THESIS TITLE: **Constructing Mental Health Problems: A critical inquiry into the views of professionals working with children, parents and families**

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Abstract

At the beginning of the 21st Century, the field of child and family mental health presents us with a paradox. Whilst over the last fifty years there have been considerable improvements with regard to the physical health of children there have not been equal improvements in their psychological functioning and mental health. Instead, there appears to be an escalation of a variety of psycho - social problems in children and young people. A critical review of current literature and research reveals that child and family mental health problems are constructed within increasingly narrow theoretical, clinical and research frameworks. These emphasise a medical and pathology based construction of children's behaviour, rather than one that takes into account the meaning of children's behaviour within a family and social context. This research project attempts to throw light on this dilemma through conducting individual interviews with twenty - one professionals representing both universal and specialist child and family mental health services. In addition, two focus groups were held consisting of other child and family mental health professionals. The research utilised a qualitative methodology that applied an interpretevist approach to the examination of the data. This included a critical examination of the discursive practices and range of discourses that professionals employ in their everyday practice and the way in which these practices and discourses reflect values and attitudes to meaning, power, and the use of knowledge and in giving legitimacy to particular actions and interventions. Whilst the findings indicate the predominance of a blame-discourse on the part of the professionals who present themselves as the buffers between the parents and the child, a closer examination reveals

that for the professionals, the use of the buffer position functions as a defense. The findings indicate a parallel process between the parents and the professionals in which the latter operate largely in the absence of a coherent framework regarding the developmental needs of children, and with an uncritical acceptance of a predominantly medical model approach to children's behaviour. The self referential and hierarchical nature of each of the professional disciplines and services appeared further to contribute to levels of fragmentation within these services as well as to the absence of the voice of the child. The discourse of complaint and compliance on the part of the professionals in relation to their managers and heads of service further compromised their ability to act as advocates for children. The findings are analysed within the context of a socio-cultural critique that suggests congruence between the bio-behavioural construction of children's behaviour and the depleted vision of childhood and parenthood in society at large. The findings lead to a number of recommendations that are predicated on the assumption that the construction of child and family mental health cannot be considered as discrete from the construction of child and family wellness. A number of specific recommendations are made concerning the need for an ethical value based and Children's Rights approach with regard to child and family mental health.

Doctor of Philosophy Declaration

I, Ruth Eleanor Diana Schmidt Neven declare that the PhD thesis entitled *Constructing Mental Health Problems: A critical inquiry into the views of professionals working with children parents and families* is no more than 100,000 words in length, exclusive of tables, figures, appendices, references and footnotes. This thesis contains no material that has been submitted previously, in whole or in part, for the award of any other academic degree or diploma. Except where otherwise stated, this thesis is my own work.

Signature **Date**

Ruth Schmidt Neven

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Chapter 1: Rationale for the Study

1.1 *An Historical Paradox*

At the beginning of the 21st Century, the field of child and family development presents us with a paradox. Whilst over the last half century there have been tremendous improvements in the physical health of children and in the life expectancy of adults, there have not been parallel improvements in children's psychological functioning or mental health (Rutter & Smith, 1995). On the contrary, according to Rutter (2002), a child psychiatrist and prolific researcher, there has been a considerable increase in the frequency of psychosocial disorders in children and young people. Rutter argues that we need to ask ourselves the question "why has this been so?" He suggests that, "if we had a proper understanding of why society has been so spectacularly successful in making things psychologically worse for children and young people, we might have a better idea as to how we can make things better in the future" (Rutter, 2002, p.15).

1.2 *Rationale for the Study*

Coming to this research inquiry as a child and family psychotherapist, I address Rutter's question with regard to the current predicament concerning the deterioration in child and family mental health. The rationale I propose is that of exploring the following paradox. On the one hand we live in a time in which

professionals are informed by unprecedented clinical knowledge and evidence from research concerning child and family development, the role of attachment in infant parent relationships as well as the understanding of the developing brain and its impact on personality functioning. On the other hand, so little of this knowledge appears to have found its way into the mainstream and specialist services set up ostensibly to deal with child and family mental health problems.

As Stanley, Richardson and Prior (2005) point out we appear to be living out a paradox of having more as a wealthy society and yet doing less for children. In parallel with this observation they concur with the view that "knowing more about child and youth development than we ever have" (p. 7) has not translated into providing effective and in particular preventative strategies and services for children and their families. They pose the challenging question that is also part of the rationale of this study: "What is it about our society that is 'disabling', rather than 'enabling', child development and well-being?" (Stanley, Richardson and Prior, 2005, p. 7).

This research inquiry therefore finds its impetus in an ongoing critical reflection and examination of professional practices concerned with child and family mental health. In what follows, the way in which this research rationale determines the focus as well as the method of inquiry and data analysis will be further clarified. The implications for the conceptual framework of this research will also be explored.

1.3 *Professionals as the Research Focus*

In order to pursue a structural analysis of the problem under examination, I propose an inquiry into understanding the ways in which professionals construct the mental health problems of the children, parents, and families they work with. Therefore, the research takes as its starting point a focus on professionals rather than the direct experience of children and families, since professionals are significant opinion shapers with regard to the way in which mental health problems are both constructed and described. Hence, this inquiry focuses on how professionals perceive themselves in relation to these problems and how the way in which they relate to the demands of their work settings may inform their construction of child and family mental health problems.

The influence of mental health professionals is of particular interest when we consider that in the field of child and family mental health there appears to be a narrowing of the theoretical, clinical and research frameworks within which child and family mental health problems are constructed in current times. Moreover, clinical evidence as well as findings from research indicate a predominantly bio-medical approach to the construction of child and family mental health, characterised by a focus on the identification of the problem within the child, often to the exclusion of the relational, family and social context (Billington,1996; Breggin, 1994,1999; Prilleltensky & Nelson, 2000).

Thus, one of the underlying theoretical interests of this research project is that of understanding the implications of an increasingly narrow conceptual

framework for child and family mental health. This narrowing of a conceptual framework for child and family mental health has implications both for the way in which the child's problems are conceptualised, as well as for the ways in which professionals share and communicate knowledge with each other.

1.4 *Rationale for Method of Inquiry*

This research inquiry utilises a qualitative research method. The inquiry draws on various sources of data and information that provide evidence from different perspectives.

Firstly, this inquiry takes the form of empirical research through interviews with professionals that elicit their responses to their everyday practice in child and family mental health. The exploration of these responses follows a developmental continuum, from infancy to later childhood, as well as on a service provider continuum, from the provision of universal services through to the provision of specialist mental health services. Thus, the interviews with the professionals described in the findings, reflect this dual continuum by considering responses to the infant and young child, the child in the child-care setting, the child at school, the sick child and the child with designated mental health problems.

Secondly, the research inquiry critically examines current conceptual frameworks that inform the way in which child and family mental health problems are constructed and described. The researcher engages in this critical

examination while being informed by the influence of discursive practices that relate to the uses of meaning, power and knowledge (Parker, 1999).

Thirdly, in this inquiry the researcher is informed by insights and knowledge gained from her own clinical practice as well as from her experience of training other child and family mental health professionals in the community. In addition, information obtained from observation in the process of carrying out this research inquiry, has also been a source of critical reflection.

1.5 *Questioning the Implications of a Narrow Conceptual Framework*

A particular feature of a narrow conceptual framework applied to child and family mental health is the identification of the problem within the individual child. In this respect, Timimi (2002) takes a critical view of a predominantly bio-medical approach to child and family mental health problems. He criticises the tendency to identify these problems as existing *within* the child, isolated from the relational and family context and the wider system of the social environment. According to Timimi:

> childhood psychiatric labels are in constant danger of defining a child's character in a narrow tunnel vision, stripped of context. Our professional attitude and techniques leave us in constant danger of thoughtlessness about differences in culture, race, gender, class, sexuality and family lifestyle and of neglecting the impact of the wider system that children live in (Timimi, 2002, p.79).

1.6 *Implications for the Conceptual Framework of the Research Inquiry*

Others, such as Sanson (2002) and Stanley, Sanson and McMichael (2002) in their publication on Children's Health and Development for the Australian Institute of Family Studies, share this view. Sanson, for example, confirms the "groundswell of concern about the lack of progress and often decline, on many indices of the health and well-being of children" (Sanson, 2002, p. 1). According to Sanson this has implications for research in this area; in particular the risk of researchers being limited to "working in disciplinary silos" (Sanson, 2002, p. 1). Stanley, Sanson and McMichael (2002) articulate this narrowness of focus in terms of their criticism of the traditional epidemiological approach which espouses a "rigid paradigm of analyses of risk factors in individuals, using cohort and case control studies, without considering how and in what contexts such risk factors might have developed" (p.7).

In this regard, Stanley et al. (2002) emphasise that it is important to discriminate between proximal risk factors (those close to the individual or the onset of the particular problem) and distal factors (those more distant from the individual, such as social and cultural factors). They refer to the example of how focusing on the immediate antecedents of antisocial behaviour in the adolescent, such as school difficulties, parenting and peer association, ignores the "causal pathways" by which these issues became entrenched in earlier years. Therefore as a researcher, it is important to acknowledge that a too rigid theoretical

framework ignores how potential risk factors are themselves "embedded in a rapidly changing socio-cultural context" (Stanley et al., 2002, p. 9).

By contrast, Stanley et al. (2002), advocate an epidemiological paradigm with respect to children's physical and emotional development that is predicated on the concept of "causal pathways." As Stanley et al. explain: "This new paradigm, most commonly referred to as a transactional model, posits ongoing interactions between influences intrinsic and extrinsic to the child across time as the driver of development" (Stanley et al., 2002, p.10).

From another perspective, the tendency on the part of professionals to favour a narrowing of theoretical conceptual frameworks regarding the construction of child and family mental health problems may represent a wider problem within health and social sciences. The sociologist Thomas Scheff (2003) situates the discussion in the context of the broader concept of social science, suggesting that one of the difficulties faced by social scientists is that of falling into "routine": "adherence to scientific routines, no matter how scrupulous, can't solve conceptual problems. For this reason, human science may need to de-routinise" (Scheff, 2003, p.1).

According to Scheff (2003), there are divisions between theorists and researchers, and between qualitative versus quantitative approaches. These not only create the professional "silos" referred to by Sanson (2002), but also contribute to the difficulty of not being able to freshly conceptualise the problem. In this sense, Scheff argues, "new problems cannot be approached in a new way,

since the researcher has a prior commitment to theory, qualitative or quantitative methods, and to one of the disciplines as well" (Scheff, 2003, p.1).

New problems, Scheff (2003) stresses, have to be approached in a new way. If the current concern about the lack of progress in children's emotional and mental health is perceived as a new problem, then as suggested in this thesis, the attempts at solving this problem may themselves become part of the problem, not least of all because professional attitudes and approaches are mired in "old" established and routinised assumptions.

1.7 *A Post Modern Critique of Child and Family Mental Health*

Inherent to the rationale of this inquiry is the critique of current professional practices in child and family health reflecting a post- modern understanding that challenges the absolutism of our modern ideas of knowledge. As critique, it emphasises the limitations of pursuing a focus on individual pathology as well as on a predominantly instrumental approach to children's problems (Billington, 1996; Breggin, 1994, 1999; Howitt, 1991). From a post - modern perspective this critique further suggests that professional practices and services cannot be separated from an assumption of values (Prilleltensky, 1997), and from the connections that are created between meaning, power and knowledge.

In this respect, the child psychiatrist Sami Timimi (2003), discusses the problem of the increasing pathologising and medicalising of childhood and asserts that our construction of the mental health problems of children and

families cannot be separated from assumptions about our values as individuals and as part of society. Timimi explains that "we could say that the belief systems which make up the form of the way we interpret mental health problems are generated by and motivated by every society's need for a defence mechanism to alleviate, reduce and minimize our awareness of the mental vulnerability of the human state" (Timimi, 2004, pp. 54-55). Therefore, it should not come as a surprise that assumptions about the "absolutism" of scientific knowledge are themselves characteristic of an instrumental approach to child and family mental health problems. In this respect, Thomas Scheff (2003) argues:

> Scientists like everyone else, live in the assumptive world of our own culture. The ocean of assumptions that each culture reflects and generates are virtually invisible. Unless these assumptions are identified and discussed, the tools of science may merely uphold the cultural/social status quo, rather than breaking new ground (Scheff, 2003, p.3).

1.8 *Examining Discursive Practices in Child and Family Mental Health*

The critical examination of discursive practices in child and family mental health is an integral part of the approach taken in this research inquiry. Consonant with the post- modern epistemology, the rationale for this approach is that the conceptual framework of applied discourse analysis is particularly relevant when we examine how child and family mental health problems are constructed and described (Burman 1996; Parker 1999; Willig, 1999). Applied discourse analysis takes as its starting point the recognition that in professional

practices, services and institutions, essential connections are created between "meaning, power and knowledge" (Parker, 1999, p. 7). In this respect Burman (1996) has emphasised how psychologists, psychiatrists, social workers, nurses, teachers and community workers utilise psychological knowledge to "legitimise actions and interventions" (p. 2). These actions and interventions in turn influence the way the same professionals "evaluate normality and abnormality, social adjustment, mental illness or disability" (Burman, 1996, p. 2).

In the light of this approach, aspects of legitimacy and evaluation, in particular when related to discursive practices of meaning making and uses of language that yield power and knowledge, become an integral part of the critical examination carried out in this research inquiry. Accordingly, the researcher adopts a particular stance in her approach to the underlying assumptions that are at work in the discursive practices concerning child and family mental health care. In this she takes into account Scheff's (2003) reflections on the work of the philosopher Quine who argues in "A Postscript to Metaphor" (1979), that in order for scientific inquiry to proceed, certain "ruling assumptions" or "tropes" require to be overthrown. Scheff reformulates the notion of tropes as "linguistic/mental routines that both reflect and hide cultural assumptions" (p. 3).

For the purposes of this research inquiry, critical examination of such "linguistic routines" are of particular relevance when it comes to gaining a more profound insight into the ways in which professionals construct and describe child and family mental health problems. "Tropes" and "linguistic routines" play

an important role in mental health assessment and diagnosis. Therefore, an analysis of these linguistic routines goes hand in hand with an analysis of the dominant discursive practices concerning child and family health on the part of those professionals who are most directly involved.

In Chapter Two, the conceptual framework of the research inquiry will be situated within the context of current dilemmas that exist within child and family mental health. These are the de-contextualising of children's behaviour, as well as the predominance of the bio - behavioural paradigm in constructing children's behaviour. Both the de-contextualising of children's behaviour and the predominance of the bio-behavioural paradigm are indicators of risk that potentially jeopardise child well – being. Other indicators of risk that inform the conceptual framework of this inquiry are the loss of a developmental perspective of child behaviour and a reductionist approach to knowledge about children.

The following chapter will also explore a parallel inquiry that questions the deficit model of child and family mental health leading to the compartmentalisation of children's problems. This parallel inquiry additionally challenges traditional assumptions concerning a factual or "scientific" aetiology of child and family mental health problems as opposed to an understanding of children's problems that is essentially socially constructed and that reflects specific values and beliefs.

Chapter 2: The Fragmentation of Knowledge and the Denial of Meaning

At the beginning of the 20th century, John Dewey, the philosopher and educationalist, introduced a dynamic and promising view of childhood that had as its central tenet the developmental understanding of children. In his presidential address to the American Psychological Association in 1899, when he compared children with adults, he stressed the differences between the two by defining the child as "primarily one whose calling is growth" (Dewey cited in Sarason, 1981, p.124).

This dynamic view of the child that has the thrust of development and growth at its core appears to be lacking from many contemporary perceptions of the task of childhood. Instead, we may observe other factors that come to the fore, particularly with regard to the way in which the problems of the child are constructed and described in current times. These observations are summarised as current dilemmas in child and family mental health as follows:

2.1 *Current Dilemmas in Child and Family Mental Health*

i) Concern about the lack of progress in child and family mental health appears to go hand in hand with an increasingly de - contextualised and fragmented view of children's problems (Billington, 1996; Karr - Morse & Wiley, 1997; Lally, 1995; Marks, 1996).

ii) This de - contextualised and fragmented view arises from the current dominance of a bio-behavioural paradigm in which the problem is perceived primarily to be located within the child.

iii) Rather than being concerned with the child's development, the bio - behavioural paradigm appears to be concerned with uncovering pathology in the child.

2.2 *Reductionism in Knowledge about the Child*

These approaches to child and family mental health represent reductionist ways of thinking and of approaching knowledge about the child. A reductionist approach to child and family mental health problems has particular implications for the way in which services are conceptualised and delivered. For example it may be represented as the difference between perceiving the child's behaviour as "a noise in the system" (Goldberg, 2000) as opposed to viewing the behaviour as having a specific meaning that can throw light on the child's interactive and emotional experience with the family and the wider social community. Valerie Polakow (1992) describes the implications of a reductionist approach for the way in which services are delivered in her research of child - care practices in the United States. Polakow (1992) refers to a fragmented view of the emotional and social landscape of childhood. Her observations in the course of her research led her to become critical of how the:

> scientific idea of childhood pieced together from fragmented atomised components of the child's existential being, results in a reductionist and degraded image of the child modelled on natural science and emulating the laws of physics with an unquestioned credibility (Polakow, 1992, p. 31).

The programmes and services described above that typify a reductionist conceptual framework for child and family mental health, are further predicated on particular assumptions about knowledge. Within the reductionist conceptual framework, knowledge is typically perceived as being factual and external, "about" a problem, rather than knowledge that is gained by "learning from experience" (Bion, 1962). The appropriation of factual knowledge about child and family mental health for example has the function of producing results, usually the elimination of the behaviour or the "symptom", rather than of creating meaning.

In this context, knowledge takes on an objectified function rather than having an inter-subjective function (Trevarthen, 1979). When knowledge is subsumed by a utilitarian ethos, the behaviour of the child is not perceived as a valid communication in its own right. In contrast, by attributing meaning to the child's behaviour this may lead us to a better understanding of what the child may be trying to articulate about his or her situation (Schmidt Neven, 1996). The silencing of the knowledge of the child has its parallel in the silencing of the knowledge of the parents. A reductionist approach that emphasises external management of a problem by implication devalues internal knowledge. Thus parents may be put in the position of not being able to "own what they know" about their child, and their family relationships.

2.3 *Questioning the Deficit Model: Exploring a Parallel Inquiry*

Child psychiatrist Sami Timimi (2002) articulates similar concerns about objectifying modes of practice within child and family mental health in his book "Pathological Child Psychiatry and the Medicalisation of Childhood" (2002). Timimi's critical analysis is concerned with the attitudes and working practices of professionals with regard to the construction of child and family mental health problems.

Timimi's (2002) thesis is that a bio-behavioural approach to child and family mental health promotes a deficit model that leads to the compartmentalisation of children's problems. He describes as a fallacy the notion that these classificatory systems of childhood disorders are "science thick", when on the contrary he believes such classifications to be "culture thick" (Timimi, 2002, p. 53). These systems reflect the various beliefs, values and practices that are inherent to the raising of children. Attempts at producing truth and certainty from the complexity of child and family experience can only therefore serve to obscure the complexity of the problems presented, as well as limit the opportunity to explore multiple meanings.

According to Timimi (2002), the critical framework of the post - modern lens enables us to analyse critically the predominant cultural and ideological influences on the way in which we construct child and family mental health problems. Timimi perceives contemporary child and family mental health services as ignoring the ever - present dimensions of power relationships, and in

so doing contribute to the maintenance of oppressive power relationships. These oppressive power relationships are expressed through the "professionalisation" of human experience and through the creation of a "cultural discourse" that undermines peoples' capacity to make meaning of their lives and to find their own solutions to problems.

2.4 *The Reframing of Meaning that Emerges out of Challenging Traditional Value Assumptions*

Timimi (2002) points out that a post-modern critique does not deny the existence of a problem but rather that it emphasizes how a problem may be interpreted in a more meaningful way, particularly with regard to context and relationships. This approach he perceives as being of particular benefit in child and family mental health since as he explains: "sometimes the real progress in tackling a problem comes not through changing the child in some way but through changing the way somebody thinks about them" (Timimi, 2002, p.160).

Timimi's (2002) critique challenges traditional assumptions about child and family mental health and asserts that knowledge in this field is essentially socially constructed rather than based on assumptions about scientific facts. He argues for the use of knowledge that is more culturally informed and that is located within local contexts and relationships that are themselves perceived as undergoing constant change. This would include opening up a multi-perspective approach to child and family mental health, one that does not focus exclusively

on pathology and which builds on the resources and capacities of the child and family.

Within the field of social work, Morley (2003) articulates similar concerns about the erosion and displacement of critical thought concerning the construction of mental health and mental illness. Morley notes that an overview of social work literature reveals an uncritical acceptance of a medical model in mental health social work in which the majority of social workers identify their role as adjuncts to psychiatric and medical treatment. Moreover, since the pharmaceutical companies have a considerable investment world-wide in promoting biochemical solutions to mental health issues, this has an impact not only on the type of research that is favoured, but also on what type of knowledge is considered to be relevant. In this regard, Morley refers to the marginalization of social work's traditional value base, code of ethics and family and community based theories that result from the underwriting of biomedical constructions of mental illness by social policy and the legal system. Morley questions the "authorial voice" contained within these medical and pathological constructions of behaviour that silence other equally legitimate voices through creating a deficit focus that obscures a broader consideration of social inequalities.

Chapter Three brings into focus some of the main clinical concerns that both underpin the rationale for the research inquiry and that illustrate the practical implications of reductionism in conceptualising child and family mental health problems. These clinical concerns lead to a critical reflection on the role

of psychiatry and to the questioning of the significant gaps in the discourse related to child and family mental health.

In addressing these gaps in the discourse the inquiry is guided by the question, “who is qualified to speak” versus “who is currently being silenced” in the dominant discursive practices in child and family mental health. Additionally, the void with respect to values is identified as a significant absence in this dominant discourse.

Chapter 3: Clinical Concerns

The predominance of the current bio - behavioural paradigm in constructing and describing the mental health problems of children and families has led to what Breggin (1999) has called the "reframing" of children's behavioural problems within the framework of biological symptoms and treatment. This re-framing procedure forms what he describes as "biological reductionism." When child and adolescent behaviour is removed from its familial and social context, it can be made amenable to what is considered to be a more "scientific" approach, ethos and methodology" (Breggin, 1999, p.4).

3.1 *Practical Implications of a Reductionist Approach to Child and Family Mental Health*

The reductionist approach to child and family problems has practical implications for the design and delivery of child and family mental health services on a number of different levels:

i) Locating the problem in the child makes it difficult to respond to the needs of children in a holistic manner that takes into account family relationships and the wider community.

ii) Diagnoses of particular problems within the child appear to reflect the orientation of the professional rather than the needs of the child. For example with regard to the diagnosis of ADD and ADHD, the analysis of rates of medication has uncovered a wide disparity in Australia as well as in the United States, whereby small numbers of

medical practitioners in certain areas can be responsible for high prescription rates. The individual States themselves can vary in their rates of diagnosis (Mackey & Kopras, 2001; Prosser & Reid, 1999).

iii) Professionals are required to fit their own observations and clinical expertise into the dominant paradigm even when their experience on the ground contradicts the prevailing or dominant model.

iv) Behaviours become constructed as properties of the personality as we witness for example in the number of abbreviations used for an ever increasing number of syndromes identified in the child, such as ADD/ ADHD, ODD, Asperger's Syndrome. According to Reid (1995, cited in the Report of the British Psychological Society on ADHD 1996), there has been a shift in emphasis from aetiology to behavioural expression as the defining feature of many problems "it seems that the symptoms have become the syndrome" (p.14).

v) The bio-behavioural paradigm further favours a programmatic collective approach to child and family mental health problems that denies the complexity and contextual aetiology of many of these problems. Billington (1996) describes this approach as "the shift in the twentieth century from physical hygiene to the complexities of mental hygiene" (p. 40).

vi) The favouring of a programmatic approach to child and family mental health problems resonates with the idea of inoculating populations of

children and parents against the expression of particular behaviours. One example of this was the investigation by the National Institute of Clinical Excellence in the UK to explore the possibility of prescribing trial prescriptions of psycho stimulants to large populations of children said to be diagnosed with the "combined type" ADHD, inattention, hyperactivity and impulsiveness (*Young Minds*, November/December, 2000).

vii) The programmatic approach has the further consequence of de-skilling professionals. Professionals are required to become adept at providing "one size fits all" programmes that often originate in another country, usually the U.S. or U.K., rather than becoming adept at developing their diagnostic and therapeutic skills in work with children and families. The programmes themselves are often discarded once the hoped for outcomes are not achieved and another programme is put in its place.

viii) The programmatic approach further pursues the illusion of the idea of a "syllabus" that once learned will be able to be applied to change behaviour. Knowledge of the "syllabus" as employed in the term Parent Education, is generally in the possession of only a designated group, namely the professionals and by definition cannot be "known" by the parents themselves (Schmidt Neven, 1994).

3.2 *The Role of Psychiatry*

Timimi (2002) is critical of the tendency of current child psychiatry to attempt to emulate medical science and scientific biology by describing the behaviour of children exclusively in medical and physical terms. This attempt at the classification of children's disorders (DSM-IV 2000), he believes, does not reflect in any meaningful way what may be occurring in the experience of the child, or indeed the family (Timimi, 2002). Timimi questions the level of consistency in the findings of research psychiatrists such as Rutter (Cantwell & Rutter, 1994) with regard to the classification of children's disorders describing them as "a social construct of theory driven ideas" (Timimi, p. 53). Adherence to their claim for objective knowledge he perceives as akin to a "professional mental health ideology" in which evidence is manipulated to fit the framework, rather than adjusting the framework to fit the evidence.

3.3 *Attending to the Gaps in the Discourse – Revisiting Rutter's (2002) Paper*

A critical examination of discursive practices in child and family mental health enables us to identify what Burman (1996) has called "attending to gaps in the discourses" (p.14). Attention to the gaps in the discourse enables us to identify and interpret the "silences" in both professional policy and practice. If we return to Rutter's cri de coeur about the deterioration in children's mental health, quoted at the start of the thesis, it may be enlightening to explore the text of his paper in greater depth. We may explore the text in the light of the limitation of discourse in relation to who can speak and what can be spoken

about. In addition, we may explore the paper in the light of the marginalisation of a discourse related to ascribing meaning to the behaviour of children and their families.

A brief analysis of the discursive practices employed in Rutter's (2002) paper reveals firstly that Rutter establishes that we must have what he calls "*a proper understanding" (*my italics) "of why society has been so spectacularly successful in making things psychologically worse for children and young people…" (p.15). As the paper continues, it becomes clear that Rutter has very definite ideas about what constitutes a "proper" understanding and what does not.

In his paper, Rutter (2002) suggests that part of the reason for the poor mental health outcomes for children is that despite the advances made in our knowledge about "nature, nurture and developmental processes", there has been a strong tendency towards "confrontation", "polarisation", and "evangelism" in presenting these findings. He adds, "these have given rise to an unhelpful level of misunderstanding of the true scientific advances and more especially, about their meaning and the implications for policy and practice" (p.1). We may note that Rutter, while attempting in his paper to find "new" answers to the problem of child mental health, firmly grounds his inquiry in the archaic nature versus nurture controversy, a controversy that has been criticised as consisting of false and outmoded assumptions about the nature of development (McCain & Fraser Mustard, 1999; Shore, 1997).

While Rutter's (2002) criticism of those who make unfounded claims both about the impact of genetic versus psychosocial factors is laudable, he nevertheless clearly identifies those areas that he considers "worthy" of further study whilst ignoring others. For example, by emphasising the need to deepen our understanding of developmental psychopathology he embeds his inquiry about child mental health further into a pathological framework. This focus on psychopathology also serves to maintain a split between what is normal development for the child versus what is abnormal, whilst excluding the context and meaning of the child's behaviour.

3.3.1 *Who is Qualified to Speak*?

Rutter (2002) is unequivocal about whom he considers to be "qualified" to speak on certain topics whilst silencing others. For example, on the subject of the findings in neuro-science that have captured the imagination of many child and family mental health professionals, he implies that only those qualified in the field of neuro - science are entitled to participate in this discourse. Whilst not referring to any literature in particular, Rutter is highly critical of those who have made what he calls "misleading" and "fallacious" claims that early experience brings about a lasting change in brain structure. These are claims that, as he puts it "come from people outside the field of neuroscience research…" (p.13).

Rutter (2002) is also brisk in his condemnation of professional groups such as psychologists who dare to challenge the medical hegemony; "Cognitive psychologists have wanted to claim the whole of mental functioning as their

domain. Such presumptuousness needs to be resisted" (p. 14). Most significantly, under the guise of lack of "scientific" proof, Rutter's paper is strangely silent about theoretical frameworks and clinical findings that have contributed significantly to our understanding of child and family development. His dismissal of the entire field of attachment is one such example, under the heading of "Misleading Claims" (p. 9). It is interesting to note in this connection that in earlier publications (Rutter, 1997), he acknowledges the relevance of attachment theory to the lives of children in a variety of settings. However in this (Rutter, 2002) paper, only the work of John Bowlby (1951) of over half a century ago is mentioned.

Rutter's (2002) reference to the now rarely used term "maternal deprivation" further supports his discrediting of this field of inquiry. Paradoxically, in relation to attachment, Rutter asks the question in his paper "why for example, does profoundly depriving institutional rearing seem to lead to both so called disinhibited attachment patterns and also quasi-autistic behaviour?" (p.14). It is as though lost in his own disciplinary silo, Rutter dismisses the possibility that at least some answers to these questions may be found in the explosion of recent writing and research on attachment (Goldberg, 2000; Rolfe, 2004). As Goldberg (2000) explains:

> The rapid proliferation of attachment research and its continuing expansion resulted in a massive body of data documenting links between the quality of early experience in the attachment relationship and

> subsequent development….the net result is a body of evidence which provides a scientific basis that was previously lacking for evaluating assumptions underlying clinical work. By virtue of the sheer mass of studies (both completed and ongoing), attachment research and its underlying ideas have become familiar to many clinicians…(p.12).

Finally, an analysis of Rutter's (2002) paper reveals a further gap in the discourse concerning the reasons for the deterioration in child mental health. This gap relates to how the conflict between the various approaches he discusses, particularly the genetic/biological, versus the psycho-social/ environmental, is never addressed within the context of a broader system of values, as well as assumptions about power and knowledge.

For Rutter (2002), the field of what he describes as "psychosocial research" is far removed from considerations of values, power and knowledge. Instead of finding ways of reconciling psychosocial research with ideas about values and ethics, Rutter asserts that psychosocial research is best allied with biology thus firmly placing the discourse concerning child and family mental health within the bio - behavioural domain. Rutter's (2002) paper opens with wide ranging and sweeping statements about the parlous state currently of children's mental health, and one becomes hopeful that this will lead to the presentation of new and challenging ideas. However, his analysis is in fact narrow and circumscribed.

We may speculate that Rutter's (2002) paper may in part reflect a discourse related to the preservation of the status quo. It may also have the underlying function of responding to, or of warding off implicit criticism towards mental health practitioners, particularly child psychiatrists. Thus, Rutter's analysis may have more to do with consolidating established positions with regard to child and family mental health particularly by re-asserting the predominance of the bio- behavioural paradigm than with an attempt to understand the complexity of the experience for children and families.

The absence of any discussion of the capacity of the child, adolescent or family members to develop a sense of personal or collective agency in the solution of their own problems further reinforces the position that only certain people, namely the professionals, are allowed to speak. It also appears to reinforce the position that it is solely professionals, who are able to be in possession of knowledge about the problem.

3.3.2 *Silence on the Question of Values*

As stated earlier, Rutter's (2002) paper is silent on the question of values, which means that he is also silent on the dimension of values that relates to the responsibility of mental health professionals toward the people they are trying to help. As indicated earlier, it appears to be easier to make an assumption that, "society has been…spectacularly successful in making things psychologically worse for children and young people…" (Rutter, 2002, p.15). Society of course includes the mental health professionals themselves who may need to carry some

responsibility in this regard. Rutter's analysis is silent on the question of professional responsibility. It is also silent on the question of how child and family mental health services are experienced by the actual users of these services; the children and parents who have been so poorly served.

Section Two is devoted to the literature and research review. The literature review in chapter four takes both a historical and critical perspective of constructions of childhood. Central to this perspective is the recognition that these constructs of childhood are by their very nature malleable thereby reflecting influential societal structures and values.

SECTION 2: LITERATURE AND RESEARCH REVIEW

Chapter 4: An Historical Approach to Constructs of Childhood

This literature review takes a critical approach to current perceptions of childhood and has been selected in accordance with critical thinking with regard to the way in which we construct ideas about child and family mental health. For these purposes, the main focus of this critique is primarily on the child. Although the position of the child within the family is acknowledged, the family itself is not the primary focus of this review.

The review of theoretical literature reflects three interrelated underlying assumptions: Firstly, that our views of childhood are constructed according to influential societal structures and values that inform practices and discourses concerned with children and families. Secondly, that the currently prevailing view of childhood is constructed under the strong influence of the bio-behavioural paradigm. Finally that the language used by professionals in their approach to problems they work with in child and family mental health practices reflects both the currently prevailing social structures and values invested in our view of childhood, and the predominant bio-behavioural paradigm.

4.1 *A Critical Approach to the Construction of Childhood*

A critical perspective with regard to constructs of childhood that prevail over attitudes concerned with children's own needs and interests, leads to a critique that builds on the assertion that throughout history, ideas about childhood have been malleable subject to the prevailing value systems of society

given the dependency of children and their lack of rights. Moreover, the traditional historical perception of childhood is one that may be perceived primarily as an adult construction, rather than one that acknowledges the child as a "maker of history" and a "meaning maker"in their own right. In this regard, children are described with reference to being the objects rather than the subjects of history (Polakow, 1992).

This view is elaborated by Zornado (2001) who, writing from both a literary and cultural perspective of childhood, asserts that in order to fully understand what he calls "the latent story of childhood", we need to recognise the place of dominant ideologies, dominant culture as well as the workings of the unconscious in constructing the story. Zornado puts forward the view that dominant ideologies and discourses are reproduced across generations through the lived experience between the child and adult. This transmission takes place through everyday child rearing practices, or child rearing pedagogy that is predicated on the institutionalised induction of the child into the adult world (Zornado, 2001).

As Zornado (2001) states, it becomes impossible for us to disentangle stories of childhood, stories of human relationships and stories of power since these are all defined within and by the predominant culture (Zornado, 2002). The child therefore inevitably becomes used "as a site of cultural and ideological production and reproduction" (Zornado, 2001, p.211).

According to Cleverley and Philips (1987), influential thinkers in the history of ideas have conceptualised models or paradigms in which particular views of childhood are embedded. In modern times, these views present us with a construct of childhood that in one way or another relates to a central idea of progress and improvement.

The classic work of Philip Aries (1960) is a particular example of this theoretical position, tracing as it does the emergence of the idea of childhood in France from the late Middle - Ages to the eighteenth century. Contributions from the philosophy of science highlight a different aspect of the same argument.

The science historian Kuhn (1968) has described the phenomenon of working within specific models or paradigms. These paradigms come to dominate particular spheres of thinking, for example influencing the way in which we observe and create meaning out of children's behaviour and development.

The prevailing paradigm determines not only what is studied but also how these problems will be conceptualised. In the view of Cleverley and Philips (1987), this is particularly relevant to the way in which children and childhood problems have been described through the ages and in current times. Most significantly, these historical constructions of childhood give us an insight into the difficulties associated with validating and ascribing meaning to the child's experience.

4.2 *A Schism in the Discourse Concerning Constructions of Childhood*

Influential thinkers over the last 200 years have emphasised different aspects of the child that reflect their core philosophies or theoretical perspectives. In referring to only a few it is evident that these core philosophies or versions of them continue to hold sway in current times. Their influence is particularly striking with respect to the perpetuation of a schism in the construction of childhood that appears to permeate many current ideas of childhood and child mental health problems.

In current constructions of childhood and of childhood problems, we may observe this schism operating in the discourse concerning the importance of nature versus nurture. A similar schism appears to operate in the discourse that prevails about the functioning of the brain as distinct from the consideration of the mind. This is particularly evident for example in the current debates about ADD/ADHD. Here the core argument appears to centre on how we understand the nature of attention. For example, whether attention in the child is viewed solely as a cognitive function of the brain, or whether it is perceived as a complex and multi-dimensional activity that emerges out of a relational process between children, parents and caregivers. What follows is a brief outline of some of the key ideas that have given rise to the perpetuation of these schisms in articulating an epistemology of childhood.

4.2.1 *The Child and the Influence of the Environment*

From the writings of John Locke, philosopher, doctor, and academic in the late 17th and early 18th centuries we learn about the far reaching influence of education and the environment on the child (Cleverley & Philips, 1987). Locke's theoretical position acted as a counterpoint to the then dominant view of innate inborn limitations in the child. In some respects, Locke's emphasis on the idea of learning from experience foreshadows the use of that term nearly two centuries later, by object relations psychoanalysts of the 20th century (Bion, 1962).

4.2.2 *The Good and Innocent Child*

Jean Jacques Rousseau, an admirer of Locke, writing in the 18th century, proclaimed the child as inherently good and innocent, in contrast to then prevailing views about original sin. The work of Rousseau and his followers have contributed to the continuing debate about the most appropriate form of education for children, particularly with regard to tapping the innate resources of the child. Rousseau's emphasis on the freedom of the child and the need to allow children to follow their natural impulses found expression in his novel *Emile* (1762). In his author's preface, Rousseau outlines his core argument, one that demonstrates a remarkable resonance with current critical views concerning not only education but also the construction of childhood. He states:

> We know nothing of childhood; and with our mistaken notions the further we advance the further we go astray. The wisest writers devote themselves to what a man ought to know, without asking what a child is

> capable of learning. They are always looking for the man in the child, without considering what he is before he becomes a man (Rousseau, 1969**,** p. 1).

4.2.3 *The Child as Meaning Maker and Sexual Being*

The work of the psychoanalyst Sigmund Freud, commencing in the late 19th century and continuing its influence well into the 20th century, has significantly transformed our view of childhood. Freud and his followers have transformed not only our perception of childhood, but also our understanding of adult life predicated as it is within the psychoanalytic canon, on the experience of childhood.

Psychoanalytic or psychodynamic ideas present us with a paradox, since in the course of the 20th century few other conceptual frameworks concerning human development have been subject to such hostility and ridicule, whilst simultaneously becoming integrated into many areas of human activity and relationships. For example, the very intense focus on childhood as stage specific and separate from adulthood, owes much to the psychoanalytic or psychodynamic approach.

Similarly, the emphasis on the importance of the first five years of life, the changes in educational approaches to teaching, the closing of community homes, the reluctance to take children into care and separate them from their families would have been unthinkable without the influence whether

acknowledged or not, of psychodynamic understanding, clinical experience and research (Schmidt Neven, 1996).

Interestingly, from a post - modern perspective, adherents to discursive approaches within qualitative research have found an affinity with psychoanalytic ideas. In particular, understanding the way in which the self is constructed through language, and the relationship with wider socio cultural elements (Burman et al., 1996).

With respect to the child, Freud's work is particularly relevant in presenting a new vision of the child, one in which the child is identified as a sexual being. Freud's theories about the continuity of experience from childhood to adulthood developed in his Three Essays on the Theory of Sexuality (1905) centred on the identification of phases of development. The elaboration of these phases of development introduces us for the first time to the idea of the child experiencing himself directly in relation to his own body. According to Freud, the child's developing sexuality is associated with the various developmental stages of the oral, the anal and the genital.

