

The promotion of emotional wellbeing for children, parents and families what gets in the way?

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Abstract

This paper presents the findings of a qualitative research project concerned with child and family wellbeing. It highlights how, in the context of contemporary professional mental health practices, constructions of children's behaviour are predominantly based on pathology and deficit. The research data included individual interviews and focus groups with professionals representing both universal and specialist child and family mental health services. This data was subjected to a critical examination including an analysis of the discursive practices and a range of discourses that professionals employ in their everyday practice. This in-depth analysis of the findings uncovered ways in which these practices and discourses reflect values and attitudes to meaning, power and the use of knowledge. Two key discourses were identified, the parent-blame discourse and the professional self-referential discourse. These contribute to levels of fragmentation in the delivery of services that in turn compromise the capacity for advocacy of the child and hearing the voice of the child. The results of the inquiry indicate that the construction of child and family mental health cannot be considered as discrete from the construction of child and family wellness. Improving services for children, parents and families would appear to be inextricably linked with improving the professional, relational and organizational environment in which these services are delivered. The outcome of this inquiry has led to the establishment of a Child and Family Wellness Consultancy.

The orientation of the inquiry

Whilst the promotion of emotional wellbeing may be considered to be increasingly an appropriate focus for child and educational psychologists, a critical review of literature and relevant research reveals that contemporary professional views of child and family mental health are constructed in ways that are opposed to concepts of wellbeing. According to Rutter (2002), child psychiatrist and prolific researcher, there has been a considerable increase in the frequency of psychosocial disorders in children and young people. Rutter asserts that we need to ask ourselves the question 'why has this been so?' He states 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). However, other clinicians in child psychiatry and child psychology

(Billington, 1996; Breggin, & Breggin, 1994; Timimi, 2002) argue that the lack of progress in children's emotional and mental health is due at least in part to professional attitudes and approaches that are mired in old established and routinised assumptions (Scheff, 2003). Most significantly, these established and routinised assumptions are reflected in the predominantly bio-behavioral paradigm that characterises much of contemporary child and family mental health practice. In particular, the bio-behavioral paradigm leads to a reductionist approach that de-contextualises children's behavior and deprives it of meaning. A potent example of this is the frequent reference to the concept of 'resilience' in relation to the wellbeing in children that has become detached from its developmental and relational context resulting in what Martineau (2000) has described as an 'ideological code' to encourage social conformity.

As Stanley, Richardson and Prior (2005, p.7) point out we appear to be living out a paradox of having more as a wealthy society and yet doing less for children. They observe that 'knowing more about child and youth development than we ever have' has not translated into providing effective and in particular preventative strategies and services for children and their families. This research inquiry therefore finds its impetus in a critical reflection and examination of professional practices concerned with child and family mental health an area in which there is currently a dearth of research. Professionals are significant opinion shapers with regard to the way in which mental health problems are both constructed and described and their experience in relation to these problems and the demands of their work settings was considered relevant in terms of throwing light on the impediments to child and family wellness.

Given the rationale of the research inquiry it was the intention of the researcher to engage in a critique of current professional practices in child and family mental health. This included exploring the 'gaps in the discourse' (Burman et al., 1996; Parker 1999; Willig, 1999) through examining professional discursive practices, based on the underlying assumptions of values and of connections between meaning, power and knowledge.

Additionally, in the light of a counter current supported by relevant literature and empirical research (Bambra et al., 2005; Maton, 2000, Maton et al., 2006; Prilleltensky, 2005) the line of approach taken in this research inquiry leans towards an active interest in the promotion of a new social-ecological paradigm. This acknowledges the inter-dependence between the domains of the personal, the relational and the collective. It supports simultaneously the empowering of the individual and the need for a community oriented psychology. In accordance with this interest, the outcome of this research inquiry leads to a number of rec-

ommendations that promote a new approach to child and family wellness.

Methodological approach

The research inquiry was concerned with four core areas: Firstly to explore to what extent professionals perceived the child's presenting problem as situated or not within the broader family and social context; secondly to explore the language used by professionals and the agencies they represented to understand how they constructed child and family mental health problems; thirdly to ascertain how the language used by the professionals in their description of child and family mental health problems may have influenced their assessment and decision making; finally to identify the dilemmas and pressures experienced by the professionals and whether or not the professionals perceived their agencies as helpful or unhelpful in supporting their capacity to provide a good service to their clients.

