An Inquiry into Child and Youth Care Narratives of Experience in Children's Mental Health Treatment

by

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M.Ed. University of Manitoba, 1990

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ABSTRACT

This study is concerned with the inter-subjectively co-constructed narratives of experience, for Child and Youth Care practitioners, in an agency-based school program which focuses on treatment of DSM diagnosed children. This school-based program is formally committed to a strength-based practice for treatment of mental disorder. A Diagnostic and Statistical Manual (DSM) diagnosis is required for admission to this program. This agency-based practice exists at the intersection of dissonant discourses of understanding, in the treatment of children's mental disorder.

In this study, a narrative methodology of inquiry, situated in a post-modern epistemology of understanding, was utilized to investigate the narratives of experience of four Child and Youth Care practitioners. Narratives are distinctive units of speech that are typically employed by the

narrator to convey evaluative meaning in context. Narratives inquiry represents a useful means for understanding questions of experience, as people use narratives to organize and evaluate their knowledge and transactions with the social world. The narrative, as a reflection of intersubjective constructs of meaning, provides a means of understanding the individual or group through its conveyance of lived experience.

The results of this study include four narratives, written in the first person, communicating the subjective experiences of Child and Youth Care practitioners in this unique practice setting. Each of these narratives suggests the importance of, and methods towards, finding ways for strength-based practitioners to practice in harmony in landscapes of deficit-focused understandings.

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DEDICATION

This study is dedicated to the memory of Steve deShazer, 1940 – 2005, whose writings and clinical work led me to become a strength-based social care practitioner.

This study is also dedicated to my Grandfather, John Melnyk 1894 – 1959, who died a victim of the Canadian mental health system.

And finally, I would like to dedicate this study to Holland, Manitoba, Canada, the home of my childhood - a place where everybody knew your name, and a most excellent place to begin a narrative.

…long may you run.

CHAPTER 1

Man [sic] is a social and an historical actor who must be understood, if at all, in close and intricate interplay with social and historical structures. -- C. Wright Mills (as cited in Hones, 1998, p. 248)

Setting the Stage: The Story of the Research

For a portion of my childhood, during the 1950's through the mid-1960's, I was raised in an impecunious, but quaint rural village in Southern Manitoba. In this community, "everyone knew your name" and the experience was somewhat like having an "Auntie" or "Grandpa" on every second street-corner. The children of our village were cared for and monitored by the community at large.

In this village, I gained understandings of my self in the context of community that became a form of identity. This identity was a narration of my self constructed for my self. My narratives of self and experience were concerned with how the world was and who in the world I was and what in the world my role could be. These narratives were always enacted in relationship-based contexts. Alternate narratives were constructed by others concerning who I was and these narratives contributed to their constructs of my identity. The predominate community story-forms I recall were of tragedy, romance, heroism, and belonging. The occasional scandal-based morality tale concerning someone's "fall from grace" also enlivened our existence. Social troubles were a normal and expected part of everyday living, taken in stride, managed and overcome. Each collective encourages its members to acquire skills and to develop mastery concerned with maintenance and re-production of the collective itself, as did the people in my village (Illich, 1990).

I recall family relations during this time as a backdrop rather than as a foreground for my experiences of self in the world, but family also played a role in the narratives of my identity. As a second born child I had to contend with three first-born children, as both my parents, and of course my older brother, were first-born children. A significant identity-narrative that grew from my family interaction was for the need for self-advocacy, which was a survival skill within a family constellation in which each of these individuals wanted to be in charge. Self advocacy within this family constellation was regularly constructed by others as opposition.

For a later portion of my childhood our family re-located, for economic reasons, to a major urban centre, some distance away. During the early part of this transition period, I spent several months of life in the care of substitute parents through private arrangement, before I rejoined my family in our new home. I construct this event as an exemplification of the community spirit of care and support that was a normal part of the cycle of life. I share this experience for its portrayal as a construct of my identity and as a suggestion of a discourse concerning models of community living. Through substitute parenting my eyes were opened to alternative narratives and models of family form.

Life in Canada's fourth largest city provided a rapid and radical assault on my narratives of the world and altered my own identity constructs. As Kelly (1955) suggests, I was caught with my constructs down. I developed an alternative sense of self that was out of sync with my previous identity. I was isolated from reminders of previous narratives and my nuclear family moved to the foreground as a dominate interpersonal influence. This was an uncertain time and I often had the feeling of not knowing where exactly I was, or perhaps who I was. The ground beneath me seemed unfamiliar and foreign. The small-town narratives used to construct and to

explain male propensity for finding “trouble” (e.g. “boys will be boys” and “he comes from a good family”) were no longer broadly available in this new and autonomous place. The communal history of my being vanished; validation of my good character was reduced to tokens and memories.

Though I considered my beliefs about school, community and family to be unchanged as a result of this relocation, I somehow “became” a defiant underachiever, according to many of the adults in charge of the environments in which I was schooled. I often found myself in trouble with adults holding authority. Supportive, historically situated peer and adult relationships were no longer at hand in my new community. In spite of an absence of involvement with the law, worries were expressed for my future prospects in this regard. I encountered labels and stories that were discouraging and confusing. I experienced firsthand, the power of unfamiliar and undesired narrative constructs that influenced the shapes of my identity.

Around this time, significant adults speculated that things would go badly for me in the years ahead. Punishment, scolding, stricter rules, and one last chance became the order of the day. At times, I was to be sent away to a private school, which I presumed was a place for the management of likeminded troublemakers. Scholastically, three years from entering Jr. High, my experience of self shifted from an identity as a high achiever, into one of scholastic mediocrity. I rose to the challenge of mediocrity, when necessary; my involvement in sport, previously a mainstay of an identity of accomplishment and success also faded away. Worthy of mention, many of my friends were defined as equally adept at the skill of amounting to nothing and all of the trouble I incurred had a relationship context.

The trouble I was entangled with included attempts to fit in or show off for friends by pushing the limits of acceptable behaviours, through curiosity and experimentation, and by

standing up against injustice as I perceived it. Undoubtedly, I was the cause of stress and worry for my caretakers. I often wished for the comfort of the village of my childhood to re-establish a connection with the familiar and with success and to restore my understanding of the world and my identity. On rare occasions I would return to the idyllic rural setting of my early childhood, to the familiar friends and neighbours we had left behind, and this was indeed like a homecoming in the best sense of the word.

The transition to city life altered my identity narratives and I developed different story lines to negotiate these circumstances. These constructs were inter-subjective as they involved many significant others in my immediate environment, in concert with the broader systems of discourse resounding through the communities in which we participated. I believe that a deficit-focused discourse surrounding my middle childhood and an absence of social supports and alternative story-lines altered my experience of self. I began to think and act in relation to these new stories; these stories defined my understanding of my own actions. I locate each of these distinct identities in different contexts and so my identities were historically, temporally, and culturally situated.

Were I to have experienced the unlikely event of a referral to a mental health clinician in this era, it is likely the clinician would have focused on my defective learning or perhaps upon inner-psychic conflict and my relationship with my father. To acquire these same problems as a child in 2010, it is likely that reactions to my behaviours by significant others would be different, as the discourse surrounding troubles of this kind, and around the construct of childhood itself (Cunningham, 2006; Sommerville, 1990), are constantly in flux. A referral to an expert in children's behaviour would be needed and would be somewhat normative; in addition to the

individual interventions I would be “offered”, intervention may have involved a family assessment and perhaps family therapy.

The world-view of this expert would have a great deal to do with defining both the cause of my problem and the intervention methods used to alleviate my “disorder.” It is likely that my troubled behaviours would be used as evidence to locate a disorder within my personality, or defective biology or faulty learning, albeit with a tip of the hat to the influences of the environment. It would be conceivable that socially influential medical professionals with expert knowledge would offer medication to address my oppositional-defiance, *my* conduct-disordered self. Meetings with significant-others would be arranged, psychological tests would be administered to measure the severity of my condition, prescriptive theory-driven treatment plans would be applied to my disorder.

Later in my youth, timely encouragement and support from a small and unconnected handful of significant adults who focused on my strengths and abilities re-awakened earlier preferred identity narratives, the narratives of possibility and of an essentially able self. It was as if their belief in me was enough to re-awaken earlier preferred constructs of self.

Later I became a Child and Youth Care worker, a Social Worker, and a Counsellor working with troubled youth in treatment settings, who were also involved in negotiating similar problems. These experiences I write of shaped my personal and professional interests. Today, I am writing as a Doctoral Candidate, with a curiosity about the constructs of experience and the stories that narrate Child and Youth Care practice with troubled children who are defined as “mentally disordered” within the Canadian health care system. I will use the term “mental disorder” in the discussion to follow for the sake of convenience and simplification for the

reader. From my epistemological positioning, I consider mental disorder as a form of social construct, but readily acknowledge that this is not necessarily so for others in our community.

I begin with this introduction to my Doctoral dissertation for several reasons. First, it serves as an exemplar of the power of narratives to influence understandings of the self, something that I believe has a critically important impact on the co-construction of identity and meaning. Second, my introduction hints at the power of narratives to define social problems in children and to delineate treatment practices that follow from these definitions. Third, during my career as a helping professional in various milieus of social care, my experiences have led me to question the nature of mental disorder and the treatment practices that surround mental disorder. And fourth, this narrative serves to situate myself as a social constructionist researcher. I speak at length about social care in a latter section of this discussion, but simply stated, social constructionist research has a responsibility to reveal its own situated-ness, including those biases which are embedded in the social circumstances and social positions of the narrator of any research. The story of this research is subjective and intersubjective; it includes both the researched and the researcher as we came together to co-construct the narratives in Chapter 7 - 11.

This research is a story of four Child and Youth Care practitioners and a researcher, whose experiences and practice are influenced either directly or indirectly by constructs of meaning that surround their practice.

Orientation to the Research Question

The children who are served in the program I investigated, titled the *Kids Place*[1] program, attend a school-based program operated in conjunction with the Calgary Board of Education (CBE) and Calgary Child and Family Services (CCFS). This program operates with a formal agency-wide commitment to a discourse of strength-based philosophy of practice. *Kids Place* is dedicated to the therapeutic care, treatment, and education of Diagnostic and Statistical Manual for Mental Disorder (DSM) diagnosed children, who are struggling to succeed within a mainstream school setting. These children experience the power of narratives to define their identities. The narratives of disorder they encounter construct identities that they often feel compelled to align themselves with or to oppose.

The construct of childhood and our understandings of mental disorder in children is discursively and historically derived (Cunningham, 2006; Porter, 2002). The forms of care and treatment these children receive and our community's sense of responsibility towards them reflects historical and discursive constructs of their needs. These historical understandings, both implicitly and explicitly, have an impact on the day-to-day practice of providing for their care and treatment.

The Research Question That Guides This Inquiry

The research question that guides this inquiry asks: What are the inter-subjectively co-constructed narratives of experience for professional Child and Youth Care practitioners in a practice setting at the intersection of two distinct and dissonant discourses of social-care practice?

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[1] As an ethical condition of conducting this research, the names of all programs, agencies, and research participants have been altered to protect their anonymity, aside from the Calgary Board of Education (C.B.E.) and Calgary Child and Family Services (C.C.F.S.).

Contextualizing the Research Question

The research question emerges from the intersections of practice discourses I have encountered as a Child and Youth Care practitioner and educator, over the years of my professional practice. Having worked in social care for more than three decades, I have witnessed the rise and fall of numerous theoretically based social care practice trends. With each of these trends, how I understood the self, and social care practice transformed, at times dramatically.

Throughout my Child and Youth Care career I have been concerned about the impact of these trends on the lives of my clients and about the broader influences of history, culture, and politics on social care practice methods. In my social care practice I have accepted these trends and have tried to impose the practices these beliefs advise, upon my clients. I have been swayed by treatment approaches to mental disorder such as "isolation rooms", "disease models" and "Antabuse." I have worked to promote "Enegrams" "Reality therapy" "Positive Peer Cultures" and "catharsis." My thinking and practice has been characterized utilizing frameworks of "castration anxiety" the "Oedipal complex" "maladaptive learning" and "level systems." I have facilitated "support groups" for "Children of Alcoholics" and "Adult Children of Alcoholics." I have viewed the psychiatric system with reverence and sought the "correct" diagnosis and the correct interventions needed to relieve the severe distress of my clients and the Child and Youth Care treatment staff who I worked alongside. These examples are only a few of the trends I have encountered in my work.

The influences of these distinct outlooks on Child and Youth Care practice results in significant shifts in the day-to-day activities of practices and meaning for social care providers.

There have been many shifts in our understandings of those who receive social care in Western society and of those who provide their care.

Overview of Chapters

I believe that an understanding of the historical and social context of Child and Youth Care practice aids in understanding the layers of influence surrounding the research question I am investigating. For this reason, in Chapter 2, I provide the reader an examination of the historical constructs of mental disorder in Western culture.

In Chapter 3, I present a discussion of our recent bio-medical orientation to understanding mental disorder and its medical classification. As the research participants in this study are working exclusively with DSM diagnosed children, I believe both our historical understandings of the construct of "madness", or mental disorder, and the political influences upon the process of its classification and treatment merit consideration.

In Chapter 4, I review the foundational influences that have contributed to the development of the strength-based approach in social care. I also consider the developmental history of the DSM as a component of the medical model of Canadian health care and its influence on the treatment of mental disorder.

In Chapter 5, I situate the role of the Child and Youth Care practitioner in Western culture over history in *A story of Child and Youth Care history*. I examine some of the influences that have served to define the role and identities of the Child and Youth Care professional. Within this chapter, I argue that a deficit-focused outlook towards the social care recipient has been a component of social care services since their earliest inception.

In Chapter 6, I review the epistemological assumptions and methodological positioning of this study; I discuss how narrative analysis is well-suited to the research question that drives

this inquiry and how post-modern narrative inquiry represents a useful means for investigating and understanding the experiences of my research participants.

Chapters 7, 8, 9, and 10 are used as a reply to the research question that drives this research. I relate the stories of experience constructed in this project, in the form of four narratives presented in the voices of my research participants. Following each of the narratives of the research participants, I provide a discussion of each narrative.

I conclude this project in Chapter 11 with a short epilogue.

CHAPTER 2

Distinct Discourses of Social Care Practices

> *The disadvantage of men [sic] not knowing the past is that they do not know the present. History is a hill or high point of vantage, from which alone men [sic] see the town in which they live or the age in which they are living.* -- G. K. Chesterton, *(1933, p. 105)*

The Story of the Research: Getting to the Research Question

As I approached the completion of high school in the 1970's I was guided by the necessity of establishing myself in a career, as a productive member of the community, as a male, as a wage earner. My identity was significantly influenced by the constructs of what you do for a living, as somehow synonymous with who you are. Without a well articulated sense of what I might "become", like many Child and Youth Care practitioners, I found myself interested in a career with children as a social care provider. I prepared for this career by gaining a liberal arts education in sociology and psychology. In these faculties I was confronted by the highly distinct and apparently incommensurable views of "deviant" human behaviour which was also known as (A.K.A.) mental disorder depending upon one's outlook.

For sociology, popular discourse was strongly influenced by the social constructionist views of Berger and Luckman (1966), by Goffman's (1959) labelling theory, and by the symbolic interactionist views of Mead (1972) and by Szasz (1970) who suggested that mental disorder was a "myth".

In psychology I encountered distinct beliefs concerning the self and how mental disorder was known. Freudian psychoanalysis was a predominating discourse at this time. It claimed humankind to be driven by the "unconscious" as a separate and essential thing within us; mental

disorder was understood to arise through unconscious intra-psychic conflict. Behaviourism explained mental disorder through faulty learning, while Humanism focused on inter-personal and intra-personal relationships to explain troubled behaviour. Each theory was grounded in a positivist assumption that held open the possibility of discovery of the foundational underlying structures necessary for explaining human behaviour.

As a novice Child and Youth Care practitioner I entered a world of treatment practice that I had previously encountered only at a theoretical level. In my earliest Child and Youth Care practice experience the actual "therapy" was left to highly trained specialists working in medicalized clinics, while the remaining hours of the day were formally dedicated to the care and management aspects of our children's lives. Our work, as Child and Youth Care practitioners, involved finding practical ways to integrate diverse theoretical streams of knowledge into our daily activities. We often set theory aside and experienced the feeling of flying by the seat of our pants. As a "childcare" practitioner, I was puzzled by how concepts of mental disorder derived from psychology and sociology, all supported by the legitimacy of science, might contribute to my model of practice, be used in part, or dismissed altogether. The presumption that lay beneath my curiosity reflected my belief that there was a "best" way to carry out treatment of mental disorder.

Attempts to gain understanding of experience are characteristic of personal agency (Bruner, 1986; Harre, 1998). We do so from a position of standing under layers of discursive meanings (Hoskins, 1997), which constitute or at least contribute to what we hold as meaningful. Schwandt (2007) adds that "we belong to history" (p. 113) in that we choose our preferred constructs of history; we are not owned by history, but are influenced by it. In some instances,

history may illuminate, in other instances the brightness of a particular form of illumination may blind us to alternative constructs of experience.

As a researcher I believe that I cannot tell "the truth", but rather will tell a "chosen" truth (Butala, 2005). The stories I present in the chapters to follow reflect my interests as a Child and Youth Care researcher engaged in a process of coming to an understanding of discourses that I judged as implicitly influencing the narratives of the research participants in this study. I have lifted out, illuminated, and bound together streams of knowledge from the clutter of past events and beliefs, and I cannot claim that this is an objective process. I can see no means by which to claim objectivity within a social constructionist epistemological positioning, nor could these topics be treated thoroughly within the space allotted for a document of this nature. However, I can provide a fair and reasoned portrayal of the concepts I engage in this discussion. I admit that I am puzzled by the complexities of the mind/body interaction. I have become much more flexible since undertaking this project, regarding how I understand mental disorder. I continue to believe that science has not articulated a certain explanation for the connection between the environment, the mind, individual biology, and mental disorder. To consider the concept of mental disorder, one enters the ambiguity of uncertain, evolving, and divergent streams of discourse. Throughout Western history humankind has grappled with socially-based and physically-based understandings of mental disorder and with variants of both. Tantamount to this concern are the questions of how best as a community those deemed to be mentally disordered should be treated.

As a social constructionist researcher, I turn a critical gaze towards those who claim certainty in their knowledge of mental disorder. Kuhn (1962) suggests that all knowledge is situated in paradigms of understanding and a critical scrutiny of all paradigms of understanding

is an important quality for those engaged in the research process. Understandings are constructed through reflection and an ongoing conversation (Kvale & Brinkman, 2009) and I construct an order upon the past in order to contextualize the present. For all of these reasons mentioned above, I present a discussion of four separate discourses that influence Child and Youth Care practice in various ways. These are:

1. The Historical Discourse of Mental Disorder
2. The History of the Diagnostic and Statistical Manual for Mental Disorders
3. The History of the Development of Strength-Based Practices in Social Care
4. The History of Child and Youth Care as an Emerging Discipline

The Historical Discourse of Mental Disorder

All disease is a socially created reality. Its meaning and the response it has evoked have a history. *Ivan Illich, The limits to medicine (1990, p. 172).*

Distinct views of madness.

Some scholars argue that "madness" or mental disorder, as it is known today, pre-dates Western civilization (Kroll, 1986; Porter, 2002). For these scholars the construct of the temporal continuity of mental disorder across cultures is used to support the claim that mental disorder represents an authentic organic pathology. For positivist science, mental disorder is known as a form of brain dysfunction and psychiatry represents a medical speciality devoted to the discovery, diagnosis, and treatment of this condition. In this view, mental disorder is a behaviourally, cognitively, and emotionally manifested bio-chemical dysfunction of the brain, and as such represents a legitimate object of empirical science (Fleming & Manvell, 1985;

Martin, 2007). In this construct the Western history reflects a steady progression in understanding and treatment of mental disorder concurrent with the advancement of post-enlightenment science. These scholars consider mental illness as "an easily treatable condition, not essentially different than any other medical problem" (Porter, 2002, p. 325).

