurate' pole given their sarcasm and implication that punishment approaches are incompetent and needlessly harsh. Furthermore, parents may position psy-professionals at the extreme 'sophisticated/accurate' pole; as they are seen by parents to be the primary arbiters of truth and offer biomedical explanations which validate their children's distress. One could also predict that a parent may position themselves on the extreme 'sophisticated/accurate' pole due to their innate and instinctual understandings of their child's distress. This suggestion is informed by the instinctual parenting discourse constructed by parents as well as the parents' endorsement of biomedical language for distress.

The effect of this strategy has clear implications for a rights-based discourse around CYPMH. The parents in this study commonly cited the behaviour of educational staff as juridically unjust when they were seen to deliberately withhold

support for CYPMH. Parents invoked a rationalist discourse of adaptation based on SEND needs being a lawful requirement of schools, the deployment of a biomedical frame allowed parents to depict education professionals' incompetence and inflexibility to diagnostic CYPMH needs as therefore ethically wrong.

The changing social currency of a diagnostic label is relevant here and useful to contextualise with Stentiford and colleagues' ethnographic study in the SLR exploring the social function of CYPMHD in an elite sixth form setting (Stentiford et al., 2023). Researchers here examined a highly unique context in which disability had become reframed to provide social capital in this college, forming a heterotopia of sorts whereby CYPMHD labels were acceptable and perceived to allow access to friendships, protection and understanding. The authors applied Foucault's theories of power in this context well and generated an interpretation that the discourses around CYPMH operated in highly unique means dependent on the type of need and where it is being expressed. This demonstrated high quality meaningful interconnection of complex and relevant theory with evidence.

Applying this contingency of CYPMHD labels as de-stigmatising in certain contexts, it is possible that the subjective effects of diagnostic labels for parents in the current study allowed them to understand one another, their children's experiences and discursively reframed the practices of educational staff as inaccurate. This is in a context whereby parents typically lack naming rights and have little say in how CYPMHD should be addressed (Avdi et al., 2000; Reid, 2024). In contrast, psy-professionals may be seen to be highly glorified as the labellers in this network and an alliance with psy-professionals against education is likely deemed a

fruitful escape from the stigmatising label of ‘feral parent’.

However, the unintended effects of a wholesale endorsement of biomedical approaches may allow access to a rights-based advocacy argument against school to provide more flexible support but the social capital of a diagnostic label may differ across contexts as Stentiford and collagues (2023) elucidate in their research. Parity of esteem campaigns are a useful example here; attempts to gain social currency and reduce stigma by promoting a discourse of similarity between physical and mental health may have been a well-intentioned endeavour, these attempts were arguably unsuccessful and may have even resulted in more stigma (Hazell et al., 2022).

Foucault’s conceptualisation of power is crucial here; Foucault posits that power cannot be wielded as a choice or decision of a person or group, power relations cannot be intentional or planned in this way because power is inextricably linked to knowledge production and discourse (Powers, 2007). In Foucauldian terms, it is therefore unwise to replace one discourse with another (as the Parity of Esteem campaigns attempted) because power is wily and does not operate in such tangible, malleable ways. In this sense, the parents’ collusion with a biomedical discourse may allow access to a rights-based advocacy. For example, the parents represented CYPMHD as strictly fixed, categorical diagnoses which allowed them to be classed as a disability in the eyes of the law. This allowed them to identify the school as acting in an unlawful way by not adapting to CYPMHD needs. In adopting such a positivistic, disease model of CYPMH, stigmatisation or effects that we may not fully be aware of yet may result in oppression in some different form in the future.

## 5.4 Critical quality appraisal

A critical quality appraisal of this study follows now informed by Tracy's eight big tent criteria for qualitative research (Tracy, 2010). This framework has been selected for cohesion as it has been used throughout but also for its applicability to FDA.

### *5.4.1 Strengths*

By keeping a reflexive research diary throughout this process I have examined my own impact and my motivations when conducting this research. My involvement in the advanced methods workshop demonstrated self-reflexivity in recognition of the parts of my social identity that may have influenced my interpretation of the dataset. Following a social identity mapping exercise in research supervision I demonstrated self-reflexivity in a way that changed how I approached analysis. For example, broaching the topic of motherhood with peers who identify as women allowed me useful context in how to explore this discourse in my analysis.

This research offers a significant contribution in that it focuses on a topic within CYPMH which is highly contemporaneous but has clear genealogical aspects that had not fully been explored in extant research. Moreover, I believe this project builds on a strong discursive research base to conceptually further knowledge by adding the layer of history and cultural/social discourse that was missing the methods previously used by researchers.

Meaningful coherence was achieved by carefully selecting a naturalistic dataset which would match the FDA approach. Previous research has explored testimony, interview and focus group data with some attempts to move into social, cultural and power implications of this (O'Reilly, 2007, 2015). Conversely, this

research intended to use FDA as a method cognizant of broader discourses beyond interaction, yet is best achieved by capturing talk in its least artificial context. In this manner, my methodological approach matched my research questions well.

Using an FDA represents a significant methodological contribution to the evidence base. As highlighted by the introduction and SLR, DA research has thus far not investigated discourse from a Foucauldian perspective in the broad CYPMH parenting literature to the best of my knowledge. Consequently, this study was novel and demonstrated application of a new approach to this topic. Though FDA is less prescriptive about the minutia of transcribing, coding and analysing data, I believe I have demonstrated rich rigour in the sources I have used to guide this analysis. By familiarising myself with core texts, in particular Willig, I have used an approach which is appropriate and transparent in presentation.

My SLR findings indicated useful ways of including history and genealogy in DA; I have incorporated these ideas into my presentation of this thesis by weaving genealogical ideas from the introduction through to discussion. I have resisted a realist presentation of the research landscape by moving against the flow of time and highlighting contingencies in the development of institutions such as CAMHS and educational policy. This supports a coherent and meaningful inclusion of Foucauldian approaches to power and knowledge which has previously been lacking in the research base. A genealogical approach here has allowed for a richer, more critical contextualisation of the literature and findings.

### *5.4.2 Limitations*

Multivocality is one potential limitation of this research, the voices featured in the dataset were those of parents and psy-professionals. Tracy suggests that a complex phenomenon is best approached with complex methods which feature a variety of perspectives and forms of evidence. On reflection, this analysis may have benefitted from the inclusion of an educational professional perspective – not to improve validity as this would not fit with the social constructionist epistemology – rather to build the complexity and analyse the subjective interpersonal effects of discourse from more viewpoints.

Moreover, inclusion of documents such as educational or mental health policy may have allowed for triangulation of data. This study focused on one form of data: verbal, which was intended to be naturalistic but inclusion of written documents may have allowed for more analysis of broad cultural and political discourse. This may be an avenue for further research to take an FDA approach to policy documents to build on the work of this thesis and CDAs identified (Callaghan et al., 2017; Emery, 2016; Hardley et al., 2021).

To some extent, the analysis completed here may have benefitted from a more explicitly archival approach to including history into the analysis. FDA is deeply connected to the concepts of genealogy espoused by Foucault (Arribas-Ayllon & Walkerdine, 2017; Kendall & Wickham, 1999). However, the specifics of achieving this genealogy is deliberately not outlined, therefore, I made a methodological choice to stay more firmly in line with Willig's guidance which has been critiqued for its relative lack of focus on history (Arribas-Ayllon & Walkerdine, 2017; Willig, 2021).

**5.5 Clinical implications**

The effects of power and discourse explicated by the findings of this research with parents extends the knowledge base on this topic. Some implications for future research and possible clinical implications are discussed.

Whilst clinicians may feel limited in their capacity to change existing structures and practices, a Foucauldian conceptualisation of power actually creates space for new ways to approach therapeutic work with families. The findings of this study suggest that the practices of individual workers (i.e. CAMHS clinicians or teachers) have a significant impact on power relationships. The expectations of who has authority to claim truth of CYPMHD is held more broadly than the individual relationship, yet a curiosity and an open mind before offering solutions could have a strong positive effect on the subjective experience of parents who feel judged and blamed before they step into a clinical psychology setting.

The findings of this study suggest that competition for resources and individualistic approaches to CYPMH appear natural and assumed. However, in Emery's CDA for example and throughout Rose's Psy-Complex, examples for different priorities around CYPMH have been constructed (Emery, 2016; Rose, 1985). Emery, for example illustrates the recent history of community-focused and diffused, public health approaches to CYPMH in Wales that predated the more individualistic, biomedical CYPMHS of contemporary times. Taking into account Foucault's conceptualisation of power, one should not seek to immediately overhaul and replace mental health structures. However, it is important to recognise the current CYPMHS priorities in their full context – the current approach is not the only way and

may not be the best way. Focusing fair, professional critique on tightening restrictive practices monitoring, assessment and competition in the neoliberal sense could build a more denaturalised sense of the CYPMHS landscape. Practices such as diagnosis, categorisation and requiring official recognition of mental health to justify school non-attendance represent a tightening regime of institutional power. Clinical psychologists can question the effects of these practices in consultation with policy makers, education professionals and parents themselves. Conversations around where parents stand in relation to the concept of administrating absence or any form of CYPMHD may produce rich discussion which could embellish work in any CYPMHS.