More than any other theory of child development, psychoanalysis makes the understanding of the meaning of all behaviour, including that of children, a central tenet. In his paper "Beyond the Pleasure Principle" (1920), Freud gives one of the first accounts of an observation of a young child of 18 months playing with a cotton reel. In this observation, Freud interprets the cotton reel play of appearance and disappearance as an attempt on the part of the child to make

sense of the coming and going of the parent. The recognition that all behaviour has meaning is critical to the way in which professionals construct the mental health problems of children and families since this takes place in relation to their experience both at an individual level in relation to the people they attempt to help, and in the light of their experiences within their organisations.

According to Cleverley and Philips (1987) the child psychologist Jerome Bruner, although not a follower of psychoanalysis, identified Freud's specific contribution as that of establishing continuities in areas in which his contemporaries and predecessors had only perceived discontinuities. Bruner(1973) identified these continuities as occurring in five areas. These are

(a) Continuity of lawfulness in nature in the physical realm and the realm of human thought and emotion;

(b) Continuity between the primitive and the infantile, the civilized and the evolved;

(c) Continuity between the child and the adult;

(d) Continuity between the apparent rationality of waking life and the apparent irrationality of dream and fantasy life; and finally,

(e) Continuity between mental illness and mental health (Bruner, cited in Cleverley & Philips, p. 56).

A critical reading of the current literature and research in child and family mental health would suggest that the clock has been turned back with regard to the recognition of continuity in human development, particularly child and

family mental health. Thus, the predominance of a pathology- based model of mental health reflects almost entirely assumptions of discontinuity in the sense of de-contextualising the child's behaviour and responding to behaviour as a discrete fragmented entity.

4.2.4 *The Cognitive Child*

The work of the psychologist Jean Piaget in the 20th century takes as its starting point an entirely different perspective of the development of the child. Unlike Freud, Piaget's interest did not lie in understanding how the child ascribed meaning to his experience and family relationships. Piaget's main interest was in the cognitive development of the child in relation to the outside world. While Piaget too postulated the child's development in terms of stages, these tended to be conceptualised within a biological framework. Piaget (1971) was concerned with the cognitive repertoire of the child, in relation to problem solving and learning, and in understanding how the child utilises cognitive skills to interact with the environment.

4.2.5 *The Conditioned Child*

Finally, the work of John Watson and B.F. Skinner takes us a step further by eliminating altogether the process of introspection as a means of making sense of human experience. According to Cleverley and Philips (1988) Watson and Skinner's constructs of behaviour particularly of the child, were based on assumptions about controlling elements in the environment and thereby controlling the behaviour of the child. Through their extrapolation of findings

from their animal experiments with classical and operant conditioning respectively, Watson and Skinner point to a different line of continuity altogether. That is, a line of continuity between animal behaviour and human behaviour.

Watson and Skinner's construction of an ideal type of childhood and family life rested on assumptions about being able to reinforce socially acceptable forms of behaviour, within the constraints of a controlled environment. Their experimental psychology with its emphasis on parsimony was to be limited only to that which could be observed and recorded. Central to this approach is the abandonment of introspection and speculative theory building.

Continuing developments in cognitive and behavioural psychology have had an enormous impact on the academic sphere as well and in psychological treatments for adults as well as children. It would be fair to say that in the majority of university psychology departments, behavioural, cognitive and experimental psychology is viewed as the only valid "scientific" psychology whilst psychodynamic approaches have become both invalidated and marginalised. Not surprisingly therefore, cognitive, behavioural and non introspective approaches are particularly influential in relation to the way in which child and family mental health problems are not only constructed but also treated.

4.3 *Challenging a Conventional Analysis of Childhood*

As corrective learning from history, social historians such as Lloyd de Mause (1975) have drawn our attention to what they describe as an historical record of childhood, with a focus on the actual experience of the child. De Mause presents a view that has some parallels with the thinkers above concerning the nature of social and emotional improvement for children over the generations. However, where de Mause differs, is in his view that life for children over the centuries has been characterised by violence, starvation and sexual abuse. The historical record of childhood according to de Mause, represents a nightmare from which we have only recently awoken (de Mause, 1975).

From taking a historical approach to childhood, we learn that childhood behaviour and experience emerge from within prevailing societal and cultural paradigms. We also learn that these paradigms do not emerge from an orderly process of human evolution. Rather, these paradigms are subject themselves to the forces and discontinuities inherent in changing social, psychological cultural and economic contexts.

Leupnitz (1988), introducing both a family and feminist perspective to the discussion about constructs of childhood, cautions against the uncritical acceptance of conventional analyses of the history of childhood. In particular, Leupnitz cautions against polarised views such as that of idealising the family of earlier times versus perceiving the family as an institution hostile to the care and protection of children. She is critical of the more conventional analyses that

suggest that social transformations can take place in a linear or step wise fashion, resulting in what she describes as the myth or ideology of progress.

Such an analysis is predicated on an assumption of continuity in society over time that is perceived as ultimately providing a more benign environment for children. In opposition to this view, Leupnitz (1988) asserts that historical change does not follow universal laws. Instead, historical change is characterised by discontinuity rather than by continuity since culture and social conditions, limit personal, social and other choices.

Leupnitz (1988) argues that we should not assume that social change for children and families comes about through an inevitable process of social evolution. Rather, social change occurs through historically informed and deliberate action. This view is supported by Polakow (1992), who points out that the idea of childhood only became entrenched in law and institutions as late as the 19th century, in response to the political and social activism of religious workers and philanthropists.

Thus, the emergence of the idea of childhood is synonymous with the need to provide reform, care and protection for children. Leupnitz (1988) argues that definitions of motherhood and childhood, and by extension the family, are dependent on a variety of factors. Economic imperatives are particularly influential in this regard. For example, the impact of industrialisation, separating the realms of home and work has had a significant influence on the way in which the family is defined in modern times.

Leupnitz (1988) emphasises the importance, particularly for clinicians in child and family mental health, of connecting the clinical perspective with the historical perspective. This she perceives as similar to combining the views of the right and left eyes that impart slightly different pictures to the brain (Leupnitz, 1988). Through the clinical eye, the behaviour of parents and children is typically described in terms of pathology, error, and dysfunction. However, perception through the historical eye enables us to understand the actions of these parents and children in the context of political, social and economic events and processes.

4.4 *Contemporary Constructions of Childhood and the Bio - Behavioural Paradigm*

We may take further the theme of perceiving individual behaviours as occurring within specific social and organisational contexts and imperatives, and of combining the clinical with the historical perspective, to explore how childhood is constructed in current times. Polakow (1992), with reference to her research on child - care in the United States, identifies a fragmented view of the emotional and social landscape of childhood. Polakow states that the new world order is one that is dominated by the power of technology. The creation of what she describes as a "technological consciousness" leads in turn to favouring specific forms of knowledge that are considered to be in tune with, and which resonate with, the predominance of the technological "world view." The technological worldview favours the creation of what Polakow terms a "science

of childhood" (p. 27) in which children's behaviour is constantly being measured, quantified and evaluated.

Polakow's (1992) critique of the ascendancy of scientific ideology, similarly to that of Scheff (2003) discussed earlier, is underpinned by the recognition that all human thought is subject to the ideological influences of the social context. In Polakow's view, the "science of childhood", modelled on an uncritical image of the natural sciences, has led to a fragmented de-contextualised view of the child's experience.

The "science of childhood" in the 20th century and now in the 21st century has spawned an immense amount of information about the child from a variety of different perspectives. Polakow (1992) is critical not only of how this information is gathered, but also what it tells us about the child. For example, Polakow refers to the appropriation of the child's experience by professionals who reduce and interpret their behaviour through the distorting lens of competing theoretical positions. In this context, Polakow invokes Donald Vandenberg's assertion of the right of the child to have a sense of being "at home in the world" (Polakow, p.21). In contrast to enabling children to be "at home in the world", Polakow (1992) refers to professionals employing "an alienating psychologism" (p. 22) typified by a " behavioural technology" (Polakow, 1992, p.40) that takes the child's behaviour out of a personal and social context, thereby invalidating the essence of what is contained in the essential life task for the child.

The professionalisation and appropriation of the child's experience, is further perceived by Polakow (1992) as having a significant influence in undermining the role of parents and parenting. The power of description and prescription wielded by professionals over generations, Polakow perceives as contributing significantly to the tendency for parents to renounce their own powers of knowing and seeing.

Zornado (2001) goes further in stating that "the adult's physical and emotional domination of the child – often justified by a belief in the child's congenital need for reform – characterises the childhood experience of Western culture" (p.xiv). Zornado confirms Polakow's (1992) view that the current dominant ideology characterised by an uncritical acceptance of the informative and healing powers of technology, as well as medical science, culturally enforce assumptions about the necessity to create a split between the mind and the body. This process, according to Zornado, leads in turn to ever - increasing levels of fragmentation and dissociation in the child - parent relationship.

Zornado's (2001) views of the threats to the child's authentic lived experience, is informed by the work of the psychoanalyst Alice Miller (1981, 1985). Miller's work portrays the child as betrayed by child rearing practices that are perceived as being simultaneously repressive and exploitative, as well as by educational and social systems that she characterises as a "poisonous pedagogy." The combination of both has the effect of robbing the child of awareness of their own life history. This view further resonates with Polakow's (1992) assertion

regarding the need to acknowledge and validate the essential life task of childhood.

The impact of the dominant bio - behavioural ideology influences not only the parent - child relationship, but also professional - child relationships. As Howitt (1991) points out, there is an inclination in current professional practice towards "fundamentally de - contextualised sorts of psychology" (p. 16) which lead to the tendency to strip behaviour of its meaning and remove it from its origins in family and social history, interpersonal relationships and intra - psychic experience.

Whilst Cleverley and Philips (1987) suggest that the predominant discourse concerning the child in the last 200 years has been that of the constrained versus the free child, a new and different discourse appears to prevail at the end of the 20th and beginning of the 21st century. The deciphering of this contemporary discourse requires us to be aware of the latent as well as the manifest content embedded in current constructs of childhood.

4.5 *Contemporary Discourses Concerning the Child*

The problematic versus the powerful child.

In current times, the discourse that appears to predominate with regard to constructs of childhood is that of the problematic versus the powerful child. This discourse may be characterised as the child who "must be helped" versus the child who "must be feared". One aspect of this discourse represents a view of the child as deficient in relation to their behaviour, thereby requiring the intervention

of professionals. The opposite side of the same discourse is characterised by a view of the child as inherently powerful and controlling, through deficits of behaviour, thereby also requiring the intervention of professionals. Both positions indicate the fine line that exists between supporting children's mental health, and what appears to be arbitrary social control. This concern is highlighted by Billington (1996), who states that the currently widespread use of the "medicalised, hierarchical model of symptom definition" (p. 37) not only serves to pathologise children's behaviour, but also to "justify and perform acts of social regulation and exclusion" (p. 40).

The sick child.

The discourse of the sick child embedded as it is within the discourse of the problematic child, portrays the child's behaviour in terms of malfunction. As Breggin (1994, 1999) explains, the current preoccupation with increasing medical diagnoses of children's behaviour hides an inability of society to deal with a range of complex social problems. Isolating a discrete problem within the child makes things more manageable and has the added benefit of being couched in the language of disease and healing.

The power of the discourse concerning the problematic versus the powerful child, becomes manifest through the institutions that traditionally cater for the needs of children, most particularly the education system. Breggin's (1994, 1999) critique from the perspective of child psychiatry of the increasing tendency to medicalise and pathologise children's behaviour has its parallel in

the field of education, with particular reference to psychologists working within schools.

In this context, Billington (1996) states that psychologists have the power to influence equality of opportunity for children through their involvement with the discourses of intelligence, class, age, gender, sexuality and race. Billington perceives that the medicalising and pathologising of children's behaviour not only defines what a child should be in the present, but also has an undeclared future economic function of regulating children's access to the labour market.

The role of the child in the family.

From the perspective of family therapy, Leupnitz (1988) adds a further dimension to the discourse concerning the conundrum of the child who must be helped versus the child who must be feared. Leupnitz makes the point that the contemporary family is entirely child centred. The child has the function of creating a raison d'etre for people, providing a reason to tolerate hardship, as well as a means to measure their worth.

Within the small nuclear family, the child may also have a role in diverting marital conflict. As Leupnitz (1988) puts it "*the child has replaced the village in the modern world"* (p.139, author's italics). This family perspective provides us with a paradox that may throw light on ambivalent attitudes towards children, since within the family context the child's power although perceived as considerable, remains latent rather than manifest.

4.6 *Professional Discourses of Power and Confrontation*

An examination of some current uses of professional language with regard to child development and child mental health may indicate how an ambivalent attitude towards children appears to be a central feature of these contemporary discourses. To complicate matters, this professional language or discourse of ambivalence, appears to derive its status from a loose alliance with what Polakow (1992) has described as "the science of childhood."

As we may see from the following examples, the discourse of ambivalence towards the child who is perceived as simultaneously problematic and powerful tends to be expressed through what may be described as relational rationing. For example, children who provoke their parents are often described as "attention seeking" whilst needy children can be assuaged by "controlled comforting." Specific stages of development may further be isolated and identified as particularly problematic as in the prevalence of the term, "the terrible two's."

One of the most common examples of relational rationing in current clinical practice is the widespread recommendation of "controlled crying" as an all- purpose solution to the sleeping problems of infants and young children. The Australian Association for Infant Mental Health (AAIMH) Position Paper (March, 2002) describes controlled crying as follows:

> Controlled crying (also known as controlled comforting and sleep training) is widely used as a way of managing infants and young children

> who do not settle alone or who wake at night. Controlled crying involves leaving the infant to cry for increasingly longer periods of time before providing comfort. The intention of controlled crying is to let babies put themselves to sleep and to stop them from crying or calling out during the night (pp. 3-4).

The AAIMH position is critical of what they describe as the Western lifestyle expectation that infants and young children should sleep through the night. This adult centric focus may obscure understanding of the complexity of infant and young child development, as well as the needs of young children. The position paper expresses concern that the technique of controlled crying teaches the child from an early age "not to seek or expect support when distressed."

The ambivalence contained within contemporary discourses concerning children is particularly well articulated in the popular Australian parent advice book "Toddler Taming" by the paediatrician Christopher Green (1990). Advice sessions given by the author based on the book, generate a large following of parents as well as professionals. Green's discourse of early childhood encapsulates the critique that has been described earlier. Despite the fact that this book was written over a decade earlier, its core thesis concerning early childhood behaviour perfectly encapsulates the critique concerning the contemporary professional discourse of power and confrontation. In fact in the clinical experience of the researcher, the language and discourse represented in this book have already become part of the "vernacular" for many parents and professionals

concerning parenting and child behavioural issues. Green's position as medical practitioner and paediatrician further appears to give his views and advice unquestioned legitimacy.

The title of the book explicitly and implicitly advocates an adversarial position in which the world of the young child and the animal world are synonymous. Green's (1990) view of the young child is one of a child without a mind whose behaviour has no meaning except to control and disturb. "If you were to list the attributes of the toddler, it is unlikely that sense would immediately spring to mind. It is my belief that between the ages of 1 and 2 years most toddlers have zero sense"(Green, 1990, p. 3). For Green, the discourse of early childhood is synonymous with the discourse of control and management, whether over bodily functions, separation anxiety or any other aspect of behaviour manifested by the young child.

The discourse of power and confrontation operates as a leitmotif throughout Green's (1990) work. Green (1990) describes toddlers as "wanting attention 25 hours a day" (p. 14) and as negative and showing little sense or appreciation of the rights of others (p. 13). It is illustrated by the use of military metaphors as in, "it is almost as if someone had left open the door of a mighty arsenal of behavioural weapons, but unfortunately they don't know how to use them wisely" (Green, 1990, p. 11). In this context, it is parents who become the victims of their children. Parents are advised to use "common sense" and "cunning" and not to blame themselves (Green, 1990, p.15). Green (1990) does

not rule out the use of "occasional corporal punishment" (p. 5) and dismisses any suggestion that this could cause emotional damage as "a complete misreading of the facts" (p. 5).

The prevalence of the adult centric discourse in Green's (1990) book concerning power, control, and self – centeredness, eerily projects onto the young child many of the baser instincts and impulses of the adult world. This interpretation of the reality of children's experience from an adult perspective is criticised by Prilleltensky, Nelson and Peirson 2001, who further point to the dearth of literature concerning the negative effects that follow from the actual powerlessness and lack of control in many children's lives. For these authors, clinical interventions and community interventions are perceived as inseparable and the fact that these fields have for so long operated in isolation from each other is seen as a significant factor in inhibiting what they refer to as the "pathways to resilience." Zogorno's (2001) analysis of this type of discourse suggests that it reflects assumptions about the child's behaviour as wilful and inappropriate, rather than understanding and responding to the child's emotional needs. In particular, expressions of anger on the part of the child are perceived as a serious threat to adult authority, and therefore must be met with even greater retaliatory force.

Silencing the child and the parents.

Green's (1990) discourse of adversarial management and control renders his toddler and toddler's parents not only silent, but also bereft of knowledge

about themselves. The discourse of power and control does not consider the child and parents as active agents with a personal history and a capacity to create meaning out of their interactions. In contrast to this predominant discourse, current research on infancy and early childhood reveals very different insights into the infant, young child and parent relationship.

4.7 *An Alternative Discourse Acknowledging the Capacity of the Infant and Young Child*

Infant research and clinical analyses over the last thirty years have given us much information about the extraordinary capacities of the infant and about the lasting effects of attachment (Fonagy et al., 2002; Fraiberg, 1980; Murray & Trevarthen, 1986; Papousek & Papousek, 1979; Sameroff & Emde, 1989; Siegel, 2001; Stern, 1977,1985; Trevarthen, 1979, 2001; Tronick,1989; Zeanah, 2000).

At the core of these findings lies the recognition of what Sameroff and Emde (1989) describe as the centrality of affect and shared meaning between the child and their care - givers. Children and parents become the subjects and thereby the creators of their lived experience. In other words, they are the subject of their experience, not the passive objects; two of the main researchers in the field, Daniel Stern (1977) and Colwyn Trevarthen (1979), eloquently describe this process. From Daniel Stern (1977) we learn about the innate capabilities of the infant, that "the infant comes into the world bringing formidable capacities to establish human relatedness. Immediately he is a partner in shaping his first and foremost relationships" (p. 33). This suggests a process of transformation in

which the child and parents contribute to, and are each transformed by, the interactive process.

At the heart of the capacity for mutual transformation is the process of what Colwyn Trevarthen (1979) has called “inter – subjectivity.” The process of inter - subjectivity implies that for the infant and young child, and his parents, communication is synonymous with shared meaning and a sense of mutuality and reciprocity. This leads in turn to what Trevarthen calls “the proto conversation” that is, the fundamental and first conversation of life that informs all subsequent communication.

A key question that the research attempts to address is how it is that these findings concerning child development do not appear to translate into common knowledge and everyday practice. In fact, it would appear that these findings, and the understanding that has been generated about the complexity of the interactive process between parents and child, are either totally omitted or appear to be relegated to the margins of the dominant discourse.

The following chapter will describe empirical research that attempts to address these issues of omission. The empirical research review will also attempt to take further ideas about the creation and transmission of meaning within the context of the provision of professional services for child and family mental health.

Chapter 5: Empirical Research Review

An examination of existing research on how professionals construct the mental health problems of children and families reveals a surprisingly limited number of studies. Research that is concerned with the attitudes and behaviour of professionals tends to focus largely on adults. This suggests that setting up a research project that critically examines professionals' construction and description of child and family mental health problems may well fill a gap in the field.

A further observation of the existing empirical research highlights the scarcity of studies that examine current professional practices in child and family mental health from a critical perspective. In line with this critique, it is striking that the vast majority of research in the field of child and family mental health, appears to take the form of a secondary discourse. In other words, the research tends to describe treatments or interventions for particular conditions that are unquestioningly perceived as existing within the child or his or her parents.

The research described in this review has been selected to represent an explicitly critical perspective of professional clinical practice and attitudes, both in relation to their work with clients or patients, and in relation to how they experience themselves in their work settings.

5.1 *Research on Diagnostic Decisions – The Professional's Perspective*

Harper's (1995) research examines examples from interviews with medical professionals and adult mental health patients that explore how

diagnostic decisions are made. Harper's findings suggest that professionals involved in the diagnosing of mental illness can present simultaneously two apparently contradictory forms of dialogue; one that is critical of the diagnostic categories used, what Harper calls a liberal position, whilst carrying out the actual tasks required by the institution. The patients' dialogue in these interviews, by contrast, is perceived as being characterised by a sense of powerlessness and the need to defend identity within the dominant discourse of psychiatric diagnosis.

A number of research projects similarly take the deconstruction of language in mental health setting as a starting point. For example, Mohr (1999) critically examined the language used in medical records and in progress notes made by nurses in a psychiatric hospital. Applying deconstructive textual analysis to the medical records and progress notes, Mohr found that only one percent of the data reported reflected a positive assessment of patients while more than 20% of entries reflected pejorative and punitive judgements. The findings from the research led Mohr to identify how readily descriptions of patients and of their behaviour became reduced to ritualistic and routinised expressions of language, heavily dependent on jargon. In her conclusion, Mohr suggests that in a number of cases, this limiting language used by the hospital staff, may be perceived as a defence against nurses' own anxiety about the limitations of their knowledge working in the complex setting of the mental health care facility. Mohr's conclusions concerning the anxiety of the nursing

staff resonate with similar findings of Menzies - Lyth (1988) from her action research in a London teaching hospital described later in this section.

Rubino (1995) carried out research related to the social construction of psychiatric diagnosis by critically examining the way in which mental health professionals identify, describe and assign labels to mental illness. Rubino analysed data from three sources: the series of DSM volumes; case history descriptions of anti - social personality disorders and multiple personality disorders; and media reports related to these two categories of diagnosis. Although Rubino did not make use of applied discourse analysis, the results of the analysis indicated that the current proliferation of diagnostic categories suggests a flaw in the older paradigm of the physical and biological sciences that has tended to ignore the importance of the larger social context in the assessment of mental health problems.

5.2 *The Patient's and the Child's Perspective: Critical Approaches*

The importance of recognising the wider social context in professional/patient relationships is emphasised in a Swedish study (Johansson & Eklund, 2003). The study investigated patients' opinions on what constituted good psychiatric care. The main category that emerged from both in - patient and out - patient groups was the quality of the helping encounter. Patients perceived the quality of the relationship between patient and therapist/staff and of being understood by these staff members, as forming the central tenet of good care. The researchers described this process as the "helping alliance" characterised by

an acknowledgement of ambivalence, time and meaning. Their findings are considered to be applicable to a wide range of provider -patient settings including work with children and families.

The importance of ascribing meaning to experience is a particular feature of the research of Polakow (1992). This research carried out over two years of children and staff in five day - care centres in the Midwest in the United States, is underpinned by what she describes as "a quest for meaning and understanding" (p. 28). In order to begin to engage with this quest, Polakow explains that, "it is necessary to become anthropologists of childhood" (p.28) and to develop the ability to be simultaneously embedded within the culture, whilst taking distance from it. Polakow's research takes as its reference points an adherence to a hermeneutical as well as a phenomenological approach (Geertz, 1973).

From a hermeneutical perspective, we learn that all behaviour has meaning, although these meanings may not be immediately understandable. Polakow (1992) perceives this task as attempting an interpretation of meaning, based on acknowledging the validity of the individual's experience. In this regard, Polakow views a phenomenological approach as having the potential to elucidate meaning through detailed and careful observation and description "to penetrate to the essence of a phenomenon, to the core themes that underlie *what* is being observed" (p. 36, Polakow's italics).

Polakow's (1992) research foreshadows many of the current concerns regarding what constitutes satisfactory day - care for children (Early Childhood

Research Network, 2000; Lally, 1995; McCain & Mustard, 1999). Her findings additionally indicate the tension engendered by the needs of working mothers and the lack of provision of an adequate system of day - care for their children.

Polakow's (1992) detailed "anthropological" accounts of each of the day care services presents disturbing insights into what constitutes acceptable care for children. In her conclusions, Polakow identified the different types of procedures that are typical of each of the Centres, as contributing to what she describes as "The Erosion of Childhood," the title of her book. These procedures took the form of restrictive parameters that undermined children's play, the dominance of daily routines and regimens over the needs of the children, the rigid adherence to control and the exclusion of children whose behaviour was considered deviant.

Interestingly, Polakow (1992) also found that the organisational problems she perceived as inherent in many of the institutions she studied appeared to be disregarded or denied by the staff. Instead, it appeared that the workers in the respective organisations, tended to individualise these problems so that these were often projected onto the children. The projection of these organisational problems disguised as individual problems, would typically take the form of "an intrapsychic diagnosis" as a way of describing the disturbance or destructiveness of a child.

Polakow's (1992) findings concerning the predominance of routines and regimens in the day care centres she studied, is supported by action research

carried out in a child care centre in the UK, by Bain and Barnett (1980). Bain and Barnett found that where staff and organisational routines took precedence over the needs of children, that this resulted in what they called "discontinuities of experience." These discontinuities would typically take the form of sudden interruptions to the children's activities without consultation. The discontinuities tended to have a further disruptive effect on the children's behaviour, making the shy children more withdrawn and the boisterous children more aggressive.

More recent research in the area of child – care in Australia (Farrell and Travers, 2005) confirms the importance of the early childhood setting in the promotion of child mental health. The recognition that child-care workers are often not sufficiently trained in working optimally with children and their families led the authors to establish a "Healthy Start" program in Western Australia that focused specifically on building their capacity and skill. Whilst the levels of confidence and skill of the child-care workers in dealing with mental health issues increased immediately after the training, these gains were not sustained over time. The authors conclude that ongoing professional staff training is a critical factor in promoting child and family mental health in the early childhood setting.

Children in school: conforming to norms of behaviour.

The tendency for professionals to attach labels and diagnoses to children who do not appear to conform to the overall "norm" of behaviour is discussed in research concerned with how subjective judgements may influence the use of

behavioural rating scales. In two small scale research projects carried out by Sonuga - Barke, Minocha, Taylor and Sandberg (1993) they demonstrated how judgements of teachers could lead to categorising children within minority and ethnic groups (BPS report on ADHD, 1996).

The researchers (Sounuga - Barke et al., 1993) compared teachers' ratings of hyperactivity with objective measures of activity, and inattention in groups of Asian and English primary school aged children. The teachers were found to have overestimated the Asian children's hyperactivity compared with their more objective measurers. In addition, children rated as being equally hyperactive as their English classmates were in fact, observed to be less hyperactive in the actual classroom.

Attempts to counteract this individual deficit focused emphasis have been made with respect to attempts to introduce a whole school approach to the promotion of mental health and wellbeing with varying results (Leurs, et al., 2005; Wyn, et al., 2000). The key to success in implementing a whole school approach clearly depends on the extent to which the school recognizes that health promotion is part of their "core business." Leurs et al point out that an integrated, long term, whole school approach is more effective than a more short term solely classroom based program. Wyn et al. report on a school project, "Mind Matters" piloted in secondary schools in Australia. Central to the success of the project was the willingness of the teachers to participate in and feel confident in

promoting not just the core curriculum but "promoting and teaching for mental health."

Children with a disability.

The findings from research carried out by Sloper and Turner (1991) illustrate the importance of an inclusive discourse with regard to understanding the needs of children and families. They compared parental and paediatricians' views of the needs of families with a child with severe physical disability. The two groups agreed on areas of greatest need, but in other areas paediatricians tended towards overestimating the negative impact of the child on the family, as well as underestimating the parents' need for non - medical information as well as for continuity of contact.

In a further study, Lightfoot and Sloper (2003) found that health services are, in many cases, not designed to meet the needs of children and young people. They describe the results of an outcome study investigating the involvement of children and young people with a chronic illness or physical disability. One of the significant findings was the need for what the children called "a listening culture" on the part of the professionals; a finding that the researchers indicated has training and clinical implications for professionals working in all settings concerned with children and young people.

Critical approaches to the perception of adolescence.

Research by Gergen, Lightfoot and Sydow (2004) on the construction of adolescent problems questions the perpetuation of a "recurring vision of youth in

crisis" (p. 393). The authors suggest that the idea of an adolescent crisis is socially constructed, and that there is a need to explore alternative ways of understanding the issues. Amongst their alternative constructions of adolescent behaviour, the authors suggest that adolescent risk taking has a particular meaning within adolescent sub - cultures, and may be better understood as a way in which adolescents construct their identity.

Critical approaches to the formulation of medical diagnosis.

Avdi, Griffin and Brough (2000) explored the way in which parents constructed the problem in the course of assessment and diagnosis of their child for an autism spectrum disorder. In contrast to a more traditional focus on loss and stress, the authors utilised a form of discourse analysis to explore the ways in which the problems were represented. Three sets of parents participated in eleven semi - structured interviews over a period of six months. The analysis suggested that parents tended to use three main discourses in the course of discussing the problem. These discourses related to the discourse of normal development, the medical discourse and the discourse of disability. Although this study focused on autism, the authors suggest that the way in which families construct these interrelated discourses may inform our understanding about the complexity of medical diagnosis in other areas.

Critical approaches to infant - parent relationships.

Research related to the centrality of affect and shared meaning (Sameroff & Emde, 1989) is described by child psychotherapist Robin Balbernie (2003).

Balbernie utilised a discourse analysis approach to identify the connections between the quality of attachment between infant and mother, and the capacity in the mother for reflective function. As Balbernie points out, attachment researchers and psychotherapists cue into what lies behind the accounts and descriptions that people give of emotionally important events in their lives. The Adult Attachment Interview increasingly utilised in current attachment research (van Ijzendoorn, 1995) is one such example. Here the researcher is interested in translating the life story of the informant, most particularly the narrative style of the informant into patterns of attachment. Balbernie's research was concerned with mothers' perceptions of their infants. It was based on the replies to a number of open - ended questions used as part of an interview. The interviews took the form of a focused conversation that centred on each mother's perception of her infant.

The analysis of the interviews was approached via elucidation of what Balbernie described as "internal world references" (Balbernie, 2003, p. 396). This included understanding how mention of emotions, beliefs and motivations on the part of the mothers could be related to their descriptions of their infants and themselves. The internal world references were in turn analysed in the context of the mother's capacity for reflective function (Fonagy et al., 1991). The analysis took the form of analysing the narrative features of each of the interviews. Although the sample was small (five mothers and infants) the findings revealed that the concept of reflective function is useful in being able to

identify an association between levels of clinical risk and the lucidity of the parent in being able to describe their emotional relationship.

The extent to which key professionals can both define as well as limit the scope of services is described in an Australian Maternal and Child Health Service Professional Needs Analysis (Keating and Barrow, 2006) carried out on behalf of the Victorian Government Department of Human Services. Whilst the findings confirm the importance of ongoing professional training mentioned earlier (Farrell and Travers, 2005) they also throw up some surprising results. Most particularly despite the fact that maternal and child health nurses represent a universal service a key finding was that health promotion and partnerships with families were not considered to be priorities by the coordinators responsible for the nurses and for promoting training within the service.

Critical approaches to ADHD assessment.

A further example of applying discursive analysis to understanding the way in which power relations influence diagnosis and the meaning of behaviour is described by Midgley (2004). Midgley refers to Bennett's (2003) findings concerning how children come to be diagnosed with ADHD.

Bennett analysed the circumstances in which children are diagnosed with ADHD in relation to various types of discourse. These discourses concern teachers and the child who misbehaves, doctors and the child who is ill, and parents who perceive their child to be naughty. Bennett's (2003) findings emphasise the dominance of the language of blame and self - blame, and how the

concept of ADHD as a diagnosis is situated within specific social, historical and cultural contexts. The interviews with the mothers explored the different levels of discourse concerning ADHD. In particular, the choices that they made with regard to use the drug Ritalin for their children appeared to affect their perception of themselves as good or bad mothers. Bennett's (2003) findings suggest that the "minefield of competing discourses" (Bennett, p.7) regarding the diagnosis of ADHD, made it difficult for the mothers to establish a positive mothering identity for themselves.

Critical approaches to the perception of resilience in children.

The concept of resilience in childhood development is particularly interesting since it encapsulates the difficulty of translating ideas that originate from empirical research and clinical experience, into everyday practice. In fact, the concept of resilience in current usage and clinical practice may be said to represent the very process of becoming "lost in translation." Whilst the essence of an understanding of resilience is embedded in a developmental approach that prioritises attachment and interpersonal relationships (Rolfe, 2004), there are many examples in everyday practice in which the concept of resilience has become entirely detached from its origins. This detachment inevitably takes the form of reducing the concept to a more limited meaning associated with coping strategies in which the child is assumed to have an intrinsic capacity to bounce back from difficult experiences. In this context, it may be used to justify less than satisfactory services or facilities for children.

Martineau (2000) undertook a critical discourse of childhood resilience, and the politics of teaching resilience to children considered to be at risk in schools in British Columbia, Canada. Martineau starts from the position that resilience has become an "ideological code" in current times to encourage social conformity and academic achievement. In addition, Martineau identified a shift in the definition and usage of resilience from the context of trauma to the context of everyday life, and from the context of traumatised to disadvantaged populations. Martineau's findings indicate that "teaching resilience" to disadvantaged children rationalises systemic inequalities by locating the problem within the child. Martineau argues that resilience should be viewed as "pluralistic", "contingent" and "always in progress". It is dependent on the experiential knowledge of the child as opposed to consisting of a concrete, independent entity that can be incorporated into a school curriculum.

5.3 *The Group and Organisational Context of Child and Family Mental Health*

The place of group and organisational understanding plays a pivotal role in this research, since all the professionals interviewed carry out their work within specific group and organisational contexts. We may hypothesise that these organisational contexts reflect both resistance and openness to change on the part of professionals, with regard to prevailing views of childhood and related constructs of mental health problems in their work with children and families. In this regard Sampson (2001) points out that it is paramount to include a broader organisational focus when engaging in such an inquiry, so that the emphasis

shifts from beyond "the acting individual" toward the "acting ensemble" or "unit of enquiry" (Sampson, 2001, p. 56).

Social systems as constructs.

A critical perspective of the function of such "acting ensembles" within groups and organisations emanates from the field of psychodynamic research and theory in the work of Bion (1961), Jaques (1990), Menzies-Lyth (1988, 1989), Rice and Trist (1990) amongst others. By emphasising "the phenomena of total fields rather than of individuals" (Rioch, 1971) it is possible to expand the context in which many relational processes may be examined. Whilst not focused specifically on inequitable power relationships in group and organisational functioning, this psychodynamic perspective nevertheless enables us to develop understanding of the underlying dynamics that may give rise to these inequitable power relationships.

The pioneering work of Wilfred Bion (1961) and Isabel Menzies - Lyth (1988, 1989), representing the Object Relations approach to group and organisational functioning identified two interrelated aspects of group function that are central to a critical understanding of relational processes within groups and institutions. Bion's identification of the existence of *basic assumption groups* and Menzies - Lyth's identification of the way in which *social systems construct defences against anxiety* represent the cornerstone of this approach.

As Hirschhorn (1988) explains, classical organisation theory (Galbraith, 1973) has its limitations, and takes too narrow a focus because it does not take

into account the nature of irrational processes that emerge out of inevitable experiences of anxiety and uncertainty. By contrast, psychodynamic perspectives of groups enable us to recognise the processes of splitting, projection and introjection that are central to group and institutional processes. This enables us in turn to take a critical view of such processes. Thus, for example, we may understand that many of the bureaucratic procedures that are fundamental to many organisations may also be perceived as representing disguised forms of social defence (Hirschhorn, 1988, p. 3).

In what follows, Bion's (1961) formulation of Basic Assumptions and Menzies - Lyth's (1988, 1989) formulation of Social Systems as a Defence Against Anxiety are described with specific reference to the way in which these conceptual frameworks can assist our understanding of the way in which child and family mental health professionals may come to "speak" their organisations.

Bion and basic assumptions.

Bion's (1961) formulation of group processes is predicated on the observation that in any group two groups are in fact present; "the work group" and the "basic assumption group." These two types of groups can be characterised by different types of mental processes. Members of a work group perceive themselves as getting on with the avowed task, whilst the basic assumption group is perceived as being synonymous with an "as - if"' mentality that distorts the ability of the members to attend to the group task.

In the Basic Assumption group, members do not address the ostensible work task of the group but as Hirschhorn (1988) explains, they retreat not only from the task but also from the role, and organisational boundaries associated with the task. The invoking of assumptions "about " the group, acting as though certain beliefs are fact, is a process that may come to have a life of its own even though these assumptions do not reflect the original or ostensible aims of the group. According to Bion (1961), basic assumptions generally take the form of covert or tacit assumptions rather than being overtly expressed. Bion (1961) identifies three main sets of mental processes that take place in groups that connect with the three basic assumptions.

The three basic assumptions described by Bion are: the basic assumption *dependency group; the fight-flight basic assumption group;* and the *pairing assumption group*. Members of the *basic assumption dependency group* act from a position of weakness as though they have no knowledge or capacity to effect change. The group members wait for a leader who will take charge and manifest almost magical powers of healing, understanding and support. Bion has described patients in a psychiatric facility as displaying elements of the dependency assumption in that the leader therapist or psychiatrist may become idealised by the group. When the leader fails to meet the patients' unrealistic expectations this arouses inevitable disappointment and hostility on the part of the group.

The fight flight basic assumption is characterised by a conviction on the part of the group members that they are struggling with self-preservation and must engage in action that involves either fighting someone outside of the group or running away from a threat perceived to exist outside of the group. The call for action in the fight/flight group promotes leadership that is not concerned with the needs of individuals but rather with mobilising the group as a force against an outside threat whether real or imagined. The anti - intellectual attitude fostered in the fight/flight group is antipathetic to introspection, self-knowledge or doubt.

In the third *basic assumption of pairing*, the group acts as though it has come together for the purposes of reproduction and to produce a leader who may become the Messiah or saviour of the group. In this basic assumption, the group puts forward two people who symbolise the hope of new creation. The unborn leader, that, it is hoped, will emerge from this union, according to this basic assumption, will rescue the group from its passivity and act as a cover for the unexpressed anger people in the group may have towards each other and to others outside of the group.

Each of these basic assumption groups is thus characterised by forms of behaviour and communication that may come to dominate the behaviour of the group, rendering it incapable of attending to its avowed task. As Hirschhorn (1988) explains, the basic assumption mentality arises from magical thinking in which members of a group come to believe that a cohesive group or group mind can come to exist without attention to work or the collaboration of its members.

The basic assumptions that emerge as part of the dynamic interchange of the group may also be understood as having a compromise function in terms of dealing with anxiety, as well as with the need to deal with differences and potential challenges that may occur between members of the group. (Hirschhorn, 1988, p.63).

Bion's concept of Basic Assumptions in groups is not intended as a criticism of groups nor does it reflect the idea that all basic assumption groups are inherently unhealthy or pathological. On the contrary, because it recognises the powerful forces of complex group dynamics in all human interchange that include negative as well as positive feelings and experiences, it enables us to develop insight into these processes rather than to deny their existence. This contributes in turn to the avoidance of blame, splitting and a dismissive attitude. The need to understand these underlying group dynamic processes, particularly in the helping professions, is of central importance to supporting professionals and to the creation of healthy and productive organisations that can properly address the needs of the people they are ostensibly set up to help. The following description of research in this area is a case in point.