A psychological orientation to mental life and mental disorder is represented in the Freudian concepts of the psyche and personality (Blundo, 2006). Here, the unconscious is postulated as an agentic entity within the mind, as an actual ontological essence with instinctual drives which constrain and compel behaviours of the self. The unconscious is explained as a primary source for psychic conflict, whose manifestation results in irrational behaviours, defined as mental disorder. These beliefs are reminiscent of the concept of a Cartesian soul or spirit, where personality is separate from, yet connected to, the body. Other influential psychological explanations for mental disorder also emerged in the 20th century, including Behaviourism and Humanism which also suggest a predominately intra-personal explanation for behaviours that are today defined as mentally disordered.

A sociological outlook suggests that mental disorder does not represent an object in nature (Foucault, 1987; Gergen, 1994; Jaynes, 1976; Szasz, 1970). That is, mental disorder and the meanings that surround it are known as artefacts of culture. This positioning suggests that mental disorder cannot be understood as existing with the ontological certainty of clearly defined physical conditions such as heart disease, diabetes, or high cholesterol. Here, mental disorder is viewed as a subjective construct that does not hold the necessary ontological foundation to make it an object of empirical science. This critical outlook views the social construction of a diagnosis of mental disorder as a step towards an efficient cost effective means for managing a troubling population found within our communities and suggests that classification and management of the

mentally disordered reflects the political needs of social care funders. In this understanding, the label of mental disorder reflects the existence of socially based problems for an individual in a particular context, but it is also seen as a means to medicate or separate those in the community who do not fit in and who are unproductive, from the mainstreams of our community.

Each distinct outlook of mental disorder is concerned with the aetiology, the "location", and with the remediation of that which is labelled mental disorder. In this discussion, I will provide a brief account of the historical development of these popular discourses of mental illness in Western culture as each discourse has influence on the treatment practices of the *Kids Place* program.

Early Western history: The construction (discovery) of the mind.

Scholars of the philosophy of mind suggest that the individual mind was socially constructed, in conjunction with the development of language and self awareness in the earliest human cultures (Dahlbom, 1994; Harre, 2005; Jaynes, 1976; Leahey, 2005; Porter, 2002). They note that in ancient Greek writings, there was no concept in language for "person" or for "oneself". They argue that for early humankind the concept of the subjective individual self had not yet come into being and the mind, as conceptualized as a possession of the individual person, only emerged as a broadly recognized construct, in the last millennium B.C.E. The source of madness, understood as arising from within the self, occurred in conjunction with this construction, (or discovery) of the brain, as the location for individual consciousness. Prior to this construction (or discovery), mental disorder was understood as a form of spiritual procession.

The debate concerning the location of mental disorder remains active today. Clearly the brain processes what the mind does, but the location of mental disorder as in the mind/psyche, as

in the brain, or as in the space between mind and culture, is undecided, and reflects the epistemological distinctions in play, at the site of this research.

A belief in madness as a form of spiritual possession derives from the earliest human history (Jaynes, 1976) and is a notion that ebbs and flows, well into the Middle Ages; remnants of this belief remain active in our communities today. What we know today as mental illness was understood by early human-kind as a conflicted and individual contact with mystic deities. The Golden age of Greek culture, represents the dawning of a subjective sense of the individual self and of the construct of mental disorder as an intra-personal phenomenon. In time, Hippocrates' explanation of madness as a physical illness replaced the belief in madness as mystic possession (Leahey; 2005), but with the decline in influence of Greek culture and the growing popularity of Christianity, Western culture returns to a spiritually based explanation for madness. This renewed explanation integrated a concept of a subjective individual self with the new accompanying construct of the soul/psyche.

Madness in the Middle Ages, 500 - 1500 AD.

Following the adoption of Christianity in the Roman Empire in 313 A.D. a mystical conception of the aetiology of mental disorder re-emerged as the predominate cultural construction of madness (Leahey, 2005; Wahl, 1995). Christian understanding held a belief that the soul was the object of a competition between good and evil. Madness was again known as a form of possession of the soul and this could be a possession by a prophet of God or by Satanic (evil) powers (Porter, 2002). Of note are the cultural dynamics in play in the process of defining aberrant social behaviour, as the social standing of the "possessed" person played a role in how unusual behaviours were interpreted. Fleming and Manvell observe that "if the afflicted person was a person of stature – his hallucinations were interpreted to be "visions" or insights and his

mumblings and rantings were believed to be messages from God" (1985, p. 22). Conversely, those who did not hold high social status "were simply considered to be deranged, and were left in the care of their families or left on the street" (p. 22).

In the Middle Ages those deemed to be behaving irrationally or suspiciously, were frequently treated as witches and held responsible for events like extreme weather and crop failure (Porter, 2002). This practice seems absurd in the context of the 21st century, yet it also reflects a desire to construct and narrate connections between phenomenons of interest. Treatment of mental disorder in the middle ages necessitated driving the evil spirits from the bewitched soul (Fleming & Manvell, 1985). The lunacy that was presumed to lie within the individual was considered to be exorcised through trial and punishment. The social impact of these views of mental disorder was considerable. Porter (2002) estimates as many as 200,000 persons were executed as witches during this period.

Enlightenment dualism: The mechanistic model and the mind as soul.

The 16th through 18th centuries were a time of transition in the understanding of mental illness. A belief in witchcraft as spiritual possession gave way to an understanding of mental disorder that held the beginnings of a modernist scientific tradition. In the Enlightenment, the location of cause for mental disorder in popular discourse again moves from external sources to natural causes emanating from a physical dysfunction, within the individual (Porter, 2002). Reason held that spiritual possession did not constitute a valid explanation for the phenomenon of mental disorder. In this newly emergent outlook, the aetiology of madness was returned to the body and like today various theories of causation were tried and tested.

In the Middle Ages, the label of a mental disorder remained a social stigma (Wahl, 1995) and a means of separating the socially troublesome from the broader society. In this era poverty

and social dislocation is widespread, resulting from rapid industrialization in this era; the impoverished and vagrant become a significant threat to social stability for European governments (Cunningham, 2006; deSchweinitz, 1975). European society in this period enters a time of radical economic re-alignment and the dawn of industrialization produces the workhouse, as the first government sponsored form of social care in European culture. The workhouse represents a place for all social undesirable or destitute citizenry including the mentally disordered (Charles & Gabor, 1991).

For scholars concerned with a critical structural analysis of social practices, the concept of madness as disease serves to separate those whom are judged unfit to live within society, from the greater whole (Foucault, 1987; Szasz, 2007). As Porter (2002) suggests "disease diagnosis constitutes a powerful classificatory tool and medicine contributes its fair share to the stigmatizing enterprise. Amongst the scapegoated and anathematized by means of this cognitive apartheid, the "insane" have been conspicuous" (p. 63). The possibility that the social and economic structures of society of the time were unable to meet the social and economic needs of its citizens was at best a dawning consideration of government. The label of individual deficiency is seen by structuralists as a cover for the ills of society and its deficiencies as a whole. Yet there was no doubt that some in society had a genuine desire to help the afflicted. Their attempts to address the needs of those deemed insane appears as a sincere effort to provide care with the limited resources available to them (Cunningham, 2006).

By the late 17th century a secularized understanding of mental disorder was established in Western discourse (Porter, 2002). Madness was drawn into the domain of medical science and by the 18th century it is defined as a social, spiritual, and medical problem.

In spite of the growth in influence of empirical science, within both the Enlightenment era and the Romantic era which followed the soul remains in a place of explanatory primacy for those wishing to understand the self (Porter, 2002). The soul was known as a fact of human existence and the new science of the enlightenment attempts to accommodate its existence theoretically (Morton, 1997). In this period of Christianity the soul was known to facilitate consciousness while the mind continued to be understood as distinct and separate from the body, the place where the soul is located. For Descartes (1596 – 1650), consciousness and the soul/spirit are considered as God-given and therefore as inherently rational. Therefore, insanity is defined as an irrational behaviour derived from a malfunction of the body. The cause of insanity must be found in and removed from the body to remove its impact on the mind/soul/spirit.

By the late 17th century, Thomas Hobbes (1588 – 1679) and John Locke (1632 -1704) refute Descartes position of rationality as an inherent quality of consciousness (Porter, 2002); their influential philosophy suggests that consciousness arose from experience. They believed that the mind and memory was a tabula-rasa and for the mad dysfunctional learning (and behaviour) was imprinted on the consciousness. Their early learning theories led to attempts to provide more humane re-educative conditions for treatment of the mentally disordered.

Hobbes and Locke were among the first in Western culture to consider the contributions of the material and social conditions of living to mental disorder; they believed that through mis-experience a deluded and false consciousness arises in the sufferer of madness, who learns to be irrational. A return to rationality was offered through a process of re-education in medicalized treatment settings. Their influence marks the earliest Western practice of separation of the mad into distinct medicalized facilities designed specifically for their treatment (Porter, 2002).

As the discourse concerning the concept of madness evolved in the mid-18th century, the movement to institutionalize those who were previously left on the streets or jailed expands to the European country sides (Porter, 2002). By the end of the 18th century, the mad are no longer jailed and Western culture witnesses the emergence of the asylum as a specialized facility for care and treatment (deSchweinitz, 1975).

Reflecting the new socio-medical understanding of madness, many asylums of the early to mid 19th century were relatively humane in their treatment of patients, and increasingly concerned with the "irrational depths of the psyche" (Porter, 2002, p. 140). Psychiatry as a discipline arose out of an interest in both patient management and diagnostic classifications, for the increasing number of asylums that dotted the countryside. The changed conditions for asylums in the 19th century reflected a belief in the effectiveness of therapy and included a strict prohibition on physical restraints. Music, movement, and milieu therapies were initiated in this era. The emerging science of asylum management, a fore-runner of the medical specialization of psychiatry, proclaimed the therapeutic value of exercise, proper diet and attire, healthy patient-staff relationships, and meaningful daily and productive routines within the asylum.

The popularization of the asylum as a place of humane treatment and refuge resulted in their overuse and overcrowding and by the late 19th century the physical conditions of the asylum-systems deteriorated (Porter, 2002). Governments of the day continue to remove the behaviourally deviant from their communities, but they were reluctant to accept the costs for humane treatment of this population. Notably, the mad then as now, were often victims of severe stressors and trauma, including social and economic displacement due to the rapid industrial growth (deSchweinitz, 1975). The problem of madness appears to increase as natural systems of social supports decline with a shift from feudal to capitalist economies. The "physicalists", who

understood madness as arising from bodily dysfunction, continued to experiment with physically-based treatments for mental disorder using a wide range of methods, including dunking into freezing water, beatings with rods, and rapid spinning of the horizontally prostrate patient on large flat rounded wheels to the point of unconsciousness (Foucault, 1987).

The Romantic era, 1780-1850.

The era of Romanticism in Western culture marks a departure in popular discourse from the empirical science-based and medicalized understanding of madness that gained prominence following the enlightenment (Fleming & Manvell, 1985; Gergen, 1994; Porter 2002). In the Romantic era, the aetiology of madness becomes broadly understood as arising from the depths of the soul or psyche, and the soul/psyche continued to be understood as apart from the body. This outlook provided theoretical consistency with Cartesian dualism and enabled empirical science to continue to co-existence in harmony alongside Christian theology. Mental disorder was given an aura of mystery and genius during this time and madness was thought to coexist alongside artistic creativity. In a counter-reaction to the domination of Enlightenment reason, in the romantic era humankind was understood as guided by something deeper than reason, that being morality, feelings, and instincts which came forth from deep within the interior self.

In the romantic era the deep interior lay beneath the "veneer of conscious reason" (Gergen, 1994, p. 20). Reflecting the discourse of these times Gergen notes "Wordsworth called the deep interior "a presence that disturbs me"; for Shelly it was an "unseen power", and for Baudelaire it was a "luminous hollow."" (p. 20). The body is again understood as a mechanism, while the soul and consciousness are set apart from the rational understandings of the body and remain a puzzle to science.

The romantic era concept of the mind as a deep interior, in union with Enlightenment empiricism sets the stage for the work of Freud in psychology (Fleming & Manvell, 1985). While studying hypnosis under Charcot and Mesmer, Freud became aware of the existence of layers of consciousness in his patients. By the late 19th century Freud published his view of the unconscious, as an agentic essence, that lay deep within the mind as a force within the self which drives consciousness, but that was independent of consciousness. Freud later suggested the construct of the personality derives from the unconscious self (Gilliland, James, Roberts, & Bowman, 1984). The construct of the unconscious, as an agentic component independent of the conscious mind is a belief popularized by Freud through psychoanalytic theory. Freud's theories play a transitional role in shifting cultural understandings of mental disorder from the romanticist to modernist discourse. Freud's writings unify the romantic era notion of the deep interior, with a modernist notion of the necessity of sound scientific theory and objective empirical evidence, though by the empirical-positivist standards of today, Freud's work is suspect.

The romantic era conception of the self and mental disorder peaked in the 19th century, yet remnants of this thinking remain with us today. The continued understandings of the concept of personality in scientific and popular discourse are an example of a commonly used concept of the romantic and modern eras. The concept of personality reflects a Freudian view of a relatively stable essence inside the self which drives the conscious mind and guides the external behaviours of the individual. The self is considered as a bounded being whose psychic development occurs as an independent entity in interaction with the social world.

Towards the end of the 19th century, psychology emerges in Western culture as the discipline dedicated to the understanding of the mind as separate from the body (Porter, 2002). Curiously, originating from a Cartesian-Kantian philosophical concept that the mind was non-

material, psychology established itself as a separate natural science of the mind (Erneling, 2005a,b). Yet Kant had argued that as a non-material entity, the mind was impossible to study as a form of science. Erneling notes the epistemological contradiction in this view

> All the main traditions or schools of psychology, after its inception as a separate science of the mind … fall within the boundaries of this Cartesian-Kantian conception of the mind. They accept this [non-material] conception of the mind, yet at the same time challenge these traditions by claiming that the mind can be studied the same way as the rest of nature and with similar methods. (p. 17)

Modernity: The 20th century.

By 1900, psychiatry was often reduced to acting "as society's policeman or gatekeeper, protecting it from the insane" (Porter, 2002, p.186). For example, the eugenics movement of the early 20th century in both Europe and North America witnessed tens of thousands of persons rendered infertile through involuntary sterilization. Utilizing psychiatric discourse to justify their actions, these people were deemed by many Western governments as mentally inferior and therefore both undesirable and disposable. In Germany, the leading professors of psychiatry provided lists to the Nazi government of over seventy-thousand patients who were later executed for having a diagnosis of mental disorder.

In this period separate schools were established throughout Europe for children who were labelled as suffering from mental disabilities. This segregation reflected an underlying concern that the mentally disordered, as defective beings, might mix with the rest of the population and procreate. An authoritative British psychiatric figure in the early 20th century, Dr. Alfred Tredgold (as cited in Cunningham, 2006), wrote:

> The feebleminded, the insane and the epileptic have been allowed to mate to such an extent with healthy stocks that, although the full fruition of the morbid process may have been thereby delayed, the vigour and competence of many families has been undermined, and the aggregate capacity of the nation has been seriously reduced. The taint is, in fact, slowly contaminating the whole mass of the population. (p. 189)

Interestingly, the narrative that surrounded this activity serves to define the nature of the activity. This same "segregation" is in evidence at *Kids Place,* yet a common narrative surrounding this segregation is one of care and concern for serving the special needs of the school population. Alternatively, a narrative that suggests the population of *Kids Place* is a detriment to the efficient operation of the C.B.E. school system suggests an alternative understanding for the purpose of the *Kids Place* program.

By the early 20th century, the medical specialization of psychiatry is established and it attempts to protect society from the mentally disordered. It is primarily neurological in its aetiological and treatment orientation in North American circles. However, as Fleming and Manvell (1985) state "during the 1920's psychiatry still emphasizes a physicalist approach, though some American psychiatrists, looking beyond mere chemistry, were beginning to stress the significance of human feeling in mental disease" (p. 31).

At this same time, in Europe, Freudian psychoanalysis was becoming increasingly popular (Gilliland et al., 1984). Throughout much of the 20th century Freud's narrative of the self, ego, the unconscious drives and defence mechanisms had a significant influence on discourse in psychiatry, psychology and popular media, particularly in continental Europe and North America (Wahl, 1995).

In the 1930's an impending World War resulted in a massive exodus of psychoanalytically oriented and predominately Jewish psychiatrists from continental Europe to North America (Gilliland et al., 1984; Porter, 2002). The sheer numbers of these psychoanalytically trained practitioners caused an abrupt turn towards psychoanalytic explanations for mental disorder in North America. This turn to psychoanalysis as a predominating discourse again suggests the reciprocal influences of politics, culture, and science. Gilliland et al. state "the results of this migration were that America becomes the strongest centre for psychoanalysis in the world" (p.11). Consequently, "psychoanalytic theory [became] the foundation of all modern counselling" (p. 10).

Concurrent to the development and predominance of a Freudian psychoanalytic understanding of mental disorder, an alternative physicalist stream continued to focus on a brain-based aetiology of mental disorder (Porter, 2002). By the 1930's electric-shock treatment, lobotomies, and induction of coma, were experimental treatment methods administered to thousands of patients diagnosed with mental disorders of varying types. This era is reported by Porter as one in which the asylum conditions are more likely to resemble "concentration camps" than hospital settings.

In the 1920's and 1930's, Adlerian psychoanalysts suggested the importance of the interpersonal origins of schizophrenia (Fleming & Manvell, 1985). The construct of an interpersonal aetiology of mental disorder contributed to Gregory Bateson's interest in the impact of family communications on schizophrenia in the 1950's. This research examined the mother's influence on the creation of schizophrenia and the idea of the "schizophrenic mother" entered mainstream discourse around this time (Becvar & Becvar, 1996). In this era, a person's relationship with their mother was broadly understood to contribute causally to both mental

disorder and homosexuality. Homosexuality was defined during this period, as a form of mental disorder.

Around this same time, psychiatrists Milton Erickson and Adolph Meyer developed context oriented and pragmatic outlooks to the processes of treatment in their practices. For Meyer "the main thing is that your point of reference always be life itself and not the imagined cesspool of the unconscious" (as cited in Fleming & Manvell, 1985, p. 33). For Erickson, "utilization" techniques and an "atheoretical" approach are a move away from interest in causal factors in treatment of mental disorder, to a search for meaning-based solutions considered as separate and apart from cause (Haley, 1985).

Following World War II, the perception of psychiatry as a means for social control of deviant behaviours continued, leading to the anti-psychiatric de-institutionalization movement of the 1960's and 1970's (Porter, 2002; Szasz, 1970, 2007). In an effort to provide a cost-efficient means to address the troubling behaviours of the mentally disordered in the late 20th century, psychiatry increasingly turns to the use of psychotropic medications as a means for symptom relief. As this development unfolds, a bio-psycho-social model for understanding mental disorder re-emerges, reflecting a notion of the person as a "*unitas multiplex"* first suggested in the late 19th century. This constructs the person as a "psycho-physical life unit" (Erneling, 2005b, p. 25), in contrast with a bio-physical or mechanical orientation that underlies many day-to-day practices in the treatment of mental disorder today (Fisher & Greenberg, 1997).

Conclusion

The evolution of understandings of mental disorder is linked to the cultural discourses from which they originate. As humankind constructed shifting paradigms of understanding the self, so too, the understandings and treatment of mental disorder follow. Early humankind

constructed or discovered the existence of the mind as an individual possession. From this period forward, various Western cultures work to define the individual self, to construct explanations of mental disorder, and its location, that reflect the broader understandings of self in the culture.

The constructs of mental disorder also reflect a polarity between the need for the management and the need for treatment and care of the mentally disordered within the collective. Throughout the period covered in this discussion, the location of mental disorder is conceptualized as triangulated between physical, intra-psychic/spiritual, and social origins. The means for the remediation of mental disorder follow in lock-step with the discourse that surrounds mental disorder, as we witness physical, spiritual, intra-psychic, and social methods that are developed for its treatment.