Working directly with parents is a key priority for the NHS as outlined in the Long-Term plan and most CAMHS service specifications (NHS, 2019; NHS England/Medical Directorate/Parity of Esteem programme, 2014). This synthesises well with the findings of this study to argue in favour of working with parents to support CYPMHD and the potential judgement and blame parents are tacitly aware of. The findings of the SLR and FDA indicate that parents have limited rights to name and label CYPMHD. In this relationship, parents may position psy-professionals as all-knowing, meaning that clinical psychologists need to take care not to replicate existing patterns of the psy-complex whereby technical, psychological knowledge is promoted above instinctual and felt knowledge possessed by parents/carers. Clinical psychologists could instead consider using formulations such as Power Threat Meaning (Johnstone & Boyle, 2018) to include discourse, power and situate distress in broader contexts with reference to the forms of power highlighted in this thesis.

Psychoeducational workshops have been highlighted by this study as a

practice primarily to evidence a ‘humble parent’ subject position. Future research could investigate the experiences and perceptions of parents attending psychoeducational workshops with reference to the deficit model of parenting CYPMHD.

This study found that parents can resist subjugation by building up their own sense of instinctual, protective parenting. This is a vital resource that could be foregrounded in clinical practice. This may be best achieved through approaches such as peer support groups, community psychology, liberation psychology, narrative therapy and systemic family therapy.

Consultation with networks around young people may offer a highly useful context from which to address power and systemic issues occurring as a result of positioning which has been highlighted throughout this thesis. Clinical psychologists are well placed to offer and facilitate consultation to networks and this already occurs across CAMHS with schools, in Team Around the Family (TAF) meetings and other consultative fora. Consultation in this setting is understood as provision of reflective ‘thinking spaces’ aided by psychological frameworks (Fredman et al., 2018). A systemically informed model of consultation delivered by clinical psychologists such as Collaborative Consultation (Fredman et al., 2018) would align well with the findings of this study with reference to semantic polarities. This is therefore recommended as a vehicle through which to implement ideas around discourse and power into clinical discussions. This approach is currently being implemented in the CAMHS team I am on placement with and sits comfortably within broader changes in CAMHS to transition into consultative and preventative models such as the

Community Relations Model (CoRe) (van Roosmalen et al., 2013; Van Roosmalen et al., 2024).

From my clinical experience of consultation with a local pupil referral unit and social care professionals, there are ample opportunities (as a psychologist) to formulate a family's needs based on ideas of broader discourse such as the hegemony of attendance conflated with success, neoliberalism and undue 'responsibilitisation' of parents over 'curing' CYPMHD. Clinical psychologists have a great capacity to influence the sense made of CYPMH in professional networks; naming issues of discourse and linking these to a formulation of distress in consultations is one way to tangibly apply the ideas in this thesis in clinical practice.

There are some ways in which educational policies are not serving and in fact may be oppressing parents as explored in this study. For instance, the effects of punishment inflicted by increasing surveillance of parents where educational institutions are concerned around the risk of deviations from the norm of CYPMH. This practice is interpreted as shaming; the consequences of this effect could be explored in future research. Accordingly, it is recommended that clinical psychologists work on a broader scale using their knowledge to inform policy that works for all parties. I am reticent to offer tangible alternatives as this may risk 'replacing one discourse with another' (Powers, 2007). However, the Department of Education policies in place may not be achieving their intended aims, they may also be causing harm to parents so it is recommended that policy makers take a reflexive strengths-based approach informed by parents and psychological professionals to reconsider how policy can be more useful in this setting.

### 5.6 Future research

The FDA approach in this study has proven useful in critiquing or building on the literature base in CYPMH, yet this study focused on one group as an exemplar from which to expand wider constructions of CYPMH. The role of blame is a clear theme throughout research, yet this study problematises the reductionist strategies researchers have suggested parents use to resist blame. The broader discourses implicated in this process could be linked to neoliberalism and austerity. As mentioned above, future research may incorporate policy documents, service specifications, NICE guidelines or other similar archival data sources outside of therapy/ peer group sessions or interview/focus groups to expand the genealogical study of CYPMH and parenting. This may help to de-naturalise current theories of how distress in CYP and families develops and how blame functions within this.

In terms of school non-attendance as a site for CYPMHD, the educational perspective was one way in which this study may have lacked multivocality, therefore it is recommended that future research explore the school fully as a habitus from a CYPMH frame. Where Stentiford and colleagues (2023) explored a disability frame for CYPMH, a more explicitly psychological focus could prove useful combined with an approach such as FDA to explore the social capital of CYPMHD biomedical labels.

### 5.7 Dissemination

In order to achieve meaningful social impact from this research, findings will be shared with the experts by experience and Family First organisation to explore the implications in context. Moreover, the study findings will be shared with a local

CAMHS team to explore the implications for clinical practice and reflect on professional responses. Next, the findings will be distilled into a page of relevant findings to support the recommissioning of FamilyFirst services in bids to provide peer support in the local area.

This study will be condensed and published in a peer-reviewed journal such as Clinical Child Psychology and Psychiatry. This will support academic engagement with the findings which should promote future research to encourage significant knowledge production and contribution to the evidence base. Finally, the study will be submitted for presentations at upcoming academic and clinical conferences as well as any special interest groups or organisations who may work in areas relevant to the research such as the Association of Child and Adolescent Mental Health.

**5.8 Reflexivity**

Conducting this research whilst working as a trainee clinical psychologist has resulted in a confronting and challenging experience of derealisation at points. Being on placement in CAMHS whilst conducting this research has meant that my practice of consultation and the service development ideas I have put forth have been deeply informed by this rich and focused project. I have been able to percolate ideas within the context of my thesis which has allowed more space for thought perhaps than a busy CAMHS setting may have allowed. This percolation is an aspect I am hoping to carry with me in practice.

One key reflection along the way with this analysis was noticing the recursive idea generation which occurred from approaching practice from a community/ liberation psychology framework. For example, my discussion around the influence

of Parity of Esteem in the anti-stigma literature was directly informed by a service development collaboration with public health I am conducting on my current placement. The project is aiming to reducing stigma in the local community through use of the Power Threat Meaning Framework (Johnstone & Boyle, 2018). I found that the practical experience of leading projects such as this on placement meant I was well informed by the literature. This layering of approaches has brought a richness to my clinical work and research that inspires me to keep critique alive by applying transdisciplinary theories such as Foucault's concepts of power to psychological work.

In terms of the research process, I have valued the input of others around me, in particular peers also conducting DA and my supervisors. Kendall and Wickham's (1999) book on using FDA summarises the value of organically and patiently applying Foucault's approach to research. This cannot be done in isolation and oftentimes benefits from speaking ideas aloud.

Where I have been conducting clinical assessments and formulating EBSA I have felt like a fraud at points knowing that my work has been critical of the very system I am working for. Yet leaning into this reflection without fear has sustained me; I believe strongly that all work benefits from de-naturalisation and a critical reflexive approach. In this way I feel honoured to have had the opportunity to 'zoom out' with my research in a professional area that I care deeply about. I intend to continue working with CYP throughout my career and feel that the experience of conducting this research will stand me in extremely good stead.

**5.9 Conclusion**

This thesis presents a broad extension and reconceptualization of the existing formulations of power in parental social construction of CYPMH. This thesis has applied FDA to naturalistic parental peer group discussions. The key findings explore the role of administrating the validity of CYPMHD through biomedical and positivistic means. This panoptical technology of power was described as productive in nature to the point where parents themselves begin to value the role of labelling and categorising CYPMHD beyond understanding the distress itself.

The latent role of the psy-complex has been held centrally throughout despite not often being labelled explicitly. Normalisation is presented as a key effect of power producing the limits of CYPMH in the discursive work of parents. This was situated in clear genealogical context with the exploration of criminality morphing to illness in the emergence of Child Guidance Clinics in the UK. Moreover, blame of parents has been reconceptualised based on extant research to work in slightly more nuanced ways than a deliberate parental shift of blame onto biomedical frameworks of CYPMH.

Moreover, the subject position of 'humble parent' is central to the productive and self-regulating power of the psy-complex. Again, the genealogical contingencies around psychoeducation's rise to dominance through IAPT is an imperative context in making sense of psychology's role in positioning parents as lacking in psychological competencies to reduce CYPMHD. This is compounded by the effects of neoliberalism and a broad capitalistic competitive, individualistic societal discourses which are through policy and practices to position parents and young people as

responsible for ‘curing’ CYPMHD with the intention of moving towards achievement viewed through a narrow and restrictive neoliberal vision of success.

This study extends and problematises previously reductionist representations of power and discourse in the social construction of CYPMH. The findings illustrated that existing frameworks for distress such as biomedical, individualistic and neoliberal visions of CYPMHD and recovery shape the way institutions work with families. Parents have been reconceptualised as working with limiting CYPMH frameworks based around assessment and monitoring but also exerting resistance with reference to discourses which reassert their authority and instinctual knowledge. Overall, this study has aimed to move beyond fixed characterisations of people, towards discourse in its socioecological and systemic context to explore how truths of CYPMH are constructed.