5.4 *The Functioning of Social Systems as a Defence Against Anxiety*

Menzies - Lyth's findings (1988) concerning the functioning of social systems as a defence against anxiety further develops Bion's ideas regarding Basic Assumptions in groups. Her action - research project (1988) was carried out in response to the concern of the nursing service of a teaching hospital in

London, with regard to the training and retention of student nurses. These concerns grew out of the realisation that one third of trainees did not complete their training, that sickness rates amongst trainees was high, and that senior staff changed jobs frequently.

In the course of the action research study, Menzies - Lyth became aware of the high levels of tension, distress and anxiety on the part of the nurses. She observed that the nursing hierarchy had put in place procedures and routines that appeared to have the primary function not of promoting patient - staff relationships, but rather of depersonalising the contact between nurses and patients.

These depersonalising training procedures and routines were interpreted by Menzies - Lyth as being used in a defensive manner. For example by rotating the nurses frequently in and out of wards to "protect'" them from getting too close to patients. Nurses in many cases were also prevented from using their own powers of discretion, as in administering sleeping drugs to already sleeping patients. Menzies - Lyth argued that these procedures and routines constituted what she described as *social defences* created with the aim of staving off anxiety about working with sick and sometimes dying patients within the hospital. Her observations indicated that these defensive manoeuvres had exactly the opposite effect.

Menzies – Lyth's (1988) findings concerning the way in which the hospital dealt with the anxiety of the nurses can been extrapolated to other

settings. Menzies - Lyth has pointed out for example, that the success of all organisations concerned with the physical and emotional care of adults and children is in large part dependent on their capacity to contain the inevitable anxiety inherent in this type of work. That is to contain the anxiety of staff and to support them without resorting to routinised and procedural defences.

Hirschhorn (1988), from the perspective of case study research in organisational consultancy, has added two further elements to the system of social defences; namely the Covert Coalition and The Organisational Ritual. The Covert Coalition, according to Hirschhorn presents a more organised and longer - term form of basic assumption behaviour: "it channels work - induced anxiety through relationships that are most often organised by the paradigms of family life" (p. 65). Thus, work relationships and alliances may mirror family relationships. For example perceiving the person in charge of a group or organisation as the father, whilst the employees are perceived as children. The parent / child, as well as sibling relationships that are enacted in the work setting inevitably contain both the positive and negative aspects of these family relationships. They may therefore act as a cover for, and obscure the actual work task. The term Organisational Ritual, according to Hirschhorn (1988), expresses the idea of a practice that takes on a life of its own, without recourse to apparent rational understanding. It may take the form of mandated actions that become externalised and thus depersonalise the relationship that people have to their work (Hirschhorn, 1988, p. 67).

As stated earlier, we may hypothesise that professionals' construction of child and family mental health problems is determined to a considerable extent by the way in which they construct the organisations of which they are a part. The description of the defensive manoeuvres described above that are typical of organisations under stress, may be helpful in contributing to our understanding of what organisational theorists describe as a "closed system" (Trist & Murray, 1990). As Trist and Murray point out, the closed system is antithetical to change and transition. A move towards more "open system" functioning on the part of an organisation however increases the levels of flexibility and variability and enables the members of that organisation to take a wider environmental perspective of their task and to address external change more effectively.

5.5 *Summary of Literature and Empirical Review and Recapitulation of Research Rationale*

The findings from the literature and empirical review confirm what we know from the history of ideas, that our views of childhood are constructed according to influential social structures and values that inform practices and discourses concerned with children and families. As Zornado (2001) explains, the child becomes used "as a site of cultural and ideological production and reproduction" (Zornado, 2001, p. 211).

From a critical reading of the literature and empirical research, we may conclude that there is a groundswell of concern about the narrow and circumscribed parameters within which child and family mental health is

constructed in current times. This concern is directed particularly towards pathological and medically based diagnoses that situate the "problem" in the child and that deny the complexity of the family, social and community elements that are intrinsic to the way the problem is presented.

By contrast, a view of child and family mental health that attributes meaning to behaviour and that recognises "the centrality of affect and shared meaning" (Sameroff & Emde, 1989) enables children and parents to be construed as the subjects, and thereby the creators of their experience. By giving children and parents a voice, it follows that we unlock the potential for both to become actively engaged in the pursuit of child and family wellness. This potential is stifled as indicated in the literature, when children's experiences become invalidated and dismissed as "a noise in the system." A poignant counterpoint to silencing the voice of the child is demonstrated in innovative projects such as the parent - influenced early childhood movement in Reggio Emilia in Italy that refers to "the hundred languages of children." The idea of the hundred languages recognises not only the enormous potential for learning in children but reverses conventional attitudes by demonstrating that adults can learn *from* children (The Hundred Languages of Children, 1994).

The silencing of the voice of parents is equally prevalent in the literature. It appears that we have come a long way from Winnicott's support of the "good enough mother" and his valuing of parents' intrinsic knowledge of their children. The current trend for parents to request formulaic strategies about how to

"manage'" children (and for professionals to offer these strategies) suggests that parents' intrinsic knowledge of their children has become devalued and denied (Leach, 2004; Schmidt Neven, 1996).

The conclusions drawn from the literature and research review, lead to a recapitulation of the essence of the rationale of this thesis. This may be articulated through the following questions: Who is qualified to speak on matters concerning child and family mental health?; What is spoken about or "allowed" to be spoken about?; How is the field of child and family mental health defined? As discussed at the outset of the thesis, according to child psychiatrist Michael Rutter (2002), the questions of who is designated to speak and what can be spoken about is a forgone conclusion; since this is an area in which psychiatry and child psychiatry assume both power and knowledge.

The prevalence of a counter current evidenced in the literature and empirical research review present a challenge to these assumptions concerning power and knowledge made explicit by child psychiatrists such as Rutter. For example, Maton (2000) in presenting a social ecological framework within which to consider child and family mental health, asserts that it is time for the lens of critical analysis to turn on what he describes as the "objectifying methodologies (and) status quo - oriented paradigms" utilised by professionals ostensibly in the service of children and families. As a counterpoint to Rutter's rhetorical question at the outset of this thesis regarding why society has been so successful in making things worse for children and young people, Maton returns to the

question posed over 25 years earlier by Caplan and Nelson (1973) who ask "whose interests are being served." Maton concludes that victim - blaming discourses and the maintenance of privilege remain the order of the day whilst the needs of children and families become obscured by the "prevailing power structure" (Maton, 2000, pp. 40-41).

5.6 *Child and Family Mental Health in Crisis*

In summary, we may conclude that child and family mental health is at a crisis point and is in some respects at a crossroads. It is clear that the continuing application of deficit-focused models to child and family mental health not only has serious limitations but may also contribute to the perpetuation of the problems. The need to examine this state of affairs in detail therefore, is a matter of urgency since what is at stake is the mental health of future generations.

This research attempts to explore in depth professionals' views of these problems and to understand how "objectifying methodologies" and "status quo - oriented paradigms" have not only come about but how they become perpetuated within the professional system. The organisational context within which the professionals operate is intrinsic to the field of study, reflecting as it does the relationship between the "acting individual" and the "acting ensembles" (Sampson, 2001). These "acting ensembles" are often subject to turbulent organisational dynamics as Bion (1961) and Menzies - Lyth (1988, 1989) have pointed out. An understanding of these organisational dynamics may assist us in offering further clarification concerning the intransigence of professional

attitudes, actions and assumptions that are not in the best interest of the child or the family.

5.7 *Legitimising Particular Forms of Knowledge*

Central to this inquiry is the recognition that the perpetuation of attitudes and practices regarding child and family mental health are intrinsically related to the elevation and legitimising of particular forms of knowledge (Burman, 1996). Reason and Heron (1995), in the context of describing the methodology of co - operative inquiry, argue that knowledge "has a quadripartite quality" that acts in an integrative manner to assist our understanding of the world.

The authors describe these four elements of knowledge as:

i) Experiential knowledge gained through our encounters with people;

ii) Practical knowledge demonstrated in a skill or competence;

iii) Propositional knowledge expressed through theories or statements but dependent on experiential and practical knowledge for its veracity;

iv) Presentational knowledge which is perceived as a bridge between experiential and propositional knowledge. This element of knowledge refers to the way in which we order our experience into spatio - temporal patterns, symbols and a sense of meaning. (Reason & Heron, 1995, pp.123-124).

Whilst Reason and Heron point to the need to integrate these various forms of knowledge, it is the disconnection and fragmentation of these various forms of knowledge that typifies the narrowly circumscribed and pathology

based discourse currently operating within child and family mental health. This narrowly circumscribed and pathology based discourse is predicated on assumptions of a deficit in the child or in the parents that require the application of practical knowledge to achieve a "mechanistic" outcome. In this context, the mechanistic response becomes disengaged from experiential knowledge, in terms of relating to, and validating the child's and the family's lived experience.

A particular example of how a mechanistic response overrides the meaning making elements of propositional knowledge is illustrated in Martineau's (2000) research on how resilience in children has become an "ideological code" to encourage social conformity. As mentioned earlier the idea of "teaching resilience" to disadvantaged children demonstrates the extent to which the original meaning of the term has become disengaged from experiences of attachment and interpersonal relationships.

The problems associated with the elevation of knowledge solely as an instrumental tool that is disengaged from the attribution of meaning and of learning from experience, is further elaborated by the social psychologist Rom Harre (1983). He notes the influence of certain forms of behaviourism that have contributed to the notion that people have to be "trained" to do things they may previously have considered part of a life task or "common sense." Their training leads to the expression of behaviours that are elicited under specific conditions and are thereby produced in a routine - like manner. Harre is particularly concerned about assumptions of "scientism" and "routinisation" that he perceives

filtering down through the teachers' colleges and the business schools and, one may add, through other professional sectors such as child and family mental health.

Harre's concern in this regard about the moral implications of human conduct when it is dominated by a routinised approach, is a position discussed extensively by Maton (2000) and Prilleltensky (2005; Prilleltensky et al., 2001) with particular reference to the influence on child and family mental health. Prilleltensky (2005) refers to the need for a new paradigm within which to consider preventative health and human services. The new paradigm he proposes is one that acknowledges and reflects through different kinds of action the interdependence between the domains of the personal, the relational, and the collective. By so doing, we are able to shift from a position that emphasises a deficit approach to "clienthood" and "patienthood" to one that supports individual self- determination whilst being simultaneously empowering and community - oriented.

5.8 *Community-Oriented and Empowering Approaches to Child and Family Mental Health*

In considering empowering and community-oriented approaches to child and family mental health, the fields of community psychology and health promotion may have much to offer but are also not without their own internal contradictions; most specifically in relation to how health itself is constructed. Williams et al. (2003) for example consider that the confusion between

prevention and promotion approaches poses a particular problem in mental health programmes that target groups deemed to be "at risk" or aim to change particular behaviours. Within this conceptual framework, health promoting activities are perceived as secondary to health service provision and health itself becomes conceptualized as the absence of disease thus maintaining the predominant medical model.

Whilst there appears to be general acceptance that health promotion cannot be defined by the absence of illness but must be driven by a focus on the enhancement of well-being (World Health Organisation, 2004), the details of how well-being may be enhanced still appears to depend on basic assumptions that are specific not only to particular professional orientations but also to assumptions about the legitimacy of knowledge. Thus for example Weissberg, Kumpfer and Seligman (2003) argue for the need for preventative services for children but are equally concerned with "establishing rigorous standards for endorsing effective practice" based primarily on what appear to be traditional research and "evidence based" models. In this regard we need to be mindful that some forms of scientific inquiry may privilege rigour, at the expense of participation, although the two are not necessarily contradictory. The notion that good science can include participation and empowerment is rapidly becoming main stream in some quarters, as in community psychology.

Three years later in 2006 a special issue of the American Journal of Community Psychology was devoted to further exploring some of these complex

issues in the context of health promotion and prevention from the perspective of community based interdisciplinary research. Maton et al. (2006) in their introduction to this special issue argue for the need for community psychology as a field of "ecological inquiry" to actively engage in interdisciplinary discourse action and research in order to fulfill its promise. They state that there is increasing recognition that the complexity of many societal problems cannot be addressed through a uni-discipline approach but require an approach that is not only multi-disciplinary but also validates a multiplicity of cultural and other perspectives (Reich and Reich, 2006). The particular challenges faced by community psychology according to Maton et al. relate to the need to develop conceptual frameworks and measurements that "integrate multiple levels of analysis." These multiple levels of analysis need to encompass individuals, families, organizations and communities as well as policy decision making.

However Reich and Reich (2006) in the same issue point to the pitfalls that may be encountered in this multi-disciplinary endeavour that involve power dynamics, the maintenance of hierarchies and "disciplinary policing." Some of these problematic elements are discussed further by Davidson et al. (2006) also in this issue, in their analysis of the links between critical scholarship and community psychology. They carried out a systematic analysis of journals associated with critical scholarship over a ten year period in order to ascertain how critical scholarship contributes to theory in relation to power and action for social change. The authors' findings indicate a paradox in that whilst community

psychology is perceived as more action oriented than critical scholarship, it falls short in terms of challenging institutionalized power structures. Critical scholarship on the other hand, whilst more challenging of institutionalised power structures, has failed to provide appropriate actions in relation to these challenges.

5.9 *The Personal is Political: Exploring the political context of health*

Literature in the field of health promotion points to a further paradox in the dearth of mainstream debate concerning how power, politics and ideology play a key role in influencing people's health (Bambra et al., 2005; Kickbusch, 2005). Bambra et al. refer to the inconsistencies in the health debate since despite the fact that the social and economic context of health outcomes is acknowledged (Marmot & Wilkinson, 2001) the discourse concerning health remains resolutely individualized. Bambra et al. refer in this regard to the transfer of power to the medical and health professionals as well as to the pharmaceutical companies who in conceptualising health in medical terms as the absence of illness, bypass the political discourse.

Kickbusch (2005) similarly points to the "retreat of the state from public health and health care provision" and the creation of a new order through what she describes as "the health society." Whilst recognizing the power of medicine, biotechnology and the market place in influencing health services, Kickbusch is more optimistic about the important role of the consumer. In particular Kickbusch refers to the 2005 European Union Programme that takes into account

the ways in which citizens themselves need to be empowered to make decisions and choices concerning their health. This empowerment is perceived as being underpinned by increasing knowledge and information concerning all aspects of health.

5.10 *Linking to the Methodology: Exploring Human Complexity and Diversity*

The utilisation of the methodology described in the next two chapters, in particular the analysis of discursive practices, enables us to take a fresh look at some of the dilemmas associated with what gets in the way of empowering and community oriented approaches to child and family mental health. In addition, through the analysis of discursive practices it enables us to explore the everyday professional practices such as the making of diagnoses. By so doing as Harper (1995) explains, this enables us to avoid the trap of referring either to individual or societal effects. The discursive analytic approach further enables us to weave together, as Prilleltensky (2005) states, the strands of the personal, the interpersonal, the social, the institutional and the societal. As Harper confirms, "the acts of an individual are at the same time social and have social consequences (and vice versa)" (Harper, 1995, p. 349).

SECTION 3: METHODOLOGY

Chapter 6: Methodological Approach

This research project, concerned as it is with highly complex elements in its area of study, utilises a qualitative approach to the data to reflect the dynamic nature of the processes to be analysed (Glesne & Peshkin, 1992). The methodology described below links most closely with the theoretical view referred to as interpretivist by Geertz, (1973) and Denzin and Lincoln (1994). Glesne and Peshkin (1992, p. 19) describe this approach as the act of making sense out of social interaction.

6.1 *The Relevance of a Qualitative Approach*

The qualitative method is particularly relevant in a number of ways to this research project, which is concerned with how professionals construct child and family mental health problems. Midgley (2004), in the course of exploring the potential of a qualitative approach to child psychotherapy research, highlights the relevance of a qualitative approach to other research enquiries concerned with human interaction. In particular, Midgley points to the usefulness of a qualitative approach in elucidating the meanings used by people to make sense of their experiences, predicated as it is on data that relates to language, interviews and observations.

A qualitative approach, through its focus on "thick" data facilitates a process whereby there is a constant interplay between observation and understanding as well as an acknowledgement of the presence and complexity of

values and ethical issues. This enables the researcher to generate rather than confirm hypotheses and lends itself to the development of what Midgley describes as "contextual case – specific explanations" from which it becomes possible to "generalise to theory" (Midgley, 2004, p. 92).

As such, findings from qualitative research have the capacity to have an impact at the policy - making and political level. As Silverman (2000) points out "the distinctive contribution qualitative research can make is by utilising its theoretical resources in the deep analysis of small bodies of publicly shared data" (Silverman, 2000, p. 143). Miller (1997) adds that qualitative research has the capacity to "develop analytic perspectives that speak directly to the practical circumstances and processes of everyday life" (p. 24).

Wolpert and Foster (2004) discuss the contribution of a qualitative research approach to evidence- based practice in child and family mental health. They point to the increasing awareness of the need for professionals to supplement an evidence - based approach with what they describe as a "values - based approach." An emphasis on values utilised in this research, highlights the potentially different and conflicting perspectives that need to be taken into account in considering what constitutes child and family mental health.

6.2 *Methodological Approach and Rationale for Research Design*

The research was designed to take into account the following specific aims:

i) To analyse the language used by professionals and the agencies they represent to understand how they construct the mental health problems of children parents and families.

ii) To analyse to what extent professionals' construction of mental health problems contributes to a process of fragmentation with regard to the child and family.

iii) To identify how professionals' construction of mental health problems influences their assessment and decision making with regard to the child and family.

iv) To explore to what extent professionals' narratives indicate that the child's presenting problem is situated within the broader family and social context.

v) To identify and explore the dilemmas and pressures experienced by professionals that contribute to the way in which they formulate these descriptions and constructs.

vi) To explore the factors that contribute to positive change for the professionals and the factors that prevent change.

vii) To explore how professionals perceive their agencies as helpful or unhelpful in supporting their professional development and capacity to provide a good service for their clients.

6.3 *Selection of the Sample – Phase One: Individual Interviews*

The sample of professionals was selected in order to represent three key elements for study:

i) Multi-disciplinary work in relation to children, parents and families.

ii) A representation of agencies from those providing universal services, to those providing specialist services specific to mental health problems.

iii) An age range from birth to age twelve of the children referred to by the professionals.

The sample thus consisted of seven professional groups. These were:

i) Maternal and Child Health Nurses

ii) Child Care Workers

iii) Paediatricians

iv) Educational Psychologists in Schools

v) Clinical Psychologists

vi) Social Workers

vii) Child Psychiatrists

Within each group, individual interviews took place with three professionals, making a total of twenty one professionals interviewed. The sample of professionals was obtained by contacting the Heads of Department in all cases, initially by telephone. This was followed by a letter explaining the purpose of the research in the form of a Plain Language Statement (Appendix A)

and a Participants Consent Form (Appendix B). The Heads of Departments gave the names of people who were interested in participating in the research to the researcher. All of the individual interviews took place over one hour. Whilst the original title of the research given to the prospective participants in the study was "Constructing Mental Health Problems: The views of professionals working with children and families" this title was later changed to "Constructing Mental Health Problems: A critical inquiry into to the views of professionals working with children parents and families."

6.4 *The Interview Setting*

The majority of the interviews took place in the professionals' work settings, that is maternal and child health centre, child care centres, paediatrician's consulting rooms, schools, psychologists' consulting rooms, a community based family support basis and a child and adolescent mental health service (CAMHS). There were three exceptions to this arrangement made in order to make the setting or the time more convenient for the professionals interviewed.

Thus, one maternal and child health nurse, and one educational psychologist were interviewed in the researcher's office, and one of the paediatricians was interviewed in their own home. All of the professionals and the work settings were based in Metropolitan Melbourne.

6.5 *The Interview Guide*

A semi- structured interview guide (Appendix C) was used as the basis for the individual interviews to act primarily as a prompt to communication about professionals' approach to child and family mental health problems. The semi - structured guide also attempted to assess how the professionals viewed problems in the light of their own theoretical framework as well as their own personal values and guiding principles. In other words, to explore the mental tools through which they screen or make sense of a problem (Minichiello et al., 1995).

It was anticipated that the semi - structured nature of the interview guide, through its open - ended questions, would elicit a narrative style response from the professionals about how they viewed and worked with child and family mental health problems. For this reason, close attention was paid to the style and nature of the language used by the professionals in the course of the interview. The semi- structured nature of the interview was intended additionally to track the evolution of professional's understanding of their practice over time and to identify the particular challenges they may have faced.

In particular, the interview process was the vehicle through which the professionals were able to consider their role in relation to the agencies in which they worked and to comment on the factors that they perceived as facilitating or hindering positive change and good practice.

The case scenario.

A case scenario was introduced at the end of the interview, in order for the professionals to consider their practice in a hypothetical case (Appendix D). The case scenario was to provide a balance to the possibility of professionals presenting a predominantly theoretical or ideal view of actual practice. It was hoped that the case scenario would present a dynamic and vivid "here and now" snapshot of how professionals actually construct child and family mental health problems and the specific language they use as part of this process.

The case scenarios were written by the researcher to be commensurate with the professionals' work practice and experience, as well as the age range of children they worked with. In asking the professionals to comment on the case scenarios they were assured that the aim of the case scenario was not to evaluate a successful or failed intervention, or to assess their professional competence, but rather to identify the specific understanding that they brought to bear on the problem.

6.6 *Phase Two: Focus Groups*

Following the completion of the individual interviews, two focus groups were set up each consisting of three different professionals, representative of some of the professionals interviewed in phase one of the research project. The participants in Focus Group One were a child psychiatrist, an educational psychologist and a maternal and child health nurse. The participants in Focus Group Two were a social worker, a paediatrician and a clinical psychologist.

Each focus group ran for one hour. At the commencement of each focus group the participants were presented with a summary of the emerging themes from the individual interviews (Appendix E) and asked for their comments and views on these themes.

The rationale for the two focus groups was to create an opportunity for the researcher's findings from the individual interviews to be challenged or refuted, as well as to include other relevant commentary. As Midgley (2004) points out, the aim of this process is not to confirm that there is one definitive account or interpretation of the data, but rather that the data collected has an inherent credibility. It was further assumed that the interactive nature of the group experience could complement the individual interviews, by bringing a different perspective to the articulation of child and family mental health problems (Morgan & Krueger, 1993).

6.7 *Transcribing the Data*

Each of the individual interviews and each of the focus groups were audio taped with the participants' consent and fully transcribed. The taping of the interviews and the transcription was considered to be appropriate to the nature of the research enquiry, concerned as it is with the uses of language in the construction of child and family mental health problems. As Silverman (2000) points out, the analysis of tapes and transcripts is intrinsic to the use of discourse analysis of data. Silverman goes on to say that tapes and transcripts have several additional advantages. Firstly, they provide a public record available to the

scientific community of what has taken place in the interview. Secondly, tapes and transcripts offer the researcher the opportunity to return to these records on a number of occasions in order to appraise the data afresh. This enables the researcher to avoid drawing premature conclusions from the data (Silverman, 2000).

The following chapter describes the method of data analysis and interpretation that reflect the complex nature of the research inquiry including as it does an in-depth analysis of the responses of the professionals. Since qualitative research is able to encompass a range of interpretive practices that elicit multiple meanings, the following interpretive practices are of particular relevance to this research inquiry. Whilst the processing of the data is informed by a grounded theory approach, the examination and analysis of the data is carried out within an "interpretivist" paradigm that takes a hermeneutical perspective to the interpretation of the data. This interpretative approach attends to discourse and the use of language thereby engaging in a discursive examination of the findings. Two supplementary modes of analysis, focusing on group and organisational processes and the observational stance, additionally throw light on the meaning of the organisational setting within which the professionals operate.

Chapter 7: Methods of Data Analysis and Interpretation

The overall method of analysis used in this research inquiry reflects that of the interpretivist paradigm. As Glesne and Peshkin (1992) explain, interpretive research views human situations as novel, emergent and most relevant to this study, "filled with multiple, often conflicting meanings and interpretations. The interpretivist researcher attempts to capture the core of these meanings and contradictions" (Glesne & Peshkin, p. 19). This methodological line of approach is particularly appropriate to an inquiry that is concerned with the way in which professionals construct and describe the mental health problems of children, parents and families. In further exploring the meaning and context of the responses of the professionals in the interview process, a hermeneutical approach to an examination of the data was also considered to be of particular relevance.

7.1 *Meaning and Context: A Hermeneutical Exploration*

Most influential with regard to the development of the hermeneutical method of inquiry has been the work of Martin Heidegger, Paul Ricoeur, and Hans - Georg Gadamer. In the hermeneutical interpretation of data, the emphasis is on a contextual approach to the nature of explanation as well as knowledge. Hermeneutics assumes the interconnectedness of all elements in the inter - subjective world (Malhotra, Bentz, & Shapiro, 1998). As Malhotra, Bentz and Shapiro (1998) explain, the hermeneutic inquiry is by its very nature "openly dialogical" requiring a return "to the object of inquiry again and again, each time

with an increased understanding and a more complete interpretive account" (Malhotra, Bentz & Shapiro, 1998, p.110). The hallmark of the hermeneutical inquiry is that the inquirer engages in an ongoing and amplified act of interpretation.

Thus in this research inquiry, the interpretative approach to the data analysis is informed by a method of working with the data that seeks to identify the meanings of what was spoken about by the participant professionals who took part in the research. Therefore, describing the process of making sense of the data, in order to gain a better understanding of the findings is an important part of the methodology. As part of this process, the "thick description" of the data is complemented by that of a hermeneutical approach to the process of making sense of the findings. In a hermeneutical exploration of the data, the focus is on key wordings, patterns, metaphors and other aspects of use of language that reveal the meaning of expressions and statements reported in the data. This involves a process of engaging with the data that requires repeated interweaving and revisiting of the findings informed by a well-developed sense of contextual awareness (Malhotra, Bentz & Shapiro, 1998). For example, in the research inquiry what comes to the fore is the interpretive perspective taken by the professionals themselves. Thus, the information that they produce in the data is embedded in the context of their own meaning making.

The researcher's engagement with the data therefore, is that of a dialogue that takes an active interest in the understanding of the meanings produced by the

professionals in this inquiry. A hermeneutical understanding of these meanings assumes an inter - connectedness within the research findings, when exploring the broader context of the settings in which they need to be interpreted. The hermeneutical exploration assumes a deep connection to the whole of our culture and the social contexts in which we live and work, without reducing the complexity of the phenomena under investigation (Malhotra, Bentz,& Shapiro, 1998).

7.2 *Towards the Identification and Analysis of Multiple Meanings*

The potential to acknowledge and identify multiple meanings in the data prompted the researcher to explore several lines of approach that would do justice to the complexity of the material. Miller (1997) for example refers to the ways in which it is possible to extend the potential of qualitative research through the construction of bridges between different theories of social life that enable us to engage in a macro analysis. For Miller, the central point of convergence takes place through "providing a venue for dialogue between different interpretive frameworks" (p. 25).

Gergen et al. (2004) similarly advocate collaborative and complementary approaches to analysing data that is substantially concerned with how people construct and make sense of interpersonal events and experiences. From the perspective of advocating a social constructionist approach, Gergen et al. confirm the potential of an "unfolding dialogue" that has the capacity to encompass both scholars and practitioners particularly in the field of child and

adolescent psychology, who come from different disciplines and backgrounds. They see this as leading to "a watershed of new ideas, methodologies and vistas of inquiry" (p. 389).

The recognition that our views of knowledge need to be encompassed within a political and moral framework, has, as Gergen et al. (2004) point out, particular implications for the way in which we consider the experience of those who are oppressed and marginalised in society. According to Gergen et al., "language is perceived as perhaps the most important resource available for creating and maintaining meaning in relationships" (p.391). Creating meaning out of our relationships in turn assumes that we shift our focus from "individual minds" to "the significance of relational process" (Gergen et al., 2004, p. 392).

7.3 *Processing the Data and the Concept of Grounded Theory*

The concept of grounded theory is also relevant to the process of this research inquiry in that as with the hermeneutical method it follows an inductive method of analysis of the data. As Charmaz (1995) points out this approach builds on the analysis of the individual case or experience and progresses through to the more abstract and conceptual categories from which theory can emerge. Charmaz identifies several characteristics of grounded theory, the most relevant of which for this research is the simultaneous collection and analysis of the data. Staying close to the data and commencing an analysis of the data from the outset, results in what Charmaz describes as a mutually influencing process which leads to the collection of further data "around emerging themes and

questions" (p.31). Charmaz also advocates collection of data that is as detailed and rich as possible from which to study not only emerging themes but also to understand the "multiple layers of meanings" of the action of individuals.

Of further significance is Charmaz's (1995) assertion, that the involvement of the researcher is acknowledged as a legitimate factor in the research process, and that this will in turn influence the kind of data that is collected. The fact that the researcher is a child psychotherapist and that some participants would have known this, is a case in point. Charmaz states in this regard, that "the interaction between the researcher and the researched *produces* the data, and therefore the meanings that the researcher observes and defines" (Charmaz, 1995, p**.** 35). For this reason, she advocates that the researcher develops a strong sense of self awareness both in the decision making about the collection of data and the actual interviews.

7.4 *Attending to Discourse and Use of Language*

As discussed earlier attending to discourse and to the use of language is central to the way in which the data contained in this research has been examined most particularly taking into account the power of various discourses regarding child and family mental health. As Midgley (2004) puts it, the analysis of the language used in this context illuminates "the way that language speaks us as much as we speak (through) language" (p.96). It also identifies the ideological context in which as Potter and Wetherell (1995) explain, the individual "both takes up a position and is positioned" (p .83).

Attending to discourse and to discursive practices, draws on a variety of influences from the fields of linguistics hermeneutics and ethno - methodology, as well as from Feminism, Marxism and the writings of Michel Foucault (Burman et al., 1996; Parker, 1999; Willig, 1999). The examination of discursive practices challenges conventional and traditional psychological views, in that language as Harper (1995) explains, is considered to be constitutive, rather than descriptive of the world. It is not used in the service of finding out about an entity such as cognition, but rather is considered to be worthy of study in its own right (Harper, 1995). Potter and Wetherell (1995) describe the goals of Discourse Analysis as follows: "to make a contribution to our understanding of issues of identity, the nature of mind, constructions of self, other and the world and the conceptualisation of social action and interaction" (p**.** 81).

Engaging in a discursive examination of the findings enables us to understand how different speakers may construct accounts of their experience in order to serve particular interests, or perform particular functions. In line with the perspective of Discourse Analysis, it is then possible to identify different discourses that represent systematic ways of talking about a topic (Harper, 1995).

7.5 *Supplementary Frames of Reference and Interpretation*

With reference to the earlier discussion concerning the creation of a dialogue between different approaches, two supplementary interpretive frames of reference have been taken into account. The first refers to an understanding of group and organisational processes that influence the role and task of

professionals in their work settings. The second relates to the taking of an observational stance in the process of conducting the interviews with the professionals.

Understanding group and organisational processes.

Understanding the individual interview within the context of the work setting, and overall organisational demands is a crucial part of the data examination. Understanding the group and organisational dynamic and context creates a good fit with a discursive approach, since it is concerned with the widening of socio - cultural and political perspectives in the examination of data. Acknowledging the relevance of the group and organisational context for the understanding of the individual interviews has the further function of enabling us to understand how the professionals as well as their clients and patients, can become "caught up in the web of competing discourses" (Midgley, 2004, p. 99).

As has been discussed earlier, the analysis of group and organisational elements is informed by the work of Bion (1961), Hirchorn (1988), Menzies - Lyth (1988), and Trist and Murray (1990), in particular with regard to the conceptual framework regarding the creation of basic assumptions and social defences against anxiety. As Holloway and Jefferson (2000) assert, since people in an interview situation are naturally defended, examination of the text of interviews must take into account both their anxieties and their defences against anxiety. Taking a group and organisational stance in addition helps us to explore the resistance to, and capacity for change within the various professional groups,

as well as the tendency for the organisations themselves to represent open or closed systems.

Taking an observational stance.

The taking of an observational stance adds another dimension to the use of the interpretative method with regard to both the interview process as well as the examination of the data. The taking of an observational stance supports the findings described earlier (Charmaz, 1995; Potter & Wetherell, 1995) concerning the need for self-awareness on the part of the interviewer. In this regard, Silverman (2000) exhorts researchers to record what they see, as well as what they hear. Their failure to do so may well lead to the neglect of crucial sources of data (Silverman, 2000, pp. 140-141).

Ellis (1997) extrapolates from the perspective of infant observation to explore how the observational method enables one to explore not only the infant - parent relationship, but also the importance of understanding specific cultural codes and the relevance of the socio - cultural context. As Ellis explains, "ultimately, the observational method enables one not only to see what is before one's eyes but also to attend systematically to its meaning in a way which takes account of internal as well as external knowledge" (p. 57).

Observing oneself as a researcher.

Esterberg (2002) in commenting on the use of qualitative methods in social research makes the point that the researcher before they commence their research needs to consider where they themselves stand on a number of

important issues. Within a post-modern context and in taking the critical stance that I do in this research, it is not possible to assume a neutral disinterested stance. The issues that the researcher needs to consider include their own biases and preconceptions and investments in the particular field related to their research. What the researcher knows and how they come to this knowledge should also be taken into account. With this in mind as a researcher it is important to declare my position as a clinician who has worked with children parents and families for over four decades. I am therefore in possession of a level of knowledge and understanding of child and family development that may be unusual as I have come to this research towards the end of my professional career rather than at the beginning. Since I have worked in a wide range of services I am also acquainted with some of the issues related to organisational and institutional dynamics and the significant impact these can have on how services are delivered. I have a strong commitment to advocacy on behalf of children as well as on behalf of parents. I have also had the benefit of observing at first hand how projects and services that truly empower parents have a major impact on child and family mental health.

The foundational assumptions that I bring to this research relate to the following areas: I place importance on a psychological approach that promotes the contribution of relationships and the attribution of meaning to development and to the identity of the self. I perceive these relationships as operating within a

systemic family framework in which there is a complementarity of parenting that attributes value equally to the role of men and women, and mothers and fathers.

I believe that in order to provide improved services for children and families that we need to improve the group and organizational functioning of these services. This requires that we become aware of the potential negative impact of power differentials within the organisation and how these can become replicated in our professional work Additionally I believe in the importance of recognising and understanding the prevailing underlying group and organisational dynamics that influence both how professionals act in relation to each other and their clients as well as in influencing how decisions are made.

Although I clearly have strong views on the subject of child and family mental health I did not go into this research to condemn people or to prove what I already know. Whilst some of the professionals in the study may have been acquainted with my professional background I do not believe that this significantly hampered the progress of the interviews. In fact drawing on my clinical skills I have attempted to make the interviewees feel comfortable and not threatened. In this regard therefore, it has not been the brief of this research to point out to the interviewees their inconsistencies in the course of the interview. Inconsistencies where they have appeared have been addressed in detail in the analysis and discussion of the findings.

7.6 *Phases of Data Examination and Interpretation*

The 21 individual interviews as well as the 2 focus groups consisting of 27 people in total were analysed on a number of different levels and in the following sequence:

i) A summary of the interview was made immediately after each interview in an attempt to record observations and begin the process of drawing out potentially relevant themes. These summaries also had the function of providing field notes for the researcher (Silverman, 2000).

ii) Once all of the individual interviews were completed, the researcher embarked on a broad examination of the transcripts based on analysing each of the professional groups. This created clusters of data and responses for each of the groups in which core themes were identified.

iii) The third phase of examination involved returning to the transcripts and analysing them with reference to a number of simple standard questions. These questions concerned what the various professionals observed and reported about their work with children. This included what the children said about themselves; what the professionals reported of their experience with parents; what the parents reported to the professionals; how the professionals attempted to make sense of their experience and observations; what the professionals expressed

about their values and beliefs; and what the professionals expressed about their role and the work setting. In addition, the researcher included her own observations of the professional's work settings as well as her experience of conducting the interview.

iv) Attending to the use of language and discourse allowed for a further examination of the data leading to the identification of a limited number of discourse frames of reference, and a particular set of discursive practices that are characteristic of the professionals' construction of child and family mental health.

7.7 *Bridging the Individual – Social Divide in Discursive Practices*

The in - depth examination of the findings makes use of a discursive approach that allows for a better representation of diversity. It enables us as Harper (1995) explains, to expose "the implicit oppositions in our talk about mental health", and to "question our taken for granted understandings of mental health" (p.2). Moreover, a discursive analysis of research findings in the field of mental health, through its focus on the exploration of process and on the interaction between the professional and the client or patient, bridge what Harper calls the "individual - social divide."

The following section will describe in detail the process of interpretative working with the findings of the research inquiry, and illustrate the application of the methodology described. Engaging in the process of data interpretation with reference to the methodological procedures described thus far, enables us to

explore the complexities associated with the construction of child and family mental health problems at the level of the individual, the organisation, and the community.

SECTION 4: FINDINGS

Chapter 8: Introduction to Working with the Data: Designing a Road Map

8.1 *Stages of Examination of the Data*

The organisation of the data is that of a process that has taken place over several steps. As described in the methodology, the data have been analysed in relation to a number of key questions that have given rise to "thick description." These key questions include the following: What do the professionals observe and report about their work? What do the professionals report of their experiences with the parents and the children? What do the parents report to the professionals? How do the professionals attempt to make sense of their experience and observations? What do the professionals express about their values and beliefs and what do the professionals express about their role and their work setting? As part of this process, the researcher also included her own observations of the professionals' work settings as well as her experience of conducting the interviews.

This section of the thesis is concerned with the examination and interpretation of the data obtained from nine groups of professionals, including two focus groups and is intended to provide a "road map" for the presentation of the findings that describes both how the material has been organised as well as the *process* of data examination. Findings from the data have been grouped into the following three areas. These are findings from the professionals in the

universal services; findings from the professionals in the specialist services; and findings from the professionals in the two focus groups.

The process of data examination has taken place over a sequence of five levels or stages and these are as follows:

Stages one and two:

A preliminary exploration of the raw data revealed a number of key wordings and phrases. A closer examination of these key wordings and phrases suggested that clusters of data were articulated and named in relation to characteristic "key concerns" that were repeatedly communicated in each group of participant professionals as well as across both the universal and the specialist services. In the presentation of the findings that follow, the description of the process of data examination starts at this level of interpretation of the findings. Thus, stage one examines the "key concerns" articulated by each professional group in both the universal and the specialist services.

In stage two, the focus of the examination of the data is on the meaning attributed to these concerns on the part of each group of professionals from the universal as well as the specialist services including the focus groups. The description of these two first stages of data examination as well as of the following stages is illustrated with findings that reflect the original data material. This includes quotes taken from the "phrasings" that are characteristic of the way in which the professionals express and communicate their responses.

Stage three:

In stage three, the examination of the data moves beyond the responses in each professional group to bringing them together in a cross section examination that reveals core and interrelated themes for all of the professionals.