Selection of sample and interview setting

Individual in-depth interviews as well as two focus groups were conducted with a total of 27 professionals drawing from seven professional groups with both universal and specialist orientation. These were maternal and child health nurses (known as health visitors in the UK), early childhood workers, paediatricians, educational psychologists in schools, clinical psychologists, social workers and child psychiatrists. Within each group, individual interviews took place with three professionals, making a total of 21 professionals interviewed. The sample of professionals was obtained by contacting their various Heads of Department. This was followed by a letter explaining the purpose of the research in the form of a Plain Language Statement that stated that the researcher was 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. The Heads of Departments gave the names of people who were interested in participating

to the researcher. Each of the interviews lasted for one hour and were tape recorded with the participants' consent and fully transcribed. The interviews took place in the professionals' work settings in Metropolitan Melbourne.

The interview guide and the case scenario

A semi-structured interview guide was used as the basis for the individual interviews to act primarily as a prompt to elicit a narrative style response from the professionals about how they viewed and worked with child and family mental health problems. The semi-structured interview guide also served 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. (Minichiello et al., 1995).

Close attention was paid to the style and nature of the language used by the professionals in the course of the interview in order to track the evolution of their 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.

A case scenario was introduced at the end of the interview, in order for the professionals to consider their practice in relation to a hypothetical case. This was intended to provide a balance to the presentation of a predominantly theoretical or ideal view of actual practice. It was hoped that the case scenario would present a dynamic 'here and now' snapshot of how professionals construct child and family mental health problems and the specific language they used 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. The professionals 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.

Focus groups

Following the completion of the individual interviews, two focus groups were set up each consisting of three different professionals, representative of some but not all of the professionals involved in the individual interviews. At the commencement of each focus group the participants were presented with a summary of the emerging themes from the individual interviews and asked for their comments and views on these themes.

The rationale for the two focus groups was to create an opportunity for the themes that emerged from the individual interviews to be challenged or refuted, as well as to include other relevant commentary. 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). Each of the focus groups was audio taped with the participants' consent and fully transcribed.

Method of data analysis and interpretation

Grounded theory and complementary methods of data processing

The qualitative approach taken in this research project reflects the dynamic process of the inquiry. Engaging in an interpretive endeavor towards making sense of the findings led the researcher to attend to 'multiple, often conflicting meanings and interpretations.' (Glesne & Peshkin, 1992, p.19). In order to do justice to the complexity of the material and following the grounded theory approach as proposed by Charmaz (1995), complementary methods of analysis were applied to the processing of the data. The hermeneutical method of data interpretation

was complemented with the method of applied discourse analysis as described by Potter and Wetherell (1995, p.81) in terms of contributing to 'our understanding of issues of identity, the nature of mind, constructions of self, other and the world and the conceptualization of social action and interaction'. This enabled the researcher, whilst staying close to the direct experience related in the collected data, in the processing of the data to gradually progress towards more abstract and conceptual categories from which theory can emerge.

Attending to the use of language in the examination of the discursive practices of the participant professionals brought to the fore the interpretative perspectives taken by themselves in the context of their own meaning making. Making use of a supplementary interpretive frame of reference in the analysis of the data further identified the dynamics of group processes and of organizational functioning in the participant professionals' work settings. In order to gain a better understanding of the findings in relation to this frame of reference the exploration of psychodynamic theory postulated by various authors such as Bion (1961), Hinshelwood and Skogstad (2000), Hirschorn (1988), Menzies-Lyth (1988) was considered particularly relevant and insightful.

Phases of data examination and interpretation

The individual interviews and the two focus groups were analysed on a number of different levels and in the following sequence: A summary was made immediately after each individual interview to record observations and begin the process of drawing out potentially relevant themes. This was followed by a broad examination of the transcripts of each of the professional groups that resulted in the creation of clusters of data and responses for each of the groups in which core themes were identified. The third phase of examination involved returning to the transcripts and analysing them with reference to a number of standard questions.