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## Appendix A

*Reflexive research diary extracts*

| Date | Research Stage | Reflections |
|---|---|---|
| October 2023 | Initial talks with external supervisor | No set idea yet. Some initial concerns around balancing the needs of the people I'm working with vs my own aims of research. Considering how I can produce social good and good quality research. Reflecting on concerns around no thesis supervisor set yet. Taking this as an opportunity to become more autonomous and take some time to reflect on research aims. Using the paper critique as a way of narrowing research aims idea. Using funnelling in literature review as a way of generating a specific idea<br>Being open to epistemology and methods depending on the types of research the question generates. |
| October 2023 | Research methods lecture | Weighing up using grounded theory, IPA or DA. Some concerns around using DA because I have not used the method. I don't need to know everything before I begin. Learning that DA can be conducted on interview/focus group and other data sources but a more naturalistic dataset might be more appropriate for this study. Critical discursive can be a helpful approach because I might be thinking about the role of parents in shaping CYPMH; combining both the top down and bottom up. |
| February 2024 | Writing proposal | Considering the utility of my research. Navigating the challenges of macro and micro – how to not waste the time of FamilyFirst but also try not to do too many things at once. Supervisor conversations supporting me to realise that it is not a service evaluation so the level of 'reimbursement' to service is different in a thesis. |
| February 2024 | Reflexivity lecture | Interrogating my position on being critical to psychology and how will this influence my observations and analysis. My position feels quite distant in a way from the experiences of the parents. Struggling to balance representing the experiences of parents combined with 'putting discourses on top of' the data. Considering my relationship to workers at FamilyFirst and my role as a trainee CP. They seem interested but how do they see me? Ensuring epistemic justice as far as possible is going to be a continual point of reflection during this thesis. |
| March 2024 | Registration viva | Have had some discussions with FamilyFirst representative around visions for the project which have suggested some |

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|---|---|---|
| | | different ideas for aims. Decided to take to supervision with internal supervisor. |
| July 2024 | First advanced methods workshop and beginning SLR | Feeling a little out of depth with knowledge of discourse and power which has challenged previously held confidence on knowledge of Foucault and discourse. Grappling with the scope of the project a lot at the moment. As thesis project has moved towards more 'doing' stage, I am feeling increasingly pragmatic about what I want to achieve. Also reflecting that FDA is less prescriptive than other approaches so I need to make more space for things to be less 'step by step'. Some concerns around not doing a good enough job of including history and everything I wanted to explore at the beginning of thesis project. Considering how to apply this pragmatic approach to inclusion of history in the project. |
| August 2024 | Bracketing reflexivity session | Considering bracketing and role of self-reflexivity within my research. Understanding how lived experience and testimony fits in my research is something I am still developing my learning around. Have realised the value of having a separate self-reflexivity meeting to explore this in a targeted way. Reflected on my insider status as a CYP professional compared with my outsider status as not a parent. I am part of the system which parents often feel oppressed or misunderstood by. Therefore, I need to be cognizant of the tacit knowledge I hold and need to be diligent in my critique of this. Considering my research design 'zooming out' beyond a testimonial or phenomenological level. To what extent have I selected a method that can broaden out to the discourse level – a level at which I can then be acceptable as an analyst? If I were to go in at the IPA level I would no longer be an 'insider' because I am not a parent. |
| October 2024 | Advanced Methods Workshop | Reflecting a lot about including self-reflexivity and EbE in ways that are actually useful in this project. Though DA may appear to be less welcoming of these elements, the analysis is only one phase of the research, therefore nothing preventing me from including EbE in other procedural elements of the research. This resolves some earlier limitations around meaningful inclusion of EbE. |
| October 2024 | Post DA AMW and | Concerns around potential limitations about 'can I collect enough of the right data?' currently. AWM revealed that I may have too much or too little data. Finding it hard to balance these apprehensions with the 'non-cookbook' approach of FDA not prescribing rules. I have some concerns that 'wellbeing' may be too broad in the SLR. Some of this relates to the inclusion of neurodiversity within CYPMH definition. Appears that autism represents something very central to debates and |

| | | |
|---|---|---|
| | | discourses around CYPMH and can remain a useful idea. This relates to wider reflections around generalisability of the project. I have concerns that too interpretative a method may be less useful in terms of generalising the results. However, generic concepts around qualitative research such as 'natural generalisability' is an established way to make qualitative research useful outside of a specific study. |
| October 2024 | Transcription | Challenges of separating my own therapist identity from that of DA researcher. As the groups contained more talking from therapists I have found myself at times being drawn more to the therapist's role in the recordings and considering their resistance or collusion with certain discourses. As this peer group is specifically for parents of children not attending school, this could reflect something more interesting about the landscape of CYPMHD more broadly being linked to education. Again, I am trying to bracket thoughts of "this is not right or bad for my study" and instead recognise the useful frame this will provide for my analysis. |
| Novemb er 2024 | Transcription | Reflecting on some concerns arising that my focus is too much on parents and not on CYPMH as I transcribing the interviews. Some thoughts around the fact that I am not including the 3 initial sessions where parents may have been explaining more about their child's circumstances to others as an introduction. Resolved to discuss this with external supervisor to understand limits for full datasets. |
| January 2025 | SLR | Having started placement in a community psychology placement, I have been feeling that my separate experiences personally, on placement, research and in lectures feel not so separate to the thesis anymore. I find thoughts of community psychology, the psy-complex and other matters highly relevant to thesis. However, though this was initially a worry for me, I am realising that practising community psychology work, exposing myself to community psychology principles, literature and theory is embellishing my coding, SLR and analysis. |
| February 2025 | Considering resubmitting to ethics | Spent a long time debating whether or not to recollect demographic information. Have been going back and forth in my mind about the relative ethics of contacting participants further after originally contacting them. My current thinking is that demographic data is not of great importance for FDA because the type of analysis is less concerned with who exactly the participants are. This will not increase validity as I am not working from this time of epistemological frame for the research. Instead, I am commenting on the wider cultural/social/political/institutional forms of power that work |

| | | |
|---|---|---|
| | | through the participants and form normalising power in these spaces. |
| February 2025 | Beginning analysis | Feeling confused juggling epistemological assumptions of SLR and analysis. Finding that my writing has come out too critical and not fixed on the data which is not necessarily linked to the contrasting methods but more about going too far away from the data. |
| February 2025 | DA coding | DA coding feels more like coming up with themes rather than coding (in terms of TA) feels as though reading between the lines and looking beyond the text every time is really challenging and a greater challenge (perhaps because it is new) than TA coding I have done before |
| March 2025 | DA analysis | Concerns around being harsh or judgemental in my analysis particularly around my use of subject positions. I am finding that although the language may be jarring, I am compelled to be as honest as possible in my interpretation of the repertoires made available by the discourses. This is perhaps one moment where my experience as a therapist and particularly being drawn to humanistic and compassionate ways of working may be holding me back from leaning into the harsh and unforgiving effects of these discourses to categorise people. |
| June 2025 | Write up | Looking back at my research questions I would change them and would have considered a slightly different focus for the project. Some of this is informed by the knowledge of FDA I have gained from conducting the method for the first time. Instead of 'understandings' I may have thought more about 'constructions'. Also, my goals for conducting a Foucauldian archaeology around all of CYPMH was likely too ambitious given the data that I had. On reflection I am pleased with how I have achieved this particularly in the introduction and discussion but my research aims perhaps inflated the scope of this. Ethically I have chosen to keep the research questions and aims worded as they are because this is how I conducted the project. |

**Appendix B**

*Search planning form including search terms with Boolean operators*

## Search Planning Form

**Question :** What discourses around young people's mental health have been constructed through different types of discourse analysis research?

**Identify the main concepts of the question (use as many as you need)**

| **Concept 1** | **Concept 2** | **Concept 3** |
|---|---|---|
| **Child/young person** | **Mental health** | **Discourse analysis** |

**List alternatives keywords, terms and phrases below**

| **Concept 1** | **Concept 2** | **Concept 3** |
|---|---|---|
| **Child** | **Mental health** | **Discourse analysis** |
| OR Kid | OR Mental disorder | OR discursive psychology |
| OR Young person | OR mental illness | OR Foucaul* |
| OR Young* | OR mental health difficulty | OR critical discourse analysis |
| OR Youth | OR wellbeing | OR conversation analysis |
| OR adolescen* | OR mental disease | OR Ethnomethodology |

| | | |
|---|---|---|
| OR Teen* | OR child psychiatry | OR Political Discourse Theory |
| OR Boy | OR psychiatrized | OR Semiotic Analysis |
| OR Girl | OR psy-complex | |
| | OR therapy | |
| | OR intervention | |
| | OR Psychotherapy | |
| | OR Diagnosis | |
| | OR Psychopathology | |


**Step 1: Use OR to combine ALTERNATIVE search terms together.**

**Step 2: Use AND to combine different concepts together.**

"Child" OR "Kid" OR "Young person" OR "Young*" OR "Youth" OR "adolescen*" OR "Teen*" OR "Boy" OR "Girl"

AND

"Mental health" OR "Mental disorder" OR "mental illness" OR "mental health difficulty" OR "wellbeing" OR "mental disease" OR "child psychiatry" OR "psychiatrized" OR "psy-complex" OR "therapy" OR "intervention" OR "psychotherapy" OR "diagnos*"

AND

"Discourse analysis" OR "discursive psychology" OR "Foucaul*" OR "critical discourse analysis" OR "conversation analysis" OR "Ethnomethodology" OR "Political Discourse Theory" OR "Semiotic Analysis"

WITHOUT speech marks

Child OR Kid OR Young person OR Young* OR Youth OR adolescen* OR Teen* OR Boy OR Girl

AND

Mental health OR Mental disorder OR mental illness OR mental health difficulty OR wellbeing OR mental disease OR child psychiatry OR psychiatrized OR psy-complex OR therapy OR intervention OR psychotherapy OR diagnos*

AND

Discourse analysis OR discursive psychology OR Foucaul* OR critical discourse analysis OR conversation analysis OR Ethnomethodology OR Political Discourse Theory OR Semiotic Analysis