Stage four:

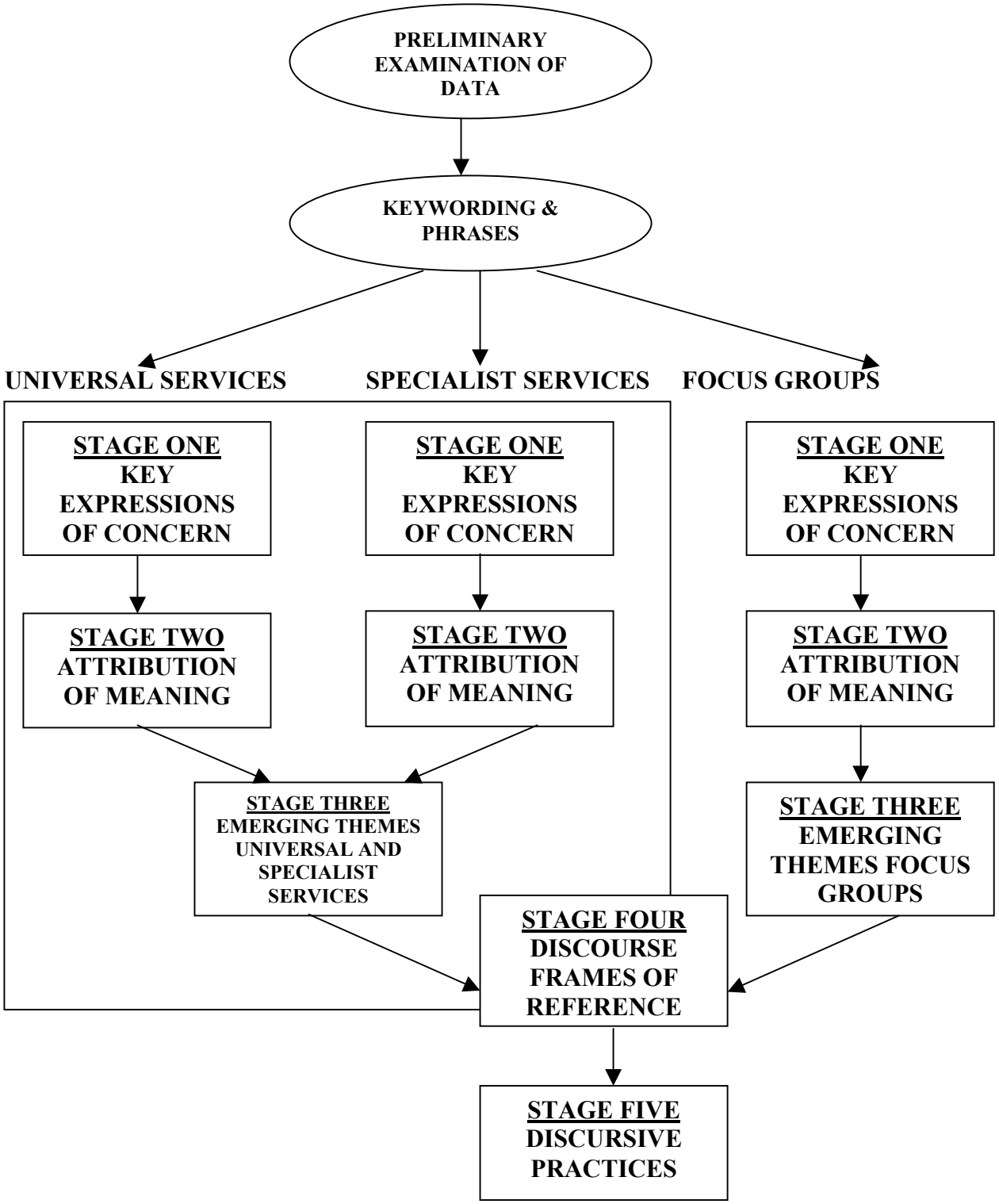
In the process of identifying these core and interrelated themes and through paying careful attention to the professionals' use of language, a fourth level of data examination emerges that is based on strong indications that these core and interrelated themes are articulated in relation to repeated patterns of a limited number of discourses or discursive frames of reference.

Stage five:

In the fifth stage of the data examination, a reflective revisiting of the findings leads to the conclusion that the identified discursive frames of reference or discourses reflect a particular set of discursive practices across the spectrum of all of the professional groupings that both inform and articulate the professionals' approach to child and family mental health. At this stage, the examination of the findings in discursive terms is predicated on the assumption that the work of the professionals takes place within a dynamic interchange with their clients and patients that is itself subject to change. The presence of group and organisational dynamics is an essential part of this interchange giving rise to the recognition that professionals "speak their organisations" in the course of carrying out their work.

The grouping of the findings at the various stages of data examination and interpretation is presented in the following schematic diagram

Figure 1. Stages in the examination and presentation of the data



8.2 *Observing What We See As Well As What We Hear*

In the process of carrying out the research, a number of observations accompanied the interviewing process that amplified the data both with regard to this process as well as with regard to the various settings in which the interviews took place. The researcher observed for example, that with regard to the interviewing process, it was striking that the first question of the interview, "can you tell me about your work?" was in many cases sufficient to elicit extremely detailed responses from the professionals interviewed. The impression gained was that the majority of the professionals interviewed appeared to welcome the opportunity to discuss their work and were eager to articulate the challenges they face.

In the process of taking an observational stance, what is seen and what is heard, in relation to the various settings in which the interviews took place, adds another layer of potential insight and perspective to the research process. In this respect, three of the professional settings were of particular note. These were a child-care centre in which two members of staff were interviewed, the Child and Adolescent Mental Health Service in which three psychiatrists, one psychologist and one social worker were interviewed and a school in which one of the educational psychologists was interviewed.

The child- care centre in Melbourne's Eastern suburbs was situated in a recently gentrified neighbourhood that had previously catered for Housing Commission families. The Centre had some years earlier operated as a

Children's Home. Despite the fact that its function had changed there was still an air of institutionalisation. Silverman (2000) has made the point referred to earlier, that the researcher should "record what we can see as well as what we hear" (p. 140). To this may be added "record what we smell." It was observed for instance, that since the entrance to the Child Care Centre was situated in close proximity to the children's toilets, it had an all - pervasive smell of faeces.

In addition, the staff office in which the interviews took place had a deprived and neglected air with old filing cabinets and rickety furniture. It appeared an unprepossessing space in which to house the administration of the child - care centre and in which to interview parents and children when they applied to the Centre. Despite this, the staff gave a moving account of daily life with the children and parents and appeared, through their strong commitment to both the children and the parents, to rise above these dispiriting surroundings.

In contrast to this, the Child and Adolescent Mental Health Service was housed in a newly renovated building in Metropolitan Melbourne. Here what was of note was that whilst the staff indicated how busy they were when contacted by the researcher, this did not appear to be borne out by the researcher's observations. In the course of the seven visits that the researcher made to this service at different times of the day, it was observed that only one or two patients were waiting in the waiting room. In addition, when taken into the offices of the five professionals interviewed at this service, the researcher observed that many of the other staff had their doors open and did not appear to be in consultation

with clients. This observation led the researcher to speculate whether one possible reason for the apparent absence of patients, may have been the fact that the service had recently moved to these premises from another site and this may have contributed to the referral system not yet becoming established.

Finally, in the school setting, the cramped office of the educational psychologist was strikingly characteristic of how office space is shared by a number of other professionals in the public education system. In this educational environment, the lack of room for the professionals spilled over into the passageways where the children were engaged with a painting project whilst rain dropped onto their sheets of paper. There appeared to be insufficient room for the painting to take place under full cover in the classrooms.

Presenting the findings.

The following chapter presents the detailed sequence of examination of the findings. This commences with the expression of issues of concern expressed in the data obtained from the professionals in the universal and specialist services as well as the focus groups. The sequence of examination continues with an exploration of the meaning that the three groupings of professionals attribute to these expressions of these concerns. The chapter concludes with the cross section examination of core and interrelated themes that in turn give rise to the identification of recurrent patterns of discourse and discursive frames of reference. These recurrent patterns of discourse and discursive frames of reference are then examined in detail in chapter ten.

Chapter 9: Presentation of the Findings

9.1 *Stages of Examination of the Data*

The schema of the findings in chapter eight indicates how key wordings and phrases emerged in each professional group and how these relate to the other professional groups as well as to the focus groups. These group key wordings and phrases emerged as clusters of data expressed through a variety of concerns on the part of the professionals with regard to their practice. It is important to note that the professionals themselves from the outset of the interviews chose to focus on concerns regarding their practice. As described in the schema in chapter eight, the report of the findings follows the expression of these concerns on the part of the professionals posed as the question, "what is of concern to professionals in their day to day work?" This question links with the next in that it explores the sense professionals are able to make of their concerns. In other words, what kind of meaning do they try to attribute to these concerns? The articulation of key concerns for all three groups of professionals, from the universal and specialist services as well as the focus groups and their attempts at meaning making come together in the third stage and lead to a consideration of emerging and interrelated themes.

An exploration of these emerging themes leads to the next and fourth level, which is the identification of the discourses and discursive practices that are at work in each of the professional settings as well as those discourses and discursive practices that are common across the board. These are presented in

this chapter and in chapter ten. Finally, an analysis of the overall findings is presented in chapter 11.

9.2 *Stage One: Key Concerns: Universal Services Struggling with Discrepancies*

The key concerns for the professionals in the universal services are expressed mainly in terms of discrepancies. That is, the discrepancies between how they view their role and what they would ideally like to achieve and the reality of their work and the limitations of what they actually do achieve. If we ask the question, what gets in the way of professionals achieving their goals? the data reveal two responses. The first reflects their concern about parents' negative and potentially hostile relationships with their children and the second reflects their concern about the organisations in which they work that are perceived as unsupportive and in some cases undermining of their work. The sense of lack of support and thoughtfulness on the part of the organisation's leadership is further made manifest by the professionals through their expressions of cynicism and lack of trust of the people "who are in charge."

For the maternal and child health nurses, the discrepancy between their ideal vision of the service and actual delivery of the service, was expressed in terms of the tension arising from on the one hand focusing "on the health and well – being of families" versus having to identify and treat ill health. As one of the maternal and child health nurses put it, "we can detect what's normal and what's abnormal." For the child - care workers, this discrepancy was expressed between on the one hand, their avowed aim of placing a high value on a one to

one relationship with the children in their care and on providing "a family service", while on the other hand not being able to achieve these goals. The reasons given for this were under staffing, the myriad demands on their time from children and parents, and an administration that was perceived as being solely concerned with cost.

The educational psychologists working in schools similarly struggle to have as their prime objective a focus on the child through the promotion of their educational and social potential. However, these objectives are challenged not only by the fact that they have to visit numerous schools, "I go to three different places in one day" but also by the fact that the psychologists and their employers, the Heads of Schools do not share the same views or objectives of the service. For example, "we're coming from a student welfare background, where a school their core business is learning, teaching. And so sometimes you're at loggerheads because they're wanting to follow their behavioural procedure, or their curriculum procedure, set curriculum."

Key concerns: the perception of parents' negative behaviour towards their children.

The reported expression of parents' negative behaviour towards their children was presented as a significant source of concern by all of the professionals as well as raising questions for them about whether and how they were best able to respond. At the level of early infancy, it was striking how the maternal and child health nurses described the mothers as being "very good at

telling each other the horror stories, how bad their child was, not telling other people how good their child was". The idea of a "good" mother and a "good" baby is rated according to whether the baby sleeps, "it's the didn't sleep I think that is at the bottom line…And I think they do rate themselves as to how good they are sometimes as to how well the baby sleeps for them."

Data from the interviews with the child - care workers more than from any other of the professional groups reveal high levels of discord between mothers and young children as well as a lack of understanding about their developmental needs. For example, with regard to handling issues of separation and transition in the child care centre, whilst the child - care workers request that the parents stay with the child to introduce them to the Centre when they first arrive, this does not often happen. As one of the child -care workers explained, "you see them come in and they're out the door as soon as, as quick as they can."

The child- care workers also reported numerous incidents of battles between the young children and their mothers in which they have to act as referee. For example with regard to the child wishing to bring in a blanket or article of clothing that reminds them of home, this can lead to huge battles in getting over the threshold of the Centre in the morning if the parent does not want them to take these items into the Centre. "We've had children here that have screamed and kicked and taken seat belts off and everything because they wanted to bring a certain coat, windcheater, pillow whatever. And they (the parents) would rather have this absolutely dangerous performance in the car than

let them bring the coat." At times parents are described as becoming distraught with their children particularly in struggling with issues of control, "come and see what he does, what he's doing to me." And "I've had parents come in and sort of put them (the children) in the front door and say "I'm going to kill him if he doesn't…if I don't leave him here with you."

The educational psychologists in the school setting face the dual problem of having to deal directly with the parents of the children as well as to "interpret" reported parenting and family problems back to the school staff whom they perceive to be less than sympathetic. One of the psychologists described this process as "a remarkable game of tennis that goes on between parents and teachers with the child as the ball in the middle." At the same time the educational psychologists have their own complaints about the parents who "look things up on the internet" and "use medical language" to describe their children's behaviour and who have a tendency to "catastrophise." Mothers in particular were singled out as being "a problem" and "anxious" and "putting pressure on the school."

Key concerns: professionals' concerns about their organisations.

All of the professionals in the universal services expressed concern about their organisations, particularly with regard to the lack of organisational support that undermines the quality of the service that they ideally wish to offer. For the maternal and child health nurses, the sense of not being supported takes place at the basic level of not being supported to be physically safe. Because

traditionally, maternal and child health nurses have to be "a pram's push for parents" many maternal and child health nurses work in very isolated settings, "an old building stuck in the middle of the park, there's no one else around."

The nurses also complained about "high work loads" and a general shortage of nurses, "so maternal and child health nurses don't tend to take much sick leave." In particular, the nurses perceive their management to be "very linear and hierarchical."

Although maternal and child health nurses are independent practitioners they are required to report their conclusions about family visits onto a computerized system managed by their employers. Their reluctance to do so suggests a lack of trust about how this information will be used by their employers. As one of the nurses explained, "we must be one of the only professions who can write something down in the computer and it's fixed, straight." In an attempt to protect their patients, the nurses reported their reluctance to put in too much detail for fear of the consequences these records may have on their clients' welfare in the future. As one explained, "I suppose you can formulate some kind of hypothesis but I tend not to when I'm writing things down and maybe I would if I was talking to somebody…cause I know that...I'm free to alter it…whereas if I've written it down I'll realise it's not changeable."

A similar situation exists for the child - care workers with regard to the maintenance of records and the collection of "the right data." This takes the form

of observations of the children that are regularly audited and that are viewed as "primarily legal documents." As one of the child - care workers put it, "it can be dangerous to put your own interpretations" on these observations. The child - care workers further indicated how burdened they were by their administrative responsibilities and having "to worry too much about the fiddly things and the paperwork" whilst the ratio of children to adult carers is "two adults in there with ten babies, it's a huge task, and a ratio of one to fifteen children in the kinder room." Insufficient planning time was also cited as an example of the unrealistic expectations of their employing organizations. The lack of planning time was viewed as an outcome of cost saving on the part of the management. "In all child care centres everywhere, now it's cost…it's the same wherever you go."

Of all the professional groups, the educational psychologists displayed the greatest cynicism, both toward their employing organisations, the schools, as well as the Department of Education. For example in relation to the Department's Framework for Student Support Services, the general view was that "if they talk about the whole school approach they don't actually have to do it." Similar cynicism was expressed towards other programmes that have been introduced into schools, for example with respect to dealing with bullying. These were described as being put in place in a half hearted way to protect the school from censure. Even when a school initiates such a bullying policy it is soon "stopped", "watered down" or "never gets off the ground."

The comments of the educational psychologists were at their most cynical when they referred to the types of training programs that are offered to them and to other members of staff, "you get the idea that they're really like Ronald McDonald, there's Bozo the clown, they entertain. They lighten up your day or two days or thee days. Give you the feel good experience. And you say, what actually were they talking about. Well I can't remember what it was."

9.3 Stage 2: What Sense Do Professionals Make of Their Concerns: What Meaning do they Attribute to These Concerns?

The meanings that the professionals attempt to create out of these concerns reflects the fact that to a large extent ascribing meaning enables the professionals to continue to work in these various settings. In other words, the ascription of meaning makes the work more bearable. Inevitably, therefore, some of these meanings resonate a defensive and justifying mode of communication intending to protect the professionals as well as the users of the service.

For the maternal and child health nurses, the myriad and often conflicting demands of their work appear to be more easily justified under a predominantly medical model. This may also be perceived as a way of attributing meaning to their work. The medical model approach is represented by their reference to the "strict guidelines" they have to follow in screening babies and young children for developmental delay, and "screening" mothers for depression. As one nurse explained, "I think coming from a nursing background…after they've had a baby

and I'll probably say…have you heard of post natal depression or do you think you've got some depression or post natal depression."

It is understandable therefore that the mothers, who are the primary users of the service, ascribe a meaning to the way in which they initiate contact with the service, through the presentation of a problem. In other words, the parents believe that presenting a problem provides the point of access to the service. The nurses in turn ascribe meanings to the children and the parents that tend to merge medical diagnostic formulations with descriptive language as though these are somehow interchangeable. For example, the nurses refer to the babies as "allergy babies, intolerant babies, grizzly, collicky babies." Mothers in turn are described as being very stressed, "she's looking uptight, she's looking stressed and the baby is most often crying…And when I say how are things going, how's your week been? Oh it's been dreadful."

It is interesting to note how the tendency to ascribe a medical meaning to the mother and baby's experience, subtly reinforces the exclusion of the father from these discussions. For example, as one of the nurses explained, "there's an awful lot of personal stuff…you're talking about their labour their breastfeeding and you know, medical, very personal details." The implication of this exchange suggests that the "personal details" have become merged with the medical details, thus justifying their exclusion from the interpersonal realm of the husband – wife relationship.

The nurses further ascribe meaning to their own identity as nurses as well as to their role. Their tendency for example in the interviews to refer to themselves as "girls" suggests that the meaning they ascribe to their role is weak on authority and may be a way of justifying inaction in relation to their employers. Thus for example, although they are concerned for their physical safety "so and so's been murdered, there's muggings around and you can become a statistic yourself" they justify their inaction by believing that their identity as a nurse will protect them. In other words they indirectly refer to the special meaning attributed to the persona of the nurse as that of selfless carer who will as one of the nurses put it, work in "situations which I don't think other people would work…"

The child - care workers attempt to create meaning out of the challenging circumstances in which they work, by expressing sympathy for the parents who struggle to meet the demands of a multitude of tasks. This was expressed as, "there must be enormous stresses and pressures on these people in the outside world" and "some people have got so much on their plate, it's just huge." The busyness of life was also cited as a reason for many of the tensions parents experienced. "Everybody is just so busy. And if they're not busy with work, they're busying the child."

The child - care workers additionally explained much of the emotional turbulence in the child - care system related to changing family circumstances, particularly with regard to the aftermath of separation and divorce. The child -

care workers are involved in many arrangements regarding access and highlighted some of the confusion that some children experience as a result of these changing living circumstances. “They’ve got a family where the parents of the child that’s here may not be together now, but the father has now got another family. And that family might come in and pick up the child. Or the mother has a different family. So there’ll be swap overs. And grandparents are involved…over the years we’ll have different issues with custody and courts orders, so that sort of comes into it as well.”

When it comes to ascribing meaning to their own role, the child - care workers similarly to the maternal and child health nurses, ascribe a meaning that not only informs how they carry out their role, but that also has wider implications in the work setting. For example, they perceive themselves and their work as having low status in the eyes of parents and the outside world, “I’m not sure child care is sort of looked on more as a babysitting type set up. That the people bring their children in the morning and we play and then they go home.” One may speculate that the low status meaning the child - care workers ascribe to their role makes it difficult in turn for them to assert their legitimate authority. The child - care workers gave numerous examples of how difficult they find it to challenge parents’ delinquency with regard to their children (not collecting them on time or not collecting them when they are sick). In this regard, their belief about their low status makes them unable to be more explicit with the parents

about what is expected, and makes it difficult for them to engage in a more realistic way with their employers.

The sense of professionals being undervalued and undervaluing themselves continues into the group of educational psychologists and is a key factor in giving meaning to their role and task. As one of the educational psychologists put it "I would say that in the majority of schools that whilst lip service is given to the importance of the welfare side and the emotional development that in reality if you choose that as your career path in the school structure it acts as a dead end." This low level of self perception on the part of the educational psychologists leaches into the way their role is perceived by others, since the psychologists also perceive themselves as having little control over their caseload, "the principal's got no idea if I have a waiting list or how busy I am at the moment and often…don't ask."

As a way of dealing with the problem of lack of recognition of their role, the psychologists gave numerous examples of how they attempt to appease the teachers by giving pathological meanings to the behaviour of children even though they are not convinced that the child has the problem. Whilst in some cases they believe the problem lies with the teacher or the teacher's classroom methods "I always agree that the child has some level of difficulty. So you don't say oh, you're wrong, this child doesn't have a problem." In these circumstances the educational psychologists go along with ascribing a pathological type definition to the child because the teachers seek these out once "normal sorts of

interventions have failed." In this regard, one of the educational psychologists explained, the teachers "would like to have maybe a pathology identified which would sort of forgive them if you like and enable them to accept the child, or accept that they can't change the circumstances."

The educational psychologists ascribed a variety of meanings to parents' behaviour. These meanings included the belief that parents are significantly influenced by the media when they discuss concerns about their children. Similarly to the child - care workers, they believed that parents were victims of the speed of family life, "things have got to be done quickly, there's a lot of things on parents' plates; there's a lot of things kids have to be good at and do." Whilst asserting that many of the children's problems in the school arose from the family and social context, all the psychologists gave a variety of reasons for not being able to deal with any of these issues directly. These varied from believing it would be "intrusive and unreasonable" to speak to parents directly about parenting issues, to citing the problem of "lack of time." When asked if the psychologist would routinely request that both parents attend when discussing a child's problem, the justification for not doing so consisted of the psychologists' belief that " to get them both (the parents) to get off work at the same time and come out in the middle of the day is difficult."

How the educational psychologists ascribe meaning to the child's experience is also of interest, since all of them made it clear that while socialising and friendship issues formed a large part of the presenting problem,

they appeared not sufficiently united in this belief to act upon this knowledge. As one of the educational psychologists put it, “they (the children) can almost survive anything with friends.” However, the possibility of intervening in any way in the social activity of the children was ruled out by another psychologist who stated that, “it’s my belief that the playground is a world to which we are not invited.”

9.4 *The Specialist Services*

The findings from the specialist services present us with a more complex picture. The professional groups here are the paediatricians, clinical psychologists, psychiatrists and social workers. Whilst all these professionals expressed concern about the children and parents presenting to their services, this did not necessarily represent as a key concern in all cases. The complexity of the responses from the specialist services may also reflect the fact that of the 12 professionals interviewed in this group, five came from the same Child and Family Mental Health Service in Metropolitan Melbourne. In this regard, it was interesting to note that the findings do not immediately replicate those of the universal services. For example, with regard to some of the responses from the professionals in the Child and Adolescent Mental Health Services (CAMHS) the professionals’ key concerns reflected their concern about the service, as well as concern about each other, whilst concerns about the child appeared to follow secondarily.

One way of understanding this difference in the findings of the professionals in the specialist services, is that we see the beginning of an articulation on their part that they, or the service, may be a contributing factor to the problem. Certainly, in this section of the findings, there is considerably more explicit as well as implicit criticism of their own and of other professional groups.

The description of the findings of the Specialist Services that follows have been grouped as with the Universal Services in the initial stage into key concerns, what gives rise to these key concerns and the meaning that professionals attribute to make sense of these concerns.

9.5 *Stage One: Key Concerns of the Specialist Services*

The professionals in the specialist services expressed their key concerns in a variety of different ways. Within this group, the responses of the paediatricians were more closely allied with those of the universal services, reflecting their work on the boundary of the universal and specialist services. The paediatricians, all of whom work with child and family mental health problems, expressed concern about the negative way in which parents described their children, as "so difficult", "a real disaster", "a real brat." The paediatricians see their role as helping the child, "I see a child sitting there squirming in their seat" and helping parents "see things from their child's point of view."

The paediatricians gave numerous examples of parents coming to them with ready made diagnoses about their children, as in "they come in with

ADHD…they come in and say they're hypo, when they're meaning they're hyperactive", and "often parents seem to come with a diagnosis in mind, particularly ADD."

Despite the fact that the clinical psychologists all worked in different settings they concurred with the view that there had been an increase in the severity of the presentation of child and adolescent mental health problems across the board. However, the settings in which they worked clearly influenced the way in which they interpreted the reason for this increase in psychological problems. The psychologist working in the Child and Adolescent Mental Health Services (CAMHS) pointed out that there is an increase of serious psychological problems for children and young people, describing these as an "exaggeration of problems of severe depression, suicidality, self harm, drug abuse." However whilst the psychologist working within CAMHS believed that the less extreme cases were not referred to the service because they were better handled in the community, this was not a view that was shared by the other psychologists. In fact the point was made that it is precisely this greater understanding of parent - child relationships that is under threat, whether in the Protective Services where children's needs are "many rungs down the ladder" or in more general counselling where parents are "disbelieving" that children can pick up subtle but profound dynamics about the relationships in the family.

The most difficult group to pin down in terms of obtaining a picture of their key concerns or their views were the psychiatrists. Although all working in

the same service, their responses were presented in a manner so at odds with each other, that one could have assumed that they were working in totally different services. It was also striking that their descriptions and assumptions about the children and parents presenting to the service were made primarily with reference to their own position in the service, and with little reference to each other or to the broader multi - disciplinary team. Their responses as a result, appeared to take the form of individual "position statements" about their current perspectives of child and family mental health. These position statements resonate with a split between a medically oriented categorising system of understanding the child, versus an approach that focuses on the meaning of the child's behaviour within the family, social and even philosophical context.

One of the psychiatrists for example expressed trenchant criticism of other psychiatric colleagues "who are very happy to find a new master to serve…they make themselves part of the system and become slaves to it actually." This psychiatrist in referring to the Department of Health that oversees the service, talked about "the lingo in mental health branch." From the interviews with the psychiatrists, one could begin to identify several different "lingos" being "spoken." For example, one "lingo" identified the children who are referred to the service entirely in terms of psychiatric disorders as in "having bipolar disorder…taking over to some degree from the ADHD type of fashion" and of "affective behaviour disorders, depressive disorders, chronic irritability, school refusal, social phobia related to anxiety…" In addition, there was mention of

"Asperger's disorder is also a fashionable diagnosis." Similarly to the paediatricians, some psychiatrists also referred to parents who "describe their children usually boys as being hypo…which is I suppose meant to be hyper." For the parents of these children who "want an analgesic" some of the psychiatrists described themselves as being the analgesic, "but then we seek to engage them (the parents) in being part of the solution."

The responses of the social workers, similarly to the psychologists, reflected to a substantial extent the different settings in which they worked, namely a school, a parenting service and CAMHS. However, it was striking nevertheless that one of the main concerns for all of the social workers was their frustration with their employing organisations. For the social worker, working in the regional parenting service, this took the form of frustration at the top down hierarchical management and of having to respond to "position papers" that do not take into account in any realistic way anyone's position, neither the professional's, nor the parent's. Since all the social workers were employed by large organizations, there was a particular awareness of the internal contradictions that predominated in these organisations. As the social worker in the parenting service put it, "different sections of the same department can put forward totally contradictory positions." For example, "they (the Department of Human Services) said that children over two need less services because maternal and child health centres stop a service at two. But that's not actual logic is it?"

The lack of validation and recognition of their skills and understanding was a particular feature of the complaint from the social worker in the parenting service. For example in referring to the directives from the Department of Human Services as "the current push in parent education for the more behavioural stuff rather than…the more psychodynamic way of looking at things…which we actually believe aren't the answer." The social workers deal with this by "cutting and pasting" the imposed parenting programme combining it with their own experience and contribution.

For the social worker in the school setting the advantage of being able to work independently in the school system was coupled with concerns about the lack of a proper organisational structure, "it's hopeless. It's fragmented. I love it in some ways because it's isolated, it gives me so much autonomy. But…there's no professional accountability…generally the accountability is quite poor…there's a lot of isolation from other colleagues…very poor information channels…facilities offered are shocking."

The criticism expressed by some of the professionals in the specialist group towards other professional colleagues was articulated particularly strongly by the social worker in the school setting. This social worker referred to the view of the teachers in the school describing the teachers as being very judgemental of parents as in "a lot of judging of the parents …till I despair of it", and in relation to finding labels for the child, "very often, they really are grappling for explanations to understand. They'll talk about …his behaviour's bizarre or the

behaviour is off… and the talk sometimes in the …staff room, it just distresses me."

One exception to the tendency in this group of professionals to express concern by focusing outwards towards other colleagues and employing organizations was the response of the social worker in the Child and Adolescent Mental Health Service (CAMHS). This social worker instead focused on the severe and potentially intractable nature of the mental health problems dealt with by the service. This social worker described the children referred to the service as "facing essentially life problems of how to deal with their feelings, too much anger, too much sadness, too frightened …too much conflict happening in their life, too much educational failure, trying to make friendships…" A core aspect of this social worker's practice was summarised as "I have an attitude that, unless you can agree in the initial interview in the first fifteen minutes of precisely what the problem is, you might as well pack up and go home." The "average patient" was described as preferring a pill more than anything else, "nice and concrete. Just a quick suck on the pill and the problem's solved."

When asked to comment on the case vignette at the end of the interview, this social worker responded by saying "a bit light on and trivial to worry too much to see" indicating the contrast with the severe child and family mental health problems presented to the Child and Family Mental Health Service. The social worker's communication concerning the demanding nature of the work

was countered by their wish that "you could find a magical way to help teachers educate all these kids in a way that the kid's brains could understand…"

9.6 *Stage Two: Specialist Services: Attributing Meaning*

The meaning that professionals from the specialist services attribute to their experience is described firstly in relation to the clinical psychologists and social workers and then in relation to the group of professionals working in the Child Adolescent Mental Health Service (CAMHS). The responses of the professionals in CAMHS have been grouped together, since their attempts to attribute meaning to their work and experience, is assumed to be mutually influencing and interdependent.

Attributing blame to the media for influencing parents and their view of their children's problems was a particular feature of the paediatricians attempt to make sense of the problems referred to them. As one of the paediatricians explained, "the internet too is somewhere that people find a lot of information so they often will have almost the DSM checklist when they come." Paediatricians cited the lack of time as one possible reason for parents presenting their children to them in such a negative fashion as in parents "feel like they've got to come in and dump the whole bucket of their problems." They, (the parents) "fear they've got sort of five minutes to give all the negatives, just so they get taken seriously."

The paediatricians commented on parents viewing the child "as sort of the scapegoat in the family" giving this as a reason for their negative comments about a child. As a counterpoint, the paediatricians talked of trying to find "a

positive focus", and to explore "what the child's actually capable of." The need to counter the negative with the positive was emphasised several times, as in "you feel like you're going to sink or swim in the consultation unless you try and sort of put a lid on it." Another way of understanding the negative communication on the part of the parent was to view it as "just pent up frustration…"

In an attempt to divert from a strongly negative description of the child, paediatricians described their own attempts to attribute meaning to the child's behaviour with reference to the concept of "temperament." For example, "I would describe that as the behavioural style of the child, some children are just really placid and easy going and some children are much more difficult, much more sensitive." Other ways for the paediatricians to attribute meaning to children's behaviour included using the terms "feisty" and "drama queen", as well as terms such as "worry" rather than "anxiety which sounds much more sort of pathological."

For the paediatricians in particular, the meaning they attribute to a problem is influenced to an extent by the referral letter that they receive from the General Medical Practitioner. These referral letters were described by the paediatricians as injunctions to "please see" or "please treat" or "not coping. That's it. Full stop." On many occasions, the General Practitioner is a "ghost writer" writing the letter of referral for Medicare payment purposes at the behest of other professionals. Thus, the paediatricians have to tease out this "double

meaning" behind the referral letter that they also describe as being "short on analysis."

Some paediatricians reported as a problem the meaning that the public attribute to their medical status, as in "You know fix this problem…the God like persona of the doctor where you have to fix it." As a counterpoint to this position, some of the paediatricians noted that it was not always possible to use a medical approach when dealing with complex relational problems. However, they believed that this is a view that is not generally encouraged as it goes against the "medical mentality" where "it's diagnose a problem, investigate if you don't know and treat or manage."

For both the psychologists working independently and the social workers working respectively in the parenting project and the school, the importance of attributing meaning to the behaviour of the child and of perceiving meaning in family relationships was of paramount importance. Their communications were presented in terms of struggling to represent the meaning of experience for the child in the context of what one of the psychologists described, as an "adultist" system dominated by self interest. "You're occasionally given a tiny window to try to crawl in and find the child underneath all of that."

Attributing meaning to children's behaviour was additionally presented as a counterpoint to what the clinical psychologists in particular referred to as "the profound ignorance in the system" both within government as well as in voluntary agencies. An example was given of how a training programme that had

been run by one of the psychologists for the Department of Human Services on understanding the impact of loss on children who had multiple deprivations, was summarily brought to an end. The reason given for this was that the Department had decided that, "the direction to go was resilience."

Echoes of this appear in the communication of the social worker, who described the difficulties faced in trying to promote a meaningful parenting programme for their clients. Paradoxically, from what the social worker reported they appear to be putting their energies into protecting their clients from the very programs that have been set up to help them, describing these as "only offering a program that parents have to sort of climb a hill to get to, you know."

In describing the meaning making processes of the professionals working in the Child and Adolescent Mental Health Service (CAMHS), the point was made earlier that the meaning making of this group is interrelated, by virtue of their working for the same service. It is also important to recognize that within this group, psychiatry is the lead profession that heads the service. The psychiatrists more than any other professional group presented many examples of meaning making in terms of attempting to make sense of the problems their clients presented, the background to these problems and justifications for the way in which these problems were handled. For this reason, as well as, because the dominant paradigm in contemporary child and family mental health is that of psychiatry, the reporting on the meaning making of this group of professionals including the clinical psychologist and social worker, is presented in more detail.

Perhaps one of the most striking comments concerning meaning making in the Child and Adolescent Mental Health Service came from the clinical psychologist, who, having worked in the service for several years, made the point that while everything changes it also stays the same. “It’s interesting because as long as you stay in the system the system changes, but it remains the same in a way. So while some things are different some things are very much the same and that always will be. And the problems are the same and the ways of dealing with them basically.” Whilst this psychologist accepted that changes in some areas of clinical practice were due to research or an “expanding theoretical perspective”, the overall service was perceived as remaining unchanged over time, “as long as I’ve been in the service people have been talking about having to cope with change, resources, ah they’re perennial in a way.”

The notion that the same problems appear repeatedly in an unending cycle, suggests that these problems can never be solved. This is also touched on by the social worker in CAMHS who stated, “if people knew what mental health promotion and mental health education meant they would have done it thirty years ago.” This comment is interesting, since it suggests that it is solely the lack of knowledge or information about health promotion that prevents people from making changes. The implication is that if people only had the knowledge then they would apply it. However, this was contradicted by another comment made by the clinical psychologist in CAMHS with regard to a preventative Infant

Parent Programme actually operating within the service, that was described as "quite peripheral" and not part of the "core" work of the service.

The meaning that the clinical psychologist and social worker in CAMHS ascribed to their work, appeared in turn to be circumscribed by what they perceived as the limitations of their clients in ascribing meaning to their experience. For example as the social worker explained, "some people seem to be quite incapable of separating what happens from why it happened and they're incapable, their brains cannot understand the difference" and "even adults even your so called sophisticated adult doesn't handle abstract thinking too well, they prefer it fairly concrete."

Whilst the clinical psychologist and social worker attempt to create meaning out of the severe mental health problems that challenge them by suggesting that they are to some extent inevitable and recurring, possibly even incurable, the psychiatrists in the services create different meanings again. The meanings that the psychiatrists articulate, may be perceived as bordering on justifications for the way in which they address child and family mental health problems. The "medical mentality" as described earlier by the paediatricians, is not one that brooks uncertainty. The medical practitioner is trained to assess, investigate and treat. The attributions of meaning of the psychiatrists therefore reflect this stance, particularly in suggesting that not only is it the requirement of the service for each child to have a diagnosis, but that this also fits with what the

parents want since as the psychiatrists stated the parents are “hell bent on having a particular diagnosis.”

However, a closer examination of the way in which the psychiatrists attempt to create meaning out of their experience suggests a still more complex picture. Reference was made earlier to the fact that the accounts the three psychiatrists gave of their work differed to such an extent that they could have been perceived as working for three different services. It was noticeable even in the course of one interview, that the language used by them to attribute meaning to the experience of children and families also changed in the process. For example, one of the child psychiatrists commenced with a description of children’s mental health problems interpreted almost entirely according to genetic meanings and influences. By the end of the interview the tone had changed significantly with the psychiatrist, now advocating a focus on “hearing the voice of the child,” taking a developmental approach and advocating for the rights of the child. This changing approach may reflect two things: Firstly, it may reflect what has been described as the advantage of stranger value (Jackson, 1987, p. 69). The researcher who is not part of the system is allowed to become privy to certain thoughts and opinions that may not normally be able to be articulated. Secondly, it may reflect a sense that the psychiatrists attribute different meanings about child and family health at different times depending on the circumstances.

In an attempt to encompass the different expressions concerning meaning making on the part of all three psychiatrists, the following is presented as a summary of their position couched in the language they have used:

i.) The tendency of the DSM IV to be used by psychiatrists in the over diagnosing of children is the fault of society that wants a "quick fix." The DSMIV was only ever designed to be a research tool and has been misrepresented.

ii.) Psychiatrists are at the mercy of the United States that has a powerful and influencing force on psychiatry world - wide. The promotion of medication is one example and cannot be resisted as it has a "flow on effect around the Western world."

iii.) Psychiatrists are at the mercy of the drug industry that is driving much of current research in mental health

iv.) Psychiatrists have difficulty getting their work published in the key opinion - shaping journals that emanate from the United States, unless they conform to the prevailing medical model.

v.) Psychiatrists' traditional ways of working have been eroded by the unreasonable demands made by their employers and by other services. This is exemplified by "increasing emphasis on outcome measures. Increasing bureaucratic demands on us for producing all sorts of statistics."

vi.) Psychiatrists are the victims of models of thinking such as the British empiricist philosophical view and of economic rationalism.

vii.) Psychiatrists struggle to counter the influence of the media in presenting diagnostic criteria for childhood problems.

viii.) Psychiatrists are at the mercy of society's demands and expectations and believe the responsibility should be put back on society to ask questions concerning its understanding of health.

ix.) Psychiatrists are at the mercy of "crazy" departments and "irrational and unhealthy systems" that display "lack of vision" and "lack of strategic planning".

9.7 *Stage Three: Bringing Together Emerging Themes from the Examination of Findings in the Universal and Specialist Services*

The themes that emerge at this stage from the examination of the findings are named and identified in response to a series of questions that relate to the way in which professionals from both the universal and the specialist services articulate their experience of working in child and family mental health. These questions are formulated as follows:

Who is heard and who is not heard?

What is heard?

What is knowledge – who has it and how is it used or not used?

What is health and what is illness?

Whose interests are being served?

Who is heard and who is not heard.

The findings from both the universal and specialist services suggest an overall concern on the part of the professionals of not being heard and of not having their skills and understanding validated. The problem of not being heard is articulated in the context of managements that do not listen and that are characterised by top down hierarchical structures. Issues related to the shortage of time, shortage of physical space and cost cutting were also cited as evidence of the problem of not being heard, and taken seriously. For example in the child - care setting when asked what kind of improvement in the service they would like to see, one worker replied, "how long have you got?" Whilst maintaining reasonable staff ratios is a key issue for the child - care workers, they indicate that the conversation they need to have with their employers about this important issue has become subsumed by a variety of instrumental directives concerning audits and the need "to worry too much about the fiddly things and the paperwork."

Similarly, the educational psychologists find it difficult to be heard or taken seriously by their immediate employers: the Heads of school who also hold the power of dismissal. Being heard in this context is also a function of how marginal or not the educational psychologist is within the school system, "it can be frustrating…because you aren't a staff member…sometimes you're seen as one of them, but generally you're seen as an outsider. You don't have a great control over how they will take issues on."