No singular orientation to understanding mental disorder is consistently definitive in the history of Western culture but in recent practice our systems of care and treatment have shifted towards a medicalized understanding of mental disorder and a business model for the provision of diagnosis and treatment, driven by the needs for efficient use of limited financial resources within our health care system. I will now provide the reader with a critical discussion of the medicalized construct of mental disorder.

CHAPTER 3

The 21st Century, the Century of the Brain:

Critical Concerns for the Medical Model and Bio-Psychiatry

> *There has never been a time in history, when so many children – are being given drugs that powerfully affect mind, mood and behaviour. This constitutes a unique mass-scale experiment in social engineering, whose outcomes may not be easily discerned at present.* (Cohen, 1999, p. 1)

To begin this section, I note that a critique of the influence of pharmaceutical interventions and of the DSM itself, is a subset of the larger epistemologically based discussion about the theory of knowledge that best accompanies our understandings of mental disorder, and the needs of the mentally disordered. As Agnew (2008), Dilthey (as cited in Schwandt, 2007), and many others have suggested, there exists two distinct paradigms or "solar systems" of knowledge in this regard. Positivists and social constructionist understandings each offer their own views of the nature of experience and knowledge, and each appears incommensurable with the other. Duffy, Gillig, Tureen, and Ybarra (2002) note "the categories of the DSM fall squarely within the positivist tradition insofar as the descriptions of mental disorder are regarded as providing coherent models of pathological behavior across contexts and over time" (p. 364). Criticism of the DSM medical model orientation to mental disorder and its influence on social care practice reflects the theory of knowledge that the one adopts. In this discussion, I have included critical concerns that emerge from both inside (positivist) and outside (social constructionist) views of the DSM and its related practices.

Critical Concerns for Pharmaceutical Interventions

President George H.W. Bush declared the 1990's to be the decade of the brain and in this declaration suggested the explanation of the mind/brain connection referred to as the "hard problem" of consciousness, were imminent (McGinn, 1991; Tandon, 2000). It was believed that once the answer to the hard problem was found, the presumed neuro-biological causes of mental disorder would facilitate a final solution in the treatment of mental disorder. The problem of defective brain chemistry and underlying genetic predispositions, viewed as culpable, would be addressed through pharmaceuticals designed to address these presumed causal neurological dysfunctions (Mental Health America, 2009; National Institute of Mental Health, 2007).

A tension that is inherent to the biologically based conceptualization of the location of mental illness, concerns the puzzling effectiveness of placebo for relief of mental disorder (Fisher & Greenberg, 1997; Kirsch Deacon, Huedo-Medina, Scoboria, Moore, & Johnson, 2008). Placebo is a non-biological psycho-social variable on par with suggestibility or expectancy. Placebo can be effective in relieving symptoms of mental disorder in clinical trials when compared to the use of an active psychotropic agent, also shown to relieve symptoms. If a biologically based understanding of mental disorder is an accurate and complete explanation of aetiology, then presumably an empirically proven active agent shown to remediate symptoms of mental disorder will have a significantly greater remediative impact than placebo. Yet this is not consistently shown.

The impact of placebo when compared with an active psychotropic agent reflects a divergence of longstanding, concerning specific and non-specific causality within medicine and biology (Fisher & Greenberg, 1997). This ongoing concern merits attention; with reference to the notion of specific versus non-specific causality, Shepard (1993) writes:

> It [specific vs. non-specific causality] is bound up with a fundamental dichotomy contrasting the Platonic or "ontological" with the Hippocratic…view of disease…The ontological notion of disease postulates an independent, self-sufficient entity (e.g., a diagnostic category) with its own natural history; the Hippocratic emphasizes the individual biography of the patient. (p. 569)

The ontological/Platonic view of disease accepts a Cartesian view of human biology as mechanistic and applies this concept to mental disorder. The individualist/Hippocratic view suggests a need for a subjectively inclusive and holistic approach in considering aetiology. For Hippocrates, the subjective individual is central to understanding the needs for treatment; for Plato, the "needs" of the disease or disorder (as an object of science) is given primary consideration in treatment protocols. While a view of human biology as mechanistic has merit in the more purely physical realms of medical sciences, its premise as ontologically foundational to the understanding of mental disorder is in question. The Hippocratic/individualized view reflects a belief that the "point of reference always be life itself" (Meyer as cited in Fleming & Manvell, 1985, p. 33) this view suggests that we cannot understand the individual and his or her actions without reference to the contexts of meaning in which these actions occur. In specific reference to mental disorder, I would also suggest that it is contradictory to consider any form of behaviour as a disease or dysfunction. Further, the mental, as a non-material realm cannot be conceptualized as disordered or ill in the same manner by which bodily dysfunction is conceptualized.

While the pharmaceutical industry explains the effects of its psychotropic medications for the treatment of mental disorders as inherent to the chemical structure of the agent in question (Kutchins & Kirk, 1997), closer examination of this claim is warranted. The impact of the

individual state of mind and context related variables on the effects of drug impact are widely known (Fisher & Greenberg, 1997; Shepard, 1993). Stated simply, the state of mind in the subject who ingests a psychotropic medication and the contextual circumstances they find themselves in cannot be separated from the impact of the drug itself. The impact of any psychotropic drug on any individual at any given time is variable and not fixed. The results of a purely biologically based drug treatment for mental disorders cannot be known, as this result is rooted in an unachievable level of objectivity and experimental design control. Subjective factors such as an individual's state of mind and the experience of context cannot be bracketed away to achieve the necessary degree of objectivity required by positivist research. Further, psychotropic medications in use are not administered in contexts devoid of these characteristics.

Numerous factors impact the effectiveness of a placebo in experimental trials making experimental design and variable control exceedingly difficult for positivist science (Fisher & Greenberg, 1997). For the social constructionist, these factors suggest the importance of the constructs of meaning established within the experimental process, as these factors influence the empirically based claims of the effectiveness of the drug in question. Factors that impact the effectiveness of a placebo in experimental trials include but are not limited to the following:

- whether the experimental active agent is administered in a group or individual setting,
- if the administrant or patient is optimistic and hopeful,
- if a therapeutic alliance exists between the administrant and subject,
- if an active placebo (a placebo with side-effects) is used and
- the overall emotional quality of the setting in which the experiment takes place

Normative labels attached to the medications and placebo also have a role to play in their impact on the user (Fisher & Greenberg, 1997). For example, the agent Thorazine, when

represented as a placebo, has a significantly distinct impact on the subject than when it is represented as an active agent. In addition, functional impact similarities are reported between placebos and psychotropic medications (Seidel, 2005). This impact is well established in empirical studies concerned with the effectiveness of anti-depressants (Kirsch et al., 2008). Interestingly, research that claims these experimental drug trial results are no better than placebo are often interpreted by the popular media as indicating that the active agent in question is ineffective. An alternative view suggests that while a medication may be no more effective than placebo, an active psychotropic agent and a placebo can both be effective in providing relief from mental disorder.

Many scholars note the linkage of biology, mental life and culture, and suggest that the shift from a sociogenic or psychogenic to a biogenic approach to intervention for mental disorder creates ontological confusion for the broader social care community (Brothers, 2002; Gergen, 2005; Seidel, 2005). Their view suggests the existence of a relationship of mutual determinism between mind and brain whereby neuro-chemistry affects the mind, while activities of the mind such as sudden tragic loss, or psychotherapeutic intervention, affect the neurochemistry of the brain. In this view, biochemistry generally plays an expressive role in psychological experience and not a causal role.

It is incorrect to suggest that neuro-chemistry is a conclusively causative factor in the majority of mental disorders. For example, in the depressed state of mind as Seidel suggests, “the biology of mental disorder is a level of expression, not the basis of psychological problems” (Seidel, 2005, p. 164). The meaning of an event is an equally plausible explanation for a depressed mood, which then results in alteration in the individual’s serotonin levels. This reaction roughly parallels the sensation of pain following a burn that has damaged tissue of the

skin. It is mistaken to treat the pain as causal in the same way it is mistaken to presume the altered brain function as causal, though similarly it may be expedient to treat both conditions concurrently. Empirical evidence shows that in instances where a placebo has been found effective in treatment of a mental disorder, the changes to brain chemistry are identical to that of the changes experienced by use of the active psychotropic ingredient shown to relieve the disorder. This phenomenon suggests that something beyond biology is taking place in neurochemical improvements in brain functioning.

Aside from the use of psycho-tropic medications, numerous other interventions, including psychotherapeutically oriented psychosocial activities are also capable of identical measurable alterations in brain functions, to those derived through medications (Fisher & Greenburg, 1997; Seidel 2005). Neuro-chemical brain functioning is altered because of non-chemical interventions in an identical manner to the alterations provided by psychotherapeutic interventions. In addition, these changes are not shown to be the result of any specific theoretical orientations to psychotherapeutic treatment (Duncan & Miller, 2000). Rather, according to Duncan and Miller positive therapeutic outcomes are attributed to the quality of the therapeutic relationship between social care providers and social care recipients.

Physiological or neurobiological changes may be evoked through use of medications, but also through physical exercise, diet, increase in blood sugar, development of a sense of hope, sudden good or bad news, meditation and psychotherapy, (Friedman, 2002; Kirsch et al., 2008; Scott, 2007). Somehow immaterial thought arouses material bio-chemical changes in ones physiological functioning while material medications intermittently contribute to the altered interpretation of subjective experiences. The relationship between the mind and body is the “hard problem” of human consciousness (McGuinn, 1991) and suggests a neuro-physiological

orientation to mental disorder is an epistemological positioning, while a bio-psychiatry model presents brain functioning aetiology as ontological; not as a means for understanding, but as a de-facto fait accompli causative agent.

Concerning the mind-brain interaction, it is also noteworthy is that where established psychoactive agents fail to ameliorate the patient's condition, brain chemistry remains unaltered, in spite of the use of medication shown to be effective in clinical trials (Seidel, 2005). This again suggests that more than a psychoactive agent is at play with pharmaceutical interventions. In these cases "drug *responders* rather than drug *recipients* tend to show brain function changes that are comparable to responders to psychosocial interventions such as psychotherapy or placebo" (Seidel, p. 165). If a socio-cultural or psychological change as reported by the subject does not take place in spite of the use of medications, brain chemistry remains unaltered. A social construction of perceived change in individual experiences often leads to changes in the brain chemistry, regardless of the specific intervention methods.

Brothers (2002), offers a similar criticism of the turn to the neurological in psychology and psychiatry and suggests a conceptual confusion in bringing these two concepts together in a reductionist manner as "experience and its meanings are nonreducible to material things like brains. Corollaries to this argument are that trying to translate them into each other distorts both" (p. 858). Brothers believes the problem is that concepts of the brain and the mind lie in two distinct realms, reflecting Dilthey's distinction between Geisteswissenschaften and Naturwissenschaften as two distinct realms of knowing. Brain related concepts involve specific and distinct locations of neuro-chemical activities. This is distinct from mind related concepts, where meaning is held and derived from interaction between "self" and culture. Somehow each

appears able to influence the other and the "hard problem" of explaining mental consciousness remains.

With mind related concepts, we are engaged in discussion of human actions explained by social practices and individual agency, and not reductionist and empirical investigation (Foucault, 1987; Gergen, 2005; Harre, 1998, 2005; Johnson, 2005; Leahey, 2005). Concepts such as drive, affect, thoughts, emotions, wishes and the concept of mind itself do not hold the same ontological status as neuro-chemistry (Brothers, 2002). These are artefacts of culture and are not objects of science in the same sense that neuro-chemistry is an object of science. To date, drives, wishes, internally derived impulses and unconscious thought, while measurable as neurological activity, hold value and understanding as both cultural constructs and as empirical science.

Both Brothers (2002) and McGinn (1991) also suggest that in spite of claims of some within the neuro-science community (e.g., Churchland, 1986), there is no central theoretical framework yet established to provide a clear understanding of the mind-brain linkage. The construction of a science of brain chemistry as equivalent to the activities of the mind is not a full and complete explanation for the phenomenon of mind and the question of where mental disorder is located remains uncertain.

Concerning the mind-body connection, Johnson (2005) adds that the problem with equating the brain with the mind is that "people who accept it often assume that all the explanatory factors necessary to make sense of the mind are present in an unproblematic, illuminating, researchable way, in the brain itself" (p. 9). However, the brain is not shaped exclusively by genetics; it is also transformed over time by the environment. For Johnson, two rival hypothetical theses exist to explain the mind. The first suggests that the mind is the same as

the brain and the second suggests that the mind is a cultural and relational product. A third possibility suggests that the mind and mental disorder exists in the relationship between biology, mental life, and culture, and the means by which this relationship occurs is not fully known to science.

Neurophysical processes are a necessity to the functioning of the mind but one cannot reduce mind to brain functioning. As Erneling states, "We are not just brains interacting with other brains, but are human beings acting as social agents undertaking various projects in accordance with local conventions" (2005b, p. 249). He adds, "To explain typically human mental phenomena only in terms of the brain is like trying to explain tennis as a competitive game by referring to the physics of ballistic trajectories" (p. 250). The processes that give rise to consciousness, as the puzzle of the ghost in the machinery, remains uncertain. The conscious self is influenced by, but cannot be reduced to brain-chemistry processes. A unifying account of how, at the level of neuro-chemistry, mental life and mental disorder is caused, structured or organized remains in doubt. At this same time, social constructionist theory contributes value to our understanding of mental life, if one supports the notion of mind as a construction of culture in linkage with a human physiological ability for language (Harre, 2005).

Brothers (2002) and McGinn (1991) are amongst many scholars who suggest that neuro-science is at a point of natural history in its development comparable to astronomy in the time of Ptolemaic theory (400 B.C.) - a time when the earth was understood as the centre of the universe. Research continues to attempt to explain the brain/mind connection but to date, for scholars like McGinn Brothers and Damasio (1994), no adequate explanation exists for how mind activity is derived from brain activity.

In the absence of a unified explanatory theory for the "hard problem" of consciousness, psychological or socio-cultural concepts cannot be satisfactorily reduced to neurological explanations. A neuro-chemical explanation for mental disorder is a convincing narrative resource to establish the legitimacy of the link between mind and brain but this story is not supported by the empirically based positivist science from which it originates. Brothers (2002) adds that this narrative is more political than [positivistic] scientific in nature. This narrative serves an explanatory and covering function that justifies specific actions that are beneficial for those who construct the story. Brothers is among many scholars who note the influence of politics on the discipline of psychology. Neuro-science, as an unquestionably "hard" science, offers the discipline of psychology an opportunity to lift itself to a higher level of scientific legitimacy, similar to that of physics or chemistry. This has been a centuries old quest for the disciplines of psychiatry and psychology (Porter, 2002).

Brothers (2002) who is a psycho-analyst and neuro-biological researcher, uses her experience to suggest that psychiatry in the decade of the brain has "embraced neuroist stories [excluding] a larger, contextual view of the patient…this narrow focus is helped by the massive financial incentives the pharmaceutical industry brings to bear on physicians to view their patients as essentially walking brain disorders" (p. 869). Brothers suggests social care in the area of mental health is being profoundly shaped by economic forces as a result of an uncertain pretext in research and unreliable diagnostic constructs, supported by financial incentives and the persuasive discourse of the pharmaceutical industry.

The Medicalization of Mental Disorder

Illich (1990) notes that the expansion of pharmaceutical industry influence in mental health treatment coincides with its expansion of influence and profit in all health care services in

Western industrialized nations. He believes that the definition of health and health care has undergone a radical technology-driven transformation in recent decades and that illnesses derived from iatrogenic[2] sources can be shown to contribute to the massive increases in health care expenditures in Western nations. He adds that significant improvements to health are much more likely to result from improvements to living conditions for the community as a whole and not because of complex technological advances.

As community members we often give over our responsibilities for our own health care, including mental health care, to the specialists whom we presume to be more knowledgeable than are we about our well-being. Yet the economic influences in play, including the drive to efficiency, represent a business model of health-care delivery and may undermine the integrity of the services that are provided. Illich refers to this process as the heteronomous[3] regulation of the individual person's bio-psycho-social homeostasis. In trusting others expertise in the realm of mental health care, we may set aside our own intuition and knowledge concerning our own well-being.

Mate (2004) supports this position and adds that the transformation Illich refers to in health care is a change in the way Western cultures construct illness and health, often removing the person-in-context from the health care equation. "The separation of mind and body that informs medical practice is also the dominant ideology in our culture. We do not often think of socio-economic structures and practices as determinants of illness or well-being" (p. 224). In support of this view Mate adds that "the media and the medical profession – inspired by pharmaceutical research - tirelessly promote the idea that next to hypertension and smoking, high

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[2] a medical disorder caused by the diagnosis, manner, or treatment of a physician
[3] the condition of being under the domination of an outside authority, either human or divine

cholesterol poses the greatest risk for heart disease." Yet research suggests that other factors are more important, supporting the view that general stress levels and job strain are more important than all other risk factors combined.

Raphael (2009) also notes the intersection of mental health treatment and the social determinants of health. He suggests that while media coverage of health care related issues continues to be dominated by an individualistic and biomedical orientation to health, social determinants make up the majority of the determinants of good health. For example, he estimates that, since 1900 for Canadians, only "10-15 percent of increased longevity is due to improved health care" (p. 8). Raphael also suggests that an individualistically oriented focus towards mental health is mis-leading and harmful to the populace, for its tendency to lead attention away from the social and economic conditions that contribute to mental disorder.

Conclusion

To state the obvious, drug companies are corporations interested in maximizing the profits of their stakeholders through marketing and research. These companies use their pharmaceutical products to do so; it is also in their corporate interests to create and promote a need for their products. Doty (2009, as cited in Mabel, 2009) and Raphael (2009) note that the pharmaceutical industry is now the third largest revenue producer in the U.S.A. In Canada its products now consume approximately 18% of the Canadian health care budget. This number represents a 100% increase in health care expenditures in the last three decades, totalling billions of dollars. Doty also adds that far more is spent on marketing drugs than on their research. It is reasonable to presume that drug manufacturers are interested in what is best for their shareholders and the shareholder is their primary concern.

It follows that in an effort to maximize profits, drug manufactures try to create markets where none existed previously. Doty (2009) refers to this as an attempt to "medicalized ordinary issues like sweat while exercising…we're seeing an explosion of disorders, and now there is a pill to treat everyone" (Mabel, 2009, p. 3). Doty adds, "Their [drug company] studies are designed to achieve pre-determined results, and negative results are not published" (p. 3). He adds that medications prescribed for conditions that are deemed chronic, such as Ritalin for attention deficit disorder, or Prozac for depression and anxiety, represent a "virtual gold mine for the industry" (p. 3).

Social care systems are naturally interested in maximizing the efficiency of the delivery of services, which includes maximizing the effectiveness of the services they offer. This can be constructed as an attempt to manage a troublesome population with the least amount of financial expenditure, or conversely, this may also be constructed as an attempt to maximize the effectiveness of their services to serve as many as possible, with the finances available. What distorts the balance in this efficiency/care equation are the promotional efforts of those who profit from mentally disordered individuals who are in need of some form of social care as profit incentives draw their motives into question. The DSM represents a diagnostic tool that serves as a basis for a pharmaceutically dominated medical model approach to treatment of mental disorder in children. It is on the basis of a DSM diagnosis that pharmaceutical interventions are tested and utilized. For this reason an examination of the positivist claims for diagnostic legitimacy of the DSM now merit consideration. I will now turn this discussion towards a brief history of the constructs of the DSM.