# Appendix C

*Quality assessment table of all papers included in SLR*

| Eight Big Tent Quality Assessment | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Paper (authors and date) | Worthy topic | Rich rigour | Sincerity | Credibility | Resonance | Significant contribution | Ethical | Meaningful coherence | Overall rating (0-8) | Overall rating (low, medium, high) |
| Avdi, Griffin, Brough (2000) | Yes | Yes | No | Yes | Yes | Yes | No | Yes | 6 | High |
| Bennett (2007) | Yes | No | Yes | No | Yes | Yes | No | Yes | 5 | Medium |
| Callaghan, Chiara-Fellin, and Warner-Gale (2016) | Yes | Yes | No | Yes | Yes | Yes | No | Yes | 6 | High |
| Denman, Smart, Dallos and Levett (2016) | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | 8 | High |
| Emery (2016) | Yes | Yes | Yes | Yes | Yes | Yes | No | Yes | 7 | High |
| Hardley, Gray & McQuillan (2020) | Yes | Yes | No | Yes | Yes | Yes | Yes | Yes | 7 | High |
| Kristen, Lecchi, Loades and Midgley (2024) | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | 8 | High |
| Mac an Ghaill, Haywood (2010) | Yes | Yes | No | Yes | Yes | Yes | Yes | Yes | 7 | High |
| McQueen, Henwood (2002) | Yes | Yes | No | Yes | Yes | Yes | No | Yes | 6 | High |
| O'Reilly (2007) | Yes | Yes | No | Yes | Yes | Yes | Yes | Yes | 7 | High |
| O'Reilly (2015) | Yes | Yes | No | Yes | Yes | Yes | Yes | Yes | 7 | High |
| O'Reilly and Lester (2016) | Yes | Yes | No | Yes | Yes | Yes | Yes | Yes | 7 | High |
| O'Reilly, Muskett, Karim and Lester (2020) | Yes | Yes | No | Yes | Yes | Yes | Yes | Yes | 7 | High |
| O'Reilly, Kiyimba, Lee, Hutchby (2023) | Yes | Yes | No | Yes | Yes | Yes | Yes | Yes | 7 | High |
| Peter (2021) | Yes | Yes | Yes | Yes | Yes | Yes | No | Yes | 7 | High |
| Stentiford, Koutsouris & Allan (2023) | Yes | Yes | No | Yes | Yes | Yes | Yes | Yes | 7 | |
| Stentiford, Koutsouris, Nash & Allan (2024) | Yes | Yes | No | Yes | Yes | Yes | Yes | Yes | 7 | High |
| Lester, O'Reilly, Smoliak, Muntigl & Tseliou (2023) | Yes | Yes | No | Yes | Yes | Yes | Yes | Yes | 7 | High |
| O'Reilly Karim, Stafford, Hutchby (2015) | Yes | Yes | No | Yes | Yes | Yes | Yes | Yes | 7 | High |

## Appendix D

*Original ethical approval letter from University of Hertfordshire Health, Science, Engineering and Technology ECDA*

University of Hertfordshire UH

**HEALTH, SCIENCE, ENGINEERING AND TECHNOLOGY ECDA**

**ETHICS APPROVAL NOTIFICATION**

| | |
|---|---|
| **TO** | Jonathan Beavis |
| **CC** | Dr Joanna Reed |
| **FROM** | Dr Simon Trainis, Health, Science, Engineering and Technology ECDA Chair |
| **DATE** | 29/07/2024 |

| | |
|---|---|
| Protocol number: | **LMS/PGR/UH/05771** |
| Title of study: | Interrogating discourses and power relations surrounding young people identified as having mental health difficulties: A Foucauldian Discourse Analysis of parents' talk in peer support groups |

Your application for ethics approval has been accepted and approved with the following conditions by the ECDA for your School and includes work undertaken for this study by the named additional workers below:

**Rachel Lambie (secondary supervisor)**
**Dr Barbara Rishworth (research mentor)**

**General conditions of approval:**

Ethics approval has been granted subject to the standard conditions below:

**Permissions**: Any necessary permissions for the use of premises/location and accessing participants for your study must be obtained in writing prior to any data collection commencing. Failure to obtain adequate permissions may be considered a breach of this protocol.

**External communications**: Ensure you quote the UH protocol number and the name of the approving Committee on all paperwork, including recruitment advertisements/online requests, for this study.

**Invasive procedures**: If your research involves invasive procedures you are required to complete and submit an EC7 Protocol Monitoring Form, and copies of your completed consent paperwork to this ECDA once your study is complete.

**Submission**: Students must include this Approval Notification with their submission.

**Validity:**

This approval is valid:

From: 29/07/2024

To: 23/10/2024

# Appendix E

*Ethics approval letter following amendment*

To: Jonathan Beavis

Your application for an amendment of the existing protocol listed below has been approved by the Health, Science, Engineering and Technology Ethics Committee with Delegated Authority. **Please read this letter carefully.**

Study Title: Interrogating discourses and power relations surrounding young people identified as having mental health difficulties: A Foucauldian Discourse Analysis of parents' talk in peer support groups

Your UH protocol number is: **0735 2025 Feb HSET**
**The Protocol Number issued from the online system replaces any previously issued protocol numbers and should be quoted on all paperwork, including advertisements for participants.**

If you wish to use the UH Ethics Committee logo disclaimer in your communications with participants, please find it in our UH Ethics Canvas site under 'Units - Application Forms': UH Ethics Approval (instructure.com

**This ethics approval expires on 01/08/2025**

**Amending your protocol**

Individual protocols will normally be approved for the limited period of time noted above. Application for minor amendments (including time extensions) of a protocol, may be made for a maximum of 4 working weeks after the end date of that protocol.

It is expected that any amendments proposed via the online system will be minor. Should substantial modification be required, it would be necessary to make a fresh application for ethical approval.

Note that you must obtain approval from the relevant UH Ethics Committee with Delegated Authority **prior to implementing any changes**. Failure to do so constitutes a breach of ethics regulations (UPR RE01).

**Adverse circumstances**
Any adverse circumstances that may arise because of your study/activity must be reported to ethicsadmin@herts.ac.uk as soon as possible.

**Permissions**
Any necessary permissions for the use of premises/location and accessing participants for your study/activity must be obtained in writing prior to any data collection commencing. Failure to obtain adequate permissions may be considered a breach of this protocol.

Ethics Administration Team

ethicsadmin@herts.ac.uk

## Appendix F

*Participant information sheet sent to participants one week prior to consent*

University of Hertfordshire UH Ethics Committee

### UNIVERSITY OF HERTFORDSHIRE
### PARTICIPANT INFORMATION SHEET

1 **Title of study**

Interrogating discourses and power relations surrounding young people identified as having mental health difficulties: A Foucauldian Discourse Analysis of parents' talk in peer support groups

**Lay title**: Analysing discourses and power relations in parents' talk in mental health peer support groups

2 **Introduction**

You are being invited to take part in a study that is being carried out as part of a Doctorate in Clinical Psychology. Before you decide whether to do so, it is important that you understand the study that is being undertaken and what your involvement will include. Please take the time to read the following information carefully and discuss it with others if you wish. Do not hesitate to ask us anything that is not clear or for any further information you would like to help you make your decision. Please do take your time to decide whether or not you wish to take part. The University's regulation, UPR RE01, 'Studies Involving the Use of Human Participants' can be accessed via this link:

https://www.herts.ac.uk/about-us/governance/university-policies-and-regulations-uprs/uprs
(after accessing this website, scroll down to Letter S where you will find the regulation)

Thank you for reading this.

3 **What is the purpose of this study?**

This study aims to understand how messages in society and culture (for example, politics and media) affect how parents of children identified as having mental health difficulties make sense of their child/young person's mental health.

4 **Do I have to take part?**

It is completely up to you whether or not you decide to take part in this study. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. Agreeing to join the study does not mean that you have to complete it. You are free to withdraw until transcription begins (immediately after the sixth session of the group) without giving a reason. You will still be able to continue your support as usual with [redacted]. A decision to withdraw, or a decision not to take part at all, will not affect any support that you may receive.

5 **How long will my part in the study take?**

If you decide to take part in this study, your participation will last for the duration of the group sessions only. You may be contacted later on in 2025 to ask if you would like to help me to share the findings of the project more widely.

6 **What will happen to me if I take part?**

If you take part you will continue with the group that you expected to join as normal. There is no further requirement from you as a participant. This research aims to capture talk in these settings as naturally as possible.

7 **What are the possible disadvantages, risks of taking part?**

The researchers do not anticipate that taking part in this research will result in any risks beyond those encountered typically as a participant in this [redacted] group session.

If you do experience any discomfort or distress as a result of participation in this research, you can seek support through [redacted] or contact the researcher directly immediately after the session or via email.

You can speak to me as a researcher before or after participation if you would like to ask any questions or have any concerns.

8 **What are the possible benefits of taking part?**

This research aims to highlight the challenges faced by parents specifically around navigating one's position in society and in making sense of children and young people's mental health experiences. It is hoped that the findings of this study will be fed back to commissioners of mental health services to improve provisions of support for parents of young people with identified mental health difficulties.

[redacted]'s CEO, [redacted] will be feeding the results of this study back to commissioners.

The findings of this study will be published in a peer-reviewed academic journal. The write up of this study will be shared with you.

As a participant in this study you will provide information that adds to the theoretical knowledge held by mental health professionals and by extension inform support provided by practitioners in this field.

9 **How will my taking part in this study be kept confidential?**

Transcriptions will be fully anonymised meaning that no identifiable information will be collected in this study. Basic demographic information (age, ethnic identity, gender) will be collected through the information you provide at sign up to the group. This information will only be stored on the secure Onedrive folder which will be password protected. The recorded audio-visual data will held for up to and no longer than 2 months after the final group session.