The educational psychologists further articulated a link between being listened to, and being allowed to speak. For example, as one of the educational psychologists explained, it was essential to work within the culture of the school, "unless you have an understanding of the culture it doesn't seem as though you can be very effective." In addition, educational psychologists reported the need for caution when going into a new school, "I'll spend time watching, I'll spend time listening…Asking their permission a lot. And until you've got that, an understanding of how they operate and what their focus is, then you can go with that and live very happily within those boundaries."

Not being heard or not having one's experience validated was also part of the experience of the clinical psychologists who were working independently. Here, it appeared that their choice to work independently had resulted at least in part from their past experience of working in a Child and Adolescent Mental Health Service. They referred particularly to not being heard by the child psychiatry directors "who had more cognitive behavioural sorts of outlooks. And a frightening disinterest, disrespect really in other ways of thinking."

As the data indicate, being heard and having one's experience validated as a professional, is inextricably associated with the value and the status that the professionals themselves, as well as others ascribe to their role. The data reveal that those professionals, who perceive themselves as not being listened to, or not being taken seriously, also perceive their position in terms of having a low status. This is the case particularly for the child - care workers, who believe they are

viewed as child minders, and the educational psychologists for whom attention to the emotional needs of children in the school system equates to a dead end professionally. In the professional group of maternal and child health nurses, there is a link between reporting that they are not listened to by their "rigid and hierarchical employers", and their tendency to downgrade their profession, as in describing themselves as "a Jack of all trades."

Interestingly, the child psychiatrists, one of the most powerful professions as well as the leaders of their service also complained of not being heard or listened to. They gave several examples of not being listened to by the Department of Health that is "crazy" and makes demands on them to provide a variety of outcome measures and statistics. They also complained of not being listened to by society at large that makes too many demands on them and has too many expectations. Finally, closer to home they expressed the concern that they would not be listened to by other members of the staff of their service when they put in place "new management structures" and began to institute "evaluation outcome based research on why some children and families do not respond to conventional treatments."

Hearing and not hearing the voice of the child.

Despite the fact that all of the professionals are concerned with children and their mental health, the voice of the child was heard only indirectly, as talked *about* or significant by their absence. Overall, the voice of the child appeared by default, almost always in reference to the views of parents or the professionals,

rather like grass appearing between paving stones. What is heard about the child or discussed about the child, appeared to be presented fairly consistently across both universal and specialist services reflecting as it does conversations and discussions that describe children across the age range in negative terms. A further corollary of this negative presentation is that professionals indicated that they were in a sense "forced" almost against their will to hear these negative descriptions about children as described in the following examples.

The voice of the infant commencing with the maternal and child health nurses, appeared primarily with reference to the description of their problems such as, allergy, intolerant, grizzly and colicky babies. In the context of the child - care setting, the voice of the child was given greater opportunity to come to the fore but again entirely in relation to the parents' complaints about them. For example, the child - care workers described how the children referred to themselves as "I'm a good girl, I'm good", or "I'm not naughty today." And "I know I'm really bad…because everybody tells me I'm bad." The child - care workers explained that some children who expressed aggression in the child - care centre may have observed parental aggression in the home. For example when playing with other children, "you'll hear them say…you stop that! You know, a really angry voice…I'm going to break your neck." Additionally, the voice of the child in the child - care centre at times gave the impression of having to shout above the crowd in order to be heard as in a sick or distressed crying child, described as "stealing attention" from other children.

In a similar vein to the child care workers, the paediatricians reported children assuming their parent's negative "black and white" descriptions of their behaviour as in "I'm naughty, I'm being naughty." When asked "what do mum and dad really like, what makes them really pleased with you?" their response was often "being good." The paediatricians further reported that parents expressed surprise when they talked to the child directly and treated them as valid informants about their experience, "I've had quite a lot of feedback from parents saying I've been to see paediatricians before and no one's ever actually talked directly to the child."

In the school setting, in interviews with the educational psychologists, little of the voice of the child was heard. Children were reported mainly as mimicking their parents' criticisms of teachers or the school, and only once as crying in the course of discussing their problems. A more indirect example of hearing the voice of the child was given by the educational psychologists in describing attempts by a school to deal with bullying by putting in place a "Dob in a Bully day." Here the children themselves were expected to take on the responsibility of finding bullies by reporting on other children in the school.

The clinical psychologists working in independent services confirmed the tendency for the child's voice to go unheard. Particularly in child protection settings, children were described as having to twist themselves into a variety of different shapes in order to be heard and to survive. In this regard, criticism was levelled at the Child Protection Service with particular reference to the service

trying to exhort children to become "resilient" in the face of their failed attachments and deprivation.

Within the Child and Family Mental Health Service (CAMHS), the voice of the child appeared to be entirely silenced, except with reference to the description given by the parents and the diagnoses given by the professionals. The social worker in this service referred to children and adolescents articulating their problems through "common street English. Aggressive, violent, sad, suicidal sort of stuff" but did not go into any further detail about what the children expressed. Similarly, according to the social workers in the school and the parenting service, the voice of the child was heard only indirectly. Whilst the children in the school setting are regularly *talked about* in the school staff room, there is no reference to what the children actually say about themselves.

What is knowledge – who has it and how is it used or not used?

Ideas about what constitutes knowledge and how it is used or not, constitutes an important emerging theme encompassing as it does the views of all the professionals in both the universal and specialist services. The use of knowledge is also critical in helping us to understand what informs professional practice in child and family mental health. Professionals' view of knowledge in addition influences their broader views of what constitutes health, and illness.

Universal services and the uses of knowledge.

Commencing with the maternal and child health nurses, we find the nurses commenting on the mothers they work with as possessing greater

knowledge than ever before. This makes them, according to the nurses, more discriminating and demanding. As the nurses explain, "they've read a lot, discussed a lot, thought a lot, have got quite perhaps definite ideas about things." However, at the same time the nurses describe the mothers seeking knowledge about the baby that appears to be formulaic particularly with regard to seeking sleeping solutions. The nurses also indicated that they share different kinds of knowledge with the fathers from the kind they share with the mothers, as in "men want the facts…if a father is going to give me the facts, he doesn't want to be dealing with a lot of emotions and tends to want the facts coming back."

The data indicate how in some cases when professionals are in possession of knowledge they are not always in a position to use it. For example, the child - care workers expressed sound knowledge about the needs of children particularly with regard to separation and transition issues. However, they appeared unable to act on implementing this knowledge by failing to discuss this with the parents. The reason for their inability to be clear with the parents about the children's needs appeared in turn to be related to their downgraded views of their role, as well as the lack of clear and delegated authority on the part of their employers. Similarly, the knowledge of the social worker in the parenting service was not taken into account by the Department of Human Services with regard to developing new parenting programmes.

The use of knowledge is of particular significance in the school system. As data from the educational psychologists indicate, the communication of

knowledge within the school system is formally circumscribed and focused on a set curriculum. The data reveal that in schools, a split is maintained between traditional knowledge and learning related to the curriculum, and knowledge and learning regarding everyday life, emotional development, and social relationships. The former model of learning also assumes the "ignorance" of the child who has nothing to teach and the "knowledge" of the teachers who have nothing to learn from the children.

In this context, emotional knowledge is not considered an important area of knowledge within the school system. In addition, the educational psychologists assert that parents also give primacy to the acquisition of curriculum - based knowledge as an avenue to their children prospering in the world. This marginalizing of knowledge about emotional development is highlighted in the findings obtained from both the educational psychologists and the school based social worker, in terms of their inability to work productively with their own professional knowledge, for fear of "rocking the boat."

Specialist services and the uses of knowledge.

In examining the data from the specialist services one notices that the focus on knowledge shifts to the knowledge that is required by the professionals in order to carry out their task. This is of particular relevance when we consider the knowledge base of the paediatricians in relation to child and family mental health. By their own admission, the paediatricians refer to their training in this area as limited. They perceived their training as "very service oriented…it hasn't

really had a lot of change in the last ten years…so you've got to learn a bit just by the seat of your pants." In fact, it is interesting to note that the paediatricians describe the knowledge they have acquired as giving rise directly to the way in which they practice. For example, they referred to their training and practice in child and family mental health as comprising the following:

One year of community paediatrics

Behaviour Modification type work

Identifying with the patient

Flying by the seat of your Pants

Witnessing

A common sense approach

When the paediatricians employ a "common sense approach" and "identifying with the patient" this involves sharing knowledge with the patient about their own parenting experiences as in: "Oh look I know a little about what you're going through, my three year old's being quite difficult at the moment too." As one of the paediatricians explained, "I don't realise how often I'll put in something about my own family in a discussion…it often helps to establish a bit of rapport too."

Acting as a "witness", is used by the paediatricians in response to working with families with apparently intractable problems, "and it's like I'm a witness, they come for me to just witness that and it's important and nobody else will listen to them to that level. So I do have a whole collection of families and

children where I don't feel like I'm doing anything, but they continue to come and see me."

For the psychiatrists, knowledge about child and family mental health appears to go hand in hand with the presentation of an all - encompassing knowledge none of which they perceive to be in any way contradictory. Thus in the course of one interview the psychiatrist could refer to the need for more systematic randomized trials to explore the impact of various medications on children's functioning, whilst simultaneously acknowledging that the findings to date were inconclusive. Again, in the course of the same interview, it could be asserted that medication for children is no more risky than psychological treatment, whilst commenting only a little later that society will no longer tolerate the continuing medication of children.

In considering the nature of knowledge and how this connects with leadership, particularly in the Child and Adolescent Mental Health Service, (CAMHS) it was interesting to note the response of the psychiatrists. They did not perceive that leadership of the service depended on specific knowledge. Rather they referred to "the medical hierarchy outside of the service" who would not find it acceptable if a non - medical professional was in charge.

Being in possession of key and all encompassing knowledge on the part of the psychiatrists appeared to enable them to have the authority to review the knowledge that other professionals have and to make judgements about its acceptability. For example, the psychiatrists referred to the fact that they would

be instituting “evaluation outcome based research on why some children and families do not respond to conventional treatment” whilst not explaining what these “conventional treatments” might be. Hence, the underlying assumption was that unquestionably “research outcomes” could become the driver for favouring some forms of treatment, whilst discouraging other forms of treatment and professional approaches.

9.8 *Findings from the Focus Groups*

Two focus groups took place after some of the findings from the individual interviews were examined. Each group consisted of three different professionals, representative of some, but not all, of the professionals interviewed. The first focus group was comprised of a child psychiatrist, an educational psychologist and a maternal and child health nurse. The second focus group was composed of a paediatrician, a social worker and a clinical psychologist. A child - care worker had been invited to attend the first focus group, but was unable to do so at the last minute.

Both groups were presented with a summary of the emerging themes from the individual interviews (Appendix E). They were asked for their comments and views on these themes. As stated earlier, the rationale for the use of the two focus groups was to create an opportunity for the researcher to test the findings from the individual interviews in terms of these findings being challenged or confirmed. The focus groups also offered an opportunity for other relevant commentary concerning child and family mental health to be included.

The professionals in both focus groups agreed with the formulation of findings made from the individual interviews, and added their particular concerns and views.

9.9 *Concerns Emerging in the Focus Groups*

Three major concerns were identified in both focus groups. These revolved around the place of mothers and the maintenance of family care; concern about prescriptive and managerial approaches to child and family mental health; and concern about the level of fragmentation in organizational and community life.

Mothering and the maintenance of family care.

Discussion about the role of women as primary carers for children and as the main promoters of the family core was a central concern in both groups. The mother's position was perceived as one of struggle and isolation, particularly of being unsupported in the care of children. In this regard, one of the participants referred to "a great deal of undiagnosed, unresponded to distress in normal everyday motherhood." Several examples were given of mothers' sense of isolation and inability to communicate their concerns. For example, in describing the communication of a mother who said, "you know, I just stand in the laundry and I open the dryer and I put my head inside and cry there because there's nowhere else that I can do this…and I have my two year old at my feet holding onto my legs in distress." In another example, a mother with several children and a new baby was described as spending the whole day in the car with the children

and a packed lunch taking them to various activities, the mother's rationale for this being, "that way the house stays tidy."

Prescriptive and managerial approaches to child and family mental health.

Both groups commented that in their experience parents had "become quite prescriptive about their children" and wanted behaviour to be labelled, as in, "it's almost as if there's this sort of label identity" and "looking for a cause." Additionally, many of the professionals described parents as wanting to disengage from the process of understanding about their child as in "fix the problem and it's nothing to do with me."

Professionals in the focus groups commented on the split between parents' high expectations of children on the one hand, and their apparent lack of communication with them on the other. In some cases, material indulgence appeared to be substituted for communication. Children were described as being busy at myriad activities, supposedly to "improve" or "stimulate" them. The professionals described children in these situations as anxious to comply with their parents' expectations but eventually becoming "burnt out" in the process.

The difficulty of accessing child mental health services was also presented as a significant cause for concern by the psychologist in one of the groups. This psychologist mentioned that a boy who was endangering himself and others, had been placed on a six month waiting list at his local CAMHS

because his problem was not considered to be sufficiently serious, "unless he's suicidal."

Fragmentation in organisational and community life.

All of the professionals in the focus groups identified an increasing emphasis on managerialism in their work places and an emphasis on "productivity outcomes" rather than on the needs of the client or the patient. As one of the professionals explained, "there seems to be more levels of management, more coordinating staff, more managers, more reports, more information sought from us on things."

The implications of an increasingly managerial ethos in the work place, was described by one of the professionals as follows: "I mean we at one stage had four different government departments imposing performance indicators and that required four separate reports." Professionals equally perceived the courses offered to parents as having a strong focus on the management of a problem. As one of the professionals explained, "there's very little understanding with the parent education courses of things like attachment behaviour and whereas it has actually been written about a lot of years ago it hasn't filtered through, it's the behavioural stuff, it's how to manage it and be in charge…and maintain that sort of façade." At the level of the community, there was general agreement that not only do the families and children not receive the service that they need but that "service providers are not getting what they need either." These problems were perceived as being passed down "to the last line of resistance which is the child."

9.10 *What Meaning Do the Professionals in the Focus Groups Attribute to their Concerns?*

The professionals in the two focus groups attributed a variety of meanings to the concerns they had articulated. Firstly, with respect to their concern about the isolation of mothers, it may be relevant to point out that although not intentional both focus groups were composed entirely of women. This may have had an influence on the tendency to focus primarily on the needs of mothers. The professionals cited anxiety about ”being with the baby” as well as the loss of the extended family as a reason for young mothers to be “fired up” to get out of the house and create “a pack mentality” by joining a mothers’ group.

Interestingly, despite their concern for the mothers the professionals did not appear to think that fathers had much of a role to play. This was reflected in comments such as “as far as education goes, I think a lot of fathers leave that to the mothers, that sort of, it’s their role, their responsibility.” When asked if this position could ever be challenged the response was “there’s not a lot you can do about a mindset.” The point was also made that women are better than men at managing emotional relationships within the family. However, there was a general consensus that women by virtue of being able to manage these relationships are “viewed as a softer target.”

As in the individual interviews, the professionals in the focus groups appeared resigned to, rather than perturbed by, the fact that fathers rarely

attended meetings with them to discuss a child who may have difficulties. The reason given for this was that the professionals themselves are under pressure to see too many people and they do not have sufficient time. The overall view was also expressed that the mothers have to "be comfortable" with the fathers' involvement.

The focus groups discussed the increasing tendency to diagnose problems in children and how they perceived this as linked to the need for labelling. Some of the professionals commented that everyone appears to have their "pet diagnosis" for a child's problem. This included magazine editors, neighbours and hairdressers. The tendency for some parents to "shop between services to get the diagnosis they want" was cited by the child psychiatrist as an example of parents themselves wanting to have a diagnosis for their child. Other focus group members suggested that parents tried to get prescriptive responses for child and family problems "because people can be very frightened of getting it wrong. There's a lot of pressure to do the right thing." The fact that parents have expectations of experts was also given as a reason for wanting a definite answer or diagnosis, "we live in a world of experts. It's as if we've made life so complicated you need a degree in something to know how to do anything at all."

When it came to attributing meaning to the broader organisational issues, some of the focus group members emphasised that "it's very hard to provide a containing, caring, supportive service when your government department is squeezing the lifeblood out of your organisation." The professionals in both

focus groups attempted to understand the problems within their services, and the needs and demands of parents, within the context of their concern about changing times and the stresses on modern family life. The professionals in the focus groups claimed that the devaluing of nurturing in the community, partly as a result of economic rationalism, has led to "a loss of meaning and place." They added that the removal of "ordinary caring and nurturing" in the community of many public services has meant the removal of someone locally on site who knows what is going on and who can pay attention to detail.

There was agreement in both focus groups that economic pressures and uncertainty can be very undermining of family life. Parents were perceived as not being able to relax into their role and enjoy their children, if there is continual vigilance about day – to - day survival. This anxiety is compounded by parents' fears for the future of their children, "there's so much anxiety in the community I think, people you know losing their jobs, or scared their kids won't get jobs."

9.11 *Emerging Themes: Focus Groups*

Who is heard and who is not heard?

Professionals in the focus groups are clear that their voices are not heard by their employing organisations and that their contribution is increasingly undervalued, thus compromising the quality of service they are able to offer their clients. The professionals alluded to the domino effect inherent in not being heard since if they are not supported to hear the parents, the parents cannot hear the children and the children ultimately become "the least line of resistance." The

theme of not hearing or not listening was also linked in the focus groups to the idea of people running away. The professionals in the groups spoke about a flight from the child and a flight from the self, resulting in "a loss of meaning and place."

New mothers were described as trying to run away from their homes to be with other mothers or to run away from the cares of the home. There was a strong emphasis on mothers particularly, not being heard and having few supports. Interestingly, little attention was paid in both focus groups to hear what the father may have to say or whether the father may feel unsupported. The professionals' lack of interest in what the father may have to say was rationalised by their statement that they did not have sufficient time to listen to both parents. In addition to this, they conveyed their belief that women are more in tune with emotions and relationships. The theme of not hearing what the father has to say was associated with the professionals' assertion that mothers need to feel comfortable about including fathers and that their existing "mindset" may militate against this.

Even when the professionals in the focus group were in tune with hearing the voice of the child, the implications were not unlike those in the individual interviews. This included acknowledging the difficulties for children to speak out on their own behalf except through the bringing of a problem. Moreover, it was suggested that children may have to bring a severe problem in order to be taken seriously, such as being at "suicidal" risk. With reference to children's

relationship to their parents, the professionals in the focus groups supported the view of those in the individual interviews; in particular with regard to fitting in with their parents' expectations even at the risk of becoming " burnt out" in the process.

What is knowledge, who has it and how is it used or not used?

Professionals in both focus groups expressed concern about the type of knowledge that appeared to be favoured by parents and by other child and family mental health professionals. That is, knowledge that is formulaic and based on finding strategies for children and their parents. The professionals in the focus groups indicated that the reason for the popularity of these approaches was that parents both want "the quick fix" but also want to do the right thing. The suggestion that parents do not have knowledge of their own, or perceive themselves as having little knowledge was given as the main reason for parents wanting to rely on "expert" knowledge. However there were also indications that even though parents might feel dependent on "expert" knowledge that they also tried to control the kind of knowledge that they acquired by "shopping around."

A particularly telling example of this came from the child psychiatrist in one of the focus groups, who mentioned that between 30% - 40% of families drop out of the Child and Adolescent Mental Health Service (CAMHS) after their initial appointment or at the beginning of the assessment. The reason given for this, according to the psychiatrist, was that the families are disappointed because they have not received "a quick fix" for the problem. However, this

interpretation was challenged by another professional in the group who wondered whether parents needed to have special knowledge to access the service, in the sense of having to know the "rules" of the service.

The knowledge that the parents or the users of the service have of the service, also appeared to influence to some extent the way in which the services are used. For example, most of the professionals described their work as short term and crisis centred. The term "putting out the campfires" was used to illustrate the harried nature of their work, and may suggest to the parents that the services are there mainly to "be reactive to individual crises."

Additionally, the knowledge of fathers like the voice of fathers was significant by its absence. The fact that the father's opinion was overlooked in both the groups appeared to be linked with the view that fathers did not have much knowledge on the subject of parenting or of child mental health. As mentioned earlier, the professionals were of the view that fathers relegated the responsibility and thereby the knowledge about parenting and education to mothers.

The process of inquiry described thus far is that of an attempt to make sense of the data through exploring the professionals' concerns. This included the exploration of the meaning they attributed to these concerns and how these expressions of meaning making led to a number of emerging themes. In the course of this process of examination, it has become possible to identify how these emerging themes in turn give rise to some very distinctive frames of

discourse that relate to particular discursive practices or ways in which the participant professionals describe and construct child and family mental health problems. These discourse frames of reference and discursive practices are examined in more detail in the following chapter.

Chapter 10: Emerging Discourses and Discursive Practices

10.1 *Individual Interviews and the Focus Groups: Emerging Discourses and Discursive Practices*

Through careful examination of various expressions of meaning and uses of language, the data reveal a number of recurrent patterns that form and inform a limited number of discursive practices, produced and reproduced within a limited set of discursive or discourse frames of reference. In other words, a number of recurrent patterns of the professionals' communication distinctively reflect a particular set of discursive frames of reference or discourses within which a significantly small number of discursive practices are embedded.

In what follows, there is firstly a description of how this examination of the professionals' uses of language led to the identification of a limited set of emerging discourses, or discursive frames of reference. Secondly, this descriptive examination of emerging discourses leads to the articulation of a significant small number of the professionals' discursive practices that illustrate how professionals frame the window of their approach to child and family mental health problems.

In the first part of this examination of the findings, the point of interest was to primarily identify the common trends and patterns of communication in the professionals' uses of language, and accordingly to name the emerging discourses, or discursive frames of reference. In the second part of this examination, the emphasis moves toward the identification of a limited set of

discursive frames of reference that go hand in hand with that of revealing essentially three intrinsically and profoundly interrelated discursive practices in the professional discourses of the participants in this inquiry. These are identified as practices that undergird these discursive frames of reference in which the discourses are articulated.

It is important to keep in mind that for the sake of clarity in the presentation, the various discursive frames of references that emerge from the examination of the data are described separately. However, in the reporting of the data they overlap and are mutually influencing. Thus, for example one cannot fail to notice the overlap between the findings that refer to the *blame discourse frame of reference* and those referring to that of the *professional as victim frame of reference*. Equally, in anticipation of a plausible interpretation of the findings, there is overlapping between the discursive practices of the professionals and what has been identified as various discourses or discursive frames of reference.

10.2 *Emerging Discursive Frames of Reference*

The primary discursive frames of reference that emerge from the analysis of the data and that appear to be common to all the professional groups including the focus groups are identified as follows:

A blame discourse frame of reference

A problem - based discourse frame of reference

An immaculate - conception discourse frame of reference

A professional as victim discourse frame of reference

A blame discourse frame of reference.

The predominance of a blame discourse frame of reference appears as a thread linking virtually all of the professional groups. The blame discourse frame of reference focuses on blaming the parents not only for the types of problems that they present but also blames them for their harsh attitudes towards their children. In addition, parents are blamed for not wanting to engage with the professionals to work in any depth on their problems, instead demanding a "quick fix." There are some exceptions to this dominant blame discourse frame of reference in the form of the two clinical psychologists working in independent settings, and the two social workers working in a school and a parenting service respectively. The school social worker although not personally identified with a blame discourse frame of reference transferred this to the teachers in the staff room.

Parents are blamed for blaming the child as in the maternal and child health nurses commenting that mothers blame their babies, "the blame is put on the child you know, maybe for the marriage, maybe for the way they're feeling for not getting enough sleep." Blaming the parents for blaming the child comes particularly to the fore in the child – care setting where the workers comment on parents' lack of understanding of their children's developmental needs. The parents are also blamed for their irresponsibility in not staying with the child to settle them in and for being irresponsible with regard to not collecting them when they are unwell.

The educational psychologists blame parents, particularly over – involved, anxious mothers, and parents who are not sufficiently involved with their children or who have too high expectations. Within the school setting the blame discourse is described as "a remarkable game of tennis that goes on between parents and teachers with the children as the ball in the middle." Additionally in the school setting, the blame discourse is almost ritually enacted with the teacher blaming the child, the educational psychologist having to "absolve" the teacher from blame, the parents blaming the school and the school blaming the parents.

Paediatricians blame parents for describing their children in overwhelmingly negative terms and for making them "scapegoats." They blame the parents for making them have to support the children who "squirm in their seats" when they hear the list of all of the "bad" things they have done. Of the three clinical psychologists one blames "the gap in the marital relationship", while another in CAHMS suggests that some parents send their children for an assessment to have their "diagnosis" confirmed, a view supported by the CAMHS psychiatrist who blames parents for being "hell bent on having a particular diagnosis."

The blame discourse continues with the psychiatrists in CAMHS who blame the parents for demonising the child as in "they perceive the child as malevolent…" and "they'll sometimes say, the child's a little shit, or use language like…I hate them." By implication in CAMHS, the parents are also

blamed for the extreme nature of the problems the children and adolescents present, as in the "aggressive, violent, sad, suicidal sort of stuff."

Blaming parents for presenting them with particular problems leads professionals to blame the media, particularly the internet and television for putting these ideas into parents' heads in the first place, as in having "almost the DSM checklist when they come." The emerging blame discourse overlaps with the emerging problem discourse that is referred to below.

The problem – based discourse frame of reference.

A problem - based discourse frame of reference in the context of the work of child and family mental health professionals is to some extent a tautology, since dealing with problems is an essential part of their job. However, examination of the data leads to the identification of a problem - based discourse that has a specific meaning in relation to understanding not only the parent but also the child.

The findings indicate that for many of the professionals, a problem - based discourse is verbalised as *discourse per se* as opposed to viewing it as a *means to communication* or a means to begin to *understand* the problem. As mentioned at the start of the thesis, there has been a shift in recent times from a concern with aetiology, towards making the behavioural expression the defining feature of a particular problem such as ADHD. The data indicate that the shift in some cases goes as far as connecting the problem with the essential nature of the child. For example from the "grizzly, colicky babies" in maternal and child

health, and the" bad" young children in the child - care setting, through to the "hypo", "disaster" and "brat" children described by the paediatricians, and the "bi-polar", "depressive", "violent sad and suicidal" children who are referred to CAMHS.

In this respect, the problem - based discourse frame of reference becomes an all - encompassing discourse within which communication about a child can only take place through the articulation of a problem. One may hypothesise that the problem - based discourse has the function of limiting the field, since it follows that a problem - based discourse is by its nature highly circumscribed as to who can speak, who is deemed qualified to speak, as well as what is spoken about, or allowed to be spoken about. An implicit but significant feature of the problem - based discourse is that the designated "source" of the problem, namely the child is not permitted to give voice in their own right. As the data reveal, the child is only "heard" in relation to the concern of the adults, both parents and professionals. Children's communications as a result are only heard in relation to the designations they are given by their parents, as in describing themselves as "bad" or not, or "naughty" or not or as the educational psychologists describe them as mimicking their parents' views.

An immaculate conception discourse frame of reference.

The question of who can speak and who is allowed to be heard comes particularly to the fore in the data in relation to silencing the voice of the father and of marginalizing his contribution. This marginalizing of the father's role

appears as the outcome of a predominantly mother - centric focus in the communications of all of the professionals.

Since the father's voice, opinion and presence is almost entirely absent in these interviews, one may conceptualise this absence in terms of an assumption of an immaculate conception, in which a baby miraculously appears but few questions are asked about how the baby came to be there. However, despite the fact that the father's voice is absent in an explicit sense, his presence is nevertheless implicit in many of the communications. These implicit communications mainly revolve around the way in which the professionals make a variety of assumptions *about* the father and the *idea* of fathering generally in negative terms.

For maternal and child health, the absence of the father is made explicit from the outset by the title of the service itself, which not only excludes fathers and fathering but also appears to be at odds with the avowed aim of providing a service for the "health and well - being of families." The separation between mothers and fathers, mothering and fathering is also made explicit by statements that divide mothers and fathers in terms of language as in "men don't want to be dealing with a lot of emotions and…want the facts coming back." The language of this discourse appears to be predicated additionally on assumptions about the mother as weak and unsupported, whilst the father is perceived as strong but uninvolved and out of touch with his emotions.

By not including fathers in the consideration of a child's problem, the professionals implicitly suggest that fathers are not involved in the parenting task. For example, the maternal and child health nurses take the view that fathers think that the mother must take responsibility for a sleepless baby. It is perceived as "her problem, not his anyway." However, fathers have to pay a price for their apparent disengagement by becoming open to ridicule. For example, one of the maternal and child health nurses in response to a case vignette described the father like a baby "sleeping the night away" and not attending to his child.

The assumptions about a father who is emotionally disengaged and the reluctance on the part of the professionals to engage with the father, appear to strengthen the *immaculate conception* discourse even further. If the father cannot be spoken about, does this imply that he can also not be conceptualised? If this is the case, we may hypothesise that the absence of the father both in terms of his lack of physical presence as well as his "absence in the mind" leaves the way open for a variety of different "fathers" to engage with the mother as well as with the children. In this regard, do the professionals perceive themselves as functioning as substitute fathers for both the mothers and the children?

Professional as victim discourse frame of reference

The professional as victim discourse runs like a leitmotif throughout all of the individual interviews as well as the focus groups. It is articulated most dramatically by one of the members of the focus groups as in, "it's very hard to provide a containing caring supportive service when your government

department is squeezing the lifeblood out of your organisation." The professional as victim discourse essentially reflects the views that professionals have of the organisations in which they work. An examination of the data reveal, that much of their discourse concerning their victim role, comes about as a result of what they perceive to be their inability to exercise discretion in their professional role. For example, at all levels, the professionals refer to their managers or employers as not hearing what they have to say and not validating their skill or experience.

The organisations in which the professionals work are referred to as "linear and hierarchical" imposing top - down directives about services that do not take into account the professionals' experience. The professionals give numerous examples of having to "work around" their employing organisation or managers in order to provide a reasonable service, and in some cases to protect their clients from the service. Implicit in the professional as victim discourse is the suggestion that the professional becomes self sacrificing in order to help the client. The professional as victim discourse also indicates how much of the energy of the professionals as a result necessarily goes towards supporting their own self- preservation.

Whilst the professional as victim discourse was understandably strong in those professional groups that are given the least amount of discretion in managing their case - loads and their day- to- day work, it was striking that the group in which this discourse most predominated was that of the psychiatrists. As mentioned earlier, the psychiatrists despite being one of the most powerful of

all of the professional groups interviewed, nevertheless articulated a discourse that was unequivocal about their position as victims. They perceived themselves as the victims not only of their immediate organisations but also of the broader constituency of opinion - shaping journals particularly in the United States. They also perceived themselves as victims of a community that forces them into over - diagnosis and prescription, and as such, they perceived themselves as being at the mercy of society's demands and expectations.

The articulation of the professional as victim discourse leads us to ask the question "who is not being spoken about as the victim?" For example, with respect to the psychiatrists we may question whether their strongly articulated discourse concerning their own "victimhood" makes it difficult for a space to be created in which we may begin to consider the "victimhood" of their patients or of the other members of the multi - disciplinary team of which the psychiatrists are a part. For example, the psychiatrists made it clear that they would be implementing changes in the treatment offered in the service without going into detail about what these changes would be. Whilst referring to the resistance they believed they would encounter from other staff members to implement these changes, little was heard about the impact of these changes on the staff members. In other words, the psychiatrists spoke about directing change in others whilst excluding themselves from the change process.

10.3 *Examining Discursive Practices*

As mentioned earlier the articulation of discursive practices on the part of the professionals goes hand in hand with the four discursive frames of reference identified above. The use of language in discursive practices runs parallel with the emerging discourses providing the scaffolding that underpins the discursive frames of reference. The discursive practices that emerge as particularly significant in the examination of the data are as follows:

The discursive framing of problems in medical and bio - behavioural terms

Articulating a "philosophy" of despair and a culture of complaint

The discursive practice of resignation about inertia in the system

The framing of problems in medical and bio - behavioural terms.

The framing of problems in medical and bio - behavioural terms is associated with the tendency to categorise the problems of children and parents. It emerges firstly through the language used by the professionals who have medical or nursing responsibilities, but also secondarily through being appropriated by other non - medical professionals. For the maternal and child health nurses, it may represent a means of ruling out uncertainty as in the nurses need to follow "strict guidelines" in "screening" mothers, babies and young children for a range of problems. This links with the earlier observation that the nurses' use of language merged medical diagnostic formulations with descriptive

language of the child's or mother's behaviour as though these are somehow interchangeable.

Whilst the paediatricians described their work with children and parents whose problems are essentially of an emotional nature, this becomes almost entirely obscured commencing from the outset with the referral from the General Practitioner. The referral made by the general practitioner and described by the paediatricians as "short on analysis" places the problem firmly within a medical context. This medical context is further reinforced by the parents who by virtue of bringing an emotional problem to a paediatrician. request a medical solution to a problem. According to the paediatricians, parents "seem to come with a diagnosis in mind…"

The medical discourse of the child as inherently disabled that is at its most powerful amongst the paediatricians, nurses and psychiatrists, also permeates the discourse of the other professionals. The paediatrician in response to the parent's negative view of the child has to find "a positive focus" and to explore "what the child's actually capable of." The educational psychologists similarly refer to the fact that teachers "would like to have maybe a pathology identified …"after their own attempts at "normal sorts of interventions have failed."

The framing of problems in medical terms and the parallel discourse concerning the child as inherently disabled is presented in a more complex fashion by the psychiatrists and other professionals in the Child and Adolescent

Mental Health Service (CAMHS). Taking a discursive approach is particularly useful in this context, as it enables us as Harper (1995) has pointed out, to take "a fresh look at everyday practices like diagnosis." The professional discourse amongst the psychiatrists and in the Child and Adolescent and Mental Health Service, presents an unequivocal view of a medical and pathology based discourse "because everybody has to get a diagnosis." The clinical psychologist in the service justifies this in terms of "a pressure to label in this system…" and "that's not really a core part of what we're on about." This discursive practice regarding the need for diagnosis presented almost apologetically, and in response to apparent "outside" pressure, resonates with Harper's (1995) identification of the "I don't believe in diagnosis…but" position. In this respect, the avowed "liberal" position of the psychiatrist or psychologist exists in contradiction to their actual day - to - day practice.

The professional discourse of the psychiatrists as mentioned earlier contained within it a high level of contradiction that appeared to encompass all possible views within child psychiatry from a traditional medical approach and the need for more randomised trials on medications, to the need to "hear the voice of the child" and to take a developmental approach. The apparent tolerance of such a high level of contradiction may paradoxically convey a message about the power and knowledge of the psychiatrist, a finding that supports Harper's (1995) comments concerning variability and inconsistency in his interviews with psychiatrists.

The power of the psychiatrist is also evident from the discourse concerning the organisational setting, in which the psychiatrists referred to working within a flawed system that nevertheless holds out the hope that change can be achieved through slow, incremental steps. Here expressions such as "a work in progress" and a "constant state of tension to be managed" tended to prevail.

The justification for the use of medical treatments fully comes into its own in the interviews with the psychiatrists, where the professional discourse is explicit with regard to apparently intractable emotional and social problems. The severity of these problems presented in a categorised manner in terms of a range of disorders, not only becomes the justification for medicalised treatments, but also becomes the justification for the scrutiny of other professionals' practice. For example as mentioned earlier, the discourse concerning "evaluation outcome based research on why some children and families do not respond to conventional treatments" does not go into detail about what these "conventional treatments" might be. Thus under the respectable cover of the "research" discourse there appears to be another discourse concerned potentially with the discouraging of some forms of treatment and the favouring of others.

Articulating a philosophy of despair and a culture of complaint.

The discursive practices articulated as a philosophy of despair and a culture of complaint, present as overlapping discourses that recur throughout the individual interviews and in the focus groups. Within CAMHS, the philosophy of

despair is at its most intense in the discourse of the social worker. Here, the discursive practice refers to the "average patient" as only wanting " a quick suck on the pill…" and as having brains that cannot understand and make sense of their experience. The discourse contains a retaliatory attitude that cuts off hope with regard to the potential for change. Thus, the patients by virtue of presenting complex and challenging problems that make the professionals feel helpless are not considered deserving enough to be thought about in a respectful manner.

The philosophy of despair is articulated differently by some of the other professionals, who talk of "despairing of" some of their colleagues and their judgemental attitudes towards children particularly in the school setting. In many of the interviews including the focus groups, the philosophy of despair is by its nature directed against an indeterminate "they" who wield control through various means such as media influence and by so doing contribute to the unravelling of family life.

Discursive practice about resignation and inertia in the system.

Professionals present themselves as largely powerless in response to the demands of their organisations and especially powerless in relation to the higher level of government departments described as squeezing the lifeblood out of their organisations. Discursive practices concerning powerlessness were prevalent in all of the interviews and the focus groups. This was particularly well illustrated in the discourse of the clinical psychologist in CAMHS who spoke of problems as "perennial." The main reference in this discourse was to inertia in the system.

In other words, as the psychologist explained, over the years, everything in the organisation had remained essentially the same. From this perspective we may conclude that discursive practices that justify an uncritical view of inertia in the system, reinforce the belief that inertia is a central and inevitable element of all organisational life. In this context therefore, challenging inertia is perceived as pointless and an attitude of resignation becomes a legitimate accompaniment to the professionals' practice.

The next section is concerned with an analysis and interpretation of the findings that attempts to throw light on the limitations that professionals' experience and express with respect to their practice. These limitations are analysed with specific reference to professionals taking up defensive positions in relation to their practice and their organisations. These defensive positions are perceived in turn as compromising professional practice and contributing to the pathological trajectory for children and parents.

SECTION 5: ANALYSIS OF FINDINGS

Chapter 11: Toward an Analysis and Interpretation of the Findings

The researcher set out to examine how professionals construct and describe the mental health problems of children, parents and families. The findings indicate that the professionals rather than presenting their own views, tended to present the views of the parents they are attempting to help. The parents, according to the professionals, are described as at times overwhelmingly negative, punitive and dismissive of their children. The tendency of parents to demand a "quick fix" from professionals was cited as a prime example across all disciplines.

With reference to these attitudes of parents and their negative view of their children, the professionals appeared to have identified a specific role for themselves as that of buffer between the parent and the child, with the ostensible aim of helping the parents understand and respond to their child's needs. Whilst this initial finding appears to place the responsibility firmly on the parents, closer examination and analysis of the data reveals a more complex picture.

11.1 *Identifying the Defensive Function of the "Buffer Position"*

Informed by the conceptual framework and method of analysis discussed earlier, the professionals' assumption of the role of buffer between the parents and the child can be interpreted as having a defensive function. This defensive function serves not only to obscure professionals' construction of child and

family mental health problems, but also to obscure what they actually do in their professional practice.

The findings from the interviews indicate that the professionals mostly operate in the absence of a coherent developmental framework regarding the ages and stages of childhood or the needs of children. In a significant part of the findings, they report how their responses in their practice tended to be reactive, ill informed contradictory and dominated by a variety of rationalisations. At times unsubstantiated "scientific evidence" was presented in favour of a medical or behavioural diagnosis.

Throughout all the professional groupings including the focus groups, a parallel process appeared to be operating in which the complaints and limitations that the professionals levelled at the parents, could be said to be characteristic of their own functioning. Particular examples of this parallel process were contained in the professionals' repeated references to the shortage of time and the scarcity of resources available to them. As a result, the professionals presented a fragmented approach to children throughout the various systems and services that are ostensibly set up to support them and their families.