These questions were concerned with what the various professionals observed and reported about their work with children. Thus, they 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.

Within each professional group it was possible to identify key wordings and phrases that formed clusters of data expressed through a variety of concerns on the part of the professionals with regard to their practice. An exploration of emerging themes with respect to the meaning professionals ascribed to these concerns and the actions they took to ameliorate these concerns formed the foundation for an exploration of emerging themes. This led in turn to the next level of the data analysis which included the identification of the discourses and discursive practices at work in each of the professional settings as well as those discourses and discursive practices that were found to be common to all the groups.

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

Summary of emerging themes from the individual interviews and focus groups

The key concerns for professionals in the universal services (maternal and child health nurses, early childhood workers, educational psychologists) were expressed in terms of the discrepancy between what they hoped to achieve in their professional role and the reality of their work limitations. More specifically these professionals were concerned

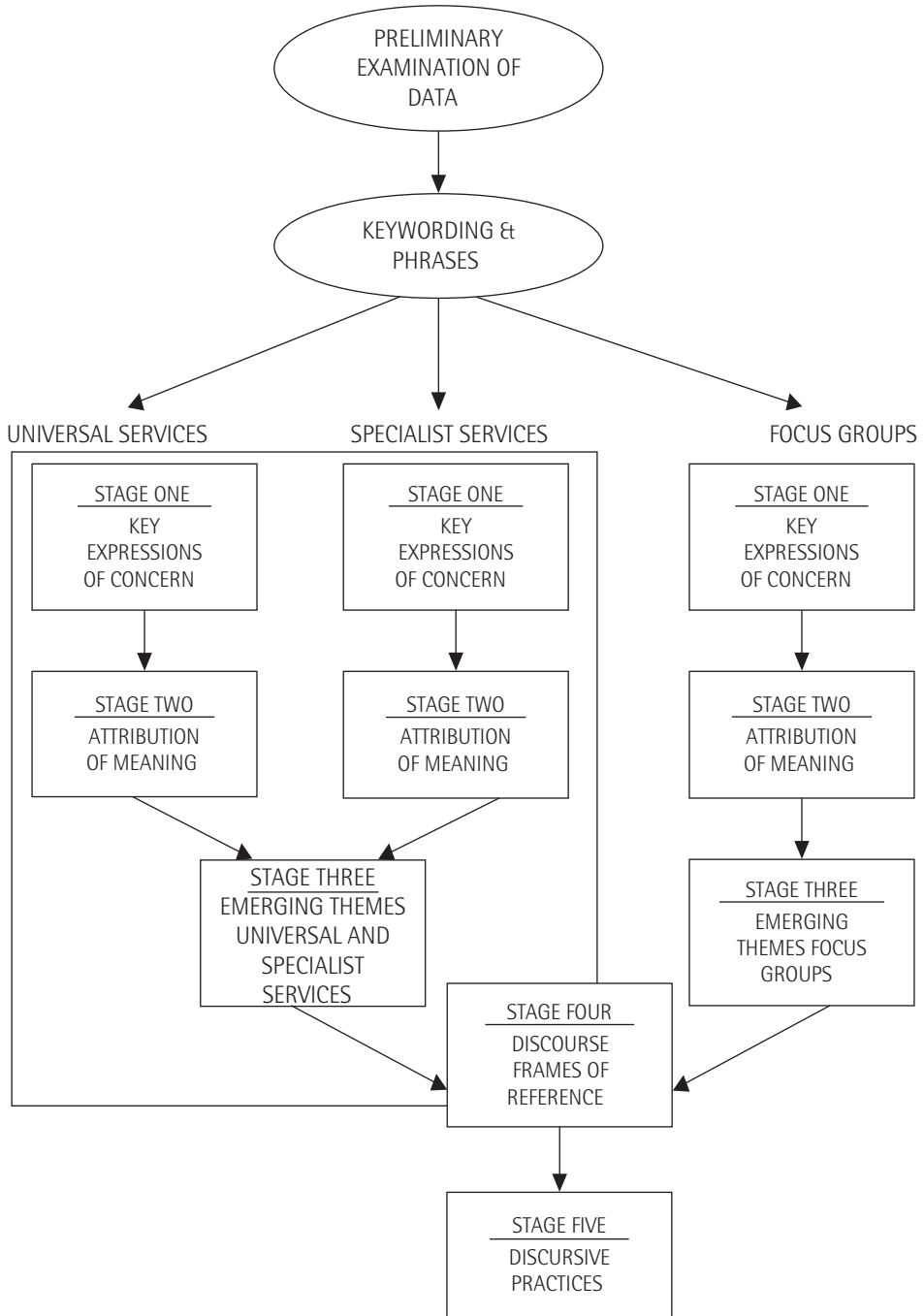


Figure 1: Stages in the examination and presentation of the data

with their perceptions of parents' negative and potentially hostile relationships with their children and their view of their employing organisations as unsupportive and in some cases undermining of their work.

Within the specialist services (paediatricians, clinical psychologist, social workers and psychiatrists) concern was also expressed about the apparent negative relationships between parents and children. However we also see the beginning of an articulation on their part that their own professions or services may be a contributing factor to the problem. Differences of opinion were expressed that tended to reflect a split between a medically oriented categorizing system of understanding the child, versus an approach that focuses on understanding the meaning of the child's behaviour within the family, social and even philosophical context. Differing views about the reason for the increase in the severity of the presentation of child and adolescent mental health problems were also expressed. These reflected the assumption that less extreme cases were not referred to services such as Child and Adolescent Mental Health Services because they were better handled in the community versus the view that preventative support services for parents and children in the community had been withdrawn or were under threat thus leading to an increase in the severity of these problems. Finally it was striking that both the individual interviews and the focus groups highlighted an almost exclusive focus on the mother whilst excluding the father from the discussion.