10 **Audio-visual material**

Online sessions observed and included in this study will be video and audio recorded using Microsoft Teams. This is to ensure that all data relevant to the analysis is captured. Video and audio recordings will be stored on [redacted]'s secure Microsoft Onedrive system and then shared securely to a University of Hertfordshire Microsoft Onedrive account accessible only to the principal researcher.

No physical forms of memory storage (harddrive, USB, SD card) will be used to store this data. Folders containing these recordings will be password protected. This data will be destroyed after transcription is completed. This material will not be used for any other research.

11 **What will happen to the data collected within this study?**

- The transcribed data collected will be stored electronically, in a password-protected environment, for 24 months, after which time it will be destroyed under secure conditions;
- The data will be anonymised prior to storage.
- The data will be transcribed and no identifiable information will be included in this transcription.

12 **Will the data be required for use in further studies?**

- The data will not be used in any further studies.

13 **Who has reviewed this study?**

This study has been reviewed by:

- The University of Hertfordshire Health, Science, Engineering and Technology Ethics Committee with Delegated Authority

The UH protocol number is **LMS/PGR/UH/05771**

14 **Factors that might put others at risk**

Please note that if, during the study, any medical conditions or non-medical circumstances such as unlawful activity become apparent that might or had put others at risk, the University may refer the matter to the appropriate authorities and, under such circumstances, you will be withdrawn from the study.

15 **Who can I contact if I have any questions?**

If you would like further information or would like to discuss any details personally, please get in touch with me by email: ***Jonathan Beavis*** ***jb22acu@herts.ac.uk***. I am more than happy to meet via Microsoft Teams to discuss any questions or concerns if you need either during or before participation in this study. You can also contact my supervisor ***Dr Joanna Reed*** ***j.reed3@herts.ac.uk*** if you have any questions or would like further information.

University of Hertfordshire UH Ethics Committee

**Although we hope it is not the case, if you have any complaints or concerns about any aspect of the way you have been approached or treated during the course of this study, please write to the University's Secretary and Registrar at the following address:**

Secretary and Registrar
University of Hertfordshire
College Lane
Hatfield
Herts
AL10 9AB

**Thank you very much for reading this information and giving consideration to taking part in this study.**

**Appendix G**

*Summary of participant information sheet produced in collaboration with steering group. Sent to participants alongside participant information sheet.*

University of Hertfordshire UH Ethics Committee

## Summary of Research Information

### What is this research?

Hello, I am Jonny Beavis, a trainee clinical psychologist from University of Hertfordshire. I have worked across various child, family and adolescent mental health for many years now and care deeply about improving this support.

I am currently completing a research project about how parent/carers make sense of their child/young person's mental health & wellbeing.

This study aims to understand how messages in society and culture (for example, politics and media) affect how parents of children identified as having mental health difficulties make sense of their child/young person's mental health.

### Do I have to take part?

It is completely up to you whether or not you decide to take part in this study. If you do decide to take part you will be asked to sign a consent form.

Agreeing to join the study does not mean that you have to complete it. You are free to withdraw until transcription begins (immediately after the sixth session of the group) without giving a reason. You will still be able to continue your support as usual with [redacted]. A decision to withdraw, or a decision not to take part at all, will not affect any support that you may receive.

### How long will my part in the study take?

If you decide to take part in this study, your participation will last for the duration of the group sessions only. You may be contacted later on in 2025 to ask if you would like to help me to share the findings of the project more widely.

### What will happen to me if I take part?

If you take part you will continue with the group that you expected to join as normal. There is no further requirement from you as a participant. This research aims to capture talk in these settings as naturally as possible.

### What are the possible disadvantages/risks of taking part?

The researchers do not anticipate that taking part in this research will result in any risks. If you do experience any discomfort or distress as a result of participation in this research, you can seek support through [redacted] or contact the researcher directly immediately after the session or via email.

You can speak to me as a researcher before or after participation if you would like to ask any questions or have any concerns.

### What are the possible benefits of taking part?

University of Hertfordshire UH Ethics Committee

[redacted]'s CEO, [redacted] will be feeding the results of this study back to commissioners.

The findings of this study will be published in a peer-reviewed academic journal. The write up of this study will be shared with you.

I am hoping to channel the voice of parents/carers to make support for families better.

## How will my taking part in this study be kept confidential?

Transcriptions will be fully anonymised meaning that no identifiable information will be collected in this study. Basic demographic information (age, ethnic identity, gender) will be collected through the information you provide at sign up to the group. This information will only be stored on the secure Onedrive folder which will be password protected. The recorded audio-visual data will held for up to and no longer than 2 months after the final group session.

## What will happen to this data?

- The transcribed data collected will be stored electronically, in a password-protected environment, for 24 months, after which time it will be destroyed under secure conditions;
- The data will be anonymised prior to storage.
- The data will be transcribed and no identifiable information will be included in this transcription.

## Who has reviewed this study?

This study has been reviewed by: The University of Hertfordshire Health, Science, Engineering and Technology Ethics Committee with Delegated Authority

The UH protocol number is **LMS/PGR/UH/05771**

## Factors that might put others at risk

This research aligns with [redacted]'s standard safeguarding policies. Facilitators are safeguarding trained. Any safeguarding or risk concerns that arise through transcribing recordings will be shared with the [redacted] safeguarding lead.

## Who can I contact if I have any questions?

If you would like further information or would like to discuss any details personally, please get in touch with me by email: ***Jonny Beavis*** ***jb22acu@herts.ac.uk***. I am more than happy to meet via Microsoft Teams to discuss any questions or concerns if you need either during or before participation in this study. You can also contact my supervisor ***Dr Joanna Reed*** ***j.reed3@herts.ac.uk*** if you have any questions or would like further information.

Please note, the title of the project is: *Analysing discourses and power relations in parents' talk in mental health peer support groups.* This is how it will appear on the consent form.

**Although we hope it is not the case, if you have any complaints or concerns about any aspect of the way you have been approached or treated during the course of this**

**study, please write to the University's Secretary and Registrar at the following address:**

Secretary and Registrar
University of Hertfordshire
College Lane
Hatfield
Herts
AL10 9AB

**Thank you very much for reading this information and giving consideration to taking part in this study.**

## Appendix H

*Consent form sent to participants via email, signed and returned via email.*

University of Hertfordshire UH Ethics Committee

### University of Hertfordshire
### Consent Form

I, the undersigned *[please give your name here, in BLOCK CAPITALS]*

……

hereby freely agree to take part in the study entitled *Analysing discourses and power relations in parents' talk in mental health peer support groups* conducted by Jonny Beavis

UH Protocol number **LMS/PGR/UH/05771**

**1** I confirm that I have been given a Participant Information Sheet (a copy of which is attached to this form) giving particulars of the study, including its aim(s), methods and design, the names and contact details of key people and, as appropriate, the risks and potential benefits, how the information collected will be stored and for how long, and any plans for follow-up studies that might involve further approaches to participants. I have also been informed of how my personal information on this form will be stored and for how long. I have been given details of my involvement in the study. I have been told that in the event of any significant change to the aim(s) or design of the study I will be informed, and asked to renew my consent to participate in it.

**2** I have been assured that I may withdraw from the study at any time until transcription has occurred (immediately after the sixth session) without disadvantage or having to give a reason. I have been assured that if I refuse to take part in this study I am still entitled to continue accessing therapeutic support with [redacted] as usual with no impact on this.

**3** In giving my consent to participate in this study, I understand that voice and video recording will take place and I have been informed of how/whether this recording will be transmitted/displayed.

**4** I have been given information about the risks of taking part in this research. I have been told about the support that I can choose to access in the event of this happening.

**5** I have been told how information relating to me (data obtained in the course of the study, and data provided by me about myself) will be handled: how it will be kept secure, who will have access to it, and how it will or may be used.

**6** I understand that if there is any revelation of unlawful activity that would or has put others at risk, the researcher has a duty of care to refer the matter to the appropriate authorities.

**7** I have been told that I may at some time in the future be contacted again in connection with this study.

Signature of participant……Date……

Signature of (principal) investigator……Date……

Name of (principal) investigator *[in BLOCK CAPITALS please]*

JONATHAN BEAVIS

UH Protocol number **LMS/PGR/UH/05771**

**Appendix I**

*Recorded parental group sessions. Cells in grey represent sessions not included in the analysis because consent was not provided by one of the parents in the group.*

| Week | Date | Facilitators | Attendees |
|---|---|---|---|
| Week 1 | September 2024 | 2 | 3 |
| Week 2 | September 2024 | 2 | 5 |
| Week 3 | September 2024 | 2 | 5 |
| Week 4 | October 2024 | 2 (Lucy & Sally) | 4 (Jessica, Denise, Lilly, Arwen) |
| Week 5 | October2024 | 2 (Lucy & Sally) | 4 (Jessica, Denise, Lilly, Arwen, Erica) |
| Week 6 | October 2024 | 2 (Lucy & Sharon) | 4 (Jessica, Denise, Lilly, Arwen) |
| Week 7 | October 2024 | 2 (Lucy & Sally) | 3 (Denise, Lilly, Arwen) |

## Appendix J

*Selected Jefferson symbols used to transcribe data*

| **Symbol** | **Definition and use** |
|---|---|
| [yeah]<br>[okay] | Overlapping talk |
| (.) | Pause usually between 0.08 and 0.2 seconds |
| (0.7) | A timed pause |
| ( ) | Unclear section. |
| CAPITALS | Louder or shouted words |
| (h) | Laughter |
| ~ | Tilde sign indicates shaky voice (as in crying) |