The Diagnostic and Statistical Manual for Mental Disorders:

Constructing the DSM and its Evolving Diagnostic Criteria

The section to follow offers a discussion of the effects of the evolving DSM constructs of mental disorder on social care practice, with an emphasis on its impacts for Child and Youth Care. The DSM is a component of the medical model of health care and represents a mechanistic and positivist-reductionist orientation to the care and treatment of the mentally disordered children in our various social care systems, including education, health, child welfare and youth justice systems. It is a particular form of understanding and offers a particular form of discourse that permeates many treatment modalities. The impact of DSM discourse, including the construction of mental disorder and mental illness is not measurable by empirical methods, yet discourse has the ability to create our understandings. It is therefore of interest to highlight the history of DSM and to consider how the impact of this medicalized discourse has an impact, perhaps incipiently, on the experiences of research participants, who are subject to its influence.

The History and Tradition of the DSM

The DSM has undergone 6 revisions since its original conception in 1952. It has evolved from the DSM I, which was a 130 page document, with 106 diagnoses to the current DSM IV-TR with 886 pages and 297 diagnoses. DSM I and II reflected a fusion of psychiatry and psycho-analysis (Kutchins & Kirk, 1997; Maniacci, 2002). When the DSM I and II were in current usage, “psychiatry and psychoanalysis were virtually identical”, according to Maniacci (p. 356). In its more recent volumes the DSM has given more attention to environmental factors (1 ½ pages) than previous versions, but it remains individually focused (Raphael, 2009). Its legitimacy is derived from its association with medical science and it is highly influential for social care practitioners (Fewster, 2004; Fleming & Manvell, 1985; Kutchins & Kirk, 1997).

The medicalized version of the DSM began with the DSM III (Kutchins & Kirk, 1997; Maniacci, 2002). The impact of this transition was a significant transformation in the way mental disorder was defined. Thomas Widiger, a co-author of the medicalized versions of the DSM is candid about the result stating: "The DSM is crucial [in the treatment of mental disorder] because, like any language, it governs how clinicians think about their clients" (as cited in Nietzel, Speltz, McCauley, & Bernstein, 1998, p. 73). Widiger adds that "The biggest challenge in the future will be an increasing reliance on neuro-chemical models of [mental] disorder" (as cited in Nietzel et al., p. 73).

Sperry (2002) describes the transition from a psychoanalytic orientation to a medical model understanding, as "revolutionary" in its impact on treatment: "I say revolutionary because DSM III soon influenced nearly every aspect of mental health treatment and even the mental health profession itself" (p. 353). According to Sperry, until the arrival of DSM III diagnostic labels were infrequently utilized in treatment, aside from generic descriptions such as a diagnosis of "adjustment reaction. Diagnostic labels such as depressive neurosis, anxiety neurosis disorders, or hysterical personality disorders were considered too stigmatizing" by its users (p. 353). With the introduction of the DSM III the manual grew from a 134 pages to 700 pages.

Typically, the DSM is a required assessment tool in the mental health care treatment process. Its formal purpose is the identification and categorization of mental pathology within the individual. A second purpose for the DSM, within the C.B.E. school system is to enable access to the social care funding necessary to provide adequate treatment interventions for DSM diagnosed students. These expenditures include the use of psychotropic medications and psychotherapeutic human resources. In many children's social care services, including the site of this research, funding for additional human resources would not be available without a DSM

diagnosis (Fewster, 2004; McGeen, personal communication). A DSM diagnosis enables access to treatment resources and reasoned criteria must be in place to determine which children in need of additional life supports receive treatment. The DSM suggests problems as more or less severe and is purposeful in this way. This judgement is highly reliant on the behavioural descriptions of the individual child by significant others in the child's lifespace.

The impact of the DSM on the education of social care practitioners is also noteworthy for its tendency to orient its users to a deficit-focused interest in detecting pathology; and often when a practitioner seeks pathology, they will find it. As Sperry states, "previously, the counseling profession had taken great pride in differentiating itself from "pathology." With the introduction of the DSM III, the health care system "embraced much of what DSM III stood for: therapeutic treatment for psychiatric conditions and disorders" (2002, p. 353). Following this transition, "reimbursement and even authorization for services were denied if the diagnosis was not severe enough to meet the criteria of 'medical necessity'" (p. 353). He adds that workshops for training practicing counsellors were "held in major cities several weekends a year. Graduate programs in counseling that had been 30-credit programs now were doubled in length" in order to qualify practitioners for licensure to enable 3rd party billing for the newly created medical conditions of mental disorder identified in DSM III. The hegemony of the health-care delivery system has significantly altered the discourse of psycho-therapeutic practices in treatment of mental disorder, with an increased focus on individual pathology.

The medical model and its diagnostic and medication orientation towards mental health remains a predominant treatment modality employed to gain control over mentally disordered behaviour in children (Leifer, 2007). A DSM diagnostic label is required in many Canadian school districts and social care agencies, before resources are allocated to address specialized

needs for children in these environments. Brendtro (2005) refers to treatment modalities typified by use of physical restraints, isolation, mechanistic punishment regimes, and psychotropic medication as a "coercive" practice. Brendtro suggests that where child behaviour management becomes challenging for adults sharing environments with children the first choice for intervention is often a coercive method of behavioural control.

Child and Youth Care practitioners are practicing in an era of endorsement and promotion of the medicating of children as a means of treating evolving DSM constructs. In many social care settings, medications are used for behavioural management and therefore represent an expedient but coercive means for cost savings to the social care system, concurrent with the removal or de-prioritization of relationship based interventions (Crary, 2007; Fewster, 2004; Philip, 2007). Also of concern, the interaction between the normal biology of developing children and the medications they are provided following a DSM diagnosis, are uncertain and under-researched (Anderssen & Picard, 2008). There is evidence that some psychotropic medications block the natural production of oxytocin and vasopressin that "may actually interfere with the youth's ability to establish a productive bonding experience in a therapeutic alliance" (Foltz, 2008, p. 3). More simply stated, a child who sleeps 12 hours per night, who can barely stay awake during the day or function in the "here-and-now" is not likely interested in or fully available for a relationship based therapeutic contact, due to their pharmaceutical impairment.

In my personal experience as an agency based social care practitioner and educator, I have witnessed many occasions where it was politically expedient to construct a child's disorder to be as severe as possible, in order to meet the diagnostic criteria necessary for continued or increased treatment funding. This is a widely reported concern among Alberta-based Child and

Youth Care educators. These actions are disquieting for Child and Youth Care practitioners educated in relationship-based practices. These practitioners may desire improved staff-to-client ratios in their practice environments, but improved staff-to-client ratios normally result from increased funding; funding is increased when a child's mental disorder can be shown to be severe. There is an incentive built into the social care system, in these circumstances, to construct a severe sick role for the client in order to provide well staffed social care services for the client.

What makes this process a concern?

As Illich (1990) suggests, when a doctor "diagnosis's a cow's distemper it does not affect the patients behaviour. When a doctor diagnosis's a human being, it does" (p. 97). As a healer, the physician confers on the disordered, rights, duties and excuses which have a temporary legitimacy that lapses once the condition is remedied. No one is concerned with the ex-appendectomy patient, or the person who has overcome a high cholesterol count, as having a particular social status. However, where the doctor acts in the capacity of a "social engineer" or as an "actuary of disorder", as Illich states, a psychiatric diagnosis "can defame the patient, and sometimes his children for life. By attaching irreversible degradation to a person's identity it brands him forever with a permanent stigma. The objective condition may have long since disappeared, but the iatrogenic label sticks" (pp. 97-98). Nevertheless, psychotropic medications are also highly valued by many Child and Youth Care practitioners in practice for their (apparent) relief of symptoms; Ritalin is cited as particularly common in use in the public school system (Cohen, 1999).

Concerning Ritalin and drug safety, Psychiatrist researchers Cherland and Fitzpatrick (1999) reported that 9% of children treated with Ritalin in their Saskatoon clinic developed psychotic symptoms, including "hallucinations and paranoia." Concerning the use of anti-

depressants, the Public Health Agency of Canada (2005) has issued warnings regarding the use of selective serotonin reuptake inhibitors (S.S.R.I.'s) in treatment of adolescent depression and anxiety, with research that suggests the use of this medication is capable of increasing the likelihood of suicide in adolescents. This finding was replicated in 2008 with a finding that the use of S.S.R.I.'s may increase the likelihood of adolescent suicide by as much as 25% (Katz, 2008).

The medical model for children's mental health offers an administratively efficient and systematic means for dealing with the problems of troubling behaviours in children in the C.B.E. school system. The trend towards replacement of human relationship based interventions with medicalized psychotropic interventions of uncertain diagnostic reliability suggests that care in mental health settings follows a model, where treatment efficiency is a primary consideration. Yet what may be financially expedient for short-term management of a health concern may have costly long-term consequences concerning the construction of a particular form of identity for the patient. Constructing sickness and the presence of a chronic condition may result in a long-term dependency upon a medicalized understanding of what arguably, are circumstantially based troubles, both for the patient, his or her significant others and the health-care system as a whole.

Examining the Validity of DSM Constructs

The DSM as a component of the medical model of health care has originated from positivist science yet its own authors question the validity of its diagnostic and construct reliability (Kutchins & Kirk, 1999; Spiegel, 2005; Williams, Gibbon, First, Spitzer, Davies, Borus, J., et al., 1992).

Since its inception in 1952 inter-rater diagnostic reliability and construct validity have been an ongoing concern and remain so with the most recent version. These concerns are

explained as resulting from “inadequate training of interviewers, information variance, and low base rates for many disorders” (Williams, Gibbon, First, Spitzer, Davies, Borus, J., et al., 1992, p. 630). The construction of the medicalized versions of the DSM is replete with stories of the domination of Robert Spitzer the Chairman [sic] of the DSM III task force whose single-handed decision making in the creation of DSM III resulted in a fundamental revision of concepts of mental disorder between DSM II and DSM III. As Allen Frances, a member of the DSM III diagnostic task force comments regarding Spitzer’s process of decision making “he must have had some internal criteria” for decision making within the process of the construction of DSM III “but I don’t always know what they were” (Spiegel, 2005, p. 3).

Allen Frances is a Psychiatrist who worked under Spitzer during the writing of the DSM III and DSM III-R, and was later appointed as Chairman [sic] for writing the DSM IV and DSM IV–R. He comments on the continuing reliability problems for recent versions of the DSM saying, “without reliability the system is completely random, and the diagnoses mean almost nothing – maybe worse than nothing, because they’re falsely labelling. You’re better off not having a diagnostic system” (Spiegel, 2005, p. 3). Troubling rates of inter-diagnostic agreement regarding the mental condition of the patient significantly complicate appropriate psychotropic treatment of a patient’s condition. The relationship between a diagnosis and empirically based research of any psychotropic remediation is therefore also in question. If there is uncertainty concerning a particular diagnosis due to concerns surrounding rates of diagnostic reliability, then this uncertainty would carry over to the experimental testing of medications. That is, an experimenter may not know with certainty what diagnostic condition a subject of an experimental trial of a particular medication is actually suffering from.

In spite of the DSM's author's claims of aetiological neutrality (Fisher & Greenberg, 1997), it is apparent that since the third edition the medicalized discourse surrounding a DSM diagnosis implies that a diagnostic category of mental disorder is a medical condition within the individual. Organizational affiliates and sponsors of the authors of DSM actively promote the belief that mental disorder is a bio-chemical imbalance with underlying genetic origins which can in many or most instances be relieved with psychotropic medications (Kutchins & Kirk, 1997; National Institute of Mental Health, 2007). These medications are developed, tested, heavily promoted and sold by pharmaceutical companies who are working with diagnostic constructions of questionable that may not be valid and reliable representations of an objective medical condition. Although the assessment methods in the DSM include consideration of psychosocial and environmental problems, this section of the manual entails only one and a half pages of discussion, out of a nearly 900-page manual. Further, this brief description has remained unaltered since the 1994 version (Raphael, 2009).

Concerning reliability of recent editions of the DSM, as recently as 2005, Robert Spitzer, the author of the first medicalized versions (DSM III and DSM III-R) states "to say that we've solved the reliability problem is just not true… it's been improved. But if you're in a situation with a general clinician it's certainly not very good. There's still a real problem, and it's not clear how to solve the problem" (Spiegel, 2005, p. 62-63)

A concern with clinical trials designed to test medications for DSM diagnosis is often the lack of independent double-bind studies that utilize active placebos to provide empirical support for the use of medication to treat mental health related conditions (Duncan & Miller, 2000). In addition, use of active placebo's make it more difficult for the subjects in clinical drug trials to determine whether or not they have been administered a placebo. Empirical investigation into the

diagnostic reliability of the DSM (Spiegel, 2005; Williams et al., 1992) indicates concerns for both diagnostic inter-rater reliability and for construct validity of DSM disorder classifications. The influence of financial incentives upon the construction of the diagnostic criteria is also concerning. As Fewster (2004) states "within the service delivery system, the drug companies have used their influence to create the mechanisms whereby agency funding and professional fees are based upon the psychiatric diagnostic labels used to justify pharmaceutical intervention" (p. 1).

On a related critical note, Tanyoue (1998) reports that 96 percent of drug research funded by the drug manufacturers concludes with favourable results concerning a drugs effectiveness. He adds that only 37 percent of drug research studies that are not funded by pharmaceutical companies conclude with favourable results concerning a drug's effectiveness.

With reference to the empirical objectivity of diagnostic criteria, particularly when used to medicate children, drug companies and psychiatry acknowledge it is lacking (Anderssen & Picard, 2009). Fewster comments on a highly common diagnosis for children: "no objective validation of the diagnosis of attention deficit and hyperactivity disorder (ADHD) exists" (Fewster, 2004, p. 2). Reliance on psychotropics is potentially stigmatising and children's conditions may not show improvement, or may worsen because of their use (Crary, 2007; Foltz, 2008).

The diagnostic procedure often relies on reports of individuals untrained in mental health diagnosis including for example, teachers and parents, who are highly involved observers of the problem behaviours they report. The social context surround the assessment process for mental disorder may characterized by high degrees of stress. This stress suggests the possibility of an imbedded bias towards a finding of pathology.

Whether the DSM as a diagnostic tool of empirical science meets the criteria for validity of the epistemological framework from which it originates is in question. If this is the case, then an inaccurate or erroneous diagnostic construct is potentially more harmful than the absence of the construct. This also suggests that there may be no relationships between diagnosis and "cure". Significant pharmaceutical research efforts are based on DSM diagnostic constructs; this research serves as the basis for medications designed to treat DSM disorders. One may ponder what medications recommended to alleviate DSM diagnostic constructs in children are being used to accomplish? One possibility suggests that by medicating the child, we make life easier for others in the child's environments (Cosh, 2009).

Defining a Mental Disorder

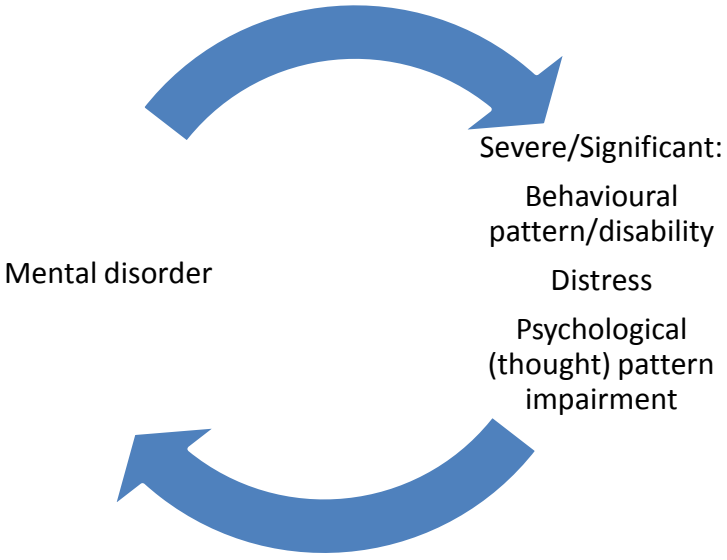
Aside from the technical concerns already identified in this discussion, consider the definition of mental disorder cited in the DSM IV:

> In the DSM – IV, each of the mental disorders is conceptualized as a clinically significant behavioural or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g., a painful symptom) or disability (i.e., impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability or an important loss of freedom…whatever its current cause, it must be considered a manifestation of a behavioural, psychological, or biological dysfunction in the individual. (American Psychiatric Association, 2000, p. xxi)

Mental disorder is located in the individual and disorder is understood as synonymous with illness. The dysfunction in question is one that implies a metaphor of underlying disease. The term dysfunction is left undefined within this text, but suggests the failure of an undefined

internal mechanism that is performing inadequately. If the reported dysfunction of concern is a problematic behaviour or thought, then this understanding represents a form of circular reasoning. The DSM/medical model defines mental disorder as a characteristic of a clients' dysfunctional biology, psychology or behaviour. A patient's dysfunctional behaviour and psychology are both a sign of the dysfunction and a cited cause of dysfunction, as mental disorder is a "manifestation" of individual behavioural, psychological or biological dysfunction. Further to this reasoning, the concept of dysfunctional behaviour and thinking is determined through social consensus concerning what constitutes normal behaviour and thought. This determination is a social construct that is influenced by political, (power and influence related) concerns in local environments. The DSM does not define mental health or normalcy.

Figure 1. The circular relationship between mental disorder and behaviour.



Adapted from the *Diagnostic and statistical manual of mental disorders* (4th ed.), American Psychiatric Association, (2000). p. xxx-xxxi.

DSM discourse locates mental disorder as an illness with a physiological basis, with contributing environmental factors (National Institute of Mental Health, 2007). Quoting the National Institute of Mental Health, "what goes awry in the brain to cause mental illness may ultimately be traced to glitches in genes - but not necessarily the parts of genes commonly suspected. Rather, to the areas of genes that code for proteins" (n.p.). Evidence of the spread of this illness-based genetic explanation for mental disorder in popular discourse is seen in various media outlets. For example, on a recent cover of *Ladies Home Journal*[4] (Renkl, 2009, January), readers are provided advice by which they will be able to "turn on your happy gene"; ironically, the method for turning on this gene is based on changing one's personal social constructs of experience. As Mate (2004) suggests "genes are turned on or off by the environment" (p. 229).

Constructs of the Medical Model Impact on Treatment of Mental Disorder

Drug therapies for children and adults are increasingly widespread and Ritalin, as an example of a commonly prescribed drug for children, is prescribed for as much as twenty percent of school-aged males in some Canadian school districts (Cohen, 1999). Philip (2007) reports that 47% of permanent wards of the province of Ontario are receiving psychotropic medications for diagnosis of mental disorders, while Zito, Safer, dosReis, Gardner, Magder & Soeken et al (2003) examined changes in the full spectrum of psychotropic medication treatment for youths from 1987 to 1996, providing analysis of treatment data on over 900,000 youth in the U.S.A. Zito, et al., report a 2 to 3 fold increase of psychiatric medications in most classes of medication

[4] I note to the reader that this section of discussion has relied on both academic sources and reports from popular media sources. The non-academic sources are used for their conveyance of discourse found within the culture and for the content that is germane to this discussion.

in this period. Zito also reports that children in foster care are 16 times more likely to receive a psychotropic prescription than their non-foster care counterparts.

According to Medico Health Solutions Inc. (2003, as cited in Sparks & Duncan, 2008), for the first time in the history of the U.S.A. spending for medications to treat childhood behaviour problems surpassed spending for all other drug categories including antibiotics. Medico Health Solutions Inc. (2004, as cited in Sparks & Duncan, 2008) also reports that between 2000 and 2003, spending for A.D.H.D. increased in the U.S.A. by 183%.

Canadians spend $60 million daily on prescription drugs, including $6 million per day on psychotropic medications (Picard, 2009). The use of S.S.R.I.'s in American children has increased 50% between 1994 and 1997 (Martin & Leslie, 2003). Most of this increase has been for "off-label" medications, that is, for medications whose use has not been approved in children by the American Food and Drug Administration.

The use of psychiatric medications in early childhood populations is correlated to the attitude the early childhood educator has towards use of the medication (Totten, Frankenburger, & Stroh 2008). The more strongly education professionals believed that psychotropic medication aided classroom control, the more likely children in their classes were receiving psychiatric medication.