11.2 *Silencing the Voice of the Child*

The voice of the child was largely silenced in all of the interviews, and children's communications rarely validated. When allowed to give voice, children were reported as identified with the negative construction of their behaviour by their parents, particularly in early childhood experiences of

parenting. This included children reporting themselves as “being bad” because their parents had told them they were bad. However, paradoxically, the children in these circumstances were also reported as longing to connect with their parents and of being understood by them.

The findings indicated that overall, the child was placed at the periphery of each of the professional systems of service, whilst the professionals placed themselves at the centre. In this context, one of the professionals described working with children in foster care as having a low priority within the community, and as “many rungs down the ladder.” However, this perception is no less applicable to the other areas of mental health in this study, in particular, in tune with the comment that “underneath that pile of self interest and adult interest, you’re occasionally given a tiny window to try to crawl in and find the child underneath all of that.”

11.3 *Contributing to the Trajectory of a Problem - Based Pathology*

At another level of interpreting the findings, each of the services in different ways significantly reflects a discrepancy between their espoused aims and objectives on the one hand and their practice on the other. In addition, each of the services and the practices of the professionals within the services, contributes to a pathology bound trajectory for children and parents. This compromises both the quality and the effectiveness of the child and family mental health services they provide. The ways in which each of the services contributes to the trajectory of a problem - based pathology for children and

parents is examined in the context of the delivery of universal and specialist services as well as within a developmental context:

In the context of the universal services.

Whilst there is a general assumption that universal services for children such as maternal and child health services, child care provision and schooling, have the potential to offer a preventative approach to child and family mental health problems, this is not borne out by the findings. Instead, the findings indicate that in many instances, these services themselves become the trajectory for child and family mental health problems. Within all three services, the lack of understanding about relational experience as a foundation for attachment and development of children appeared to set the scene for confusion and mutual recrimination between both the professionals and the parents.

In the context of infancy and early childhood.

In the findings, there are often formulaic responses to the emotional needs of children, and there is significant resistance to understanding the meaning of their behaviour within an interpersonal and family context. To begin with the maternal and child health nurses there is ample evidence of this, in particular in relation to the early childhood period. The task of the maternal and child health nurses is further compromised by the conflict between having to provide a service that focuses on the health and well - being of families, versus working within the traditional health care paradigm that is predicated on the identification of pathology.

The findings obtained from the child - care workers present us with some of the most disturbing material regarding child - parent relationships, and the negative construction of children's behaviour by their parents. The findings from the child - care workers significantly centred on issues related to struggle for control and on the management of separation and transition for the children as well as for the parents. However, placing these findings within the context of parenting and family life in uncertain times makes it possible for us to understand these responses as being symptomatic of a broader level of incoherence at a societal level, a point that is explored further in the thesis.

In the context of the school years.

Findings from the interviews with the educational psychologists and school social worker reveal the extent to which children's problems become institutionalised within the school system. The reporting of the low tolerance of teaching staff to children's emotional and behavioural problems promotes a culture that favours the identification of a problem within the child and the disposal of the problem, without understanding its meaning. Additionally, there are indications that the teachers compete with the children for protection and support in an environment in which emotional understanding is relegated to the periphery of the system. The self - referential discourse of the school system leads in turn to what in organisational terms has been referred to as a "closed system" (Bridger, 1990) in which there is significant resistance to change.

This situation is exacerbated by the narrow circumscribed view of knowledge about how children learn, and what they need to know. It is encapsulated by the schism that operates in the education system between knowledge of the curriculum, and knowledge of the self, in terms of emotional, relational and family experience.

In the context of paediatric services.

The paediatricians have a foot in both camps: that is, of the universal and the specialist services, since they are consulted for a wide range of behavioural and emotional problems as well as specialist medical interventions. The paediatricians confirmed the child - blame discourse that permeated all of the professional interviews. Similarly to many of the other professional groups, they tended to place the blame on forces beyond their control, such as current affairs programmes and the media in general for influencing parents' wish for a medico - type diagnosis of their child. However, it was clear that these justifications obscured their own limitations as practitioners particularly with regard to the limitations of their training in matters of mental health. It also highlighted their reluctance to examine more critically a medical model approach to understanding family and social dynamics when dealing with child mental health issues.

Despite openly acknowledging the limitations of their training in mental health matters, this did not present as an impediment to practice for the paediatricians. In fact, they uncritically considered their home – spun, "common-sense" approaches as valid professional practice. By virtue of the power invested

in them through their medical status, paradoxically the paediatricians are required to know less about child and family mental health than non - medical professionals. One would have to conclude in this regard that knowledge about child and family development is not validated in its own right, but is marginalised as a superficial appendage to the medical clinical core of knowledge.

In the context of specialist child and family mental health services.

Findings from the specialist mental health service indicated an even greater tendency towards an organisational discourse that is self - referential. This may reflect the fact that these services are part of the large bureaucracies of the Departments of Health and Human Services. The professionals in these services reported that they have to deal with more complex child and family mental health problems. The findings from these interviews indicate that within these specialist services a variety of discursive defences operate in relation to the construction of child and family mental health problems. One way of understanding their defensive discourse is that at least in part it constitutes a response to, and a distraction from, their perceived blame for the increase in child and family mental health problems. A similar discourse concerning perceived blame for the poor outcomes achieved by child psychiatry was referred to at the outset of this thesis in the commentary on Rutter's (2002) paper.

11.4 *Discursive Practices Contributing to the Problem - Based Trajectory*

Psychiatrist as victim discourse.

Along similar lines as indicated earlier Harper (1995) reports how interviews with adult psychiatrists highlighted the contradiction between their assumed "liberal position" and their actual practice. In the case of the child psychiatrists, the suggestion is that they, not unlike the patients, are "victims" of the system. They would prefer to act differently if they would be able to do so. However, they are obliged to make bio - behavioural diagnoses of children, not only at the behest of the Departments of Health and Human Services, and their professional colleagues, but also at the behest of the broader community. Their overall assumption is that the broader community is inclined to disengage itself from addressing mental health issues. This makes one speculate that psychiatry can justify its culture of complaint by believing that responsibility for mental health care has in fact been "delegated" to them almost by default. If so, this state of affairs enables them to sustain the contradiction between appearing to act as "advocates" for mental health on the one hand, while on the other, resisting accountability with regard to the proliferation of medical type diagnoses.

The mother centred discourse.

A mother centred discourse predominated in all of the individual interviews as well as in the focus groups and was a unifying factor between the universal and specialist services. The mother centred discourse may reflect the fact that there were five males in the group of individual interviews and none in

the focus groups. The mother centred discourse encapsulated as an “immaculate conception view” of childhood that excludes the father, led to accounts of the parenting experiences as one that was viewed as being almost entirely synonymous with mothering.

The professionals employed a variety of rationalisations about why it would be difficult to include fathers. This, despite the fact that the professionals were in the majority of cases dealing with intact families, and the father was often central to the resolution of the problems presented. One may hypothesise that the exclusion of the fathers facilitates the possibility of the professional maintaining power, and the client (in most cases the mother), remaining in a dependent and child - like position.

The exclusion of the father may also reinforce a process referred to earlier as the parallel process, in which the professional and client and their complaints mirror each other. Thus, the female professionals appeared to be more comfortable with a one to one exchange with mothers, which tends to offer the potential for an identification with the mother, and a collusion against the father, who in some cases was perceived as part of the problem. The male professionals whilst complaining about a too intense identification between mothers and children paradoxically did not consider that this problem could be addressed by including fathers in their attempts to address the problem.

11.5 *The Denial of Knowledge about Child Development*

Findings from the research indicate that the surge of knowledge and understanding in the last thirty years about attachment, infant - parent relationships and the impact of the early years on neurological development, have not been translated into the everyday practice of professionals concerned with child and family mental health. Instead, the overarching impression is of knowledge used not in the service of understanding children and families, but rather to support particular vested interests. In many cases, the findings indicate that professionals are forced to deny their knowledge and observations of the child and family, in order to conform to, or provide a service that is "prescribed" by an organisational hierarchy at several removes from the client. In discursive terms, professionals could be said to have to "speak their organisations" rather than to advocate on behalf of the child.

The lack of a consistent core understanding of child and family development on the part of the professionals makes the construction of child and family mental health problems particularly susceptible to individual levels of experience, potential bias and confusion. This confusion was further demonstrated by an apparent lack of appreciation on the part of the professionals of the need for systematic training in child and family mental health and in child and family development that would in turn inform their practice.

11.6 *Contributions to the Pathology Bound Trajectory: Taking an Organisational and Systemic Perspective*

Professionals and the self - referential discourse.

The fragmentation that was characteristic of the reports from the professionals about their services may be further understood within the context of the self - referential and hierarchical nature of each of the professional disciplines and their organisational settings. These reflect a culture in which the requirements of the profession, the dynamics of the organisation, and the latest government directive, take precedence over the needs of children and families.

A characteristic of the self - referential discourse is the tendency for professionals to abnegate personal responsibility for decision taking, instead placing the responsibility on their employing authorities. In so doing for example, many of the professionals expressed frustration with the organisations in which they worked. They also conveyed dissatisfaction at having to respond to government directives about practice that often contradicted and undermined their own direct practice experience, and the needs of children and families. In relation to these expressions of frustration, the professionals presented themselves as being passive and helpless not able to effect any change, or to act as advocates of children. Instead, they reported that they resorted to covert ways of "subverting the system" which appeared to render them even more ineffectual. Telling examples of this were, withholding information from their superiors to

protect their clients, and re - arranging government sponsored programmes to fit their client group.

Resistance to change.

Taking an organisational and systemic perspective of the pathology bound trajectory engendered by the professionals leads us to explore more closely one of the over - arching findings in the research, namely the resistance to change on the part of the professionals. This resistance is examined first in relation to evidence concerning the cyclical nature of the conceptual frameworks that have informed the provision of child and family mental health services over the last half century. Secondly, the examination focuses on how professionals identify inertia in the system as an inevitability thereby justifying their lack of action on behalf of children and parents in the mental health context.

Cyclical trends in the construction of child and family mental health problems.

One of the themes of this thesis is that the cyclical trends that influence the way in which child mental health problems are constructed and described are as much connected with the social and environmental context as they are with the particular child. Thus, child and family psychiatric services also known as child guidance clinics have reflected these cyclical trends. For example, the introduction of psychodynamic approaches into child mental health services in the 1960's was a reaction against the medically bound definition of children's behaviour in the 1950's. The 1970's and 1980's saw the introduction of family

systems approaches and family therapy, while in the latter part of the 20th century and beginning of the 21st century we may perceive the pendulum swinging back to medical models and approaches some of which were introduced over half a century ago (Laslett, 1998).

Inertia and bio-behavioural diagnoses.

As the findings indicate, the systems within which many of the professionals work appear to be highly resistant to change. This is exemplified by the account given by the psychologist working in the Child and Adolescent Mental Health Service (CAMHS). As the psychologist commented, "it's interesting because as long as you stay in the system the system changes but it remains the same in a way" echoing the French phrase, plus ca change, plus c'est la meme chose. The concept of an unchanging system suggests that these systems are essentially characterised by a degree of inertia.

However, it is interesting to note some of the paradoxes that emerge in relation to the comments about an unchanging system. For example, the same psychologist referred to the fact that professionals in CAMHS were now able to treat children differently because of the availability of what was described as "new knowledge." However, given that this service like many others of its kind, refer almost exclusively to bio - behavioural interpretations of children's behaviour, what is construed as "new knowledge" may in reality be little more than recycled old knowledge. The *illusion* of change is created through responding in a cyclical fashion to the perceived wisdom of the day. It is further

interesting to note in this regard how the sense of inertia in the system and the complacency it appears to generate, contrasts with the high level of diagnostic activity in CAMHS related to diagnosing children in pathological terms thus firmly locating the problem as existing within the child.

11.7 *The Lack of Organisational Support for Professionals: The Impact on Children*

It is clear from the findings that all of the professionals perceived themselves as being under great stress in their work with children and families and within their organisations. This finding presents as a further example of the parallel process, in which the professionals mirror the experience of the families they work with. Arising out of their experience of stress and their wish to be solution focused, professionals put in place strategies that neutralise and rationalise these experiences.

However, it is equally clear, that these neutralising and rationalising strategies are not in the interests of children. This was particularly noticeable with regard to the confusion that can arise when concepts such as "attachment" and "resilience" are used interchangeably. The suggestion that the professionals in some cases have replaced training on understanding the attachment needs of children, with training on how children can be "made" resilient, is a potent example of this confusion. The confusion further underscores professionals' anxiety to hear "good news" about their difficult clients whilst denying the reality of the child's painful emotional experience.

The proliferation of bio - behavioural diagnoses of the child, referred to in all of the interviews, further appears to serve the function of simplifying the work of the professional by suggesting that they need only attend to one element, namely the problem that exists *within* the child. A focus on the problem within the child "protects" the professional from seeing and knowing; in particular, from seeing and knowing about disturbing events and knowing about the emotional experiences of the child within the family and social context.

Finally, the findings indicate that in the course of the parallel process, professionals inevitably bring their own child selves into the work setting. As Menzies - Lyth (1988) has pointed out the containment of anxiety in organisations is of particular importance where the professionals within these organisations are concerned with the direct care for vulnerable and dependent people, both children and adults.

All the professionals indicated that their work settings were poorly equipped to contain anxiety on any level, primarily because they deny its existence. There were scant opportunities for professionals to deal with tolerating uncertainty, or to have opportunities for appropriate mentoring and containment. The resulting blame discourses that emerge from this predicament create a situation in which as one member of the focus groups put it "the problem is passed down to the least line of resistance which is the child."

The following table summarises aspects of this organisational predicament in which the professionals from both the universal and the specialist

services find themselves. The table highlights how the professionals articulate their core position with regard to their avowed aims and objectives and the impact of the organisational work setting on their ability to carry out these aims and objectives. The table demonstrates how for the professionals, their individual professional stance is essentially intertwined with the organizational setting in which they practice. In each case the organizational setting is perceived as restrictive and limiting as opposed to supportive and encouraging of their skills. In this context we may perceive the emergence of an underlying theme that is returned to later in the thesis which is how the sense of powerlessness of the professionals undermines their capacity to act as advocates of the child. For example, all the professionals expressed a sense of powerlessness in relation to their employing organizations and it is interesting to note in this regard how little power of discretion they appeared to exercise in their respective roles. In fact perhaps as a result of having little opportunity for power of discretion their professional roles and organizational roles appeared to merge. In other words it appeared to be difficult for the professionals to articulate a set of values and ethical principles and practices specific to their own professions without reference to their employing organisations. This was particularly striking for example with regard to the professionals who described themselves as independent practitioners such as the maternal and child health nurses and the psychiatrists.

Table 1

Universal Services: Professional and Organisational Dilemmas

	Maternal and Child Health Nurses	Educational Psychologists	Child Care Workers
Professionals Articulate their Position	Nurses try to reconcile avowed aims of supporting mothers, infants and young children through normal life events, with a surveillance function of "uncovering" depression and childhood problems	Ed.Psych's attempt to deal with the emotional and relational issues of children, parents and staff within school, whilst experiencing these issues to be pushed to the margins of the school system	Child care workers try to reconcile their avowed aims of creating continuity for the child and a one to one relationship, with the high numbers of children in their care and scarce resources
The Organisational Dimension	Nurses describe sense of physical isolation in work settings coupled with sense of their powerlessness within their organisational setting	Ed.Psych's are the servant of two masters, employed by the school and Dept. of Education whilst responsible for mental health of children As a result, their capacity to exercise judgement and have appropriate authority is severely undermined	Child - care workers articulate a sense of powerlessness in the face of management, who are perceived as primarily concerned with cost cutting. Child care workers have little authority and are trapped between organisational limitations and parents' expectations and demands.

Table 2

Specialist Services: Professional and Organisational Dilemmas

	Paediatricians	Child Psychiatrists	Clinical Psychologists	Social Workers
Professionals Articulate their Position	Paediatricians attempt to resist pathology driven interpretations of children's behaviour in the family	Psychiatrists perceive themselves as dealing with most disturbed child and family population. This is used to justify exclusive adherence to bio-behavioural treatment. Psychiatrists articulate strong discourse of complaint	Clinical psychologists represent a split in the way they view child and family mental health problems depending on where they are employed. Some identify with psychiatry and justify exclusive use of bio - behavioural treatment, whilst others struggle to resist pathology driven description of children's behaviour	Social workers work with most disadvantaged families. Some articulate a discourse of despair and hopelessness about these families. Others find ways of being resourceful on behalf of their clients, whose voices often cannot be heard
The Organisational Dimension	Paediatricians have difficulty recognising the limitations of their medical knowledge in dealing with complex relational issues. Resistance to considering further training in child and family mental health	Psychiatrists' resistance to consider children's problems within social and environmental context. Resistance to power sharing. Resistance to recognising they are part of a change process	Psychologists who concur with the view of traditional child psychiatry are "rewarded" by being recognised as valued members of a team, whilst those who do not are driven out of the public system	Social workers articulate a sense of weakness and disadvantage in their work and organisational settings that echoes the weakness and vulnerability of their clients

The following chapter presents a detailed discussion of the findings in which the problematic intersection between professional and organisational elements is analysed in relation to the implications for the provision of mental health services to children parents and families.

Chapter 12: Discussion

12.1 *Overall Data Evaluation*

In the data obtained from the interviews there is clear evidence that parents and professionals alike are significantly limited, over determined or biased in their approach to matters of child and family mental health. Under the influence of particular attitudes, values or paradigms that dominate the professional, organisational as well as the overall culture we live and work in, the data from the interviews consistently demonstrates predominantly and often rigidly constructed reductionist perceptions and ways of approaching child and family mental health issues.

This reductionism comes to the fore in three domains dominated by three distinctive conceptual frameworks:

i. *The domain of the health care professionals* who espouse the bio-medical model, taking an approach characterised by perceiving the child's behaviour as having primarily a medical aetiology. Within the bio - medical domain and approach, the aim is to locate and identify the health care problem within the child. The bio - medical discourse is characterised or over determined by the application of methods that aim at reducing, solving and eradicating the identified problems within the child.

ii. *The domain of child education* characterised by the expectation and promotion of the child's individualised cognitive learning and

performance. In this domain, the discourse is primarily concerned with the child's individual achievement in the learning of a factual body of knowledge, as distinct if not severed from knowledge gained through learning from experience of the self and relationships.

iii. *The domain of child - care and parenting* in which the discourse is predominantly concerned with the perception of children's behaviour understood as intentional in a concrete literal sense; In particular in relation to challenging parental control and of the management of the child's behaviour in terms of promoting compliance.

Overlapping of the three domains.

In practice, these three domains overlap with each other and the (predominantly espoused) dominant conceptual frameworks that operate within them mutually reinforce each other. For example within psychiatry and the domain of mental health care, one will find attempts to re - educate both children and parents. Similarly, psychologists are influenced by the bio - behavioural paradigm, using this model to identify and locate a mental health problem within the child, as well as using a child/parent behaviour management approach.

12.2 *Reductionism and the Utilitarian Ethos*

The primacy of reductionism in the construction of child and family mental health is a significant part of the findings in this research. This goes hand in hand with a highly functionalist and utilitarian ethos that pervades the approach to child and family mental health issues. There is ample evidence of

this ethos reflected in the data, where the emphasis is primarily on the delivery of results and outcomes in parent - professional encounters as well as in the establishment of a utilitarian professional work culture and environment. This utilitarian approach is further predicated on underlying assumptions about time and space limitations that are presented in the data as justifications for practices that aim at the control and manipulation of children's behaviour.

In the data, the language used to express and make effective this ethos, is that of reducing the complexity of child and family mental health issues in terms of over simplifications; for example through the use of labelling and suggestions or expectations of an easy or "quick fix" problem solving approach. These over simplifications tend to be more acceptable in that they reduce uncertainty and offer a more controllable way of dealing with child and family mental health problems.

12.3 *The Professional Dilemma of the Counter Current*

When taking a closer look at the data gathered from the interviews, one can discern indications of a counter current to the predominantly reductionist approach. This is clearly illustrated in interactions between parents and professionals, when the latter attempt to correct parents' attitudes with regard to expected compliance and management of the children's behaviour. However, the data reveal how difficult it is for the professionals to step outside the constraints of the prevailing paradigm. They find themselves in a dilemma since the way in which the parents convey to them their perceptions and expectations of the

professionals' tasks, objectives, treatment strategies and outcomes confirms and reinforces the dominant reductionist approach. One of the most telling examples of this in the data is that of parents being "amazed" at how the paediatrician demonstrates that it is perfectly possible to directly and openly communicate with a child.

12.4 *Utilitarian Pragmatic Approaches to Service Delivery*

The data indicate two further complicating factors for professionals who attempt to challenge the predominant reductionist paradigm. The first resides in the nature of the organisational settings for which they work which favour utilitarian pragmatic approaches to service delivery, with a focus on outputs, throughputs and results. Scant attention is paid to the emotional meaning of children and parents' experience. Equally scant attention is paid to the emotional capacity of the professionals to contain these experiences. This is reflected throughout the data in the numerous complaints of professionals of the lack of opportunity of debriefing as well as their perception of a lack of support from management and a lack of vision in the area of leadership.

Narrowing down the scope of acceptable knowledge.

The second significant contributory factor that challenges professionals who attempt to step outside of the prevailing reductionist paradigm, is that it is made clear in the data that any other view is deemed not to be real knowledge and is irrelevant to the understanding of child and family mental health. In their practice, professionals are expected to conform to the dominant paradigm,

narrowing down the scope of acceptable knowledge to an exclusive frame of practice. As a result, key areas of knowledge that are irrefutably relevant to child and family mental health become excluded. That is, knowledge related to infancy and early childhood and the impact on the development of the brain; knowledge related to emotional and social milestones in the development of the life cycle; knowledge related to the understanding of family systems and knowledge related to parent support and empowerment.

Silencing the child.

Finally, the data indicate that the child in the majority of cases is silenced despite the fact that in the counter current, attempts are made by some professionals to effect change through allowing children to give voice and to articulate their experience. The silencing of the child in effect constitutes another level of the elimination of an important category of knowledge, namely the knowledge of the child. Through being silenced, and talked about, the child ceases to be an active agent and is relegated to the position of category that is designated as the problem.

12.5 *Assumptions, Attitudes and Interventions of Professionals: Maintaining the Prevailing Reductionist Approach*

From the data it becomes clear that underpinning their attitudes, actions and interventions as professionals in child and family mental health, there are a variety of assumptions made about children, parents and families, as well as with regard to their own professional task and work environment. Both the

assumptions and attitudes or actions taken by the professionals, contribute to the maintenance of the prevalent reductionist approach and paradigm. The data indicate that these underlying assumptions can be explicit or implicit. Some of these assumptions are clearly based on individual subjective perceptions, others on opinions or misperceptions adhered to in the group, organisation or system in which they operate.

In the data gathered from the interviews one can clearly identify the following underlying assumptions. These may be made at the individual, the group or the organisational level.

12.6 *Assumptions Made At the Level of Individual Practice*

i) The "deficit/fix the deficit" assumption in relation to the behaviour, personality and capacity of the child

ii) The exhortation to "be good" versus the lack of evidence that the child had done anything wrong

iii) The absent voice of the child's assumption – taking for granted that the child has nothing to say, nor knows anything

iv) Assumption about the overall pressure of time – that being busy means that complex matters cannot be addressed

v) Assumption about exhorting children and parents with "have to" and "should" imperatives

vi) Assumptions by the professionals about being a buffer between children and parents

vii) Parents' implicit assumption that there is no intrinsic value in their own ideas or experience of their children and parenting

viii) Parents' explicit assumption that the value lies in what the expert or public opinion has to say about parenting

ix) Assumption or assertion that medication is not harmful to children.

12.7 *Assumptions Made At the Group and Organisational Level*

i) Assumption by professionals about the lack of time and space within the work setting

ii) Assumption by professionals about the lack of peer support and discussion

iii) Assumption by professionals about their weakness and vulnerability in relation to the power of their employers and organisations

iv) Assumption by professionals of having little capacity to influence their working environments

v) Assumption by professionals of being at the margin of their organisations

12.8 *Assumptions and Modus Operandi in Child and Family Mental Health Practices*

These assumptions made at the individual as well as the group and organisational level of professional practices in child and family mental health, form the basis for an exclusive set of operational criteria that apply and operate at the individual, group and organisational level of these practices and that

determine the reductionist approach of their modus operandi. The reductionist modus operandi narrows the scope of adequately conceptualising children's mental health care, and reduces the professionals' mode of operation. Within the organisational setting of their practices, this reductionist mode of operation goes hand in hand with the reduction of their authority and discretionary powers and flows on to reducing their capacity for advocacy on behalf of the child.

The objectification of the child.

Espousing the above defined reductionist view of child and family mental health problems, splits off, sidelines or even obliterates the emotional and other experience of children, parents and professionals that do not fit the dominant line of approach. Behaviour as having a meaning and being a communication on the part of the child is given no value.

The child is perceived as being in a sense the objectified "product" of the parents, and as such is required to produce objective "products" in the form of learning at the pre-school and school level. The child is also expected to produce acceptable social behaviour and compliance within the family and broader school and community environment. Both parents and professionals relate to children predominantly in terms of asserting time and space limitations that similarly are used to further justify this perspective of objectification.

Children as rivals for scarce resources.

The objectification of the child sets the scene for the denial of acknowledging the intrinsic value and identity of childhood. This undermines the generational differential and hierarchy between parents and children, traditionally based on the assumption of parental responsibility for the child. It is also dependent on a proper understanding about appropriate time- frames for children's development into adulthood. The data reveal an inter - generational blurring of boundaries in which children and parents are forced to compete with each other for the same scarce resources.

Along similar lines, the data indicate that in some cases there are rivalries between children and professionals for the attention of other professionals. The scarce resource notion is expressed in the interviews at multiple levels of interaction in particular by the craving of children, parents and professionals alike for meaningful relational experience over time in which their concerns can be validated and understood.

12.9 *The Group, the System and the Organisational Environment: Vacuum of Direction and Organisational Culture*

In the data obtained from the interviews, the professionals involved in child and family mental health convey the overall perception of seeing themselves as working within monolithic organisational structures that are impervious to outside influence and thereby impervious to change. Their

reductionist mode of operation is reinforced by an organisational culture in which there is a vacuum of directorship: no head in the sense of a "presence of mind" or the capacity for thought that would provide clear direction. In reality, it is difficult in any of the professional groupings to identify who is actually in charge.

Leadership and accountability are unclear and are pushed outwards. Authority is not invested in individual professionals or groups of professionals but rather in distant groupings such as "the government" in the way in which a business might refer to its shareholders. As a result child and family mental health professionals appear to operate in a vacuum with regard to organisational culture that fosters *ad hoc* and reactive individual professional interventions since the decision making process resides nowhere.

Group and organisational structure and the self - referential discourse.

What emerges from the interviews is that the child and family mental health professionals operate within organisational structures that only present "as if" versions of a cohesive vision for child and family mental health services. They are in receipt of a constant stream of written directives about different aspects of child and family mental health, which has the tantalising effect of holding out a hope that can never actually be fulfilled.

Analysis of the findings reveals that the most obvious reason for this "as if" mode of operation is that the directives have an essentially self - referential function. The self -referential nature of the organisations within which the

professionals work, promotes self - protective and self - generating systems that ensure the maintenance of their own bureaucracy, rather than the pursuit of the primary task, that is, what is in the best interests of children and families. This comes very much to the fore in the myriad of internal contradictions reported in the interviews, illustrating systems of operation in which different groups within the same department can produce diametrically opposed directives. Moreover, in the individual interviews, there are many examples of internal contradictions and inconsistencies when different members of the same team report diametrically opposing views of their task.

The self - referential system leads to a defensive method of coping that results in an inability on the part of the organisation to engage with the demands and challenges of the outside world (Hirschorn, 1988). However, Gareth Morgan in his comprehensive (1986) analysis of the functioning of groups and organisations suggests a deeper understanding of the self - referential system in relation to the work of biologists Maturana and Varela (1980). Maturana and Varela argue that all living systems are characterised by the features of "autonomy, circularity and self – reference." They use the term *autopoiesis* to refer to the process whereby systems reproduce themselves and their own identity through a closed system of relations. Change inherently therefore becomes subordinated to the maintenance of the organisation and its own assumed set of relations and circular pattern of interaction that have implications for the broader ecological system. Morgan extrapolates from this position to

assert that we may be able to use the theory of *autopoiesis* as a metaphor for understanding organisations. In particular, he draws attention to the fact that "organisations enact their environments" (Morgan, 1986 p. 3). As such, it becomes essential if the members of an organisation wish to better understand their environments that they begin by better understanding themselves. In other words, many of the problems that organisations (or professions) encounter with the wider world emerge from not recognising that they are an intrinsic part of that world or broader environment. In the findings for example this was particularly striking in the communications of the psychiatrists who talked at length about effecting change in their service without appearing to acknowledge that they were themselves part of the change process.

"*Programmes" as a substitute for services.*

The tendency towards fragmentation within the various organisational settings as described in the findings is exemplified by the way in which the child mental health services themselves are fragmented. For example, it is clear that change when it occurs in the larger organisational structures, comes about through top - down hierarchical decision - making. The latter is characterised in current times by the decisions taken by government departments to turn child and family mental health "services" into individual "programmes", generally for cost cutting purposes. These individual "programmes" often sourced from countries outside of Australia are grafted onto the prevailing organisational structure. The snappy euphemistic titles of the majority of these programmes belie the

longstanding inter-generational deprivation of the client group who are the apparent beneficiaries of these programmes. Typically, the programmes are carried out within a limited and unrealistic time – frame and are invariably discarded when they do not yield the hoped for results within the specified time - frame. However, by this time the organisation has usually found another "programme" to put in its place.

12.10 *The Uses of Power and the Child Professional Victim Discourse*

What is reported in the findings in terms of low morale on the part of professionals indicates a lack of self - agency and authority. Along similar lines, the professionals present themselves and the children as the helpless victims of the uncaring, unresponsive broader organisational environment in which they work, and indeed the community to which they belong.

In this context, the findings from the interviews produce a secondary discourse in relation to the professionals' identification with the child. This discursive identification with the child may well function as a justification to abnegate leadership, responsibility and to resist change. If so, this identification would put the children at risk precisely when they are most in need of appropriate action, authoritative guidance and advocacy on the part of the professionals.

Paradoxically, the findings reveal that it is the professionals with the highest level of qualification and actual positions of power, who perceive themselves as the most weak and vulnerable. They often express themselves in a

use of language that is over determined by their collusion or identification with the child as victim. In terms of their work environment, they actively identify the "enemy outside of" the organisation while avoiding a commitment to professional responsibility. The latter would include a commitment to power sharing with other disciplines that would lead to a broader and more appropriate conceptualising of child and family mental health problems.

12.11 *Conclusions Raising Further Questions*

In conclusion, the findings from the research raise a number of questions concerning both professionals' construction of child and family mental health problems as well as the apparently chronic nature of these problems. Whilst the resistance to change on the part of children and families is presented as one of the main problems, it is the resistance to change on the part of professionals in their understanding of child and family mental health problems that comes particularly to the fore. This resistance articulated as it is through the *child professional victim discourse* and the *leader as victim discourse* may be understood as a justification for resistance as well as conversely conveying the wish to maintain power.

In addition, the *leader as victim discourse* may be perceived as a vehicle to undermine innovative initiatives both from within the same discipline (for example the medical discipline) as well as other disciplines in mental health.

In so doing, it would appear that this attitude effectively serves to ward off any challenges to the maintenance of the status quo and the predominance of

the prevalent reductionist bio - behavioural paradigm in the construction of child and family mental health problems.

In Section Six the findings from the research are discussed within the broader context of a socio - cultural critique. This critique takes as its starting point that professionals' construction of child and family mental health problems, reflect a broader societal view of the construction of childhood itself. The critical discussion leads to a conclusive reflection concerning the depleted construction of childhood and parenthood. Within the broader social context it is argued that the voices of child and parent equally are silenced through the marginalising of knowledge that creates meaning. The depleted construction of childhood and parenthood and professionals' responses is further analysed in relation to different levels of fragmentation that exist at the level of system and structure and at the level of process and function.

SECTION 6: CRITICAL REFLECTIONS

Chapter 13: The Depleted Construction of Childhood and Parenthood

13.1 *Children and Ambiguity*

The thrust of this thesis is that the predominance and exclusive application of the bio - behavioural paradigm in services concerned with child and family mental health does not adequately serve the needs of children and their parents. Furthermore, the findings from both the individual interviews as well as from the focus groups indicate an emergence of attitudes and perceptions that lead to a depleted perspective in relation to the status of childhood and of parenthood. These attitudes and perceptions implicate the undermining of the rights of the child and challenge the irreducible experience of what it means to be a child. They also highlight how professional's construction and description of child and family mental health come to parallel the contemporary construction of childhood and parenthood within society at large.

The findings from the research lead one to the conclusion that attitudes to children reflected as they are in the way in which professionals construct their mental health problems are threaded through with ambiguity (Lee, 2001). The failure to acknowledge the nature of this ambiguity in our attitude towards children, results in the inability to reconcile children's need for dependence and protection whilst simultaneously giving them a voice. This dependence independence dialectic lies at the heart of how we may approach children's needs particularly their mental health needs. The resolution of this ambiguity involves

acknowledging the relational capacities of children as well as validating and attributing meaning to their behaviour. The failure to do so and the absence of the voice of the child in many of the interviews described in the research lead instead to an alienated discourse *about* a child. This alienated discourse fails to make the imaginative leap required to connect the real experiences of children with the demands of the adult world (Hanvey, 2005).

A critical reflection is presented in what follows that explores at the macro level those social and organisational issues that give rise to expressions of concern regarding a depleted perspective of childhood and parenthood in current times and that silence the voice of the child. These social and organisational issues also give rise to the concerns raised at the start of the thesis regarding the current crisis in child and family mental health (Polakow, 1992; Stanley, Richardson and Prior, 2005; Timimi, 2002; Zornado, 2001). This critical reflection will be presented first in terms of identifying different levels of fragmentation that contribute to both the depleted perspective of childhood and parenthood as well as the problems inherent in child and family mental health. Thus the critical reflection attempts to throw light on what lies behind Maton's (2000) "objectifying methodologies (and) status quo - oriented paradigms" that have come to dominate child and family mental health and to explore how they are perpetuated within the system.

Secondly, this critical reflection more specifically includes examining the aetiology of the problem pathology based construction of child and family

mental health. A link is made between this problem based construction and the marginalising of knowledge related to the search for meaning and interpretation of behaviour in child and family mental health. It is argued that the marginalising of knowledge that creates meaning, has led to various levels of fragmentation concerning our understanding of the child and family and thereby to the fragmentation of those services ostensibly established to assist them. The various levels of fragmentation are further explored in relation to contemporary sociological commentary concerning social and political change and transformation related to family life.

13.2. *Creating a Culture of Disconnection that Leads to the Fragmentation of Child and Family Mental Health*

Looking through the distorting mirror.

The construction of child and family mental health problems through the pathologising of the child, and through the institutionalisation of a blame discourse, lead to descriptions that tell us more about the professionals, than about the child and family. It is argued that the construction of child and family mental health problems in pathology - based terms, creates a culture of disconnection that is characterised by the positioning of opposites. Thus, where there should be cooperation there is polarisation; where there should be integration there is splitting.

These processes of splitting and polarisation are demonstrated within the discourse of the professionals who, having assumed their “buffer” positions,

perceive themselves as “good”, the parents as “bad” and the children as “victims.” Within the culture of disconnection, we may further identify the assumptions that underlie each of these positions contributing in turn to the “cultures” of childhood, parenthood and professional - hood. As discussed earlier the blame discourse that characterises so much of the professionals’ responses contributes to the denial of the contradiction inherent in many of their responses; in particular in espousing a privately held compassionate view whilst operating in a conservative manner in their actual practice (Harper, 1995).

13.3. *Analysing the Different Levels of Fragmentation that Contribute to the Breakdown in Child and Family Mental Health; A Socio - Cultural Critique*

The findings from the research enable us to look through the lens of narratives and discursive practices to consider what is meant by child and family mental health and child and family wellness (Prilleltensky & Nelson, 2000; Prilleltensky, Nelson & Peirson, 2001). Additionally the findings enable us to explore who can talk about what it means to be well and who can talk about appropriate behaviour in childhood and indeed about appropriate parenting (Burman et al., 1996). This perspective opens up multiple levels of meaning in which our views of childhood and family life are perceived as constructed according to influential societal structures and values that dictate what is normative and authoritative.

The socio - cultural critique that follows takes as its starting point the recognition that contemporary views of what constitutes child and family mental

health and wellness are beset by problems of fragmentation on a number of different levels. These levels of fragmentation operate at the level of structure as well as function; at the level of the systemic and societal, as well as at the level of the processes that give shape to these structures. The fragmentation that occurs at the structural and systemic level is summarised below and discussed in more detail in what follows:

Fragmentation at the level of the system and the structure.

i) Fragmentation at the societal level or macro system; collective conceptions of wellness and illness and the implications for the contemporary construction of childhood.

ii) Fragmentation at the level of the micro system; professional confusions, collusions and entanglements that permeate the construction of child and family mental health.

iii) Fragmentation at the level of the everyday lived - experience for children and their parents.

Fragmentation at the level of process and function.

The fragmenting processes that give rise to and that characterise these structures or systems may be summarised as follows:

i) Epistemological fragmentation – The fragmentation of knowledge, both propositional and experiential concerning child and family mental health.

ii) Emotional fragmentation - Alienation of the emotional meaning of experience for the child in particular by denying its validity and responding to behaviour outside of a family and social context.

iii) Role Fragmentation – For families - The implications of the breakdown of hierarchy between childhood and adulthood

For professionals - the implications in the work place of a split between management and leadership leading to the emergence of "managerialism" in the form of emphasising concrete goals and outcomes over the primary task of the organisation, namely promoting child and family mental health

iv) Institutional Fragmentation – the impact of economic and social uncertainty and social change. Rivalry between parents and children for scarce resources.

These areas of both structural and systemic fragmentation and the processes that give rise to them are represented in Table 3:

Table 3: *Interconnected Levels of Fragmentation*

	Epistemological Fragmentation	**Emotional Fragmentation**	**Role Fragmentation**	**Institutional Fragmentation**
Level One: The Macro System – Influences on Children and Families	Denying connections between meaning, power and knowledge. The predominance of knowledge related to bio - behavioural paradigms and a mechanistic world-view Marginalising of knowledge related to attribution of meaning in parent - child relationships, theories of attachment, understanding of family systems.	Childhood not considered a useful status in its own right. Confusion about dependence/ independence. Blurring of boundaries between parents and children. Ambivalence in advocating for children – safety and sexuality.	Breakdown of hierarchy between childhood and adulthood. The commodification of childhood. Absence of men from the parenting discourse.	Social and economic uncertainty. Economic Rationalist Discourse – emphasis on "product" and "outcome." Contradiction in stated aim of protecting children from exploitation and simultaneously exposing them, as in "User Pays" mentality towards children – lack of community responsibility. Media presentations of childhood collude with fragmented view.
Level Two: The Professional System	Denial of knowledge of stage specific and emotion specific experience of childhood. Evidence based discourse used to justify the re-framing of children's behaviour within bio-behavioural paradigm. Mother centric discourse renders father's knowledge superfluous. Denial of parents' own knowledge creates dependency on professionals.	Professionals' collude in de-contextualising children's problems outside of family system and social environment. Split off behavioural discourse – emphasis on problem "within the child."Mother - centric focus excludes contribution of fathers. Uncritical acceptance of the "evidence" in evidence based practice.	Confusion between management and leadership in organizations leads to split between the task and skills required to carry out task. Predominance of top down hierarchical structures. Imposition of programmes "from above" denies skills on the ground. Lack of collegiate environment and appropriate supports and de-briefing.	Economic uncertainty creates rivalries between professionals. Self referential discourse and Resistance to change. Services become reactive not proactive. Denial of appropriate time-frame for services to develop.