**Appendix K**

*Excerpt from transcript*

Denise: it's much more important I think that your daughter feels listened to (.) she feels safe and you take it at her pace

Jessica: yeah it's hard some days though isn't it

Denise: it is absolutely [cuz in the back]

Jessica: [I just get so frustrated with her]

Denise: [of your mind] you're thinking well everyone does their [GCSEs]

Jessica: [it's exactly that]

Denise: [and the] school are telling you their life chances are affected and they won't do this they can't do that and basically they'll be on the dole they'll be homeless (.) and you know their lives over if they don't take their GCSEs (.) and that's just rubbish

Sally: absolutely

Denise: there's plenty of people go to college

Sally: yes

Denise: go in their late teens in their early twenties [cuz]

Sally: [and they flourish]

Denise: they've worked out what they wanna do it's their time and they just go (.) you know and it's their terms (.) you know and I say all the time it surprises me how children survive school it really does because it is absolutely brutal

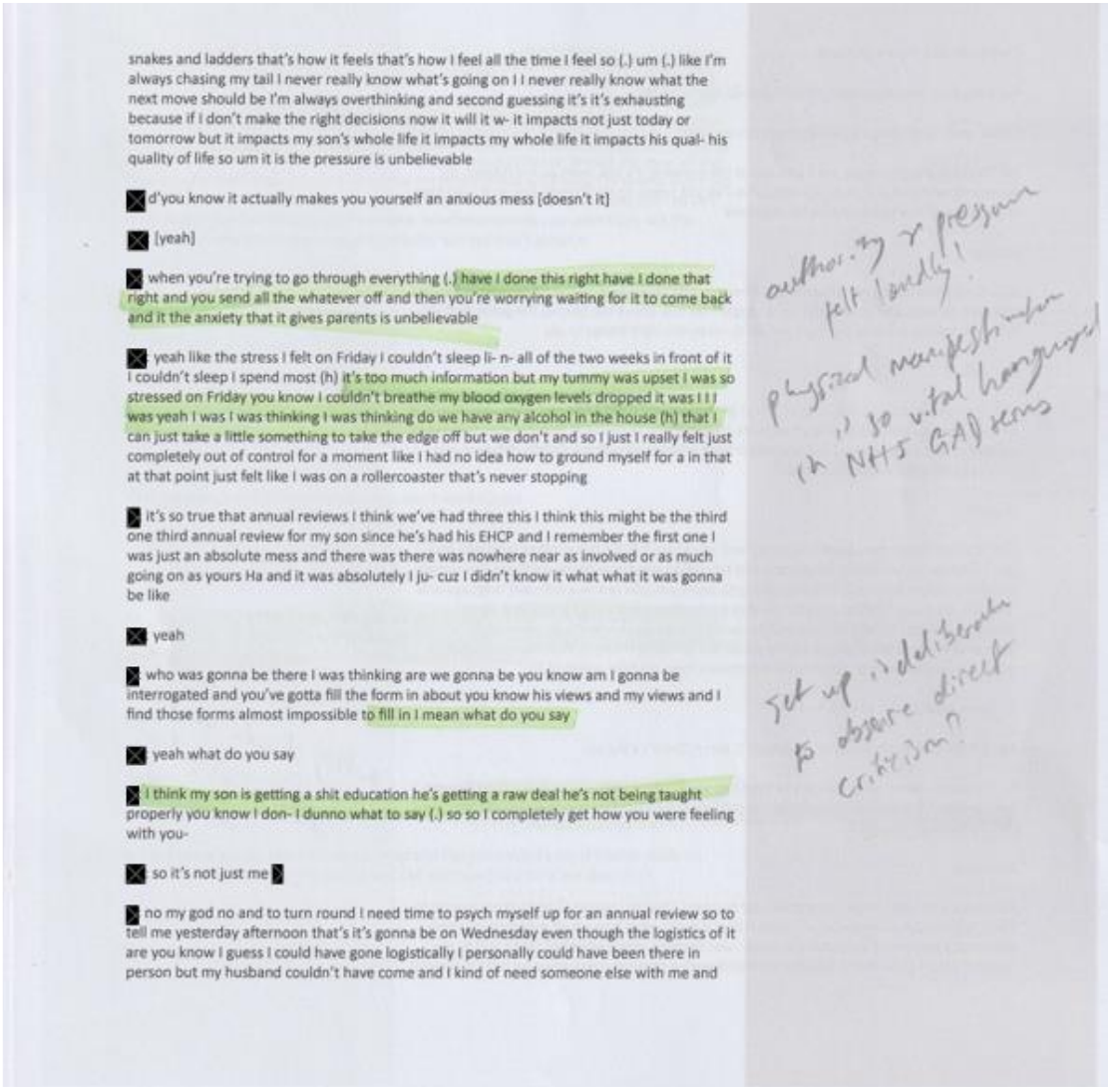
Jessica: (h)

Denise: and I think I just scraped through but school in the nineteen eighties was a very different beast to school these days um but (.) it's more important that they're okay that your child's okay

Jessica: yeah

## Appendix L

*Excerpt from handwritten coding*



snakes and ladders that's how it feels that's how I feel all the time I feel so (.) um (.) like I'm always chasing my tail I never really know what's going on I I never really know what the next move should be I'm always overthinking and second guessing it's it's exhausting because if I don't make the right decisions now it will it w- it impacts not just today or tomorrow but it impacts my son's whole life it impacts my whole life it impacts his qual- his quality of life so um it is the pressure is unbelievable

[redacted] d'you know it actually makes you yourself an anxious mess [doesn't it]

[redacted] [yeah]

[redacted] when you're trying to go through everything (.) have I done this right have I done that right and you send all the whatever off and then you're worrying waiting for it to come back and it the anxiety that it gives parents is unbelievable

[redacted] yeah like the stress I felt on Friday I couldn't sleep li- n- all of the two weeks in front of it I couldn't sleep I spend most (h) it's too much information but my tummy was upset I was so stressed on Friday you know I couldn't breathe my blood oxygen levels dropped it was I I I was yeah I was I was thinking I was thinking do we have any alcohol in the house (h) that I can just take a little something to take the edge off but we don't and so I just I really felt just completely out of control for a moment like I had no idea how to ground myself for a in that at that point just felt like I was on a rollercoaster that's never stopping

[redacted] it's so true that annual reviews I think we've had three this I think this might be the third one third annual review for my son since he's had his EHCP and I remember the first one I was just an absolute mess and there was there was nowhere near as involved or as much going on as yours Ha and it was absolutely I ju- cuz I didn't know it what what it was gonna be like

[redacted] yeah

[redacted] who was gonna be there I was thinking are we gonna be you know am I gonna be interrogated and you've gotta fill the form in about you know his views and my views and I find those forms almost impossible to fill in I mean what do you say

[redacted] yeah what do you say

[redacted] I think my son is getting a shit education he's getting a raw deal he's not being taught properly you know I don- I dunno what to say (.) so so I completely get how you were feeling with you-

[redacted] so it's not just me [redacted]

[redacted] no my god no and to turn round I need time to psych myself up for an annual review so to tell me yesterday afternoon that's it's gonna be on Wednesday even though the logistics of it are you know I guess I could have gone logistically I personally could have been there in person but my husband couldn't have come and I kind of need someone else with me and

## Appendix M

*Excerpt to indicate digital record of codes matched to quote*

| | Code | Quote |
|---|---|---|
| Transcript 1 | Invoking relief<br>Psychology defends from juridical processes<br>But actually it creates these (see Hook) | we went to see a doctor at CAMHS yesterday and umm after everything we've been going through for about 4 years um he's decided to say that (name of Lilly's child)'s unfit for school at the moment and he's getting ESMA involved so he will [no longer]<br><br>Sally: [*excited sigh]*<br><br>Lilly: be under the threat by the attendance officer |
| | Need to reveal truth<br>Is this to Dr<br>Blame? | you've got the opportunity to be honest and say how much you're struggling with school and the people in school and everything else for him to actually help |