Similarly, Pringle (2006) reports on the whistleblower efforts of Dr .Stefan Kruszewski, a Harvard trained Psychiatrist whose job it was to oversee psychiatric programs in the state of Pennsylvania. In his attempts to end psychiatric prescription abuse, Kruszewski reports that both adults and children in state care were commonly prescribed as many as five psychiatric medications at once. According to Dr Kruszewski "they were putting almost all the patients on the same concoction of antipsychotic and antiseizure drugs," (n.p.) in spite of the fact that most

of these patients were neither psychotic or suffering from seizures. The motivation for this practice is reported as behavioural control and drug company profit, as state sponsored programs are billed by drug manufacturers directly for their products.

Pringle (2006) also reports that drug company Eli Lilly in 2004 billed the state of Florida Medicaid "over $20 per pill for [anti-psychotic medication] Zyprexa according to a Presentation to Senate Health and Human Services Appropriations Committee on January 13, 2005" (n.p.). The discontinuation of this single drug in Florida alone cost Eli Lilly over $70 million (U.S.D.) annually according to the Indianapolis Business Journal (November, 2005, as cited in Pringle, 2006). The results of the medicalization of mental health reinforce the belief in popular media and culture that troubled feelings or behaviours is a medical phenomenon that requires pharmaceutical intervention.

Fewster (2004) reports that in the U.S.A. psychiatric medication is prescribed for 15% of all school-aged children; this represents a 75% increase in the use of medication in the last five years. He adds that the use of psychiatric medication, "for children *two to four years old* tripled between 1991 and 1995" (p. 3).

Duncan and Miller cite that in the U.S.A. "in 1996, 600,000 prescriptions for Prozac alone were written for kids under the age of eighteen and 203,000 for children between the ages of six and twelve. Three thousand scripts were written for infants under the age of one" (p. 20, 2000) in spite of the absence of clinical support for the effectiveness of their use in children (Fisher & Greenburg, 1997). Typically, the motivation cited by health care professionals for prescribing medication for troubling behaviours is that the medication in question relieves the problematic behaviour due to a brain-chemistry imbalance - the evidence for which is the behaviours of children in specific environmental contexts. This neurochemical imbalance has not

been established as a causal factor with certainty by empirical science while the link between pharmaceutical company profit and the promotion of drug therapies is well established and of concern to social care providers (Fewster, 2004; Kruszewski, 2005; Leifer, 2007; Seidel, 2005).

Money Talks and an Insider Speaks

Concerning the impact of profit on diagnosis and treatment of mental disorder, Steenhuysen (2009) reports that "undisclosed financial ties between researchers and drug makers have eroded public confidence" (n.p.) in the integrity of the research conducted by drug manufacturers. While Kruszewski (2005), also expresses a concern for the deteriorating public perception of the psychiatric profession and reports that there exists a credibility gap within psychiatry. He states that the "credibility gap is widening as the disclosure of public psychopharmaceutical embarrassments continue to destroy its [psychiatry's] image." Addressing the American Psychiatric Association (APA), Kruszewski offers two suggestions towards improving the wellbeing of psychiatry as a discipline. He identifies both research integrity and conflicts of interest within the discipline as of major concern. Concerning the conflict of interest Kruszewski states the "A.P.A. cannot continue to bankroll its operations and research efforts with monies from pharmaceutical companies and expect the public to respect either its advertising hyperbole or research results" (n.p.). Kruszewski also adds:

> A fundamental problem for A.P.A.'s governing bodies is denial. It is not unlike the denial pervasive in drug and alcohol addictions or any other problem when a person, group, or organization either refuses or - for whatever reason - cannot deal realistically with issues that confront it. [The] A.P.A. and its governing bodies need to look within themselves - with the capacity for honest and revealing gut-wrenching, insight-oriented organizational analysis. Until [the] A.P.A. is able to shake loose the chains that bind it to the pervasive

> influences of pharmaceutical and technical-gadgetry corporations (whose hefty price tags include an assault on the credibility of every research and clinical Psychiatrist), the golden age of psychiatry will be only a glimpse of what has been, since the seeds of psychiatry's future failures will have been nurtured by psychiatry's current inability to address the prostitution of its core values and worth. (n.p.)

Implications for Child and Youth Care

Understandings of mental disorder and the communities' social responsibilities to intervene are carried forward in our culture through the discourses emanating from the scientific sources of knowledge that we commonly turn to for understanding. Some scholars suggest that neuro-psychology is attempting to replicate for psychiatry what physiology has done for medicine (Brothers, 2002). As a social constructionist researcher, I believe that "mental pathology" requires methods of analysis different from those of organic pathology and that it is only by an artifice of language that the same meaning can be attributed to "illnesses of the body" and "illnesses of the mind" " (Foucault, 1987, p. 10).

As an interesting forerunner to a position later adopted by narrative therapists, Foucault suggests the task of the therapeutic agent in treatment is to intentionally undermine the patient's sense of the reality of his condition. In so doing the understanding of personal problems as a form of mental disorder, held by the client - the clearing created for the individual for his own understanding of self - is expanded. In a manner similar to that suggested by White and Epston (1990), therapeutic interventions may re-story the experience of the client. The client will benefit from understanding that his problems are *a* way of understanding and not *the* way of understanding.

Child and Youth Care practice in recent years, has been drawn to an outlook of growth and development and a non-pathological orientation to social care (Anglin, 1999; Durrant, 1993; Ferguson, Pence & Anglin, 1993; Maier, 1991). At the same time there appears to be uncertainty as to how a Child and Youth Care practitioner maintains this commitment in the face of often overwhelming pressure from other professionals in interdisciplinary settings, and from the influence of the broader deficit-focused discourse itself. The influence of medical model and deficit focused outlooks that dominate the field of social care is pervasive.

The treatment practices for mental disorder continue to be influenced by a medical model and deficit-focused outlook and by a continuation of an orientation towards the use of technology and technological skills by social care funding bodies. Some suggest an alternative to a medical model epistemology of diagnosis and treatment is available in the guise of strength-based practice. I will now consider the development of strength-based practice and the context of modernist theories of therapeutic intervention for mental disorder.

CHAPTER 4

The Development of Strength-Based Practices: Modernism and Psychoanalytic, Cognitive-Behaviourist and Humanistic-Existential Theory

At the time of my first client contact as a Child and Youth Care practitioner, the theoretical ground for practice appeared to be wide ranging, and highly diverse. Each of the three major theoretical orientations of the day, which included psychoanalytic, behaviourist, and humanist theories, appeared to offer distinct and plausible narratives for treatment of mental disorder. Each outlook either overtly or implicitly focuses on a problem solving model of intervention (deJong & Berg, 2008). Each model also conceptualized the individual as containing an interior self as a more or less stable entity. Although the behaviourist discourse of the day played down the importance of the interior self while focusing on faulty or maladaptive learning, the individualist orientation of the self remained. For the behaviourists the mind was constructed as sets of patterns of concrete, observable behaviours and dispositions to behave (Johnson, 2005).

Each of the predominant models I speak of was oriented to resolving what is known today as mental disorder, in its own unique manner. The problem-focused outlooks of each of these models situated these problems within the individual while acknowledging the influence of environment. Typically, the environment was a backdrop for the development of the individual internal self. Faulty ego development and intra-psychic conflict, maladaptive learning, or incongruence between meaning, emotion, and one's experience of self concept represent some of the thinking underlying the psycho-dynamic, behaviourist, and humanist views of the self (Gilliland et al., 1984). Today, a problem-focused outlook in social care practice is widespread.

A treatment position that understands mental disorder as within the individual is a perspective that is held by many social care practitioners.

In my years as a practitioner, I have engaged in assessment processes in highly professionalized multi-disciplinary medical settings, where vastly expensive and elaborate procedures were undertaken in the process of definition of the problem. The embedded presumptions within this assessment practice were that the definition and causation of the mental disorder in question could be established. It was believed that defining the problem and its cause with the certainty of the diagnostic system would lead to a means to resolve the problem and within some models of treatment of mental disorder assessing and defining a client's problem is a process that may take several sessions of client contact. In my practice experience with some children this process has taken several weeks of psychiatric-inpatient care, for problems to be diagnosed with "certainty". While stabilizing a child in crisis is a valued intervention, in retrospect, these diagnostic activities seem like a form of performance that was based upon a premise surrounding mental disorder that was questionable in its ontological status. It was also impressive how many social care professionals from within many disciplines of knowledge were able to co-ordinate our roles within the assessment process in order to perform this ritual.

Today, many social care practitioners continue to believe it is anathema to engage in a client contact without a proper assessment of the problems that have brought their clients in contact with the social care provider. In this way a deficit-focused story of one's social history is often a typical beginning step within the larger construct of defining the traditional helping process. An assessment-diagnosis-treatment process reflects a medical model orientation to establishing cause and providing cure and as I have reviewed in Chapter 3, behaviour is a means

for determining what illness or disorder is existent within the individual. I will now consider the discourse of the medical model and its influence on the community of social care providers.

The Medical Model

The apparent diversity of thinking between the three influential theoretical orientations to social care I speak of hold in common a medical model or deficit-focused outlook, and this commonality results in similarities in treatment approaches to social services. Regardless of what brought the social care provider in contact with the "patient," "client," or "consumer" of social care, each model of understanding shares the sense that the problem and its resolution originates within the inadequacies of the self of the individual. Here, the individual is viewed as an independent and bounded entity, separate from others.

The helping process within these models of social care follows a similar structure. The problem and its solution are necessarily inter-connected within this approach (deJong & Berg, 2008). If the cause of the problem is determined, attention is focused on alleviating the causal factors. Where social context is of interest in treatment, it is viewed as useful for shaping learning through rewards and punishments or as a place to play out the dynamic tensions that existed within each patient/client/consumer the professional encountered (Becvar & Becvar, 1996).

Additional commonalities within each of these models for intervention are a sense of the objective reality of the problem and a hierarchical top-down, or expert-driven orientation to it's treatment. Each model is prescriptive in defining the problem for the client and for defining the means to its remediation. A theoretically defined sense of the problem and its causes as knowable implies that social care practitioners can become knowledgeable about these problems as objective constructs, and that science can gain knowledge and develop expertise about these

constructs (deJong & Berg, 2008). This theoretical object-knowledge then constitutes the expertise of the helping professional. The social well being of an individual is turned over to expert professionals, who then direct a client towards their version of cause, effect, and remedy. This hierarchical process parallels much earlier beliefs in Western culture of turning over one's responsibility for personal well-being to mystical faith-based solutions. This practice ironically, may be of benefit because of a client's belief in their efficacy. Illich (1990) suggests health can only decline when survival depends, beyond a certain point, on the heteronomous[5] regulation of the individual person's homeostasis. Gergen (1994) refers to this process as a cycle of progressive infirmity.

A Paradigm Shift: The Discourse of Systems Theory

In addition to the three previously mentioned theoretical orientations to social care that predominated modern thought, a fourth significant therapeutic movement and re-configuration of thinking in the 20th century is found in systems theory. Representing a paradigm shift in the area of treatment of mental disorder, systems theory located problems of mental disorder as originating from within a family interactive process. Rather than focus on the individual, this approach represented the development of a unique view in understanding social problems. Mental disorders were defined by systems theory, as located in the *interactions* between persons, rather than primarily within the person. The certainty of linear causality came under scrutiny with systemic thinking.

The family therapy movement developed as a systemically oriented interdisciplinary approach in social care. Its early scholars were influenced by Freud's associates Jung and Adler

[5] the condition of being under the domination of an outside authority, either human or divine.

as both noted the impact of the context and relationship on the individual (Becvar & Becvar, 1996).

While researching the influence of context on madness in the mid -1940's, researcher Gregory Bateson (1971), influenced by the work of Psychiatrist Milton Erickson, investigated the communicative aspects of behaviours, and how problem behaviours seem to be supported in context, via a process of feedback loops, referred to as cybernetics (Haley, 1985). Cybernetic theory was developed in conjunction with a wide range of disciplines and was concerned with organization, patterns and processes, rather than content. Bateson's research in the relationship between communication and mental disorder was joined by Jay Haley and John Weakland in 1953 as they worked to develop a communications and interactions based understanding of the cause of schizophrenia (Becvar & Becvar, 1996). In 1956, the double-bind hypothesis was developed in a paper titled *Toward a Theory of Schizophrenia*, based on the earlier philosophy of Bertrand Russell's theory of logical types of 1901, applied to communications within an intersubjective context. A theoretical approach that was primarily concerned with the external dimensions of relationships in context emerged in this period.

Relocating the Problem

Building on Bateson's project, in the 1960's, Paul Watzliwick, John Weakland, Don Jackson, Virginia Satir, and Janet Beavin explored the influences of communications on the aetiology of schizophrenia (Becvar & Becvar, 1996). The problem for the schizophrenic individual was defined as an ineffective or faulty double-bind family communications style. Later, the biological systems theory of Ludwig von Bertalanffy was combined with cybernetics, and the family systems method of therapeutic treatment of whole family units gained prominence in the 1960's. This theorizing lent itself to Germain and Gitterman's (1979/1996) life model or

ecological model of practice widely adopted by social work educators and practitioners in the early 1980's. This model for social care and treatment of mental disorder viewed individual development as a contextually based interactive process, viewing identity construction as a source for problems and as a resource for change.

A significant contribution the systemic outlook makes to the understanding and treatment of mental disorder was to re-visit the relationship between context and the person. Systems theory stressed the importance of understanding people's behaviour in context and the importance of working to establish healthy contexts of living. As Bateson (1971) wrote "It is the context that fixes meaning" (p. xx). Prior to the popularization of systems theory the symptoms of the mentally disordered patient were "examined in isolation, apart from his or her network of family relationships" (Nichols & Schwartz, 1995, p. 69) - a medical model tradition of constructing the problem of mental disorder as within the patient.

The family systems approach to social problems in the 1970's was a new understanding in the way to know mental disorders that were previously understood as contained within the individual. Explanations for individual mental disorders were re-narrated to suggest that specific individuals within the family were "symptom bearers" serving to express the families' interactionally-based disorder. With the shift in location of cause the tensions and responsibilities for whatever deviant behaviour was of concern were disseminated in such a way as to remove or at least reduce the impact of blame towards the individual,.

Bowen (1978), Haley (1976), Minuchin (1974), Satir (1967), Watzlawick, Weakland, and Fisch (1974) amongst numerous others developed theories to resolve the problems that brought their clients to therapy utilizing a systemic-interactive paradigm of understanding individual problems in relational contexts (Nichols & Schwartz, 1995). These clinicians developed

reputations as *Master Therapists*, reflecting the continuing importance of hierarchical-theoretical expertise in treatment of mental disorder. Typically, each model of systemic intervention reflected the earlier theoretical backgrounds of their authors. Those with histories in psychoanalytic, behaviourist and humanistic interventions tended to construct their systemic model, incorporating these outlooks into their own unique theory of systemically based aetiology. Each of the predominate systems models continued to be problem focused and most were silent concerning concepts like resilience, strengths, narratives, or movement directly towards solutions. Also of note, the therapist's expertise and the model for intervention were credited for the change that occurred in the process of therapeutic contact.

The location of mental disorder shifted during this time, but the focus for intervention remained the problem as defined by the model of treatment (Nichols & Schwartz, 1995). It is also noteworthy that many of the problems addressed within the therapeutic processes of social care were more likely to be defined as problems of living, rather than being defined as forms of mental disorder, as they are today.

The process of treatment at this time continued to resemble a doing-to process rather than a doing-with process and the goal of restoring the fully functioning capacity for the individual, or individuals within the family (as determined by the model for treatment) reflected this understanding. The professional helper as expert was understood as responsible for the processes of change during this time, as he or she often continues to be today. The concept of resistance was often employed to explain failure to achieve successful therapeutic outcome (deShazer, 1984).

Mental Disorder and Meaning as a Social Construction

Working with an understanding that a family is a system composed of a multitude of shifting meanings, a group of Psychiatrists in Milan, Italy, became known for the development of the Milan model of family therapy (Selvini Palazzoli, Cecchin, Prata, & Boscolo, 1979). This group theorized causality for problems as a circular event and in relation to meaning as constructed and evolving. This model of therapy shifts the locus of interest in treatment of mental disorder, from individual narratives to narratives of relationship and communally constructed meaning.

In conjunction with the Mental Research Institute in Palo Alto, California and researcher-practitioners Watzlawick et al. (1974), the Milan group began to focus on the meanings individual family members attached to the problems within the family, and on behaviour as a communications tool for expressing meaning. Their interventions focused on new constructs of meanings (positive reframes) for behaviours in the family and on environmental contexts and not necessarily on changing behaviours themselves. Behaviours were understood as a form of communication and were therefore purposeful. Moving beyond a behavioural focus meant addressing the needs that were communicated by problem behaviours.

Berger and Luckmann (1966), Gergen (1971) and others were, simultaneously, working on the development and articulation of a social constructionist perspective of meaning during this time. Social constructionism later became adopted as an epistemological grounding for many of these new communications oriented theories for intervention (deShazer, 1994). When mental disorder was seen as an interactive construct within the context and not as material to the context the certainty of mental disorder as a material object of science lessened.

An Alternative to Problem and Deficit Focus

In the late 1940's, Milton Erickson, an Arizona Psychiatrist narrated his psychiatric practice as an "atheoretical" approach to the treatment of mental disorder (deShazer, 1994; Haley, 1985). When questioned about his treatment model Erickson offered little by way of coherent theory or epistemological outlook concerning methods. It appeared Erickson was uninterested in explanations for causation and moved directly towards problem resolution for his intervention efforts. Erickson worked to change the patient's view of the problem and the means by which they would enact their problems. He would utilize whatever his patients would offer, including their cooperative nature, to facilitate positive outcomes. His work was closely investigated by many of the family therapists and theorists in the 1950's, 1960's and 1970's, who would later create and enact their own theories to explain and replicate Erickson's successful outcomes (for example, Zeig, 1988).

Two students of Erickson, Steve deShazer (1979) and Bill O'Hanlon (1987), began a shift in their approach to treatment of individuals and families in difficulty. DeShazer believed that one could make changes in a family, while working with individuals alone, and this itself was unusual to many traditional family therapists of the day. However, what was more noticeably received during this time was his insistence that the cause of the problem was not of concern, and at any rate, cause could never truly be known. Utilizing Wittgenstein's (2001) language games concept in his social constructionist based therapy, deShazer (1984, 1994) aimed to turn the attention of the therapeutic community exclusively towards constructs of solutions, strengths, and abilities in a collaborative client-helper relationship. Admittedly, deShazer's approach represented another theoretical construct that was applied within the intervention process between client and therapist, and was hierarchical in this respect. However, he worked to

incorporate the client's beliefs concerning problem definitions, goals and means to achieve preferred outcomes, and this aspect of his model was collaborative. In addition to his "compliments" technique and his radical views about resistance, deShazer's model contributed to the establishment of a strong therapeutic alliance between client and therapist, though he did not consider relationship building as important, particularly in his earliest work.

Around this same time and working independently, White and Epston (1990) developed a similar outlook of looking to unique outcomes - times when the problem "should have" existed but did not. Utilizing a narrative understanding these researcher/practitioners worked to create what Foucault (2006) had suggested much earlier. The task of the therapist in treatment of mental disorder was to undermine the patient's sense of his "disordered" state of being. In so doing, the ontological is turned back to the epistemological. The understanding of problems, the clearing created for the individual for his own understanding of self, was expanded to facilitate a new narrative for the client.

Strength-Based and Solution-Focused Discourse

Many predominate theories of intervention in individual psychology have been built upon a presumption of a linear cause-and-effect orientation. This understanding of the world requires a reductionist examination of what is, broken into its smallest components in order to understand the determinist nature of its causal factors (Bruner, 1990; Gergen, 1994; Nichols & Schwartz, 1995). This reductionist tendency in traditional individual psychology attempts to gain understanding by focusing on specific individual behaviours in an antecedent-behaviour-consequences format, or on internal events, such as biochemistry, or intra-psychic conflict.