Level Three: The Parent/ Child Experience	Denial of parents' knowledge and child's knowledge. Parents cannot own what they know. Children have nothing to teach parents. "Dumbing down" of parents' innate understanding in face of "superior knowledge" of professionals. Fathers' knowledge deemed irrelevant to the parenting process.	Denial of appropriate time- frame for development. Denial of validity and meaning of child's experience – perceived as a "noise in the system." Parents' "ignorance" of themselves and their children leads to depleted emotional exchange. Undermining of parents' authority follows from undermining their knowledge. Leads to search for instrumental strategy focused solutions split off from the parent child relationship.	Role confusion – undermining of authority – who is the parent and who is the child. Disempowerment of parents. Parenting as an increasingly "professionalised task." Loss of locus of control for parents.	Children targeted as independent consumers – commodification of childhood. Rivalry for scarce resources between parents and children. Both compete for understanding from professionals who tend to respond with interventions geared to eliminating the presenting problem of the child. Lack of acknowledgement of changing family life. Increasing isolation of parents.

The widespread tendency towards fragmentation in the various areas summarised in the table indicate the intertwined and interdependent nature of these processes and suggests that a greater understanding of these processes can best be achieved by considering them within the broader context of interaction, influence and counter influence. The critique that follows attempts an analysis of several of the concerns raised by these many layered levels of fragmentation, that relate not only to the mental health issues of children and families but also to contemporary considerations of childhood and of parenting in society at large. The analysis takes as its starting point the marginalisation of knowledge that creates meaning with regard to child and family mental health. It goes on to

explore the various levels of fragmentation associated with the professional knowledge system and practice; the fragmentation of knowledge concerning parenting; fragmentation within the organisational setting, and finally the implications for fragmentation in the wider societal context particularly with regard to neutralising a value base.

13.4 *The Marginalising of Knowledge That Creates Meaning*

The findings from the research confirm the tendency for the bio - behavioural paradigm to be perceived as the dominant discourse with regard to child and family mental health. It is argued that this has led to the exclusion and marginalisation of other discourses as well as to the marginalisation of research and clinical evidence that does not fit strictly within the bio - behavioural paradigm.

Rose (1996) refers to "regimes of truth" with reference to the way in which particular arguments, evidence, theories and beliefs are thrust to the margins, not allowed to enter "the true." Truth according to Rose does not depend solely on the way in which events and experiences are constructed, but emerge through a contest. For Rose (1996), "truth is always enthroned by acts of violence" (p. 6) in which the argument, the evidence, the results and the status of the protagonists are utilised as resources. As a result, particular ways of acting and thinking about a problem become enshrined as the solutions to presenting problems, whilst other truths and perceptions about the problem are silenced.

Within the domain of child and family mental health it appears that ways of knowing that are informed by an interest in the search for meaning have become marginalised and silenced within current professional practice and discourse. The marginalising of knowledge that creates meaning leads to the marginalising and fragmenting of knowledge about the child's individual psychology; the child's relationship with parents and the family and the ability of children and parents to draw on their own inherent knowledge.

The marginalising of knowledge concerning meaning in child mental health.

An integrated psychodynamic approach as proposed in my own work (Schmidt Neven, 1994, 1996) provides an interpretive framework that presents an alternative to a reductionist model of mental health that presents different levels of experience as mutually exclusive. The psychodynamic approach based as it is on an assumption of *continuity of process and meaning* highlights the interactive nature of experience at the level of the individual, the interpersonal, the systemic, the social and the organisational. In other words, it highlights how the complexity of human experience resides in the need to be able to operate within and negotiate these varied and different fields simultaneously. Central to this integrative perspective is the recognition that all behaviour has meaning and is a communication that runs like a leitmotif through the different levels of experience from the individual through to the organisational. From a

psychodynamic perspective therefore, the individual experience can influence the organisational and vice versa.

In the course of the 20th century and beginning of the 21st century a number of influential inquiries representing a psychodynamic approach have taken place concerning the meaning we attribute to child and family functioning. These inquiries may be summarised as the psychoanalytic inquiry, the family systems inquiry and the inquiry concerning a theory of attachment that incorporates research on infant/parent relationships and its impact on brain development. Whilst these inquiries continue to operate as some level within current child and family mental health practice, their overall influence on the construction of child and family mental health appears to be both limited and transient.

The psychoanalytic inquiry.

Orbach (1998), writing from the perspective of a feminist therapist and social commentator, states that psychoanalytic ideas have had an influence not only on therapeutic practice but also on social policy and as an adjunct to academic studies such as cultural, gender and media studies. In particular, she identifies the recognition of unconscious processes that lie at the heart of the psychoanalytic enterprise that enable us to address covert as well as overt communication. By so doing we not only create meaning but also touch on that which may be subversive in the meaning attached to the construction of our emotional experience.

Orbach's (1998) reference to the psychoanalytic task of hearing and bearing witness to communications that may typically be kept secret for fear of censure, resonates with Burman's 1996 ideas about identifying the "gaps in the discourse" as well as with an understanding of the way in which power influences relationships.

For Orbach (1998) the value of the psychoanalytic inquiry lies in its broad content of study. This encompasses knowledge of child and family development and adult interpersonal relationships. The psychoanalytic inquiry also contributes to our understanding of the underlying processes or dynamics present in groups and organisational life that can hinder or promote growth for the individual as well as for the organisation.

The contribution of child psychotherapy.

Related to the psychoanalytic inquiry, the field of child psychotherapy has spawned an extensive literature on understanding the meaning of children's behaviour, much of it marginalised or silenced within the current discourse concerning the bio - behavioural aetiology of children's behaviour. In particular, child psychotherapists have made a significant contribution to the application of psychodynamic ideas, clinical and research evidence outside of the clinical setting in a number of different areas. A brief list only includes: work with severely deprived children (Szur & Miller, 1991; Trowell & Bower, 1995); mental and physical disability (Sinason, 1992); autistic and deprived children (Alvarez, 1992; Tustin, 1981); sleep problems in children (Daws, 1989); child

development (Pozzi, 2003; Schmidt Neven, 1996; Waddell, 1999); infant parent psychotherapy, (Acquarone, 2004); and childhood trauma (Lanyado, 2004).

The inquiry concerning the family system.

The tendency for contemporary child and family mental health approaches to identify a problem "within" the child is a far cry from the work of family therapists that emerged amidst high hopes in the latter half of the last century (Ackerman, 1966; Minuchin, 1974; Satir, 1967; Skynner & Cleese, 1989). One of the basic tenets of systems theory is that it is not possible to create change in one aspect of a system without this affecting change in another part of the system (Bateson, 1973; Watzlawick et al., 1967) thus conceptualising family systems as organisations of interdependent parts. Silencing knowledge of the working of the family system silences our knowledge of the interrelationship of individuals within the system and the complex meanings ascribed to these relationships.

The evidence from the interviews with the professionals indicates that family therapy and systemic approaches did not appear to play a significant part in their everyday practice. Neither did these approaches appear to present a significant point of reference for their understanding of child and family mental health problems. In fact the interviews point not only to the marginalising of family and systemic approaches but also to increasing opportunities within the bio - behavioural discourse for the marginalizing and actual scapegoating of the child.

The identification of the process of scapegoating is a central tenet of family therapy and a systemic approach. It is particularly ironic therefore that many current diagnostic descriptions in child and family mental health favour references to the problem existing almost solely within the child, often to the exclusion of the meaning of the child's problem within the family system. As Leupnitz (1988) explains, the process of scapegoating enables the family to store what may be perceived as bad or split - off feelings in one particular member of the family. This enables the rest of the family to maintain a sense of goodness and to carry on as though nothing had happened at least on a superficial level.

The inquiry concerning the connecting thread of attachment.

Whilst as Rolfe (2004) explains, the meaning making elements that underpin attachment theory place relationships at the centre of the infant parent experience, this understanding rarely featured in the interviews with the maternal and child health nurses who are ostensibly concerned with infant -.parent relationships. As Rolfe explains "attachment theory alerts us to the very important role that all caregivers - parents and others have in contributing to a child's emotional health" (Rolfe, 2004, p. 9).

The concept of the *internal working model* (Bowlby, 1973a, 1973b, 1973c) is central to the theory of attachment. It is also central to the capacity to ascribe meaning to experience and events, as opposed to responding to "presenting problems" such as infant sleeping and feeding out of context, which inevitably places them within a problematic as opposed to a relational discourse.

It is through the *internal working model* that the infant and young child forms an internal representation of the relationship with the caregiver, which is itself subject to change over time.

From this perspective, attachment does not constitute a "stage" of development to be outgrown, but rather a developmental process that endures throughout the life span and undergoes transformation. Bowlby's long time association with psychologist Mary Ainsworth resulted in the beginnings of the empirical research that laid the foundations for the development of a typology of attachment (Ainsworth et al., 1978) by identifying patters of attachment from secure to avoidant.

As Goldberg (2000) has pointed out, research and practice in the field of attachment has been important in assessing the quality of early attachment relationships between infants and their parents, as well as for predicting later features of social and emotional development. Rolfe (2004) states that continuing research in the field of attachment moves our understanding of child development into "exciting new territory" (p. 7) and has spawned a considerable literature in the field.

The making of meaning and the unity of brain and mind.

The splitting and fragmentation of meaning making elements in child and family mental health, comes particularly to the fore in ways of thinking that institute a separation between our understanding of the function of the brain, from our understanding of the development of the mind. It is this split between

"brain' and 'mind" almost more than any other area that has come to epitomise the split between the bio - behavioural discourse and a mechanistic view of the child's behaviour, versus a view that acknowledges that cognitive and other behaviours arise out of complex relational meaning making processes.

Of particular significance in this regard are the findings of infant - parent mental health researchers (Sameroff & Emde, 1989) that emphasise how the shared meaning between infants and their caregivers relies on a partnership based on attunement and attention. There is further evidence (McCain & Mustard, 1999) that these capacities for emotional reciprocity are elicited at prime times in the early developmental period. Infant - parent clinicians and researchers conclude that it is the attunement and attention of caregivers that contributes to the child's capacity for self regulation, the absence of which appears to underlie so many of the problems described by the professionals in this research (Brazelton & Cramer, 1990; Leach, 2004; Murray & Trevarthen, 1986; Perry et al., 1995; Schore, 1994; Streeck-Fischer & van der Kolk, 2000). Thus as Shore (1997) states, the early infant and young child/parent relationship not only creates a context for brain development but also "directly affects the way the brain is wired" (Shore, p. 18).

Siegel (2001), in an attempt to bridge the divide between the brain "versus" the mind, states that the essence of the function of the mind (which he sees as patterns of the flow of energy and information) is a product of neurophysiology as well as interpersonal interaction. This Siegel believes leads

to an exciting convergence of findings in creating links between neuroscience and behavioural science in particular our understanding of child development. In this regard Schmidt Neven et al. (2002) attempted an integrated neuropsychological and psychodynamic approach to the understanding of Attention Deficit Disorder and Attention Hyperactivity Disorder and refer to the need to "move beyond linear thinking of symptom and syndrome allowing us to look for patterns of interrelationship within a broader context" (p. 11).

Sugarman (2004) in his review of the work of Schmidt Neven et al. (2002) considers that a preoccupation with linear thinking leads us to the "linear epistemological trap" that surrounds many bio - behavioural diagnoses of the child. Sugarman states that the problem is that linear thinking relies on a "single causative agent" and asks the question what makes this child ill, rather than asking the question, "Why has this child produced these symptoms at this stage of her/her life?" Sugarman describes the application of medical and other linear models to children's behaviour as producing "punctuation points" in a complex system that are similar to the description obtained from a cross sectional slice, a description that can only give us a limited perspective of the child's problem.

The fragmentation of knowledge concerning the task of parenting.

"There is no such thing as a baby" said Donald Winnicott (1965b), paediatrician and psychoanalyst in a provocative attempt to assert the interactive and contextual nature of human development. From the way in which the professionals describe the parents describing their children's problems, we may

conclude as do the professionals that parents present as having little knowledge about their parenting task or the reasons for their children's behaviour. However, by exploring the gap in this particular discourse we may speculate that it is parents' intrinsic knowledge of their children that has become devalued and denied. The research findings reveal that in most cases the professionals are not concerned with increasing parents' capacity to "own what they know" (Schmidt Neven, 1994) about their children, but rather to override their intrinsic knowledge with the introduction of formulaic and instrumental responses that are rarely grounded in a relational and family context. In addition, the professionals take a highly circumscribed view of parenting which in most cases is perceived as synonymous with mothering and which excludes the father. The high prevalence of excluding the father in both the individual interviews and the focus groups leads to the view that it is professionals who decide how the parenting group and family is constituted, a position that has implications in turn for asserting professional power and control.

Parenting advice and the new authoritarianism.

As Leach (2004) points out, much of the "knowledge" that is favoured in contemporary parenting advice advocates a discourse that is based on the idea of the parents, particularly the mother, as managers who are encouraged to find ways of controlling the behaviour of the child. Leach cites the increasing use of the technique of "controlled crying " as an example of this management discourse despite the fact that infant - parent clinicians have issued position

statements (AIMH, Australia 2002; AIMH UK, 2004) describing its use as inappropriate, outmoded and not in the best interests of the child.

Appropriating the feminist discourse.

The discourse concerning mothers in control, whether it takes the form of controlled crying or formulaic strategies in caring for children may be viewed as subtly reinforcing a politically correct feminist perspective in which the "peace of mind" of the mother as woman is paramount. This perspective is further subsumed within what Manne (2005) describes as the "cult" of competence in contemporary times, whether this refers to the need for the mother to be resilient and independent or whether it refers to the child's need to be competent and resilient particularly in less than satisfactory child - care settings. Research by Renda and Hughes (2004) at the Australian Institute of Family Studies reflects this preoccupation with mothers' sense of control as separate from their interaction with their children and partners. The authors found a close relationship between mothers' well-being and their having a sense of control particularly in the area of choice of work. They concluded that policies that enhance the capacity of mothers to engage in work that they consider appropriate and rewarding will in itself contribute to their enhanced health and well being as well as that of their families. This despite the fact that the findings were confounded by the revelation that mothers, with what was called "low work orientation" who worked part time, actually expressed the highest levels of control.

13.5 *Professional Fragmentation: Confusions, Collusions and Entanglements*

The findings of the research that identify aspects of the professionals' confusion with regard to their task in dealing with child and family mental health problems has its parallel in Billington's 1996 critique of psychological practices. Although writing from the perspective of an educational psychologist, his analysis is nevertheless relevant to other professionals concerned with child and family mental health in terms of identifying what he calls "discourses of regulation" that permeate the various services. Billington perceives psychology in general as having become co - opted into servicing the needs and requirements of government and of producing what are in effect socially constructed analyses of what is normal and what is deemed to be pathological.

Billington connects this regulatory function with the regulation of access to the labour market. In particular, he identifies the marginalising of knowledge concerned with understanding the child (as in the marginalising of psychodynamic approaches) with the current emphasis on the pre-eminence of market forces. The demands generated by changing economic and social conditions and the eroding of the traditional family support system contribute as Billington points out, to the breakdown in the hierarchy between childhood and adulthood, leading to the commodification of childhood in which children can be directly targeted by the market place.

The intrusion of the market place into the ways in which professionals construct the mental health problems of children takes the form of favouring

"cost effective" reductionist forms of knowledge that "reduces all interaction to simplistic cause and effect" (Billington, 1996, p. 50). Medicalised and bio - behavioural definitions of children's behaviour thus enable practitioners to operate in ways that deny the child's essential identity and create a justification for the reluctance to engage directly with the child. Billington's (1996) observation that in the school system there is a demand for a "solution" from the psychologist as opposed to finding a way to engage directly with the child similarly resonates with the findings from the interviews with the educational psychologists in this research, as well as with some of the other professional groupings.

13.6 *The Impact of Organisational Fragmentation*

As the findings from the research indicate, the importance of group and organisational functioning permeates all aspects of how professionals construct and describe the mental health problems of children parents and families. The findings also support the view of the continuity of process and meaning referred to earlier in which individual experience influences organisational experience and vice versa. For example, many of the professionals described their frustration at working within settings in which their views and skills were not sufficiently validated, or taken into account, or in some cases entirely disregarded. As was described in the findings, some professionals adopted subversive methods as a means not only of "beating the system" but also of surviving within it.

Krantz and Gilmore (1990) present a compelling analysis of this type of organisational fragmentation from the perspective of understanding the nature of social defence mechanisms. Krantz and Gilmore argue that at a time when contemporary organisations of every type are undergoing unprecedented change and operate in conditions of increasing complexity, various defensive and dysfunctional actions or behaviours come into play in order to deal with these uncertainties. They identify the splitting of leadership and management as one of the key dysfunctional and defensive manoeuvres employed by organisations.

Krantz and Gilmore (1990) demonstrate how the split between sound leadership and management leads to a situation that effectively undermines the possibility of either of these functions being carried out satisfactorily. An outcome of this split is the emergence of a technocratic "managerialism" or ideology that is separate from the original aims, purposes and values of the organisation. This technocratic managerialism is typified by the elevation of tasks such as "goal setting, supervision and performance appraisal" that become set in concrete as objectives in themselves, overriding the wider objectives and philosophy of the organisation. This further promotes a fragmented work culture that inhibits the possibility of innovation and of recognising the need to adapt to new and challenging circumstances, a state of affairs that is characteristic of most professional work settings in this research.

Thus for example the organisation, by pinning all of its hopes on the imaginary powers of management systems, methods or texts displays a *Basic*

Assumption Dependency way of functioning (Bion, 1961) in which the individual members perceive themselves as essentially weak and ineffectual. The Basic Assumption of dependency may at least temporarily serve to divert the members of an organisation from the challenges as well as the responsibilities of their task.

This was demonstrated in the interviews whereby the professionals through their own beliefs, or through management directives, came to pin their hopes on the imaginary powers of management systems, texts or methods. For example, in the interviews with the professionals concerned with the delivery of parent programmes the fact that these are generally imported from overseas or "elsewhere" suggest that someone else has devised a "magic" answer or cure.

Adherence to the power of text and management systems was demonstrated particularly in the interviews with the professionals working in the Child and Family Mental Health Service. Here, various managerial directives such as the directive that each child must have a diagnosis appeared to act as a conceptual "punctuation point" that served to justify the identification of a problem within the child outside of a family and relational context. Additionally, the very act of creating the diagnosis appeared to serve the function of binding the professionals together in an apparent common purpose whilst simultaneously absolving them from the responsibility of thinking more deeply about the meaning of the child's problem.

13.7 *The Neutralising of a Value Base in Organisational Functioning*

Krantz and Gilmore's (1990) critique of "managerialism" in the organisational context identifies the process whereby a highly circumscribed discourse becomes predicated primarily on the notions of control and authority by one designated group. The split between managerialism and the overall mission or objective of the organisation leads to what they describe as the neutralising of potential conflict concerning the values that individual members of the organisation bring to the work. This may throw light on the recurring theme in the research findings, of the gap between professionals' espoused values and views, and their actual practice.

The neutralising of a value base in organisational functioning particularly with regard to psychological practice is discussed by Prilleltensky (1997) who states that, "values, assumptions and practices are closely connected" (p. 519). However he points out that they are often not sufficiently or clearly enough articulated within the organisational context, or become edited out altogether through the espousal of what he calls "the strict division between facts and values" (p. 527). The resistance to acknowledging a value base in clinical psychological practice may reflect the underlying view that this would act as a contaminant to a "scientific" attitude.

A key finding in the research is that of the professionals' expressed sense of powerlessness in relation to management. This resonates particularly with Prilleltensky's (1997) concern with the problem of inequity in power

relationships and its potential to undermine “the advancement of values such as self determination, collaboration and democratic participation.” Clearly, as discussed earlier the sense of powerlessness of the professionals has a direct influence on the services they are able to provide in the context of child and family mental health.

In the following chapter, a number of related issues will be discussed that have a particular impact on the way in which childhood is constructed in current times. These pose the problem of the redefinition of childhood and parenthood in the light of contemporary sociological commentary concerning the impact of social and political change and the transformation of family life.

Chapter 14: About Children: Towards a Redefinition of Childhood

At the outset of Section Five the point was made that professionals' construction and description of child and family mental health has come to parallel the contemporary construction of childhood and parenthood in society at large. In addition, as was discussed earlier, historically, childhood has been perceived as a malleable concept defined by the socio - economic and cultural conditions of the times. We may therefore question how childhood and family life is perceived in the 21st century and whether we may be in the process of redefining the meaning of childhood and childhood experience.

14.1 *Children and a "Runaway World"*

Commentary from the field of sociology concerning social and political change and transformations related to family life, takes the view that self, self - identity and society have become transformed in what is referred to as the late modern age of the 20th century and the period of transition to the 21st century (Beck, 1992; Giddens, 1991, 1994, 1999). Giddens (1999) in particular, in his series of Reith lectures for the BBC aptly entitled "Runaway World", addresses some of these key issues of transformation and change with regard to family life. He highlights four key changes that have taken place with regard to the way in which family life is constructed in contemporary Western society. These are firstly the "detraditionalisation" of male and female roles, secondly the lack of economic benefit of having children; thirdly the waning of male power and patriarchal domination through asserting the legal rights of children, and finally

the assertion of the sexual rights of women. For Giddens "there is no route back to the traditional family."

Giddens's (1992, 1994) analysis of the transformation of intimacy, love and sexuality in contemporary relationships has implications for the way in which we construct family life and parent child relationships; in particular his identification of the high priority placed in current times on personal satisfaction in marriage and relationships. Giddens describes this position as "confluent love" in which adult relationships are sustained only to the extent that they fulfil the needs of the respective partners. Giddens acknowledges the challenge faced by individuals in contemporary times of having to be responsible for "a project of the self" in which they are challenged to create a sense of identity for themselves through the integration of past- history thereby creating what he describes as an individual biography or narrative of the self.

We may consider the particular challenges faced by children and indeed their parents in having to construct an identity for themselves within this changing and highly volatile emotional environment. Achieving a sense of continuity may also be difficult in an environment in which many of the traditional supports for families and family life are dissolving. Thus while in past times a sense of continuity and stability may have been provided by traditional (albeit oppressive) family structures, in Giddens' (1992, 1994, 1999) terms, a sense of continuity now has to be provided by the individuals themselves.

The demands of this task lead to what Giddens (1999) describes as "the key pathology of late modern culture", that is, the inability for many people to create a sense of identity and meaning for themselves. It may therefore be understandable that parents as well as professionals may turn to formulaic solutions and strategies split from emotional meaning in order to be able to maintain a sense of control and purpose. There is the further challenge for both parents and professionals of having to operate in a fluid environment in which "what is acceptable/appropriate/recommended behaviour today may be seen differently tomorrow in the light of altered circumstances or incoming knowledge claims" (Giddens, 1991, pp. 133-134).

Attention to the need for the individual in contemporary times to reappraise and renegotiate their position in the context of changing circumstances, resonates with similar views concerning the speed of change within the organisational context. Organisational theorists such as Bridger (1978), Morgan (1986), and Trist and Murray (1990) have commented consistently over the last thirty years on the challenges and stresses that emerge from accelerating technological, social and economic change. They have referred in particular to the changing dimensions in social living that force individuals to continually re - appraise their relationships with the various groups, organisations and communities of which they are a part.

In this regard earlier sociologists such as Berger and Luckmann (1966) have also commented on the challenges faced by individuals with respect to the

loss of unity of space and time in the context of increasing technological change. This problem may be of particular relevance for example when we consider the harassed responses of the parents in the child – care centre.

14.2 *Finding a Way to the Child*

Giddens's sociological analysis tells us about the broad canvas of social change but it does not tell us a great deal about the impact on the developing child. A new branch of sociology, the sociology of childhood, attempts to fill this gap by exploring children's life experience within the context of these changing social and political perspectives. In particular, the sociology of childhood is concerned with ensuring that children have a more active voice and a higher level of participation in decision making about events that concern their everyday lives (Brown, 2002; Morrow, 2002).

The sociology of childhood challenges fundamental assumptions concerning the traditional segregation of child and adult worlds and the idea of the construction of childhood as the "human becoming" versus the adult as the "human being" (Lee, 2001). These constructions according to Lee are based on the underlying assumption that the complete adult is deemed to be independent whilst the incomplete child is deemed to be dependent.

Lee (2001) describes these assumptions as giving rise to a "dominant framework" that is concerned with the maintenance of personal and social order. Within this context, it is those children who react against the social order, who find themselves in the position of carrying the full burden of society's

ambivalence. In this respect, “adult authorities have tended to see the children themselves as the location of the problem…” (Lee, 2001, p. 70). These observations resonate with the findings of the research that the bio - behavioural paradigm represents a potent example of the conviction that problems can legitimately be located within the child without recourse to understanding the contribution of the family and wider social setting.

14.3 *Addressing the Ambiguity of Childhood*

Lee (2001) and other sociologists of childhood (e.g. Prout, 2005) argue that at a time of economic and social uncertainty the boundary between childhood and adulthood, “being” and “ becoming” is blurred since adulthood itself has now entered into a state of instability and transition with regard to employment opportunities and changed gender and family relationships. In response to this state of affairs, Lee (2001) for example suggests that the burden of “childhood ambiguity” be distributed more equitably between children and adults.

Lee’s (2001) argument and those of other sociologists of childhood present a refreshing perspective on the need to value and validate the experience of the child and of childhood. However, its weakness lies in what appears to be a lack of resolution concerning the considerations of ambiguity associated with childhood. As Lee explains, the status of childhood involves both dependence and independence. This paradox as stated earlier goes to the heart of the problem since in their dependent state children do require to be protected.

In opposition to the "dominant framework" Lee (2001) states that what is required is a more "even handed approach to adults and children." However, in considering the needs of children and in particular their mental health needs, an even - handed approach may be precisely what is not in the best interests of children. The research findings for example indicate that the blurring of the child/adult boundaries prevents us from articulating the needs of children as entirely differently from those of adults. Proposals for "self determination" for children without first considering their protection, may thus lead us down the path of replicating the rhetoric of resilience described earlier in the thesis, in which the full implications of children's dependence is denied.

Thus, we would literally be throwing out the baby with the bathwater if we dismissed knowledge and understanding about child development and attachment, for example, as vestiges of the "dominant framework." It may therefore be more pertinent to reframe the question to ask how we can reconcile the requirement to give children protection with the requirement to give children a voice, to validate their experience and to learn from them.

14.4 *Hearing the Voice of the Child*

Reconciling the child's needs for both dependence and independence cannot be achieved outside of a developmental context. In other words how we construct childhood needs to be considered from the inside out (psychology) and from the outside in (sociology) in a manner that can be integrated rather than representing opposing disciplinary silos (Sanson, 2002).

Finding a way to the child in the sense of giving children a voice in these matters continues to be difficult to achieve. For example in Lee's 2001 work, the voice of the child whether as human "being" or "becoming" is strangely absent. Hanvey (2005), the director of British children's charity Barnados, refers to the social studies of childhood as "a new industry" and notes that it is difficult to relate this new industry to the real lives of children. As he puts it "the one common experience we all share (that of having been children) somehow becomes the one from which we are often most divorced" (p. 37).

Chapter fifteen will summarise the contribution of the thesis to critical and community psychology whilst chapter sixteen will present a number of recommendations with regard to the promotion of child and family mental health. These recommendations will attempt to address the challenge posed by having to meet the needs of children in terms of their development and their appropriate dependence, in a manner that avoids repressive categorisation and foreclosure concerning the meaning of their behaviour. These recommendations will also include ways in which we may begin to hear the voice of the child by considering the creation of a "constituency of childhood" in which children can be consulted about, and enabled to give voice to their own experience.

Chapter 15: Conclusions and Contributions of the Thesis

15.1 *Contribution of the Thesis to Critical and Community Psychology, and to the Literature*

This thesis informed by a conceptual and theoretical framework that is part of critical and community psychology, contributes to scholarship in terms of a critical understanding of the complexities involved in the promotion of child and family mental health and child and family wellness. The critical reflections on the findings from the research, enrich and amplify this inquiry with particular reference to the following areas:

i) It provides a critical analysis of the limitations of the current professional discourse concerning child and family mental health

ii) It identifies the link between the perpetuation of psycho-social problems in children and families, and that of the self-referential discourses and activities within the professions and organisations set up ostensibly to assist with these problems

iii) It challenges the uncritical acceptance of what is deemed to be objective knowledge that gives rise to practices of medicalisation and pathologising of children's behaviours. It also challenges the marginalising of those areas of knowledge concerned with the development of relationships and the creation of meaning in relation to child and family mental health

iv) It demonstrates how the importance of advocacy for the child is intrinsically linked to an integrated approach to child and family health. In this the core emphasis is on the centrality of relationships, shared meaning and hearing the voice of the child within a child developmental context.

v) It identifies the gaps in the predominant discourse and relates it to the poor progress made in child mental health. It highlights the exclusion of parents and children from participating actively in the discourse concerning the meaning of mental health as well as from acting as partners together with professionals in the shared enterprise of promoting child and family wellness.

A Critical Analysis of the Limitations of the Current Professional Discourse

The thesis applies a critical analysis of the dominant discourse concerning child and family mental health. In this it takes its lead from contributions to applied discourse analysis made by Burman (1996), Parker (1999) and Willig (1999) with regard to the legitimising of professional practices and interventions in health and welfare. More specifically, it demonstrates how particular discursive frames of reference and practices make the "order of words" become "the order of things" (Good & Kleinman, 1985, p. 492). Hence, it is argued that as a result, instrumentality in child and family practice undermines the capacity for an authentic engagement between the professional and the child and family.

In this thesis, it is also argued, how the world of meaning and experience is a significant variable in professionals' construction of child and family mental health problems. In this regard, the thesis confirms the critical observations made by Good and Kleinman (1985) as well as by Timimi (2002), on how categorising professional psychiatry and psychology reflect foundational assumptions made within contemporary Western culture. Within the framework of categorising psychology, the predominant idea of the child is that of an isolated subject whose behaviour is stripped of its contextual, social and cultural meaning in order to arrive at descriptions that can be slotted into psycho-physiological or cognitive categories.

The Self-Referential Discourse and the Perpetuation of Psycho-social Problems

The findings from the research throw light on how professionals' construction of child and family mental health problems is essentially related to their perceptions and experiences of the organisations in which they carry out their work, and of the way in which they represent their professions. The findings confirm the need for professionals themselves to have containment and support in their organisational settings. Effectiveness of organisations, according to Menzies Lyth (1987, 1989) depends on attending to this need.

The findings indicate how attending to the primary task of responding to the mental health needs of children and families, is compromised by existing power structures, vested professional interests and self- perpetuating policies and

practices that give rise to a sense of organisational inertia. Others in the literature concerned with the dynamics of organisational processes, Hirschhorn (1988) Morgan (1986) and Krantz and Gilmore (1990) have argued how this counter productive compromise relates to the impact of the self-referential discourse in organisational life and culture.

In other words, the inertia and sense of powerlessness in the professional groups parallels that of the inertia and powerlessness in the child and family system. Thus, the service users and the service providers, mutually contribute to, and reinforce, the perpetuation of the psychosocial problems of children and families.

The Critique of the Prevailing Professional Epistemology

The research inquiry of this thesis, follows a post-modern epistemology that takes into account insights with regard to the relationship between power, knowledge, meaning and values (Parker,1999; Prilleltensky, 2005). The thesis provides a critique of how assumptions concerning knowledge with regard to child and family mental health rather than being based on observation and understanding of the needs of the child, adhere to prevailing power structures and the predominantly bio-medical paradigm. In this regard, the thesis critically examines current practices informed by knowledge concerned with a biological and instrumental description of children's behaviour.

In addition, the thesis makes further contributions to our understanding of the implications of the malleable nature of constructs of childhood, and how

these reflect contemporary social and cultural preoccupations. As Zornado (2001) points out, the child becomes used as a site of cultural and ideological production and reproduction.

Promoting an Integrated Approach to Child and Family Mental Health

The study contributes to scholarship in the field of child and family mental health by highlighting the fragmentation in professional approaches to child and family mental health problems, essentially because these are informed by conceptual frameworks that in practice operate in a mutually exclusive and incompatible manner.

The critical reflection on the findings from the research inquiry, points to the need for an integrated approach to child and family mental health problems. This acknowledges a sense of continuity from the inner world of the child, through to family relationships, and connections with community and culture. An integrative approach further emphasises the importance of process in the sense of perceiving behaviour not as rigid and fixed, but as dynamic and constantly changing.

Attending to continuity and process implicates an emotional and systemic ecology of childhood that promotes health and growth rather than emphasising pathology (Polakow, 1992; Sarason, 1981; Winnicott 1965b). Along similar lines the thesis argues that there is an urgent need for an integrative approach to child and family mental health, as confirmed by Billington, (1996), Maton (2000), Sanson, (2002), and Stanley et.al. (2005). Similarly to what is concluded in the

thesis, these authors also assert how professional rigidity and outmoded practices that do not have the child as their central concern, contribute directly to the trajectory of children's mental health problems.

The thesis makes particular recommendations with regard to the need for changing professional practices towards encompassing an inclusive understanding of the child that integrates the individual, the family, the community and organisational perspectives. This integrative approach implies that in the field of child and family mental health practices, professionals need to be able to hold in mind and operate simultaneously in these different dimensions. What this integrative approach also requires is the need for a more robust and open dialogue and cooperation between the different professional groups that are concerned with these different aspects of child and family mental health and wellness.

Questioning the Exclusion of Children and Parents from the Discourse, Debate and Practice of Child and Family Mental Health

The thesis contributes to knowledge in the area of community psychology by presenting a fundamental re-positioning of the discourse and practices concerning child and family mental health. The research inquiry responds to the question posed by Rutter (2002) at the start of the thesis that asks why society has been so spectacularly successful in making things psychologically worse for children and young people. Findings from this research inquiry indicate that what has gone so badly wrong is the exclusion of parents and children from both the

prevailing discourses and practices concerned with child and family mental health. Therefore, in order to be legitimate (Timimi, 2002) the construction of child and family mental health has to be inclusive of parents, children and young people. They should be included when it comes to identifying and addressing the core issues in mental health and well- being.

In conclusion, this new vision of child and family mental health posits change in the use of knowledge as well as in the relationship between parents, children and professionals (Fajerman, Jarrett & Sutton, 2000; Matthews, 2003). This implies acknowledging that children and parents themselves are in possession of important knowledge and need to be encouraged to "own what they know" (Schmidt Neven 1994). For professionals however, the "specialised knowledge" they possess in particular with regard to development, has to become "common knowledge" available to all (Miller & Sambell, 2003;Schmidt Neven, 1994). The new vision for child and family mental health further advocates changes to the relationship between parents and professionals that is based on a partnership in which the resources of both groups are harnessed in the service of addressing not only mental ill health, but also child and family wellness.

15.2 *The Resistance to Change*

Findings from the research point to particular areas of the child and family mental health constellation that can most benefit from change and that may in turn have a positive impact not only on the way in which we construct

mental health problems but also on how we attempt to resolve these problems. In line with the critical approach taken in this thesis is the recognition that any agenda for change turns on the recognition of two fundamental propositions. The first is that change challenges established hierarchies, orthodoxies and vested interests. Secondly, that our construction of child and family mental health problems must be predicated on, and not considered as discrete from the construction of child and family wellness (Prilleltensky, et al.,2001).

In considering the first proposition, we need to acknowledge the resistance to change inherent in many professional groups and organisations. These are embedded in established attitudes and beliefs, specifically defined role relationships, and ways of "managing" the anxiety of caring for children and their families through a variety of diversionary tactics (Bion, 1961; Colman & Geller, 1985; Hinshelwood & Skogstad, 2000; Hirschorn, 1988; Hornby, 1993; Huffington & Brunning, 1994; Morgan, 1986: Obholzer & Roberts, 1994).

In addition, as the findings from the research demonstrate, organisations concerned with child and family mental health are underpinned by assumptions of authority and the privileging of particular areas of knowledge as well as by discourses that are associated with the maintenance of power often by one group (Burman et al., 1996).

The recommendations that follow in the next chapter are therefore formulated in relation to interpreting Burman's (1996) ideas concerning "resistance" to established positions of power and control, as having a double

meaning that also takes into account an acknowledgement of the "resistance" to change.

The recommendations also refer to the need to incorporate what has been described as the "new knowledge" concerning child development, relationships, attachment and the brain. Anne Manne (2005), writing about the needs of children and their mothers from the perspective of a critical feminist, takes the view that an acknowledgement of this "new knowledge" regarding infant parent attachment and the development of the brain, implies taking up a radical political position. As Manne states, such a radical position "reveals the deeply layered interplay between social and economic factors and their translation into inter - generational cycles of deprivation, abuse and neglect" (Manne, 2005. p. 136).

Manne's (2005) conclusions that, "this new knowledge contains a moral imperative" goes to the heart of these recommendations. As Manne states, "we must use it (the new knowledge) to do something genuinely creative, and form social policies that will start children's hopeful life trajectory. It must include all children, all parents and all caregivers" (p.136).

The recommendations that follow therefore acknowledge that change in one area such as organisational change have a flow on effect to changes in the way interpersonal relationships are constructed. Thus, the personal *becomes* the organisational and the organisational *becomes* the personal.

Chapter 16: Recommendations and New Perspectives

The recommendations summarised below and represented in Table 4 are described in greater detail later in this chapter. These recommendations are intended to give explicit direction to solving the problems identified in the thesis.

16.1 *Summary of Recommendations*

i) That we assume a value - based approach to the way in which we construct child and family wellness and child and family mental health problems.

ii) That we place the child at the centre of our concerns through invoking a Children's Rights agenda to ensure that services and policy reflect what is in the best interests of the child.

iii) That we create a shift from the monopoly and limitations of an "individual illness" model to a pluralistic, multi - disciplinary and systemic model that places the child within a family, social and community context.

iv) That we reframe our vision of parenthood and parenting in terms of promoting parents' own knowledge and skill, and assisting them to find their own "voice" within this process.

v) That we create a constituency for children and childhood in which children are encouraged to participate in decision making concerning their welfare and the provision of services in a manner that protects their interests and is non - exploitative.

vi) That we reframe the usage of the environments in which children spend much of their time such as schools, thereby expanding their potential. Since schools and health care centres "belong" to the community they are in a good position to offer child and family services of a more universal nature that are as much focused on preventing mental health problems as dealing with them.