Emerging discourses and discursive practices

Further analysis of the themes from the individual interviews and focus groups led to the identification of a number of emerging discourses and discursive practices with regard to the way in which the professionals constructed the mental health problems of children, parents and families.

Emerging discursive frames of reference

The primary discursive frames of reference that were common to all the professional groups including the focus groups are identified as follows:

- A blame discourse;
- A problem-based discourse;
- An immaculate-conception discourse;
- A professional as victim discourse.

A blame discourse frame of reference

The predominance of a blame discourse frame of reference appeared as a thread linking all of the professional groups including the focus groups. The blame discourse focused primarily on blaming parents not only for the types of problems they presented but also for their harsh attitudes towards their children and for wanting a 'quick fix' for the solution of their problems. For example, as one maternal and child health nurse commented, '*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.*' Child care workers blamed parents for not understanding their children's developmental needs particularly over issues of control. As one of the early childhood workers said, '*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, wind-cheater, pillow whatever.*' In the school setting the blame discourse was described by one of the educational psychologists as 'a remarkable game of tennis that goes on between parents and teachers with the children as the ball in the middle.'

Paediatricians blamed parents for describing their children in overwhelmingly negative terms and as one paediatrician explained, making them 'scapegoats' whilst child psychiatrists blamed parents for demonizing the child and as one child psychiatrist put it, being '*hell bent on having a particular diagnosis.*' Blaming parents for presenting them with particular problems led many professionals to blame the media, particularly the internet and television for putting these

ideas into parents' heads in the first place, for example one paediatrician describing parents as 'having almost the DSM checklist when they come.'

The problem-based discourse frame of reference

Whilst a problem-based discourse may be considered to be intrinsic to the work of child and family mental health professionals the findings indicate that for the majority of the professionals problems are perceived as existing within the child rather than having a meaning that may represent a communication about the family and their relational context. These findings concur with the view that 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 (Reid, 1995).

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 but is only 'heard' in relation to the designations assigned to them by their parents and the professionals. Taking a critical stance, one of the clinical psychologists, described this 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.'