Strength-based and solution-focused outlooks in treatment of mental disorder are often built upon a social constructionist epistemological foundation (deShazer, 1994). In adopting a

social constructionist outlook, linear cause-and-effect sense of causality is set aside (Becvar & Becvar, 1996; deJong & Berg, 2008). An emphasis is placed upon present and future interactions, in contrast to a tendency towards historical orientation to cause found within an individualist approach. Context as a place for the re-construction of meaning and as an embodiment of treatment moves to the foreground of consideration. The foci for strength-based interventions are on re-constructing meaning and on a present and future focus. Meaning is considered an interactive construction of group processes in context as influenced by the discourses that impact the social environment. The object for change in a social constructionist outlook is subjective experience; it involves reconceptualization and re-storying of self through meaning, for both the individual and those in the day to day environments of the individual.

Strength-Based Theory.

In a strength-based approach, "*everything* you do ….will be predicated, in some way, on helping to discover and embellish, explore and exploit clients' strengths and resources in the service of assisting them to achieve their goals, realize their dreams" (Saleebey, 2006, p. 1). Saleebey notes strength-based practices as philosophically based on the "possibility" of constructing successes, in the face of a storied existence of self that is often depleted of hope. A hopeless client is recognized as one with little interest or motivation in the process of change. For strength-based practitioners hopelessness means there is no possibility for change. Freire 's (1996) comment reflects this view:

> The attempt to do without hope, in the struggle to improve the world, as if that struggle could be reduced to calculated acts alone, or a purely scientific approach, is a frivolous illusion. To attempt to do so without hope… is tantamount to denying that struggle as one

of its mainstays… Hope as an ontological need, demands an anchoring in practice. (pp. 8-9)

Hope is a core construct in strength-based therapy (Duncan & Miller, 2000) and hope is understood as a quality significant to the change process. Strength-based theory has a focus on the concept of hope and includes placebos, as a tool in re-construction of meaning. Indeed, the positive impact of placebo in empirical research on psychotropic medication is documented for its ability to raise expectations of change. Saleebey (2006) offers the following visual depiction (Figure 2) of his conception of the strengths perspective.

Figure 2. A strength-based outlook.

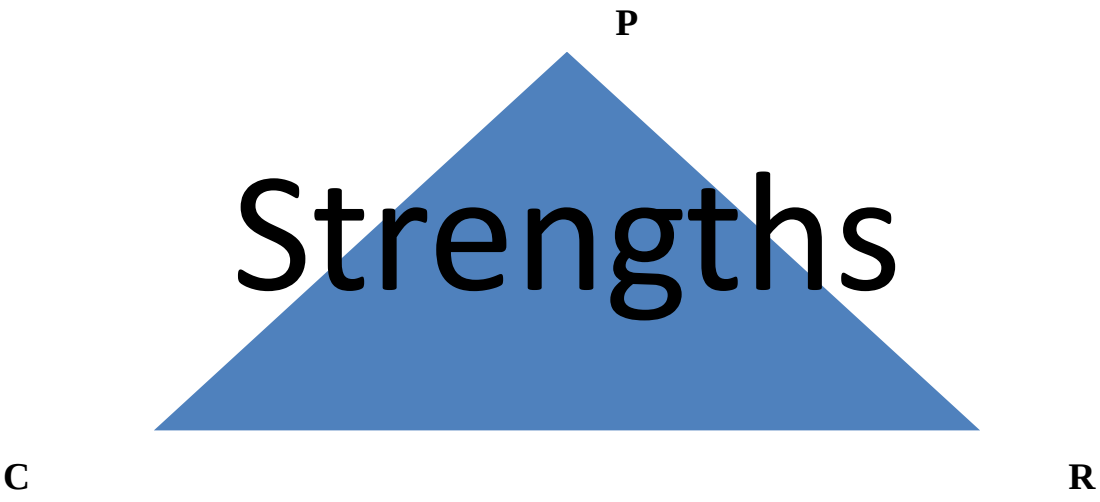


Figure 2. Where "C" stands for: competence, capacities, courage

Where "P" stands for: promise, possibility, positive expectations

Where "R" stands for: resilience, reserves, and resources (p. 10)

Adapted from *The strengths perspective in social work practice* (4th ed.), by D. Saleebey, 2006, p. 10.

Principles of a strength-based approach to social care services include:

1. A belief that every client is unique and an effective prescriptive solution for any category of disorder is contra-indicated. A strength-based orientation treats the subjective individual and not the object-concept.
2. A denial of the concept of resistance as central to the social care treatment process.
3. A view that cause and effect are unworkable constructs in considering social and interactionally based problems.
4. A belief that a helper cannot change a client, rather, a client can only change themselves.
5. A sincere and genuine belief that each individual, group, family and community has strengths and resources to help themselves.
6. A belief that trauma, abuse, illness and personal struggle are adverse, but that they may also act as a source of challenge, opportunity, and may be a source of motivation for change and altered meaning.
7. A presumption that the upper limits or capacity of any group, individual, family or community cannot be known.
8. A non-hierarchical orientation to the change process in which collaboration is a key component of change. The quality of the client/helper relationship is critical to a preferred outcome. The client does the work of change and at best the social care provider can create an invitation for the client, to the process of change.
9. A belief that resources can be constructed within every environment, regardless of its conditions.

10. Caring, in spite of its negative connotation within a social discourse that prizes individualism and independence, is a natural and normal human need. All members of society will need care at some time in their lives; caring should not be pathologized, as caring is an ethical obligation in society.
11. A belief in thoughtful use of language, reflecting a view that language constructs reality and that within language and meaning change takes place. Meaning is constructed through use of language and is flexible, arbitrary, and unstable.

Critiquing Strength-Based Theory.

Some practitioners of strength-based practices suggest that the operationalization of this theory is poorly defined and as such, its implementation in day-to-day practices is difficult. Unlike other theories of social care interventions, (for example cognitive behaviourism, humanist counselling, or behavioural management approaches), strength-based practices leave its practitioners unsure of how to use techniques to address day-to-day circumstances that their client bring to the treatment contact. In this sense, a strength-based model or practice represents a way of thinking more than a particular set of techniques or methods for engaging in the processes of treatment. The few techniques that are attributed to it, for example, “the miracle question” or “scaling questions” quickly grow tiresome after repeated exposure to client populations. There exists the possibility that a strength-based approach to social care intervention become a system of techniques devoid of a genuine sense of compassion or therapeutic alignment with the client.

Other concerns exist around the view that social constructionist and strength-based theory suggests that reframing meaning is all that is necessary to the processes of change. It is suggested that strength-based perspective denies the pain, hard work, and difficulties of the processes of change. Clients may feel misunderstood by those who wish to move to reframe or re-story their

narratives of experience too quickly. Some clients are simply not ready to process the steps they need to take to be rid of their troubles. In this instance, a technique like the miracle question moves too quickly towards the resolution of their difficulty and therefore may damage the client-practitioner relationship.

The strength-based approach is also criticized for its use of slogans and mantra's and for some is a form of "polyannaism". There is also a suggestion that viewing the world through "rose-coloured glasses" may offend both the client and the significant others in the clients immediate environment, who are caught up in their own day-to-day management and stress of troubled behaviours in children. In addition, framing social problems or mental disorder as a form of social construction may also be offensive.

Conclusion

I have briefly highlighted influential theories and paradigms for understanding the experience of mental disorder in the 20th century, including various means for its management and treatment. In an effort to contextualize the experience of the research participants involved in this study, I will now present a story of Child and Youth Care history. This history is one that parallels the temporal and cognitive transitions that I have examined up to now in previous discussion.

CHAPTER 5

A Story of Child and Youth Care History

The reader may be aided in maintaining a footing within the discussion to follow through a brief orientation to the components within the story I am about to present. I have included a discussion of the history of Child and Youth Care in this project as a portrayal of how evolving social circumstances and discourse construct identities around the recipient and provider of social care services. In the discussion to follow, I suggest that throughout the history of social care in Western culture it has been a common and relatively consistent practice that some form of deficit-label be attached to the recipients of social care interventions.

The history of both Western and North American Indigenous cultures suggests the existence of helping networks that provided care for children from people other than their immediate blood relations (Brendtro, Brokenleg & van Brocken 1998; Cunningham, 2006; Pence, 1987; Sommerville, 1990). In tribal and pre-industrial Western societies substitute care was a practice resulting from shorter life spans, alternative social norms, and the frequency of natural misfortunes and war. Cunningham suggests that in this period the proportion of single-parent families and orphaned-children combined is roughly equal to current divorce rates of approximately 40% of families in this category. Discourses concerning the concept of childhood and the care-needs of this group of beings are reflected in the writings, laws, and social customs of the era. Pence suggests that the origins of Child and Youth Care lies "not in the establishment of specific care giving institutions but rather in the sociocultural conceptualizations of children and youth as requiring specific forms of care" (p. 12).

In Western culture, a feudal economic system gave way to early mercantile capitalism at the end of the middle Ages (approximately 1500 A.D.). This was followed by the rapid economic

expansion of the mercantile system and the industrial revolution in the 18th and 19th centuries. It is in this period we witness the dissolution of self-sufficient rural socio-economic systems and helping networks (deSchweinitz, 1975). The dissolution of the feudal economic system was followed by the rise of the state sponsored social welfare systems of today.

Today one may presume that our current concepts of childhood have been relatively consistent over time. However, the historical record suggests that throughout the last millennium the concept of childhood as a distinct and unique "class" of beings is a concept that has been frequently revisited and revised, in Western culture (Cunningham, 2006; Pence; 1987). The construct of childhood is subject to ongoing reinvention as society evolves and this process continues today. So too, the historical development of social care services for children exists in unison with constructs of childhood, mental disorder, and of the constructs of government's obligations to the needy. Social care institutions designed to address the perceived custodial and mental health needs of children, and the discourse that influence them, reflect these developing concepts.

I begin this narrative at the early dawn of Western social welfare systems. I trace the earliest forerunners to our current social care systems to the mid-14th century enactment of vagrancy laws (deSchweinitz, 1975; Cunningham, 2006). By the 16th century, European governments began to take both lawful and physical responsibility for the welfare of its citizens, by providing basic residential care for the destitute, including the mentally disordered. To oversee this population, governments required a group of people who were inexpensive to employ and who willingly enacted the prevailing management and "treatment" methods of the day. Like those whom they served, care providers relied upon the largesse of government and church for their livelihood. Their job security depended on the wishes of governments, in their

desire to manage the destitute. Over time, as the role of care providers evolved, these people formed a community and identity as service providers. As their care-role increased in specialization, they grew professionally disciplined in their work, and ethically committed to the needs of their client population. In time, they began to see themselves as distinct from other recognized social care providers; they began to tell their own stories.

In the discussion to follow I will review the historical evolution of concepts of the child in need and the contexts that contribute to the emergence of specialized Child and Youth Care social services in Canada.

Early Western Discourses

Early seeds of government sponsored social care services for children in Western culture and the beliefs regarding those needing care are traced to the reign of King Edward the III of England [1327-1377] (deSchweinitz, 1943). Edward's reign coincided with the beginning demise of the English feudalist system of serfdom. Serfdom involved the forced labour of the individual on the properties of landowners, in return for protection and the right to work on leased fields. In exchange for labour, a serf was ensured a basic level of subsistence and an occupation. The serfs of the feudal period lived and worked in large self-sufficient collective family enclaves. The modern concepts of family slowly came into being during this period[6] and took on a form unfamiliar by today's definition, as family was understood as *familia* - those with whom one is familiar (Hayford, 1988). This allowed for a looser association of people within both a household and community, and did not necessarily indicate a blood relationship. This collective was dominated by the patriarch and the parent-child relationship of this era was not typified by either

[6] Anderson (1988) points out the word family only came into use in the English language in the early 1300's.

the emotional attachments or the constructs of meaning surrounding the needs of children, which are typical today. The absence of emotional attachment to one's offspring was particularly apparent leading to and following the 16th century Protestant reformation and Puritan era (Cunningham, 2006).

As the feudal system of serfdom died out, the ensuing economic shift coincided with the growing possibility of wage labour, the beginnings of industrialization and an acceleration of the pace of urbanization (deSchweinitz, 1975). These changes meant the destiny of the individual person was no longer fully dominated by the monarch, the feudal lord, the church, or the family patriarch. Wage labour and the emancipation from serfdom enabled the freedom of the person to move about the country and to live through whatever means they chose, often through beggary and the lifestyle of the vagrant. Many preferred the living conditions of the vagrant to the harsh life of the indentured serf.

The opportunity for social mobility resulting from the possibility of wage labour, drew both vagrants and labourers from the farmlands to the new population centres (deSchweinitz, 1975). Farm labour shortages, food shortages and the perceived immorality of idle hands drew the attention of the power interests of the day. As an earlier indicator of the discourse of this period, King Edward's "statute of labour" of 1349 was passed to make vagrancy and beggary illegal. This act characterizes the beginning of a formal interest of Western government in the social welfare and social management of its citizenry and communities. King Edward succeeded in making vagrancy illegal. From the time of Edward III forward to the 16th century, European governments attempted to eliminate poverty through severely repressive means that ultimately proved ineffectual.

By the 16th century, beggars were widespread and the numbers of the impoverished grew threatening to social stability. It was in the mid-16th century and the rule of Henry VIII, that the first government sanctioned almshouses was legislated to provide for their basic needs. These early forerunners of today's social security systems in Western society demonstrate a deficit-focused view of those in need. Reflecting the discourse of the reformation, the destitute were viewed as inherently sinful and therefore immoral (Cunningham, 2006); their idleness was considered by the Protestant reformers as a serious threat to the moral fabric of the community.

A Precursor to Child and Youth Care

The attempt to remove the idle and vagrant from the community by making their existence illegal failed. The English poor laws and the almshouses [or workhouses] of the mid-16th and early 17th centuries represented the first government established and funded form of charity, and were recognized as a capitulation towards the poor (deSchweinitz, 1975). Previously, charity was undertaken by the church or by private acts of philanthropy (Sommerville, 1990), and in some instances separate facilities for children are in evidence. In this period, the almshouse offered a last opportunity for food, shelter, and moral salvation through work, for those persons who were destitute. This population included the aged, the infirm, the mentally and the physically handicapped, the mad, the destitute, and the orphaned, who were all housed together (Charles & Gabor, 1991; deSchweinitz, 1975). Physical conditions were exceedingly harsh in these setting. Evidence suggests a mortality rate of between 80-99% for children under the age of 5 years living in these almshouses (Beukes & Gannon, 1999; deSchweinitz, 1975).

Typically, the earliest almshouse proprietor was a church functionary who would attempt to provide salvation for the presumed immoral souls in his care. The destitute were set apart

from society by the minority of propertied peoples who wished to utilize their labour while maintaining social order; nevertheless, some care was provided as a reflection of both Christian charity and pragmatic governance (deSchweinitz, 1975, Charles & Gabor, 1989). Early Protestant discourse has had a significant influence upon the Western model of social welfare.

Concepts like the "moralistic-saviour" era (Charles &Gabor, 1991) and the "Puritan"[7] era, (Ferguson et al., 1993) are used to characterize the predominating Protestant influenced discourses of this time. The views of children, social justice, and social care in Western culture have initially evolved through the knowledge systems emanating from the church, popular culture, and from the economic needs of the sovereign (Cunningham, 2006). Coinciding with the Enlightenment, an increasingly specialized industrial economy resulted in the emergence of a new family form as the male increasingly became the family "breadwinner", occupied outside the family home. A growing class of specialists with an interest in childrearing practices targeted towards enhancing the growth of the child as a developing being (Pence, 1987) was also born of this era.

The Era of Industrialization

The rapid expansion of industrial capitalism in the late 18th century significantly disrupted the remains of the feudal social and economic order (deSchweinitz, 1975). As the affluence of society increases and discourses surrounding the concept of the child evolve, the almshouse continued as a place for their refuge. Its physical conditions began to reflect an Enlightenment understanding of the impact of the environment on the person (Porter, 2002). The concept of the child as a tabula-rasa, or blank slate, suggested these presumed immoral children

[7] Someone who lives according to strict moral or religious principles, especially someone who regards any form of pleasure as suspect. The Puritans opposed the Church of Rome and were highly influential in Europe from the mid-15th to the mid-17th centuries. Some remnants of Puritan thinking remain today in social care practices.

could be re-educated to re-enter society, through the influence of a healthy milieu.[8] In this period custodial specializations emerge as the child in custodial care was separated from the adult, the criminally involved child was separated from the orphan, handicapped children were separated from the able-bodied and mad adults were separated from the sane.

As residential specialization emerges, social care systems intended exclusively for children are increasingly in evidence. The role of the overseer of various groups of children and adults evolved to become the custodian of the orphan's asylum, or the madhouse-asylum manager. This period of industrialization in Western culture is referred to as the "refuge-manager" [1750 – 1890] era, by Ferguson, et al. (1993) - a concept that reflects a view of dislocated persons as a social management concern for government. In this period, we also witness the expansion of emigration from Europe to North America.

Staff to client ratios in these asylums and orphanages were as high as 1 to 100 in the 18th and 19th centuries and as many as 2000 children were housed in one location (Stein, 1995). Never-the-less, the conditions of the orphanage by this time represented an improvement over previous forms of care. During this time, criminal law was equally applied to both children and adults. The hanging of a 13-year-old boy in New Jersey in the mid -1800's and reports of the hanging of an 8 year old in New England for petty theft are evidence of this practice (Cunningham, 2006). As age 7 was considered the age at which the individual "comes to reason," in this period, adult laws apply to any individual beyond age 7. Reflecting the ongoing discourse concerning the age of reason, the Canadian Juvenile delinquents act of 1908, in most provinces, exempted children up to the age of 16 years, for criminal acts. This act was supported

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[8] The concept of blank slate as "unscribed tablet" is attributed to Aristotle but was revisited and revised by Locke in the enlightenment era.

by a belief that children could not form criminal intent until age 16. The debate concerning the age at which a child comes to reason continues in Canada to this day.

By the mid 19th century, the first child protection laws in Western culture begin to emerge in New York City (Stein, 1995). These laws coincide with the growing wealth and occupational specializations in industrialized nations and a beginning of the modern scientific recognition of and interest in the healthy psyche, as a concept of mental health (Porter, 2002). Reflecting the discourse of the "romantic" era (1780-1850) and the construct of the deep interior within the self, Freud re-constructs the Christian notion of the soul into the concept of the developing psyche.

Gaining momentum in the mid-19th century, a "psychologising" of the needs of the child and the mad results and physical conditions in care facilities reflect a more humane and scientific understanding of client needs. Ferguson et al. (1993) refer to this period as the "child saving" era (1850 – 1925). This period witnessed the arrival of a new and distinct social discourse where children gained the right of protection by law, from parental abuse and designation as a form of person distinct from adults. Until this time, children were considered property of the parent, to discipline as they saw fit, with very few restrictions; exceedingly harsh discipline and living conditions often resulted from this belief (Cunningham, 2006). Until this time children were expected to take on adult responsibility by age 7.

Industrialization brought into being the "modern industrial" family, whereby mothers and fathers' "natural" domains of specialization are physically separated (Pence, 1987). Women became responsible for the interior household, romanticized as "the nest", while men occupy the exterior world of the workplace. Increasingly through the industrial era, men are considered as

less suitable and capable in the role of child rearing, coinciding with a re-emergent discourse of women's maternal instinct.

The influence of the printing press and widespread educational improvements results in women increasingly availing themselves of "how to" knowledge in child rearing practices. This discourse was provided by a continual increase in the numbers of specialists whose work is dedicated to understanding the newly constructed "psychological" needs of the developing child. Society increases in complexity and in occupational and vocational specializations. Child-rearing, as an occupational specialization emerges in this period and once commonly held natural childrearing knowledge is overtaken by expert knowledge. As Pence states, "the growing gap between decreasing familial "ability" to perform various functions and an increasingly complex set of societal needs opens the way for child care and other human services professions (specialists) to develop" (p. 6).