Table 4: *Recommendations and Outcomes*

No.	Recommendation	Primary Outcome
i.	Favouring an ethical and values - based approach to the construction of child and family mental health problems and the promotion of family wellness.	Goes beyond "blame- discourse". Challenges domination of "scientistic philosophies" (Prilleltensky, 1997). Articulates an explicit "dialogue about values and obligations" on the part of professionals, particularly psychologists (Prilleltensky, 1997). Promotes a "social responsibility model" (Prilleltensky et al., 2001). Promotes universal health and well being policies and advocates for partnerships between public and private sectors (Prilleltensky et al., 2001).
ii.	Acting in the best interest of the child through invoking a Children's Rights agenda via The UN Convention on the Rights of the Child (1989).	UN Convention on Rights of the Child places responsibility on nation signatories to submit regular progress reports in respect of implementation of mental health services (Payne, 2003). Shifts locus of control away from diagnostic and pathological interpretations of children's behaviour. Identifies long term damaging effects of medication for behavioural problems on children (Breggin, 1997, 1998; Mackey & Kopras, 2001). Challenges the creation of "pathological identities" for children contributing to social exclusion (Billington, 1996; Sorensen, 2005).

iii.	Acting in the best interests the child by recognising that all children's behaviour has meaning and is developmentally – based.	Perceives children as agents of change in their own right. Attributes validity to children's communications. Perceives children as individuals within families and communities (Philpot, 2004, on the UK Children's National Services Framework).
iv.	Creating a Constituency of Childhood.	Enhances children's self esteem and capacity for independent learning through shared and inclusive consultation (Fajerman, Jarrett & Sutton, 2000) Establishes a typology of community action to assist children's involvement in decision making in networks and communities (Matthews, 2003).
v.	Using professionals differently: Shifting the medical model monopoly.	Moves from a uni - disciplinary individual health based model to multi - disciplinary pluralistic and systemic approach to the child within a family and social context. Acknowledges limitations of medical training for mental health concerns (Australian Division of General Practice, 1993; O'Hanlon et al., 2004). Introduces wider range of professionals such as psychologists, child psychotherapists, family therapists and parent support workers into mainstream primary health services such as general medical practices, schools and maternal and child health centres making these more family oriented.
vi.	Reframing Our Vision of Parenthood	Helps parents to " find their own voice" and to "own what they know" (Schmidt Neven, 1994). Creates partnerships between parents and professionals that makes "specialised knowledge common knowledge" (Schmidt Neven, 1994). Promotes parent support based on facilitating parents' inherent skills and understanding not a 'parenting syllabus'or 'right answers' (Miller & Sambell, 2003). Encourages local community based parenting initiatives away from government dominated parent programs

vii.	Reframing the uses of physical spaces in the service of child and family wellness and a versatile environment.	Re - assesses the function of spaces such as schools, health centres and medical practices to promote a broader vision of child and family wellness. Explores a "life and learning" curriculum in schools to incorporate parents as well as children to overcome disadvantage and social isolation. Invites a broader range of professionals into schools and health centres, to normalise health and wellness services for both families and professionals.

16.2 *Detailed Recommendations: Towards New Directions and Perspectives*

In what follows, the key recommendations contained in Table 4 are described in more detail. These key recommendations take as their starting point the need to act in the best interests of the child at the level of everyday professional practice whether in specialist mental health settings, in schools, early childhood settings or in general health settings. The recommendations include suggestions for the way in which schools can approach learning in a way that promotes a broader vision of child and family wellness. Recommendations are also made concerning the creation of a constituency of childhood and how children can be assisted to be actively involved in decision making in networks and communities that promote a vision of children as change agents in their own right. Finally recommendations are made concerning the promotion of health and well-being at the broader societal level through favouring an ethical and values-based approach and Children's Rights agenda that challenges the predominance of medical and pathological interpretations of children's behaviour.

16.3 Acting in the Best Interests of the Child: Emphasising Health Growth and Development Rather Than Pathology

The research findings indicate that many professionals and institutions pay lip service to acting in the best interest of the child and that the reality often contradicts the rhetoric. The nature of entrenched thinking concerning the pathologising of children's behaviour certainly limits the capacity to act in children's best interests. It is clear that the increasing focus on pathologically-driven constructions of children's behaviour has not contributed to an amelioration of child and family mental health problems (Rutter, 2002) which is why we should be sceptical about attempts to widen the scope of these pathological constructs further even when they come under the guise of what is described as "developmental psychopathology" (Fonagy, 2005), which appears to represent a contradiction in terms.

Similarly it has been pointed out within the field of psychotherapy (Meltzer, 1989) that our past attention to a focus on understanding psychotic processes in adults may have contributed to our knowledge of how the mind can go utterly wrong in its functioning but appears to have contributed little or nothing to how it can go right. Meltzer uses this analogy to make the point that a sole emphasis on pathology can draw us into a conceptual *cul de sac* and that a focus on development rather than psychopathology must become the driver for change in how professionals construct child and family mental health.

Implicit in taking a developmental stance is the recognition that children's behaviour has meaning in the fullest sense and is a communication. Attributing meaning and validity to children's communication enables them in turn to be perceived as agents of change in their own right. This recognition places children's behaviour within a family context and contributes to a growth and development model, rather than a pathology driven model. For example as Philpot (2004) explains in referring to the new Children's National Service Framework in the UK, supporting child mental health is "about seeing children as individuals within families and communities."

Working at the level of everyday clinical practice: changing the focus of the assessment process.

The research findings highlight a failing in the various services at the point of entry for children and their parents in relation to how their request for help is processed and responded to. This failure at the point of entry to the service may be articulated as a failure of the initial assessment process. The initial assessment process where it exists appears to function as a kind of "waiting room" in which the professional goes in search of various externally constructed labels to be attached to children and families, most of which are narrow, circumscribed and pathological in nature. This encapsulates the core dilemma that is at the heart of this thesis that important findings concerning how children develop and flourish through attachment relationships, and the impact this has on cognitive and social function has still not been translated into

professional practice at the day to day level. Clearly, both training and in some cases retraining of professionals in these areas is an essential prerequisite for change.

A starting point to assist professionals in whatever setting they work would be to encourage them to look, listen and understand before rushing into action. Additionally, professionals need support from their agencies to help them develop a capacity for observation and to trust their own clinical judgment. Rather than seeing themselves under pressure to "provide the answer" professionals may more fruitfully begin by asking a different question of themselves and the people they are trying to help. This first essential question would relate to the empowerment of parents as well as to power sharing in the process of finding a solution for the problem.

Acting as advocates for the child.

A secondary problem in the assessment process that emerges in everyday practice and that was touched on in the research is the confusion that arises when professionals act as though a multi-disciplinary approach is synonymous with offering children and families a variety of different interpretations and solutions to their problem presented as though they are mutually exclusive. This serves to create greater confusion and fragmentation both for the family and the professionals. This confusion is often compounded by the lack of clarity concerning whose needs should predominate, the parent or the child, with professionals feeling torn between the two. A clear way through the confusion

is to recognize that acting in the best interests of the child must always inform all action on the part of professionals. Far from creating a split between parents and child, acting in the best interests of the child ultimately serves to integrate action and responsibility. Professionals in this regard set the scene by needing to be clear about their position as advocates for the child and to be explicit about this position with the parents. This creates a value bound context for all subsequent discussion and helps to engage parents more honestly and openly.

Asserting core principles in child and family assessment.

As a corollary to the position of being advocates for the child, two core principles come into play that need to inform the assessment process whatever the professional setting. The first of these core principles is that professionals must attribute validity to children's communications and recognize above all that children are reliable "witnesses" to their own experience. The second core principle is that all children's behaviour has meaning and is developmentally based, in the sense that their behaviour needs to be interpreted according to their age and stage. These two core principles are perceived as providing a clinical scaffold for all subsequent clinical decision making and action. The need for a clinical scaffold based on an understanding of the meaning of behaviour within a developmental and family context is critical at a time when much of what passes for diagnostic assessment in child and family mental health in fact already constitutes the "treatment." A typical example of how "diagnosis" and "treatment" become conflated is that of prescribing medication for a behaviour

that is not fully explored in terms of its meaning or developmental family context.

It is important to note that adherence to the two core principles described above does not commit professionals in practice to only one mode of therapy such as psychodynamically oriented therapy. In fact, many different forms of therapy may be considered appropriate to the needs of the child and family. Rather it recognizes that any recommendation for treatment, including medically oriented treatments, need to be justified in terms of these core underlying principles. One of the main outcomes therefore of initiating these core principles is that they provide a much needed unifying element to these many different forms of clinical practice.

Training for professionals.

Changes in clinical practice concerning the implementation of these core principles presupposes a level of understanding and skill that as the research findings indicate are fairly patchy at present. Thus an important element of this recommendation is the need for professionals to have training as well as ongoing support that will facilitate better practice in this regard. My own experience of running training programmes for professionals within Australia who work in a wide range of settings with children and families indicates that such training enables them to feel sufficiently supported to make changes to their everyday practice. However it is essential if these changes are to be implemented more widely across the board that they are also implemented from the point at which

professionals commence their training such as within schools of medicine, social work, psychology, teaching and nursing.

Empowering professionals.

From the professional perspective it is clear from the research that many professionals concerned with children and families are sceptical of an exclusively focused bio-behavioural approach. However they express considerable reluctance to be open about their misgivings within their own professional agencies and even within their own professional associations. By encouraging professionals to share their views across disciplines and organizations as well as by taking an advocacy approach this may assist professionals to develop a critical attitude as well as encourage them to speak out more publicly about their concerns.

16.4 *Using Professionals Differently: Creating a Shift from the Medical Model Monopoly*

The complexities and changing nature of child and family mental health problems in current times indicate that conventional uni-disciplinary individual health based models can no longer be considered the only means of response. Models of help in child and family health care therefore need to become multi-disciplinary, pluralistic, and take a systemic approach to the child within the family and social context.

Nevertheless the persistence of the uni-disciplinary health model in everyday child and family mental health practice is testament to the entrenched

nature of professional hierarchies and vested interests. Thus the first port of call for virtually all mental health concerns continues to be the medical practitioner, nurse or maternal and child health nurse. From the outset therefore, the construction of the problem is influenced by the medical model frame of reference. An important consideration is that the monopoly exercised by these health practitioners is not in many cases consonant with their training or experience in the field. For maternal and child health nurses there is acknowledgement of the shortcomings in their continuing professional training in the mental health field (Keating and Barrow, 2006). Maternal and child health nurses tend to follow governmental "guidelines" on mental health, often relying on screening tools in the form of questionnaires rather than on the development of their clinical skills.

As the research findings indicate, for medical practitioners experience in child and family mental health is largely assumed as an "add on" to their earlier trainings. The research findings further indicate that the paediatricians do not hold the mental health skills of General Medical Practitioners in high regard, whilst they refer to their own training as limited and present their skills as being often of an ad hoc nature. These factors are of concern when it would appear that a large number of referrals to general medical practitioners for example reflect mental health issues. In Australia, for the period 2000 to 20001 nearly 11 million visits to General Medical Practitioners were for "mental health conditions" (Australian Division of General Practice, 2003).

In fact General Medical Practitioners may be the first to acknowledge the inadequacy of their training and experience in the area of mental health as reported in a scoping study (O'Hanlon, Wells and Parham, 2004) concerned with the GP's response to prevention and early intervention for mental health. The study although mainly concerned with adult mental health care, has implications for the way in which consultations take place with parents as well as with families and has parallels with this research. One of the findings of the scoping study was that many GP's do not ask questions or go into any depth about mental health problems "because it is considered too difficult and time consuming, or they do not feel confident about their skills" (O'Hanlon et al., 2004 p. 21). These findings echo my experience over many years as a practitioner in Britain and in Australia in which I have run a variety of training programmes on child and family mental health for GP's, paediatricians, maternal and child health nurses and hospital nurses. The inescapable conclusion from this experience is that there are limited gains to be had from these attempts because any new learning concerning understanding of mental health and emotional experience appears to be in fundamental contradiction to the powerful original learning of the medical model.

Broadening the professional scope of universal child and family mental health services.

Findings from the research, and from my clinical experience moreover indicate that it is the medically qualified professionals who possess the greatest

power and control within the primary care health services by exercising a "gate keeping" function in terms of excluding those professionals whose skills and experience may be more effective than their own in meeting child and family mental health needs. For example, observation of the field of child and family mental health and its practitioners presents us with a paradox since the inadequacy of child and family mental health services appears to exist in contradiction to the number of new trainings spawned in Australia in psychotherapy and psychology, many of them concerned with child and family mental health practice. The significant increase in child psychologists, child psychotherapists, educational psychologists, family therapists and parent educators does not mean that these professionals are represented in senior practitioner positions in the public services. In fact many of these professionals once they have reached a senior level leave the public sector altogether to work in private practice. For example as the clinical psychologists in the research explained, they found that their skills were not recognized in the public system or were considerably undervalued and that there was a lack of appropriate career structure.

Widening the professional focus.

It is recommended therefore that in order to create change and promote prevention in child and family mental health, that we take a broader view of those universal services particularly the universal services that represent the first "port of call" for children, parents and families requesting help for emotional and

social difficulties. Taking a broader view would in the first instance relieve both doctors and nurses from the kind of "multi-tasking" in preventative and family mental health for which they are singularly ill equipped. Instead General Medical Practices as well as Maternal and Child Health Centres should employ psychologists, child and family therapists and parent educators whom parents and children can access directly without having to be "referred" by the General Medical Practitioner. In fact the provision of these services should be part of the compliance concerning mandatory registration for medical practices. The work of these professionals within these practices would need to reflect the demographics and needs of the particular areas being served.

The child and family mental health practitioners who work in these medical centres should be carefully selected so that they do not simply seek to mimic a medical model approach in terms of diagnosing "mental syndromes." Their focus should be on promoting child and family wellness through supporting relationships in the context of the family system and the wider community.

Maternal and child health centres.

The function of the maternal and child health centres similarly need to be expanded and transformed to respond more effectively to the recognition that the period of infancy and early childhood represents a critical opportunity for positive intervention and change on a number of different levels. Thus it is recommended that a range of mental health promotion services take place

alongside those of the traditional physical care and advice of the maternal and child health nurses. These services would be carried out by a broader range of professionals with skills in infant and young child/ parent mental health.

These centres reflecting a broader concern with young child and family mental health would be in a better position to take an inclusive approach to fathers and fathering at this crucial developmental period. To this end the archaic title of "maternal and child health centre" should be replaced with a title that more appropriately reflects an inclusive and welcoming approach to fathers and to other members of the family. Titles such as Parents, Child and Family Health and Wellness Centre would more accurately reflect these changing functions.

16.5 *Reframing Our Vision of Parenthood – Helping Parents to Find Their Own Voice*

The findings from the research indicate that professionals perceive parents as having little understanding of their children particularly their mental health needs. However as the findings further indicate the way in which professionals construct child and family mental health problems may itself play a role in contributing to parents' dependency and in undermining their capacity to act in the best interests of their children. Since many contemporary parenting programmes are problem centred, they do not lend themselves to the kind of dialogue between the parent and the professional that can throw light on the meaning of the child's behaviour or indeed that of the parents. In fact many of these programmes echo the predominant bio-behavioural paradigm of

emphasising the need for control, of taking behaviour out of context and of becoming exclusively solution-centred rather than meaning or development-centred. As the research indicates professionals blame the parents in this regard and justify their circumscribed approach by claiming that parents insist on immediate solutions to behavioural problems as personified by the request for the "quick fix."

An alternative reframing of a vision of parenthood requires a reframing of the shared responsibility or partnership between parents and professionals based on a relationship of mutual respect. The national organisation Exploring Parenthood (Schmidt Neven, 1994; Skynner, 1996) I established with colleagues in the UK had as its core philosophy the acknowledgement of parents own inherent knowledge and the need to help them find their own voice. Exploring Parenthood was one of several pioneering parent organisations in the UK that foreshadowed the more recent establishment of a National Family and Parenting Institute in the UK. Exploring Parenthood demonstrated that parents and professionals could work together successfully to bring distinct and different contributions to the enterprise of parent support. Most importantly the organisation took a radical approach to the nature of knowledge itself by advocating that the apparent "specialised knowledge" contained within professional understanding needed to be translated into "common knowledge" to be made available to parents as well as children. The group work model of Exploring Parenthood further demonstrated that parents had much to teach each

other as well as teach the professionals, and that it was in the context of this unique learning environment that change could most productively take place.

The findings from Exploring Parenthood demonstrate that parents respond positively to a model that is based on facilitating their understanding and inherent skills rather than a purely didactic or instructional approach that is based on the assumption that only one group, the professionals "own' the answers" as well as the "parenting syllabus." These findings are supported by the interview study of Miller and Sambell (2003) who explored parent's beliefs expectations and experiences of parent support. Miller and Sambell express concern about what they call the "dispensing" model of parenting that "endorses and legitimises views of the child and the parent-child relationships as problems that need to be fixed" (Miller and Sambell, 2003, p.40). They are also critical of parent programmes that are exclusively solution focus and that enjoin parents to acquire a particular set of techniques.

By contrast, Miller and Sambell highlight the need for effective parent support programmes to enable parents to develop "a process of trying to make meaning from the situation, by looking for questions and issues, rather than 'right' answers …" (Miller and Sambell, 2003, p.33). The authors concluded that the use of a reflecting and relating model of parent support facilitated by a trained professional enables parents to move from the position of seeing the problem "as being within the child" to reflecting on their own approaches, values and their views of their children's needs. This model has the further advantage of

enabling parents to think for themselves, thereby enabling them to act more independently and find their own solutions and as such has significant implications for the promotion of child and family wellness.

16.6 *Re-Assessing the Role of the School as a Centre of Learning for Life*

The findings from the research concerning the role of the professionals in schools, clearly indicates the importance of the school environment and its considerable potential for the promotion of child wellness. Sadly, as the findings indicate the school often becomes a site for the institutionalization of childhood problems. Children are forced to fit with the existing values and culture of the school that is antipathetic to the notion of children's needs beyond a rigid adherence to a formal learning curriculum. Schools, like all of the other institutions and organizations referred to in the research want their clients (the children) to change, without considering that their own organisation needs to embrace change. Thus for example, directives about "a whole school approach" are not complemented by a directive about a "whole child approach." Instead schools remain firmly committed to a way of operating that exhorts children to "leave themselves behind at the school gates." In this context one may observe that parents too are left behind at the school gates. For real change to occur schools need to undergo a process of transformation (Weisberg, Kumpfer and Seligman, 2003).

Don Edgar founding director of the Australian Institute of Family Studies challenges the narrow and what he calls the "antiquated" focus of schools and the

school system in terms of questioning who is there to learn and what is to be learned. Edgar advocates that it is time to take the community into the classroom (Edgar, 2005). He states that we must shift the boundaries between school, family and the community by welcoming parents, grandparents, visitors, business leaders, mental health professionals and welfare workers as people who all contribute to the learning process. Edgar's vision for schools is as family learning centres that function as true community centres supporting the fostering of multiple intelligences that are an essential part of learning for life, linking emotional and relational learning with the learning of a curriculum.

Building on Edgar's ideas of taking the community into the classroom enables us to consider that the school in effect "belongs" to the community, and the community particularly the parents of the children, therefore are entitled to right of access. Even taking into account the need for reasonable security and the protection of the children and staff, schools in their present format create artificial divisions between teachers and pupils and teachers and parents. A more open and consultative process between parents and teachers and teachers and pupils would be particularly beneficial in breaking down the barriers of mutual suspicion distance and recrimination that often prevail.

Most importantly, the school needs to move from its current position of isolating mental health issues to the margins of the school system thereby pathologising particular children and even demonizing particular families, towards normalizing health and wellness as its core concern aligned with the

teaching of the core curriculum. Teaching staff should not be burdened with mental health responsibility for individual children but the school should be used as a base from which a variety of professionals concerned with child and family mental health are able to operate. In order for this to take place the school needs to invite into the school a range of professionals who are able to undertake preventative and other types of therapeutic work with children and parents as well as of course with the teachers who are an essential part of the system.

Placing mental health services within the school premises would have the function of normalising these services and emphasising the wellness rather than the illness dimension. It would also assist in closing the divide between curriculum learning and life learning and present a life cycle learning approach. These services could include parenting programmes as well as individual and family counselling and health based programmes. The use of the school in promoting adult learning should also not be underestimated as many families living in deprived circumstances may more easily support their children in the learning process when their own needs in this regard are taken into account. Adult learning in the school setting since it also has a social function may contribute to easing the sense of isolation and social exclusion experienced by many disadvantaged families and of offering a starting point for women in particular to avail themselves of educational opportunities.

16.7 *Creating a Constituency of Childhood*

The absence of the voice of the child has been referred to at several points in the thesis. Pronouncements, diagnoses and decision making are described as taking place around the child in many cases without their full participation, and in a manner to render them not only passive but also at times invisible. In order for child and family wellness to become a reality, we need to commence not only with a commitment to acting in the best interests of the child, but also to encourage children to participate in decision making concerning their welfare and the provision of services in a manner that protects their interests and that does not absolve adults from taking responsibility.

Here again we may first need to acknowledge the inherent ambivalence in attitudes to children that often accompanies attempts to give them a voice. For example whilst children are often considered incapable of giving a valid account of their experience, particularly emotional experience, this assumption appears not to apply when they are directly targeted by the adult business world with respect to the marketing of an array of goods and clothing.

Ambivalence is also expressed in the other areas such as within the context of community support. James and James (2001) for example refer to the paradox contained in attempts to revitalise social democracy and civic society in the UK through community involvement, whilst simultaneously observing the trend towards the marginalising and increasing social control of children rather than engaging them as full participants in community projects and citizenship.

Nevertheless, there are a variety of models aimed at engaging children in decision making with encouraging results. Matthews (2003) refers to a typology of community action that articulates a variety of ways in which children can become involved in decision making particularly with regard to neighbourhood regeneration and the strengthening of social commitment. Matthews emphasises the need for dialogue with, and encouragement of, children to help them to gain a sense of their own competence and skill in contributing to the shaping of their communities.

As Matthews (2003) explains it is a fundamental principle that children as citizens have the right and entitlement to be involved in contributing to the shape of their own communities. Matthews advocates children's involvement and participation as a necessary preparation for developing "a sense of communal responsibility" in later life. However as Matthews points out many attempts to involve children in decision-making are both half hearted and often fraught with difficulty because of a significant societal resistance to giving children a voice and taking what they have to say seriously.

Finding practical ways of consulting children directly about issues of concern to them have also been devised through Save the Children in Britain (Fajerman, Jarrett, & Sutton, 2000; Fajerman & Treseder, 2000). Their guides to consulting children and young people distinguishes between those services that have a direct impact on children and young people, those services with indirect impact and those services with no real impact.

The authors give a number of practical examples of good practice in consulting children across the age ranges. For example, a group of seven-year olds in a school were given sheets of paper on which they were invited to write down their ideas for their ideal playground in a speech bubble. A nursery consulted a four year old with behavioural difficulties who was about to go to school, asking what would help him to positively make the transition. He suggested a book about himself in which he could record his achievements and which he could show to his new teacher and friends. Another example was of a group of children in care who ran their own conference for young people after a group of trainers had helped to train them to plan and facilitate the event.

The authors report a number of mental health benefits to children and young people as a result of instituting shared and inclusive consultation in different settings. They report an increase in a sense of self-esteem, improvements in the child's capacity for independent creative learning as well as a reduction in potential conflict.

16.8 *Invoking a Human Rights Agenda*

The findings from the research point to the urgent need for a new order of thinking and action with regard to the way in which we construct child and family mental health problems. As Prilleltensky (2001) points out we need to have policies that promote universal health and well being for children and families. In his 2005 paper on promoting well-being, Prilleltensky outlines the need for a paradigm shift that supports "strength-based, preventive, empowering

and community-oriented approaches" as opposed to those that are "reactive, individual, alienating and deficit based" (Prilleltensky, 2005, p. 59). In order to do so however, it is essential that these policies do not merely represent changes at the fringes of existing policies and approaches many of which are articulated in relation to the bio-behavioural paradigm. It is at the level of policy change that the recommendations made above with regard to strengthening the positions of both parents and professionals come full circle.

Parent power.

Changes at the policy level need to take place from the bottom up as well as from the top down. This process of change needs to be integrated and all of a piece. It must involve parents, professionals, organizations and governments. As the evidence indicates, programmes as well as attitudes that empower parents to think for themselves and articulate their needs, in the long term provide the best outcomes for children (Stewart-Brown, 2000). Parents as voters have the power to influence policy at the level of state and federal government in terms of demanding changes to schools, family financial support and personal services for emotional and relational difficulties. In other words parent power can go a considerable way to place relationships at the top of the political agenda.

Invoking a Children's Rights Agenda.

Shifting the locus of control away from diagnostic and pathological interpretations of children's behaviour is a key factor in promoting positive health and social outcomes for children and families. Prilleltensky (2005)

powerfully states in this regard that "as long as local governments, states, nations and international bodies neglect prevention and acquiesce to the dictates of the medical model, not much will change in the health and well-being of the population." (Prilleltensky, 2005, p.56). As discussed earlier there is a groundswell of concern about the creation of "pathological identities" for children (Sorensen, 2005) as well as increasing evidence about the damaging effects of medication (Breggin, 2006; Furman, 1996; Mackey & Kopras, 2001).

It is clear that the power and control of drug companies collectively known as Big Pharma in influencing clinical decision making in the area of child mental health is considerable. McCoy (2005) writing from the British perspective states "As it stands, the arrangements and systems that govern the pharmaceutical sector, including the patents regime, are inefficient, inequitable, clinically harmful and deeply corrosive of ethics and trust within the medical system. Civil society should expect and demand a better deal from government and the medical profession." (McCoy, 2005,p.48).

It is clear under these circumstances that the control of Big Pharma can only be challenged at a governmental and international level. Since the biological as well as social control of children exemplified by an increasingly medical approach to psychological problems puts them at significant risk it follows that it also compromises their human rights. One way of addressing this is to hold professionals as well as the government institutions responsible for child and adolescent services accountable to a higher international level of authority

concerned with the rights of children. The increasing and in many cases unjustified medicalisation of children is clearly in breach of the UN Convention on the Rights of the Child (1989) that states, "In all actions concerning children…the best interests of the child shall be a primary consideration." The UN Convention further refers to the rights of the child to "the highest attainable standard of health and to facilities for the treatment of illness and the rehabilitation of health" a state of affairs that is far from satisfactory even in a wealthy developed nation such as Australia. The Convention's emphasis on the need to develop "preventive health care" for children and their parents is also undermined by the predominant medical and pathological interpretation of children's behaviour.

Silencing the child and not giving them appropriate information about their treatment also constitutes a breach of their rights according to the UN Convention. As the Articles of the Convention state the views of children must be given due weight and "The child shall have the right to freedom of expression; this right shall include freedom to seek, receive and impart information and ideas of all kinds…" (Article 13, Convention on the Rights of the Child, 1989).

Since the UN Convention on the Rights of the Child places responsibility on nation signatories to submit regular progress reports in respect of a number of services for children including the implementation of mental health services this could provide a genuine participative opportunity for child health and welfare

professionals and services to unite to challenge the existing system. As Payne (2003) explains signatories to the Convention are required to present a report every five years. The UN Committee on the Rights of the Child issues a response to the Committee that notes progress in various areas *as well as* pointing out shortcomings.

16. 9 The Limitations of Professional Expertise

This final recommendation comes full circle in recognizing the inherent limitations of all professional practice in this case in child and family mental health. Learning from these limitations is a critical factor in any endeavour that concerns the promotion of child and family wellness. Widening the debate concerning what constitutes expertise is an essential part of this process. As Stilgoe, Irwin & Jones, 2006 point out we need to question the rhetoric concerning professional "received wisdom" and expertise. For example when we talk of professional "transparency" do we really want to open up expertise to new questions and perspectives or do we only want to let people see "the experts at work?" Similarly, we need to be vigilant about statements concerning the "evidence base" of findings that may simply be a code for justifying existing policy and decisions that have already been taken

At the heart of professionals' capacity to change policy and practice lies the need for our capacity to change ourselves. At the individual level Stewart-Brown (2000), a researcher in the field of parent support states that well-being needs to be understood through subjective reflection as well as through the

observation of others. At the organizational social and political level, Stilgoe et al. equally assert that policy is there to be engaged with, to be opened up and exposed to criticism. Challenging the assumptions of professionals of policy and policy makers is not only a legitimate but a necessary precondition to emotional and social well-being.

The next and final chapter of the thesis identifies the limitations of the research and makes suggestions for future research that may expand further on the findings.

Chapter 17: Limitations of the Research and Suggestions for Future Research

17.1 *Limitations of the Research*

The size of the sample restricted to three professionals for each profession making a total of 21 professionals interviewed may be seen as a limitation in terms of generalizing from the research. However the research was not intended to represent the views of all professionals in each field but rather through its in depth interviewing to elicit perspectives about the current discourses concerning child and family mental health as well as providing insights about organizational functioning.

The decision to modify the methodology by interviewing different professionals for the focus groups rather than the professionals from the individual interviews may have influenced the type of communication elicited in the focus groups. For example if the same professionals had participated in the focus groups this may have given them the opportunity to revise or amplify some of the comments they had made in the individual interviews. This possible advantage needs to be weighed up against the advantage of interviewing different professionals who were not influenced by any previous contact with the researcher and who therefore brought a fresh perspective to the discussion.

The research had some organizational limitations in that the three psychiatrists, one clinical psychologist and one social worker all came from the same organization, namely one Child and Adolescent Mental Health Service. It

would have been interesting to have heard the views of psychiatrists from other services. However there were some advantages to having been able to interview core members of a multi-disciplinary team from the same service to ascertain how they combined their different perspectives of the same work.

Further limitations concerned the predominance of women in the sample. The fact that there were only five men interviewed in the group of 21 individual interviews is perhaps indicative of the existing ratio of men to women in the child and family mental health services as a whole. The absence of men in both the focus groups represented a significant limitation in that their presence could well have countered the strong mother-centric focus in both groups.

There are a number of theoretical limitations to the thesis. Firstly, the focus on the limitations of the bio-behavioural approach in the main body of the thesis as well as in the analysis of the results may be perceived as implying a non-critical attitude to the wider ideological processes that shape discourse and practice. In particular, it may have implied a generalized acceptance of any humanistic approach to child and family mental health problems as preferable to the bio-behavioural reductionist discourse. In this regard the thesis could have examined in more detail the limitations of the humanistic discourse particularly with reference to the provision of improving child and family mental health services.

Secondly, the limitations of the research concern my own presence and influence as the researcher. At the heart of a critical analysis such as the one

contained in the thesis is that of interrogating a range of professional discourses. This reflects the dilemma as a researcher of having to interrogate one's own discourse; that is to become aware of how one can be misled by one's own bias and "blind spots." For example, as a professional concerned with psychotherapeutic work with children and parents some of the professionals' responses at times appeared challenging particularly when they appeared dismissive or intellectualizing. It was important at these times to attempt to maintain a self vigilant, non-judgmental position that may not always have been successful.

A further challenge to interrogating one's own discourse is contained in having to be mindful of how as the researcher and interviewer one uses language oneself. This posed a particular dilemma in constructing the questionnaire for the individual interviews in terms of asking about the problems the professionals dealt with without pre-empting an explicit problem-based discourse or reinforcing a deficit orientation. Whilst in the main this did not appear to be the case since the majority of the professionals responded overwhelmingly to the opening question "can you tell me about your work?" there may have been a few occasions in some of the interviews where this was assumed to be the case. However a focus on problems also reflected the actual nature of the services; for example for the child and adolescent mental health service.

Finally, the influence of the researcher on how professionals responded to the interviews needs to be considered since some of them would have known that

the researcher was an experienced clinician and had previously occupied a senior position at the Royal Children's Hospital in Melbourne. Additionally, some of the professionals interviewed may have known that the researcher has a psycho-dynamic orientation in her work and this may have influenced to some extent the direction of their responses.

17.2 *Suggestions for Further Research*

Future research in this area may take the findings further to explore the contradictions contained in many of the professionals' responses. Whilst in the present research it would have been inappropriate to have explored these contradictions they could be usefully analysed within a different research focus such as that of an action research format. This could be action research concerned with exploring in greater depth how a particular agency approaches its service to children and families. Since pointing out inconsistencies and contradictions requires considerable levels of trust between the researcher and participants as well as an extended time frame, such an inquiry could prove to be a useful adjunct to helping professionals explore and understand what may get in the way of creating positive change in their organisation.

Future research may also consider taking up the recommendations made above to evaluate and assess their effectiveness with regard to positive outcomes in child and family wellness. For example, it would be interesting to assess the outcomes in relation to using professionals differently, incorporating their services into schools, GP practices and maternal and child health centres in order

to promote prevention. Future research may also explore how engaging with parents as partners can diminish a deficit and dependency focus and facilitate child and family wellness at a community level.

APPENDIX A

Plain Language Statement

My name is Ruth Schmidt Neven. I am a Doctor of Philosophy student supervised by Professor Isaac Prilleltensky at the Department of Psychology, Victoria University, St. Albans Campus.

I am interested in gaining a better knowledge of how professionals who work with children and families think about and describe the mental health problems of their clients. I hope that the results of this research will lead to a greater understanding of the needs, criteria and standards in relation to best practice in the field of child and family mental health.

I would like to interview professionals who work with children in different settings from infancy through to 12 years of age. These professionals are maternal and child health nurses, social workers, psychologists, doctors and early childhood workers. I believe that you can make a valuable contribution and would like to hear your views and experiences on this topic. Your contribution may consist of two interviews:

i) an individual interview
ii) a group interview as part of a focus group

The interview and the focus group will take approximately one hour each. It would be very helpful if you could participate in both. However, the decision to do so is completely yours. Before you decide to participate in the research, I need to clarify some important points.

i) Your participation in this research is voluntary. You may withdraw from this research at any time
ii) The interviews will be audio-taped with your consent
iii) All the information that you provide will be confidential. If any direct quotes are used in the research, I will not include any identifying information and will make sure that no one can identify who made the quote. The only exclusion to this will be the group interviews where full confidentiality cannot be guaranteed. However, all participants in the group interviews will be asked before the group commences to respect and protect confidentiality. Names will not be used on the interview transcripts. Identification numbers will be used as codes instead.
iv) At the end of the research, a summary of the results will be available. If you wish to obtain a copy, please provide your address in the space below.

Any queries about your participation in this project may be directed to the researcher (Ruth Schmidt Neven, Tel. 9830-0422). If you have any queries or complaints about the way you have been treated, you may contact the Secretary, University Human Research Ethics Committee, Victoria University of Technology P.O. Box 14428 MCMC Melbourne, 8001 (Telephone: 03-9688-4710).

Thank you for being involved in this research. Your help is greatly appreciated.

RUTH SCHMIDT NEVEN

APPENDIX B

Consent Form for Participants Involved in Research

Information to Participants

We would like to invite you to be part of a study into how professionals who work with children and families think about and describe the mental health problems of their clients. We would like to interview professionals who work with children in different settings from infancy to 12 years of age. We hope that the results of the research will lead to a greater understanding of the needs, criteria and standards in relation to best practice in the field of child and family mental health.

Certification by Participant

I,

Of

Certify that I am at least 17 years old and that I am voluntarily giving my consent to participate in the study entitled: Constructing Mental Health Problems: The Views of Professionals Working with Children and Families.

Being conducted at Victoria University by Ruth Schmidt Neven

I certify that the objectives of the study, together with any risks to me associated with the procedures listed below to be carried out in the study have been fully explained to me by Ruth Schmidt Neven

And that I freely consent to participation involving the use of these procedures.

Procedures: Individual interviews
Focus groups

APPENDIX C

Interview Guide

Can you tell me about your work?

Can you share with me your approach to child and family mental health problems?

What would you say were your main or key guiding principles in your approaches?

How do you think your own personal values influence this approach?

Can you describe how the problems you deal with are usually described – for example what kind of language would you tend to use when describing a problem – for example a particular word or phrase

There may be many different problems – what are the most frequent problems you encounter?

How do you think the child would view the problem or situation?

How do you think the parents would view the problem?

How do you think the families would view the problem?

Would they use similar or different words or phrases to describe the problem?

How do you think that the referrers view the problem?

What view do you think your agency has of the problem?

Would you say that your work is largely the same now as when you first started work?

Do you think that you have changed the way in which you view child and family mental health problems?

What factors do you think have contributed to this change?

Would you work differently if the organisation you work for was different?

What kind of organisational structure would best facilitate the work in your opinion?

APPENDIX D

Case Scenarios

Participants will be asked to respond to one of the following case scenarios which will be commensurate with the age group with which they work and the work setting. They will be asked three questions as prompts to facilitate discussion: Can you describe the situation as you see it? What words or phrases do you think you would use to describe what is happening? What kinds of solutions do you think would be helpful?

For Under Fives

A mother is anxious for her child Tim who has just turned three to be accepted into Kindergarten but is concerned that he is not yet toilet trained. The kinder will not accept him unless he is toilet trained. In the course of her conversation the mother mentions that Tim is a very demanding child and often wants things his own way. She feels that he has been demanding since he was a baby. Tim also has sleeping problems and comes into his parent's bed every night. In order to get some sleep Tim's father has taken to sleeping in Tim's bed. He thinks it is best not to interfere with his wife's management of the situation and that Tim "will just grow out of it."

For Primary School Age

John's parents became concerned about his behaviour in the second term at his new school. He is in year 4. His parents had moved from interstate. His parents had hoped that going to the new school would help him to start afresh socially.

He has always been a shy boy and has had some difficulty making friends. Recently he has come home from school and has started to pick fights with his younger sister. He seems angry all the time and there are regular battles with his parents over not doing his homework. Recently John confessed to his mother that he is being bullied at school by a group of boys who started out being his friends. They push him around and call him names. Telling the teacher has not helped as the teacher wants the boys to sort it out themselves. At parent teacher interview the teacher told John's parents that John has difficulty concentrating in class and on occasion has been disruptive.

Adolescent

Tania has been a studious polite girl up until year nine. She has always been a little concerned about her weight and has compared her appearance unfavourably with other girls in her class. Recently she has become swept up by a new circle of friends and is very pleased to be accepted by this "cool" group. The problem is that the group make their own rules and there is great pressure on Tania to conform. She appears not to be interested in her work and her academic results have been poor. Tania and her friends are eager party- goers and spend most of the week planning which party they will attend. Tania's parents know that at some of these parties there is no parental supervision and that alcohol as well as drugs are available. Tania's parents are unclear about how much freedom Tania should have and there are constant fights in the house. Tania has become very

confronting and abusive towards both her parents and has threatened to attend the parties regardless of her parent's wishes.

APPENDIX E

Presentation of Emerging Themes to Members of the Focus Groups

I have been carrying out research interviews for most of this year. To date I have interviewed 16 professionals from multi - disciplinary backgrounds. They are, maternal and child health nurses, paediatricians, child psychiatrists, early childhood workers, educational psychologists, and one social worker. Each interview took place over one hour. In the course of these interviews the professionals have described their work and the particular concerns that arise from it.

A preliminary analysis of the transcripts of these interviews has yielded a number of emerging themes. I would like to present these emerging themes to you and would be grateful for your views. In particular it would be helpful to know whether these themes confirm or contradict your own experience. It would also be helpful to hear from you about other important issues that have not been mentioned that you believe should be taken into account.

The emerging themes are as follows:

i) That there appears to be a disjunction between parents' perception of their children's behaviour and the actual meaning, or intention of their behaviour. Parents appear to describe their children's behaviour in increasingly negative and pejorative terms. Their descriptions of their children as "aggressive" or "naughty" or "hypo" seems to become the description of the child's personality.

ii) Professionals appear to be under pressure to offer parents "solutions" for these apparent misdemeanours or problems. Increasingly they feel that they have to try to "explain" the behaviour of the child to the parents, and help them make allowances for it.

iii) In some cases professionals find themselves out of their depth in knowing how to respond, and fall back on offering strategies to the parents. This avoids having to confront the often painful relational component.

iv) Children are rarely listened to. On the occasions when they are directly involved, they have a great deal to say and long for a better relationship with their parents, to be heard and understood.

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