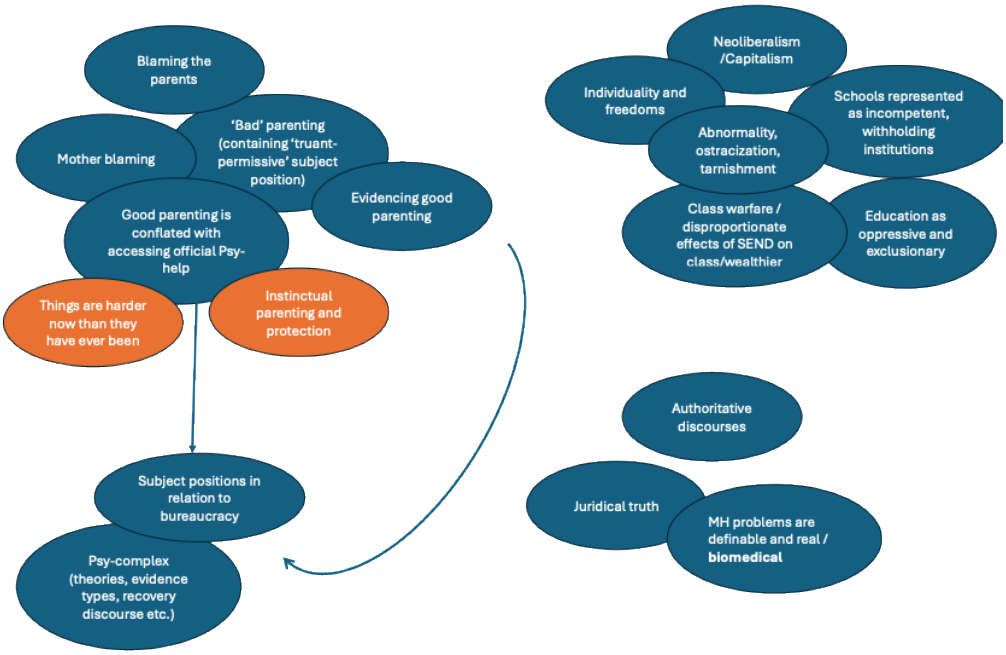
## Appendix N

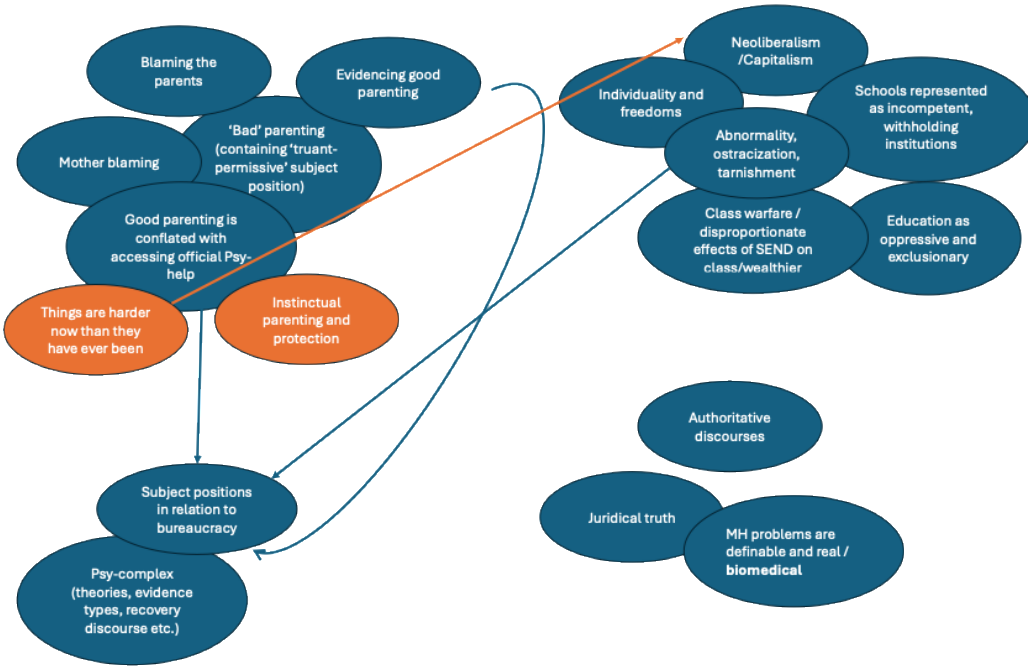
*Example from full record six stage FDA process*

| Discursive object | Discourse | Action orientation | Positionings | Practice | Subjectivity |
|---|---|---|---|---|---|
| Attendance officers have a phenomenal amount of power, control and surveillance as an entity set up to blame parents<br><br>Categorical authorised diagnosed conditions are a route to avoid parental blame<br><br>Courses telling us we don't know<br><br>As perfect ideal parent = educating self and submitting to rules of system<br>Some implied resistance elsewhere but this overachieving discourse is more powerful<br><br>Resistance to parental blame. **Counter discourse** | Parental blame | Application of the parental blame discourse allows parents to illustrate how they have been unfairly scapegoated and targeted by institutions<br><br>Also defends retributive acts against education<br><br>Sometimes they feel the need to lean into this blame to accept responsibility and prove their actions<br><br>Moving away from 'fridge mother' generally to 'send parenting' | Humble parents<br><br>Defensive parents | Asking for a diagnosis – confession to professionals. Honesty and transparency constructed as essential<br>Documentation<br>Administration<br>Confession in an assessment<br>Engaging in learning/courses acceptance that they don't know the right thing to do so they do what is prescribed (relationship to psy-saviour)<br><br>Parents protect children from what they see as harm and oppression | Knowing you don't know anything, a desperation, frantic call for help. Lonely?<br><br>Injustice leading to the resistance<br><br>Psy-professionals feeing moral duty to support through available means<br><br>Possible guilt from attendance officers? Or a tightening of rules and punishment if this is conceptualise |

## Appendix O

*Chronological presentation of different configurations of discourses brought together to form a coherent narrative for presentation of findings*