These early residential care providers are the custodial forerunners of today's Child and Youth Care practitioners, while social care of children remained a mélange of services, often legislated but not funded by governments of the day. The responsibility and costs of care during this era was usually downloaded to local government levels, or to charities. Day-to-day provision of care remained largely in the hands of the church, but we also see a beginning shift to secular organizations and the professionalization and medicalization of care services (Ferguson, et al., 1993).

The 20th Century

In the early 20th century, the predominating Protestant-Puritan influenced focus on individual deficit "shifted from the shortcomings of the young person to the weaknesses of the family" (Charles & Gabor, 1991, p. 4). This emerging construct reflected a growing interest in

both the family and in the impact of environmental influences on child development. In this era Residential child welfare services were designed to replace the deficient family; while the youthful criminal received punishment and re-education in separate facilities designed for this purpose. Attempts were made to assimilate both back into mainstream society. The Juvenile Delinquents Act of 1906 represented a humanistic example of the state as a responsible and benevolent replacement parent in a "parens patria" approach to Juvenile Delinquency. This legislation remained in effect until 1984.

In Canada, the early 20th century discourse of the necessity of family replacement for the child in need is also applied to an entire culture as both government and religious authorities attempt to re-educate First Nation's children in a Christian Euro-Canadian value base via the residential school system. This process defined an entire culture as deficient and this attempted assimilation cultural carried forward into the 1970's. Canadians also hosted the arrival of orphan boats from Britain during this period to help colonize the new land, accompanied by the use of the "vendue" system, as a means to provide farmers with cheap labour. This was a 20th century type of child indenture (Cunningham, 2006; Charles & Gabor, 1991). Within a vendue system, foster children are chosen by bid at auction. They were provided food and shelter in return for work. On our local scene the *Lethbridge Herald* of October, 1908 reports two separate instances in which children are sold at auction to the highest bidder. In one instance the winning bid was made by a male-bachelor.

The vendue system required the care provider to do little more than feed and house their charges, who in turn provide labour to earn their keep. A discourse of moral salvation through labour is used to justify these acts. In state funded child welfare settings, the concepts of re-education and assimilation act as a philosophical underpinning for services for the orphaned and

troubled child. A discourse of the damaged psyche gained ground over the discourse of salvaging souls, as one form of deficit discourse was replaced by another. During this period, the custodian of the child provided little more than basic care, with an eye towards driving the presumed immorality from the child, while educating the child to integrate into "mainstream" society.

In the first decades of the 20th century, large orphanages were replaced by smaller cottages and foster home placements, reflecting a belief in the importance of "family like" conditions for developing children (Charles & Gabor, 1991). The great depression of 1929 and the near collapse of the capitalist economy results in a significant shift in understanding the role of government in providing for the social needs of its citizens. The "new deal" (Black, 2008) that emerges marks a shift to a more active role for governments in social care provision. This faith in active government responsibility for social care, fuelled by post-war economic expansion remained in place well into the 1970's, until monetary constraints and deficit budgets curtailed the rate of expansion in services.

Returning to the concept of the healthy milieu, once popularized by Hobbes (1588 – 1679) and Locke (1632 – 1704), scholars of children's services, including Fritz Redl and David Wineman (1951) and Bruno Bettelheim (1955), amongst others, re-popularize the concept of milieu in the care and treatment of troubled children. With this shift, the professionalization of Child and Youth Care as a distinct discipline in social care practice is seeded. These psychiatrists, psychologists and social workers, established the beginnings of a professional body of knowledge directly targeted at what was to become the discipline[9] of Child and Youth Care. The discourse surrounding children's services in this period suggests a continuously growing

[9] Discipline: A field of study.

concern for the psychological care and treatment of the troubled child in the North American context.

The classic Child and Youth Care text *The Other 23 Hours* (Trieschman, Whittaker & Brendtro, 1969) and *The Dynamics of Residential Treatment* (Polsky & Claster, 1968) facilitated a paradigm shift in the understanding of the concepts of psychotherapy in relation to the role of Child and Youth Care practitioner. With the advent of these texts, Child and Youth Care practice moved beyond a basic custodial function to include a concern for the totality of the child's well being. Until this time, the psychotherapeutic work in treatment of troubled children was understood as the exclusive domain of highly trained mental-health specialists. Conceptions of the Child and Youth Care practitioner as a custodial agent in the background of the residential program were transformed. Youth workers began to move to the foreground of the practice landscape as they earned recognition as junior participants in the social care and treatment of children and youth. The services previously provided by the orphanage are now increasingly specialized, as distinct mental health treatment services. Some children are streamed into foster care services, while others are placed in treatment oriented cottage facilities that are better able to manage the challenging behaviours of troubled children and youth. The broadly accepted notion of children as mentally disordered had not yet emerged and troubled behaviours are not yet synonymous with mental disorder.

Children's social care services continued to become increasingly specialized beginning in the 1970's. This is a time of "specialization-intervention", as increasingly sophisticated means were developed to treat the individual psyche or to facilitate behaviourist re-learning in positive peer cultures (Charles & Gabor, 1991).

Later developments in the 20th century include the broad recognition of the alarming frequency of child sexual abuse in Canadian families. In the late 1970's and early 1980's this treatment specialization exploded onto the Canadian social care landscape through the influence of researchers and practitioners alert to the previously denied prevalence of child sexual abuse in Canadian communities (Finkelhor, 1979). Freud's broadly accepted concept of infantile sexual fantasy was reconstructed as a pervasive experience of familial sexual abuse for many children throughout the history of Western societies.

Foster care remained a mainstay residential setting throughout the latter part of the 20th century, for youth whose behaviours do not prove to be management problems for foster families. Through the influence of a new systemic understanding of the family, lip-service efforts are made to keep families intact wherever possible. The custom of family preservation reflects the construct of a clinical treatment practice based on the discourse of the family as central to the child's wellbeing; family preservation oriented in-home social care also represented a significant cost savings for governments that fund social care services. The practice of family preservation coincides with the influence of the family therapy movement of the 1970's and 1980's and the movement for Child and Youth Care practitioners into community-based in-home interventions. As this evolution of the role of Child and Youth Care practitioners occurs, Child and Youth Care education evolves to reflect the importance of the context and the environment to treatment practices.

Another late 20th century influence in the provision of social care included the increased emphasis on budget restraints. The election of neo-conservative governments in the U.S.A., Britain, Canada, and Alberta signified the coming of a new attitude towards funding in social care services. The 1980's and 1990's witnessed Western governments increasing attempts to

curtail budget deficits through cuts to select social care services including services for residential child welfare services. Funding for social welfare systems in many jurisdictions did not keep pace with the growth in populations or inflation, relative to other budgetary considerations - particularly as compared to health care and education. The discourse of neo-conservative governments towards its citizens in this period was succinctly summarized by Margret Thatcher who once declared, "there is no such thing as society" (King, 1987, p. 12).

During this time, Child and Youth Care practice continued to move from a residentially based identity of practice into the spaces where children can be found in their day-to-day living. As professional education in Child and Youth Care advances, its scholars work to construct a discipline that prizes its own generalist and non-hierarchical nature. Child and Youth Care educators establish Child and Youth Care as a discipline known for its philosophical grounding in non-pathological, growth-oriented, strength-based practice utilizing relationship as a primary practice tool (Anglin, 1999; Ferguson, et al., 1993 University of Victoria School of Child and Youth Care, 2008a). Child and Youth Care professionals enter the schools, community based child welfare treatment programs, home-support programs, street-youth programs, and crisis and recreation programs, in addition to its traditional residential services base.

Today and Tomorrow

The discourse of the "new deal" that supported government expenditures in social care services (Black, 2008) has declined in influence in the 21st century, replaced by a concern for efficiency, cost curtailment, and the necessity of a medical model influenced and diagnostically driven approach to care and treatment of children. For child-welfare service funders the family remains as the preferred location for the child when their physical safety can be assured. However, when this is not likely to be the case our local authorities are often reluctant to provide

funding for care beyond basic foster care. Many children on our local scene reside in shelters for the homeless on a day-to-day basis. In these instances they have been deemed to have "exhausted" their placement options and are not offered custodial care. This circumstance represents a full-circle return to the "services" received in the days of the almshouse. The discourse of non-interference and budget efficiencies result in a development Pence (1987) suggests, "undermines the paradigm of children and youth as needing and deserving special care" (p. 13). The current extensive use of basic foster care services represents a return to a custodial orientation in the role for care providers, albeit in family like living conditions. While this move represents a financial efficiency in service delivery, inadequately trained, under-staffed, and under-supervised foster homes often result in problem-saturated outcomes for child welfare recipients, particularly those once defined as "troubled" who are now defined as mentally disordered[10].

Today, the Freudian, humanistic, and purely behaviourist concepts of treatment have diminished in influence. Concurrently, discourses involving a physicalist orientation involving concepts of defective brain chemistry to explain troubled behaviours have grown to replace these earlier views. Today, as many as 50% of child welfare recipients in Canada receive psychotropic medication concurrent with a DSM diagnosis (Philip, 2007), and children in Canadian foster homes are now sixteen times more likely to receive psychotropic medications than their non-foster counterparts (Zito et al, 2003).

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[10] Of note, between 2000 and 2006, 31 children receiving care from child welfare authorities have died as the result of homicide (Canadian Broadcasting Corporation, May 9, 2007). Since the year 2000, 43 children in Alberta alone have died while receiving child welfare services. Of this total 5 died as a direct result of "an injury inflicted by another" while the remainder died of accidental causes or illness while "in care" (Trevor Coulombe, Alberta Child and Youth Services, Communications director, March 25, 2009, personal communication).

In many social care programs today a diagnosis is necessary to receive social care intervention (Fewster, 2004). The DSM acknowledges environmental and social considerations in its descriptions of mental disorder, yet there appears to be a gap in practice between the knowledge of the social determinants of mental health and systemic actions that address these concerns (Raphael, 2009).

The implications for the medicalization of troubled behaviours through psychiatric diagnosis suggest a return to the emphasis on the custodial-management function for social care providers. If alleviation of troubled behaviours, reconstructed as mentally disorder, can occur through medication, funders legitimately question the necessity of highly trained practitioners providing relationship-based interventions. One might pessimistically envision a medical model dominated future of children's social care for the mentally disordered as employing well-trained security guards with advanced communication skills.

Alternatively, a strength-based approach to social care appears compatible with the espoused essence or ethos of Child and Youth Care practice. A strength-based model of social care relies on client-practitioner collaborative development of skills, based in experience and the co-construction of affirming identities. This positioning moves our discipline away from deficit-oriented psychological and medical model outlooks. A strength-based positioning also moves our discipline towards understanding the person as a holistic being, needing support to construct and strengthen empowering experiences and stories of the self. This positioning suggests that a need for social care and support should not, of necessity result from the requirement of pathology in the individual, family or environment. Rather, care in the form of social supports, in schools, communities and families in a strength-based perspective is viewed as a normal and expected human need, experienced universally throughout the community

Conclusion

The evolving role of the Child and Youth Care practitioner and his or her forbearers coincides with the evolving definitions of the child and of the child in need, and with the expansions and contractions of the social welfare state and health-care services, in Western cultures throughout the 20th century. Child and Youth Care has grown from an after-thought to the provision of social care to become an emerging discipline, albeit one threatened by monetary restraints, and by an orientation to social care services primarily based on financial efficiencies and the medicalization of human troubles. The influences of deficit-focused discourses have a long history in Western culture. I construct the current medicalized understanding of the needs of the client population who are defined as mentally disordered as reflecting a continuity of deficit-focused thinking in Western culture. Herein, neediness is inherently defined as an inability or impairment of one's functional capacity. As the discipline of Child and Youth Care has grown, there remains, in the broader landscape of social care practice, a conceptual uncertainty concerning Child and Youth Care practice and identity (Phelan, 2005).

Canadian Child and Youth Care professionals and educators turn to the University of Victoria, School of Child and Youth Care for leadership in regards to our future philosophical direction and to a scattered group of scholars located in newly emergent Child and Youth Care degree and diploma programs. As Child and Youth Care practitioners take up a strength-based practice, it remains clear that a significant portion of the client populations we serve continue to be defined through a deficit-focused outlook within the broader community. Many Child and Youth Care professionals involved in children's mental health treatment confront this diagnostically driven deficit discourse daily and many practitioners are influenced by deficit-focused thinking.

CHAPTER 6

Methodology and Methods

> *At a minimum, a "story" involves an Agent who Acts to achieve a Goal in a recognizable Setting by use of certain Means. What drives the story, what makes it worth telling, is Trouble: some misfit between Agents, Acts, Goals, Setting and Means.* --
> Jerome Bruner (1997, p. 94)

This Chapter reviews the fit between the methods for data management, analysis and interpretation, and the research question. It contains a discussion of the methodology and methods of narrative inquiry and the epistemological considerations of how to conduct research into the phenomenon of others' stories of experience.

The Story of the Research: Epistemological Positioning

This research is concerned with the narratives of experience of Child and Youth Care practitioners and the influence of discourse upon these narratives, in a unique Child and Youth Care practice location. This research is situated in a post-modern and social constructionist paradigm of scientific inquiry. A post-modern paradigm of understanding articulates scepticism towards foundationalist epistemological outlooks and "totalizing" discourses that claim to explain social relations and social phenomenon with objective certainty (Kvale & Brinkman, 2009; Schwandt, 2007). Post-modernism endorses heterogeneity, difference, fragmentation and indeterminacy in the subjective experiences of individuals and cultures. A post-modern approach to scientific inquiry questions the belief in universally valid and disinterested knowledge. Post-modernism suggests that knowledge is fixed in standpoints of interest, is contingent on history, and is shaped by social circumstances. I consider the discursive influences that shape our knowledge and meaning as inescapable.

The metaphor of traveller conveys my understanding of the process of post-modern narrative inquiry (Kvale & Brinkman, 2009). As a traveller I have wandered through various discursive landscapes in exploration of constructs of knowledge that influence the experiences of the research participants in this study. As a traveller, I wander alongside the research participants who are the "locals" whose narratives I wish to engage. I elicited these narratives through conversation - which in its original Latin meaning refers to "wandering together with". This journey has resulted in new understandings of Child and Youth Care practice for me as a researcher. I have co-constructed and re-narrated the interview data with a goal of sharing my understandings of practice experience at *Kids Place* and its relevance for the discipline of Child and Youth Care.

The choice of a social constructionist epistemological outlook and narrative methodology is aligned with my assumptions about life and the nature of reality. My choice of methods reflects my own experience with the narrated character of my existence as introduced in Chapter One. The research question chosen for this project was intended to enable research participant's to tell their stories of experience in the context of the relationship between discourse, Child and Youth Care identities, and practice.

The Value of Narratives in Qualitative Research

The following section focuses on the value of narratives in qualitative research.

Knowledge as localized narrative.

Narratives as a form of conversation communicate the dialectic relationship between what we do in the world and the material conditions that influence meaning (Kvale & Brinkman, 2009; Parker, 2005). Human experience cannot be extracted from context to be understood apart

from history and discourse (Rossiter, 2001). Rather, social care practices and the individuals who perform these practices are located in an historical and narrated context of being.

Narratives structure and link experiences that are then conceptualized as the past, present, and (anticipated) future. Narratives enable a perception of continuity in the life of the individual or collective. In recalling a past experience, narrative meaning is brought forward into the present and serves as a point of demarcation. Like a beacon in the night on the shoals of the undefined, storied meaning guides experience in the present informing us that "this is how things are" or "this is who we are". Narrative serves to connect the individual not simply to others in similar present contexts. Narrative also links members of identified collectives to predecessors and successors through a perception of collective membership. Narratives of experience reflect interplay between one's perceived circumstances and one's ability to act within those circumstances.

Narrative inquiry as a means for conveying human experience is well supported in the scholarly conversations concerned with qualitative research methods (Kvale & Brinkman, 2009; Lieblich et al., 1998; Parker, 2005; Polkinghorne, 1995, 2005). Narratives illuminate constructs of the mind in inter-action (Chafe, 1990 as cited in Cortazzi), offer the researcher a view of the influences of culture upon the person (Cortazzi 2003), and highlight the value of situated knowledge (Gergen & Gergen, 2005). Situated knowledge is the knowledge that is indexed to local contexts, conditions, and circumstances.

The narratives that emerge from *Kids Place* facilitate a sense of control of the environment for the narrator or enable the narrator to make "sense" of their circumstances. Narrative inquiry respects the individual story and the meanings the individual or group constructs around their circumstances; narratives also portray emerging constructs of the self. As

Parker suggests, "personal identity emerges as 'figure' against the 'ground' of culturally given images of the self" (2005, p. 71 – 72). Through story construction, the individual or group can define and refine their identities and performance and can act upon this knowledge purposefully.

History and culture do not determine meanings, yet identity and experience are understood in relationship to contexts of meaning. These contexts of meaning are part of our continuous conversation with the world. Meanings circulate through the body of the community by way of discourse. One may not have explicit awareness of the historical precursors to one's experiences, but none-the-less may be influenced by these cultural constructs. The research participants I interviewed are part of a culture, as are their clients. They understand themselves belonging to a discipline of practitioners and they understand their client population as holding a unique "dis-ordered" identity within the contexts of the health care and education systems.

Narratives as performance.

Story emerges from experience allied with events selectively recalled in memory and presented for a particular purpose. Memory is subjective and incapable of capturing experience fully, nor is it accurate in the way a video recording of an event is conceived as such[11]. As Ochs and Capps (1996) suggest "we immediately transform the present moment into abstraction. We need only recount an episode experienced a few hours ago: the dialogue contracts to a brief summary, the setting to a few general features" they add that "remembering is not a negative of forgetting. Remembering is a form of forgetting" (p. 21). The narratives recalled in this research were initiated by the research process and were influence by the formal rules and constraints for

[11] This is recently in evidence in the Canadian context for those following the Robert Dziekanski inquiry hearings in British Columbia. The video recorded data of the taser related death of Mr. Dziekanski are incompatible with the recollections of four R.C.M.P. officers involved in this incident. The officer who investigated the actions of the Police in question did not lay charges, reasoning that the "perception" of the events resulted in the actions taken by the police, and not the actual event as shown on videotape.

a formal type of conversational interaction known as an interview. As Gergen and Gergen (1988) suggest, "What is remembered and how events are structured is vitally dependent on the social processes in which people are immersed" (p. 20). These narratives are a product of the research process.

I view any narrative as a performance that is liable to change in the telling and with a change of audience. A narrative is a form of speech that is often intended to convey evaluative meaning. Narratives convey a "point" that a narrator wishes to express. For example, the research participants in this study typically concluded the many narratives of experience they related during the interviews with a statement of summary evaluation. The summary evaluations convey the point of the narrative and is a means for the researcher to understand the conveyed meaning intended by the narrator. The audience for which a narrative is intended influences the evaluative meaning conveyed within the narrative.

Narratives, as mentioned above, are performative in that "what is narrated in performance is not said *to* the audience, but *for* it" (Cortazzi, 2003, p. 40). A narrative enables an individual or group to construct a sense of their own agency and to perform their identity as a story of experience and self in a particular context (Kvale & Brinkman, 2009; Parker, 2005). A narrative is a presentation of chosen meaning to a particular audience. Therefore, narratives are purposeful - a narrator implicitly or explicitly considers the audience when a narrative presentation is performed for an audience.

In the case of my research, the participants have their own views of what they are attempting to achieve in the stories they tell, the points they wish to make. The context of a research interview and the questions asked within the interview as a form of conversation solicit the creation of the narratives found in the chapters to follow; the research participants in this

study attempt to meet their perceived expectations of the interview circumstances in which they find themselves. As a type of audience the researcher takes up the role of co-participant to the stories that are told. The research participants in this study are also speaking to a broader audience – that being the community of Child and Youth Care practitioners and educators, who they believe would become privy to the content of this research by way of its publication.