An immaculate-conception discourse frame of reference

As an outcome of the predominantly mother-centric focus in the professional's communications the question of who can speak and who is allowed to be heard came particularly to the fore in silencing the voice of the father and marginalizing his contribution. Various rationalizations were given for excluding fathers, most of them concerned with assumptions about the father's lack of willingness to attend interviews or the belief that women are more in tune with emotions and relationships. These rationalizations were made explicit through the type of language used as in one maternal and child health nurse saying 'men don't want to be deal-

ing with a lot of emotion and ...want the facts coming back.' The language contained within the immaculate conception frame of reference further reinforced assumptions about the mother as weak and unsupported whilst the father was perceived as strong but uninvolved and out of touch with his emotions.

Professionals as victim discourse frame of reference

The professional as victim discourse similarly to the blame discourse ran like a leitmotif throughout all of the individual interviews as well as the focus groups. It was articulated most dramatically by one of the focus group professionals who stated '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 emerged particularly in response to professionals' concern about their inability to exercise discretion in their professional roles. Numerous examples were given of organisations imposing top-down directives; of professionals having to 'work around' their employers to provide a reasonable service and in some cases having to protect their clients from the service.

Whilst the professional as victim discourse was understandably strong in those professional groups with the least amount of discretion it was striking that the group in which this discourse most predominated was that of the psychiatrists, one of the most powerful of the professional groups. The psychiatrists perceived themselves as the victims not only of their immediate organizations but also of the broader constituency of opinion-shaping journals. They expressed the view that they were the victims of a community that forced them into over diagnosis and prescription, and as such, were at the mercy of society's demands and expectations. This finding concurs with Harper's (1995) interviews with psychiatrists in relation to diagnosis, in which the psychiatrists presented simultaneously two apparently contradictory forms of dialogue; one that was critical of the diagnostic categories used, what Harper calls 'the liberal position', whilst nevertheless

carrying out the actual tasks required by the institution.

Examining discursive practices

The four discursive frames of reference described above gave rise in turn to a number of discursive practices that were considered to be of particular significance. These were:

- 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 and categorising of problems in medical and bio-behavioural terms appeared to have the function of managing uncertainty for the professionals as well as representing their perceived or actual need to comply with the requirements of their professional setting.

The discursive practices articulated as a philosophy of despair and a culture of complaint presented as overlapping discourses that appeared to place responsibility outside of the immediate realm of the professionals' actions. This was articulated through their criticism of other professionals' judgmental attitudes as well as expressions of despair expressed about the power wielded by their employers and organizations and the media influences over which they felt they had no control.

The discursive practice of resignation concerning inertia in the system appeared to be a further example of placing responsibility outside of the self as a rationalization for lack of action. In this regard the problems in the Child and Adolescent Mental Health Service were described by one clinical psychologist as 'perennial' and remaining essentially the same over many years. 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 organizational life. In this context therefore, challenging inertia is per-

ceived as pointless and an attitude of resignation becomes a legitimate accompaniment to professional practice.

Discussion

The research data of this inquiry indicate that, firstly, the professionals who participated in this study perceived themselves as having to act as buffers between the parents and the child and, secondly, they expressed considerable levels of stress in relation to their work with children and families due to the demands of their employing organizations. However, a closer examination of the findings revealed a parallel process in which the professionals appeared to mirror the experience of the families with which they worked.

In order to gain a better understanding of these findings it was important to take into account the characteristics of the professionals' work setting and organizational environment particularly with regard to the provision of containment in helping the professionals manage their anxiety in relation to their professional task. As Menzies Lyth (1988, 1989) has made clear, it is crucially important to provide containment of anxiety for professionals who are concerned with the direct care of vulnerable and dependent people, both children and adults. In considering the professional's work settings two main characteristics were identified: firstly, employing organizations deny the existence of anxiety in the professional/client relationship and are therefore poorly equipped to assist the professionals with the containment of their anxiety; secondly, employing organizations give primacy to the maintenance of the organizational bureaucracy above concerns related to the primary task, that is, to consider what is in the best interest of the child, the parents and the family. In the absence of appropriate containment, the emergence of a blame discourse becomes understandable or as one member of the focus group put it, *'the problem is passed down to the least line of resistance which is the child.'*

Along similar lines, the self-referential nature of the professionals' responses

becomes understandable in that they need to protect themselves against an organizational culture that they perceive as preventing them from giving priority to the primary task. In this context they find themselves preoccupied with a philosophy of despair, a culture of complaint and practices that produce an ironically mirroring responsiveness. The findings of this inquiry demonstrate these preoccupations in the following ways:

- The professionals are expected to conform to the dominant bio-behavioral paradigm, so that when they attempt to step outside of this prevailing reductionist framework, they find themselves confused and uncertain about what constitutes 'real knowledge'. They find themselves in a situation of despair, having to narrow the scope of acceptable knowledge to an exclusive bio-behavioral frame of reference and practice.
- The professionals in most cases do not focus on the empowerment of parents or facilitate their capacity to 'own what they know' about their child, their history and family relationships (Miller & Sambell 2003; Schmidt Neven, 1994). However, while their focus is on a problem based approach, the professionals complain that it is the parents who want a 'quick fix' – a stance that may be understandable in terms of the parents' belief that presenting a problem provides the only point of access to the service. In addition to this, the 'quick fix' complaint also mirrors the professionals' own assertions concerning their limited time and resources.
- Similarly, whilst the child is expected to produce acceptable social behavior and compliance within the family and social community, their voice, opinion and experience was rarely heard or validated. This obliteration goes hand in hand with the negation of knowledge about understanding the developmental task for children and appropriate time-frames for their development (Schmidt Neven, 1996; Schmidt Neven et al., 2002). It further serves to blur the intergenerational

boundaries between parents and children. In this regard, the findings from the research revealed the production of a secondary discourse in terms of how the professionals' identified with the children. This was exemplified by the 'professional as victim discourse' that in the context of the professionals' work environment seemed to function as justification to abnegate leadership and responsibility as well as to resist change.

Conclusion

In summary, the research inquiry provides a critical analysis of the limitations of the current professional discourse concerning child and family mental health and child and family wellbeing in particular identifying the 'gaps in the discourse' that contribute to the poor progress made in this area. More specifically, the findings demonstrate 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 their family.

Finally, several areas that contribute to the perpetuation of the problem have been identified. These are firstly, the uncritical acceptance of what is deemed to be objective knowledge that gives rise to the practice of medicalising and pathologising children's behaviour; secondly, the marginalizing of those areas of knowledge concerned with taking a developmental stance and recognizing the importance of relationships in the creation of meaning; and thirdly, the self-referential discourses within the professions and organizations set up ostensibly to assist with these problems. The findings demonstrate how advocacy for the child is intrinsically linked with an integrated approach to child and family mental health and wellbeing. They also highlight the exclusion of parents and children from participating actively in the discourse concerning the

meaning of mental health and of acting as partners together with professionals in the shared enterprise of promoting child and family wellness.

From research into practice: Providing a child and family wellness consultancy

This paper took as its starting point the views of professionals in order to pursue a structural analysis of the problem. If we are to create an environment in which the dominant paradigm shifts from child and family pathology to child and family wellbeing then it is essential that we support the professionals in the field to embrace this change. The findings from the research make it clear that improving services for children, parents and families is inextricably linked to improving the professional relational and organisational environment in which these services are delivered. Intrinsic to this approach is the recognition that professionals are part of the process rather than separate from it. The author has therefore developed a Child and Family Wellness Consultancy in Melbourne that attempts to provide a stimulus for practitioners in their thinking, together with practical tools to support their work with children, parents and families as well as with the school and broader community.

The primary objective of the Child and Family Wellness Consultancy is the building of capacity on the part of professionals, children and their families through an active

partnership. Within this partnership the professionals' own individual and family wellness is a significant factor in the delivery of optimum services. The child and Family Wellness Consultancy encompasses five elements intrinsic to the promotion of an emotional and systemic ecology of childhood that promotes health and growth rather than pathology. These are as follows:

- Reframing current professional practice. Working directly with parents in a new action partnership.
- Reframing our vision of childhood. Encouraging an open and consultative process with children to hear and respond to their views and concerns.
- Giving professionals the right tools to do the job. Providing a clinical training scaffold that helps professionals take a developmental and relational perspective to understanding children's behaviour.
- Attending to the relational capacity and needs of the work force. Supporting the health and wellbeing of professionals.
- Introducing reflective practice at the level of work with the individual, the family, the organisation and the community.

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