Blaming the parents
'Bad' parenting (containing 'truant-permissive' subject position)
Mother blaming
Evidencing good parenting
Good parenting is conflated with accessing official Psy-help
Things are harder now than they have ever been
Instinctual parenting and protection
Subject positions in relation to bureaucracy
Psy-complex (theories, evidence types, recovery discourse etc.)
Neoliberalism /Capitalism
Individuality and freedoms
Schools represented as incompetent, withholding institutions
Abnormality, ostracization, tarnishment
Class warfare / disproportionate effects of SEND on class/wealthier
Education as oppressive and exclusionary
Authoritative discourses
Juridical truth
MH problems are definable and real / biomedical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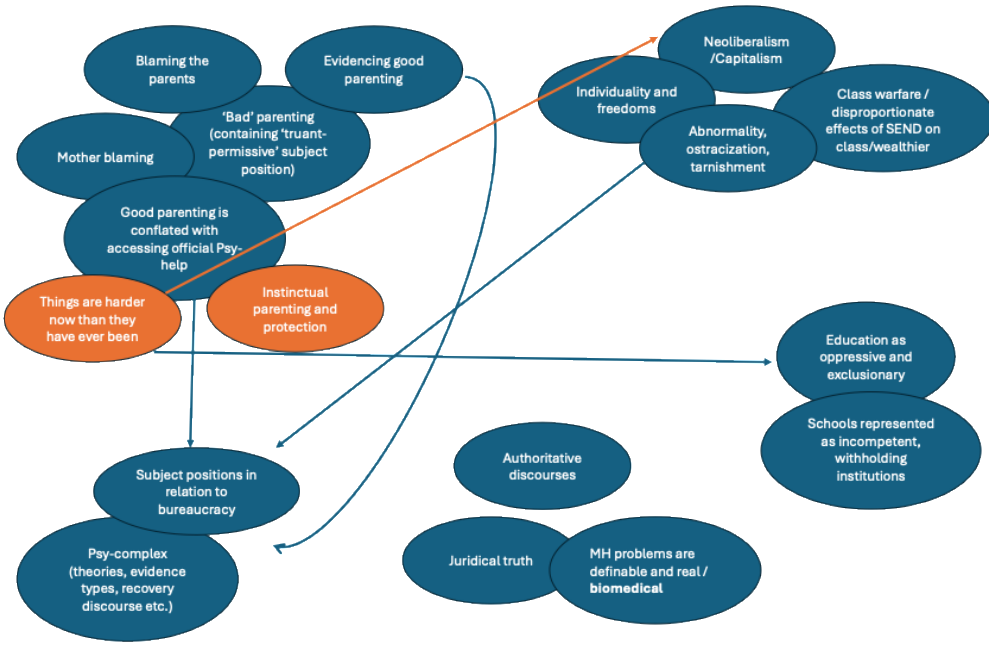
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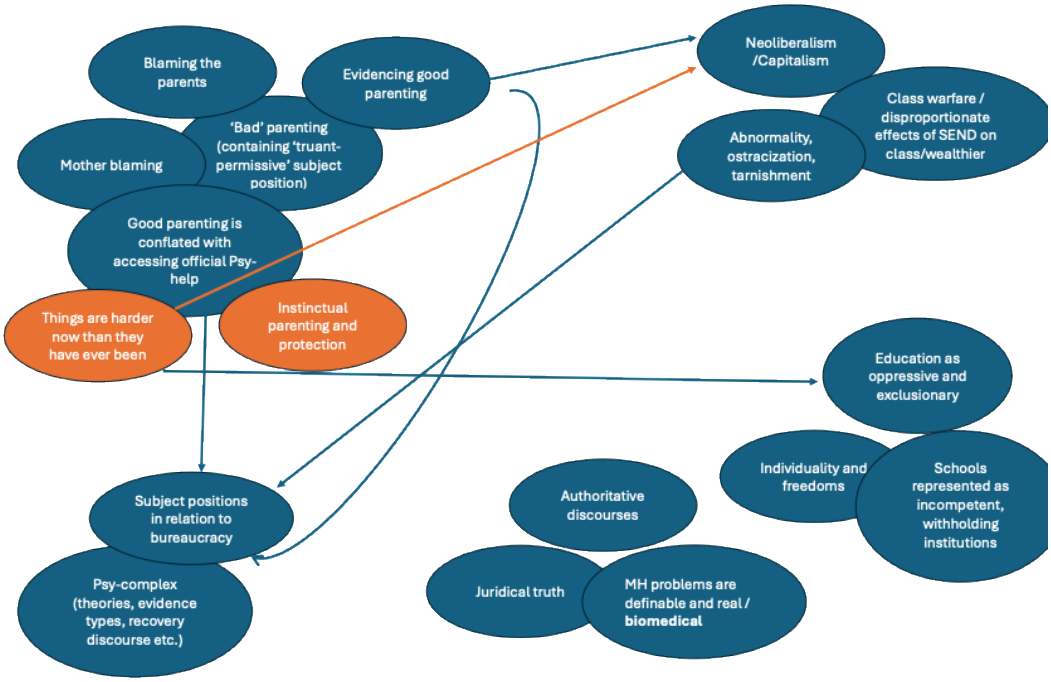
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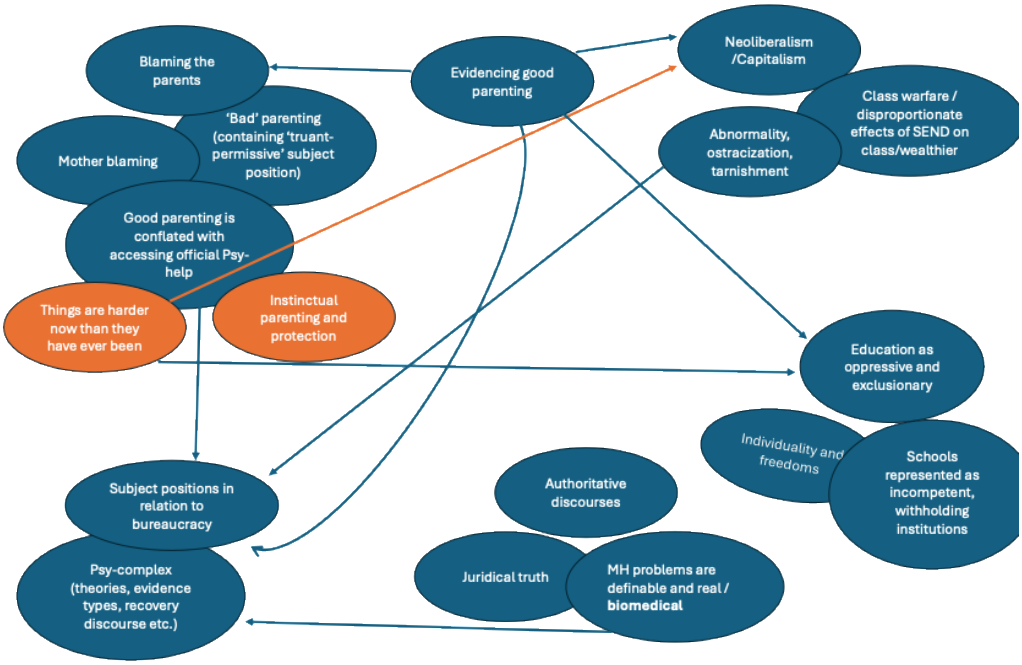
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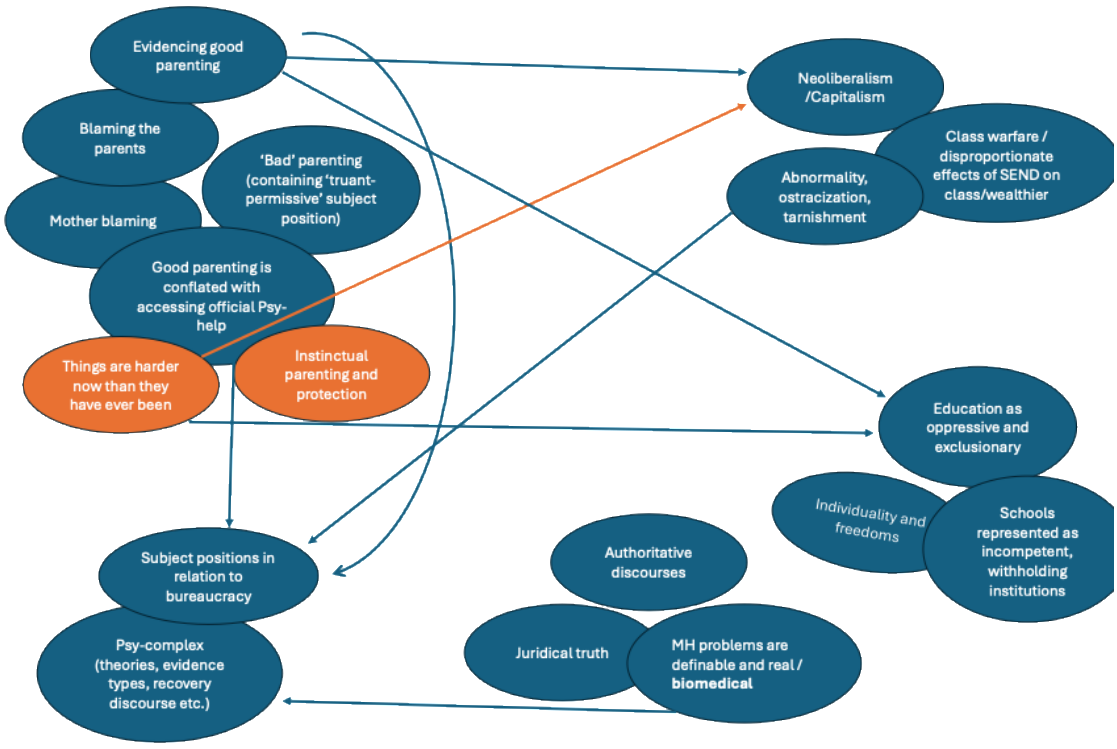
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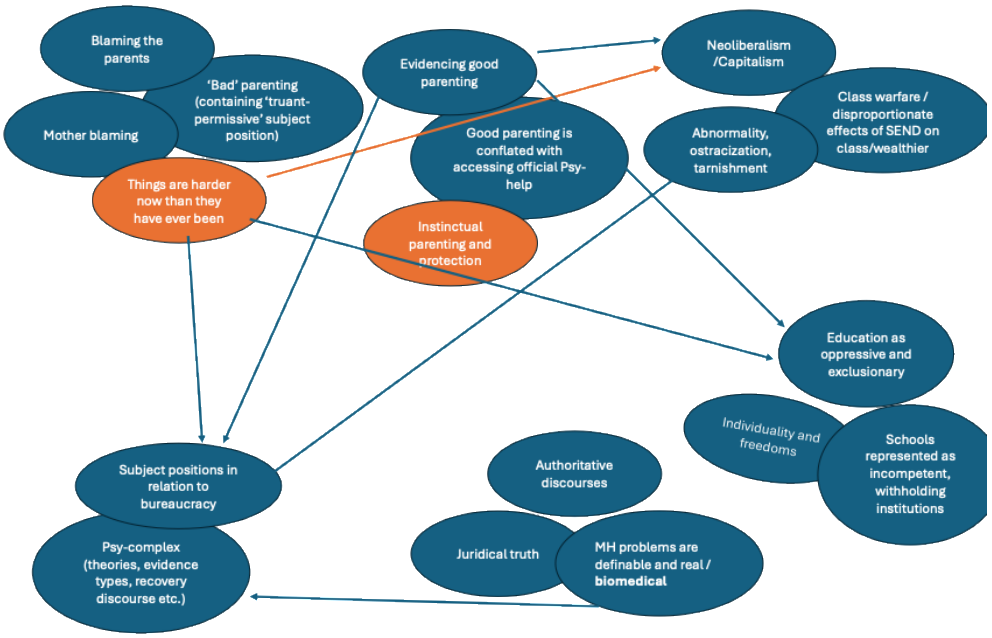
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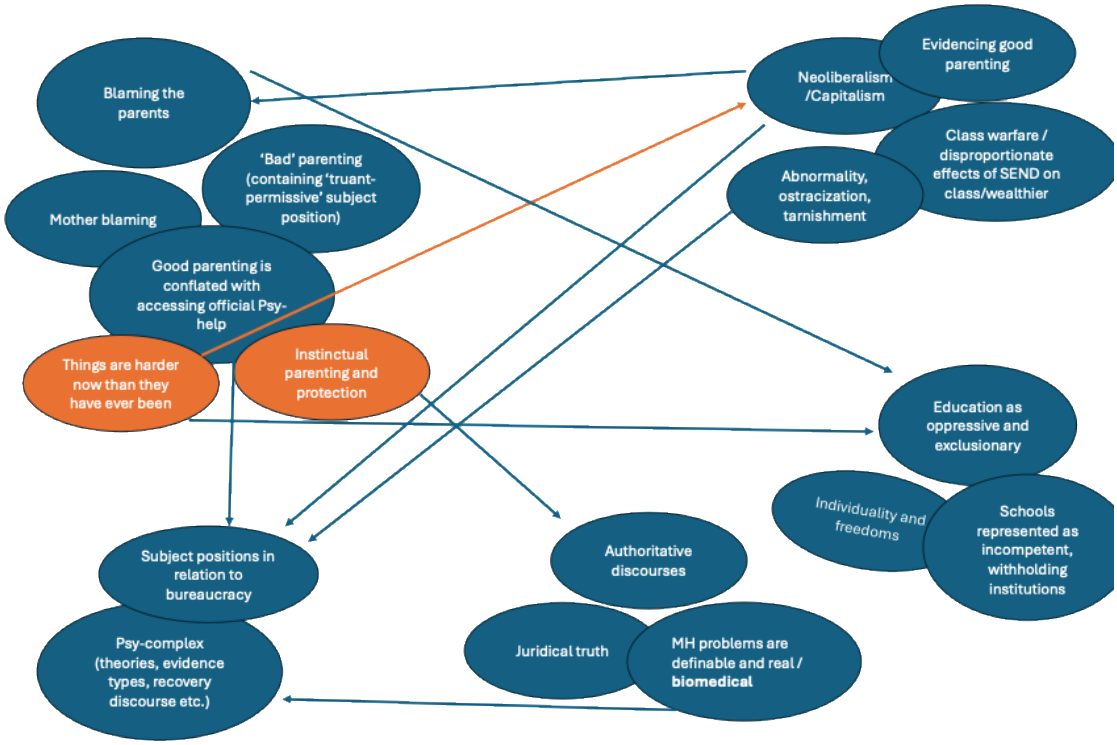
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