Data Management, Analysis, and Interpretation in Narrative Inquiry

The following section focuses on the specific methods that I adopted in order to manage, analyze and interpret the data.

Fitting the method to the research question: Structuring the data for narratives.

In any research project the method of inquiry must be epistemologically compatible and congruent with the research question. My interest as a researcher was to understand

- the "stories" of Child and Youth Care practice experiences for the participants in this research
- the influence of discourses of social care practice upon the stories that are constructed at the intersection of practice presented in the research question and
- how these stories may contribute to the ongoing conversation concerning Child and Youth Care identity and clinical practices.

The details of how I was to analyze and interpret this data came after my immersion in the data and this is not unusual in the research process (Hoskins, 1997). As I began the process of managing the data I faced the methodological question of how I was to identify narratives from other forms of communication. An initial step was to determine what constitutes a "narrative" and how a narrative was distinct from other forms of conversation.

The structure of a narrative as a distinct form or "unit" of speech is identified in a relatively consistent form by many narrative researchers (Bruner, 1986, 2005; Cortazzi, 2003; Gergen, 2005; Gergen & Gergen, 1988; Lieblich, Tuval-Mashiach & Zilber; 1998; Kvale & Brinkman 2009; Polkinghorne, 1988, 1995). I refer the reader to a table of narrative form comparisons in Appendix A.

To test a method for data organization I conducted a pilot interview with a seasoned strength-based Child and Youth Care practitioner and applied Cortazzi's (2003) steps for identifying narrative "evaluation" to the pilot interview. Kvale and Brinkman (2009) endorse Cortazzi's method because of the way it structures interview data. I found Cortazzi's method useful in delineating the distinction between narrative and other forms of communication such as simple back and forth dialogue. The narratives of the research participants were strewn throughout the raw interview data. Using Cortazzi's method to organize the raw interview data into narratives eliminates digressions, repetitions, and the non-essential content of an interview.

Cortazzi recognizes 6 components in the typical narrative. The abstract (1) is a narrative introduction and a lexical signal that a story is about to follow; the narrator claims the conversational space needed in order to tell the story. The orientation (2) provides the context necessary to understand the point of the story. The complication (3) represents the trouble or issue that is negotiated within the tale; it is an event of interest or a turning point. The evaluation (4) is the point of the story representing the summary the narrator wishes to convey. The result (5) is the resolution of the conflict or concern. The coda (6) is a lexical signal that indicates a narrative is complete and the regular conversational turn-taking resumes.

Cortazzi's method reduces the interview content that is extraneous to the "point" of each narrative within the interview. Using Cortazzi's method enabled me to re-construct raw data into

a flowing narrative in answer to the research question, in the voice of the research participant. The narrative evaluations and thematic-content derived from this process inform the discussion that follows each narrative in Chapters 7, 8, 9, and 10. The re-narration of the interview data is a reconstruction of the many narratives from within each interview into a richer, condensed, and coherent story as compared to the scattered stories of the separate research participants.

Cortazzi's method for constructing narratives from interview data: an example.

The speaker is "Ray". His comments are broken into the six components of a narrative as a unit of speech as defined by Cortazzi (2003).

1. Abstract: "The moment that captures the essence of my experience with the strength-based approach was a year ago, a nice spring day."
2. Orientation: "I had been working with this boy for many months – and I work in a medium using photography – with his permission. This has been debated amongst the staff - is this [use of photography] okay? In this one moment, my client had been having a bad day. He was off to the side on the playground, on his own, isolated, and withdrawn. There had been a lot of turmoil in his life. He was moving from one [foster] home to another and he did not know what was stable in his life. It was a day when things were too much – all these things going on in his life – and he just withdrew. I took some photos of him at this moment. No words were spoken."
3. Complication: "I am a photo geek you know, so I start to take shots from about 50 feet away. He knew I was doing this – all the kids are comfortable with this – used to it. He let me get very close while I continued to take shots. I didn't realize until I got home [and saw the photographs] what he had allowed. He'd allowed me into his

world of feelings – seeing the words, the expressions, the moves, the feelings come out. This was trust. I didn't say anything to him. He just allowed to me do this."

4. Evaluation: "Trust is so moving, when the client trusts. From the moment we started building relationship, I have always seen trust as something that builds. We had trust, he looked directly into the camera, a picture tells a thousand words. There was so much pure emotion there…And he opened himself to me, he became vulnerable to me, he allowed himself to be vulnerable and unprotected, he showed me this and trusted me. The prior experiences of these kids mean they learn to protect themselves…It was a perfect moment… When you have openness like that or you're developing things… its closeness together, that lets you be close and open up to each other. This complete trust just allowed us to be whoever we wanted to be – with no expectation that he had to do something different. He felt the trust and acceptance that allowed him to be just who he was in that moment."
5. Result: "After I was done taking pictures I just sat and chatted with him. It pulls you together – this event allowed us to trust one another further. I knew what we were doing was going well. You know that when you build things – you are able to move in, you are going to make changes."
6. Coda: "this is how it goes here sometimes…"

The interpretation of the context and the evaluative component suggests Ray believes it is important to establish trust in order to be effective with the clients in this program. The importance of establishing trust is understood knowing that the research participant intended this example to be illustrative of the construct of trust as a whole. Trust enables Ray to simply "be" with this client during this time of trouble. Ray also highlights an alignment with his personal

interest of photography and creative practice methods. The employer earns his respect for this freedom to experiment with practice methods. The interview data contains numerous narrative speech acts similar to the example above; evaluative points are made and the results are explained.

Data analysis: Meaning condensation and categorization.

Meaning condensation as a method for data analysis involves a compression of the main points of a narrative into a few words, utilizing the evaluation component of each narrative to understand the intended meaning of the narrative. Once the narratives were delineated from the raw interview data I took the following steps:

1. A determination of the intended meaning of each of the narrative units within each interview using Cortazzi's (2003) evaluation method.
2. A reading for the holistic content of each of the narratives.
3. A reading for the research question as reflected in the evaluative themes.
4. The evaluative theme of the narrative was stated in the language of the research participant in a way that reflected the context-based meaning. The evaluative themes derived from this process were structured into descriptive narrations of experience, utilizing a narrative story-telling form whenever possible, as a reply to the research question (Kvale & Brinkman, 2009).

Thematic categories were compiled in a table and checked for consistencies and inconsistencies in the content across all the narratives. This is a laborious practice of sorting subtexts into categories, generating ideas for additional categories, and refining existing ones. As a researcher this process required me to evaluate the significance of the stories being told and to develop the meanings of each interview through combining the research participant's evaluations

with my own perspectives. This re-narration also includes a reading for the influence of historical discourse, a critical consideration of the positions of the research participants and researcher, and a reading for Child and Youth Care identity constructs. The discussion and analysis that follows the narratives of each research participant in the Chapters to follow are my own narration of the stories told by the research participants. My analysis of what was said resulted in a new story, developed from the themes of the original interview (Kvale & Brinkman, 2009).

As mentioned above, my preparation for the analysis and interpretation included immersion in the interview data and also in the discourses surrounding Child and Youth Care practice at *Kids Place.* This discourse included a consideration of: the literature of historical and current Child and Youth Care identities and practices, concepts of mental illness, and the historical constructs surrounding the concept of the child. I traced the development of diagnostic and treatment services for mental disorder, considered the question of "what is treated in the treatment of mental disorder?", and reviewed the literature surrounding strength-based, solution-focused, and resiliency oriented social care practices. All of these discourses were briefly reviewed in earlier chapters in this document.

During the analysis process I considered various metaphors and interpretations and noted the linkage between these stories and the discourses that inform Child and Youth Care practices. I also considered these stories

- from the intra-personal level of the individual story teller;
- from an inter-personal level as emerging from a culture of practitioners;

- for how these stories reflect constructs of the concept of mental disorder as an "it" with consideration of the discourse of a positivist outlook towards mental disorder;
- for how these stories reflect various "it's" – that is, how they construct relationships between systems of practice knowledge and the interplay between this knowledge and the identity of the research participants.

Holistic analysis: Narrative forms.

A common treatment for interview data in narrative research is the description of the condensed thematic construct of experience (Cortazzi, 2003; Kvale & Brinkman, 2009; Lieblich et al, 1998; Josselson, Lieblich & McAdams, 2003; Parker, 2005), and this method has been discussed previously within this chapter. A second method for treating the data within narrative inquiry involves a holistic consideration of the content derived from the evaluated themes that emerge from the data as considered (Booker, 2004).

In the analysis of the holistic-form of a story, the researcher considers the traditional plot forms and plot-line progressions available within the culture (Gergen & Gergen, 1988; Kvale & Brinkman, 2009; Lieblich et al. 1998). This form of narrative research is a "mixed genre" of inquiry – a linkage of science and the humanities, combining a systematic analysis of data, with literary forms of text and hermeneutic analysis of meaning (Josselson, Lieblich & McAdams, 2003). Narrative story form represents a means for interpreting the holistic meaning of the events portrayed in the experience narrated.

There are a wide range of views concerning the number of basic story forms in Western culture and the number of forms range from two, to beyond seven. Distinct story forms illuminate the central characters with a particular light; protagonists are often wrapped up in a

process of overcoming an obstacle or accomplishing an important and symbolic task (Booker, 2004).

In a holistic analysis of the plot form, the researcher considers the requirements of a story, the possible plotline trajectories, and the characterization of self by the narrator(s), in the analysis. The holistic analysis of a story form is valued for how story form may express as much about the holistic constructs of the narrator(s), as does the content of the narration (Booker, 2004; Lieblich et al., 1998; Parker, 2005). The story form communicates the constructs of evolving life experiences for the individual or group.

The Role of Reflexivity and Standpoint in Research

My presence as a researcher is an integral part of the context and social phenomenon I seek to understand and my presence affects the outcome of this project. Reflexivity is critical to the authenticity criterion in post-modern research and as Hones (1998) suggests, "in understanding another person and culture you must simultaneously understand yourself. The process is ongoing, an endeavour aimed not at a final and transparent understanding of the Other or self, but at continued communicating, at an ever-widening understanding of both" (p. 225).

As a Child and Youth Care educator, I may be advantaged because of a readily available rapport with the participants. Alternatively, I may be disadvantaged by my history in Child and Youth Care that contributes to my own pre-conceived notions of the experience of the research participants. This history also results in a sympathetic reading of the interview data as I sensed that both researcher and researched hoped to gain from the research process as we each seek outside recognition for our efforts. At the same time I am clear that this is an inquiry into the narratives of experience of the research participants and not my own. During this project I was mindful of Kvale and Brinkman's (2009) recommendation for post-modern research, suggesting

that “reflective objectivity” is a process of striving to be sensitive about one’s own prejudices and to expose these to the reader through my own narrative of this research.

The research process is inescapably linked to my constructs of self and experience. I focus on the experiences of the research participants, co-constructed within the interview data while acknowledging these narratives are performed for the researcher as a particular audience and that I interpret the data from a sympathetic position. I also attempted to conduct and process these interviews from a position of deliberate naiveté, a position I refer to as “not knowing”. In taking on this position the researcher exhibits openness to new and unexpected phenomena, rather than having readymade categories for interpretation (Kvale & Brinkman, 2009).

Data analysis is a trial and error process of cross-referencing, involving examining the data critically for both regularities, inconsistencies, and for the viability of thematic constructs and narrative interpretations. This is not a process of unearthing, as the meanings in this data do not lie in wait for discovery. I do not claim that there are “correct” or certain meanings embedded in the narratives, but the outcome of the data analysis and interpretation process can be judged by those in the Child and Youth Care community for their utility in practice, for the resonance of these narratives in regards to their own experiences, and for their ability to continue the conversation surrounding Child and Youth Care clinical practice.

I have attempted to be transparent through the writing of this dissertation concerning my descriptions of the personal, professional, and political influences that have influenced my being. I have also strived to achieve an ethical and fair-minded reading of the data. This reading included my own openness to confrontation of any pre-existing constructs of experience, by the interview data.

Variations in thematic-analysis depend in part on the epistemological positioning of the researcher. Research undertaken from within a positivist or modernist paradigm of understanding would generate alternative data from the interview process and alternative interpretations of this data as compared to my own results. My thematic analysis is based on the categories that emerge from the text as co-constructed and I consider my findings as a presentation of the "inter" views - the views that emerge in the inter-actions between researcher and research participant.

The Interview

An interview is a negotiation of meaning between the researcher and the research participant. Kvale (1996) states "interviews are particularly suited for studying people's understanding of the meanings in their lived world, describing their experiences and self-understanding, and clarifying and elaborating their own perspective on their lived world" (p. 105). The purpose of the interview is to focus on the everyday "life world" experiences of the research participants. The interview constructs meaning and elicits description of the participants' experience, expressed in the language of the research participants. It is typical of many cultures that a speaker conveys this in narrative form (Bruner, 1997). This conveyance includes descriptions of specific actions and circumstances surrounding the phenomenon of interest.

Kvale (1996) characterizes interview data as often ambiguous, with meaning evolving through engagement in the interview process. This was the case in this project, as reported by the research participants. New understandings arose during the inquiry process, for both the researcher and the research participants.

Kvale (1996) describes the interview as a three dimensional conversation. The first dimension is that of the conversational technique he identifies as a construction of knowledge

between the researcher and the subject-participant. The second dimension is that of the conversation as a basic way of knowing. Citing Rorty (1979), Kvale (1996) frames knowledge as follows:

> [Knowledge is] a matter of conversation and social practice, rather than as an attempt to mirror nature. The certainty of our knowledge is a matter of conversation between persons, rather than a matter of interaction with a nonhuman reality. If we regard knowing not as having an essence but as a right to believe, we may see *conversation* as the ultimate context within which knowledge is understood. (p. 37)

The third dimension Kvale (1996) identifies is the dimension of "human reality" that is understood in relationship to his conceptualization of conversation. The human being in this perspective is in constant conversation with the world, just as the world is in constant conversation with the person through discourse. Conversation characterizes our engagement in the world and as such is significant to our being. Through dialogue we may create a temporary harmony, a momentary settlement, and concurrence to our way of being and our understanding of ourselves. The dialogue will continue, as a constant means for negotiating the tensions that typify the interplay of experience, meaning, and identity. I suggest that history and our present are characterized by engagement and exchange and the interplay between the constructs of meaning. In my research I paid attention to how these three dimensions – construction of knowledge between researcher and research participant, conversation as a way of knowing, and the ongoing experience of "human reality", all contribute to the narratives that were formed within the research process.

Transcription of interviews as data construction.

Each of the four research participants involved in this study were interviewed on two separate occasions. Each interview was recorded and transcribed by the researcher. Interview conversation is characterized by incomplete and partially coherent sentences, repetitions, pauses and contradictions, use of colloquial language, and emphasis through vocal intonations, body language and facial expressions. These aspects of verbal communication were considered in the analysis and interpretation of these interviews.

In the transcription I noted any emphasis on specific verbal content, indicated short and long pauses and other nuances of communications. For example, a STRONG EMPHASIS on a particular phrase was indicated by block capitals. The use of body language to indicate when the research participant is speaking in the voice of another person, a sigh, indication of strong emotion, or use of sarcasm was indicated utilizing brackets [ ] to fill in the implied but missing meaning and words.

Concepts of Validity in Qualitative Research

Validity is a significant benchmark factor in assessing the value of a research project in a positivist paradigm of inquiry. Social constructionist and post-modern perspectives raise concerns for the positivist applications of this concept within alternative epistemological outlooks. As Kvale states “in a post-modern approach the quest for universal knowledge, as well as the cult of the individually unique, is replaced by an emphasis on the heterogeneity and contextuality of knowledge, with a shift from generalization to contextualization” (1996, p. 232). A social constructionist perspective is in opposition to the positivist criteria for validity for the following reasons:

1. A "rejection of naïve or direct realism – the belief that we can have direct unmediated contact with the world" (Schwandt, 2007, p. 309).
2. A rejection that truth lays outside of its own construction – a refutation that truth is somehow attached to objects lying in wait for discovery.
3. A rejection of objectivism – a belief that there is some means, some power to defer to, aside from the local contexts, for determining the certainly or uncertainty of truth claims.

Narrative research makes claims about the meanings life events hold for those involved in the research process, about how the research participant's understand their circumstances, themselves, and others. Validity and value in qualitative research can be judged by a project's ability to persuade through crafting an alignment between the data, its analysis, and interpretation (Kvale & Brinkman, 2009). Validity in narrative research is also dependent upon an argumentative practice that convinces readers that the support for the claims of the research is authentic and that the research may guide understanding and action in the human realm (Polkinghorne, 2007). The reader is persuaded by the soundness of the point of view presented in the research process that supports the claims made in the research and by the utility of these findings for Child and Youth Care practitioners. The validity and value of this project will be judged by the standards of the communities who are privy to it.

In respect to validity, the first community of concern is that of the research participants who were contacted for member validation (Kvale & Brinkman, 2009). This context of interpretation is that of self-understanding, where as researcher I presented the narratives from the chapters to follow, to each individual interviewee. Research participants were asked to comment on whether this story represented their own understandings of the meanings they

conveyed. All of the research participants in this study were aware they had an opportunity to comment on their own stories. “Ray” indicated that his story was acceptable in the form presented. “Monique” declined comment, while “Rick” and “Shandra” were both, due to unfortunate circumstances, unavailable for final followup contact.

In respect to validity, the second community of concern is that of the community of Child and Youth Care practitioners and educators. This community will judge the narratives of the research participants and my discussion of these narratives considering as a wider frame for understanding the experience at *Kids Place.* The judgement of this community is measured by the usefulness of my research outcomes and its authenticity towards an understanding of Child and Youth Care practice. I will consider the criterion for authenticity shortly.

A third community for validation of my analysis and interpretations is that of the committee of scholars who have contributed to this project as my research supervisory committee. This community is familiar with either the ongoing conversation in Child and Youth Care concerning identity and practice, the criteria for sound post-modern scientific inquiry, or both. They will also judge the authenticity of this research and will ultimately determine if this research reaches the broader community of Child and Youth Care practitioners.

Authenticity criterion.

As an alternative to the constructs of validity that have emerged from positivist research, Guba and Lincoln (1989) have developed an authenticity criterion, designed to address concerns for validity, in post-modern research paradigms. The criterion they suggest includes:

1. Fairness. Are the concerns of the research participant’s solicited and presented in a balanced and even handed manner, by the researcher.

2. Ontological authenticity. Are the constructs of the research participant's enhanced, through participation in the inquiry.
3. Educative authenticity. Do the understandings of the research participants enhance the constructs of those who are privy to this knowledge.
4. Catalytic authenticity. Is the research useful in facilitating actions in local contexts.
5. Tactical authenticity. To what extent are the participants and others empowered to act on the constructs that emerge from the research.

For the most part I have been sensitive to these criteria in my research and research participants commented upon the value of participation in this project for how our discussions enhanced their understanding of their own practice.

Validity threats in Narrative research.

From a post-modern paradigm, it is argued that validity concerns arise in relationship to how well the presented narratives are believed to express the meanings conveyed by the research participants themselves. I will review areas of concern in the process of representing assembled texts as the narratives of experience of the subject participants in a research process. I will also review the means I adopted to address these concerns.

First, I recognize that my ability to express the experiences of the research participants is limited by the parameters of our language constructs and the ability of language to reflect felt experience. Research participants are constricted by the limits we all experience in making presentations or descriptions of experience. This is one reason for the popularity of metaphorical and storied analogical comparisons in our day-to-day lives. These forms of expression enable the conveyance of a greater sense of meaning by referencing previous experiences that the listener may have had or at least can understand. The analogy, metaphor, and story tap into a richness of

experience that is often lost with less descriptive approaches to conveying meaning. As a researcher, I encouraged the research participants to utilize descriptive expressions and I was an active participant in the stories through this effort. I sought illustrative examples of points the narrator was conveying with their narratives.

A second common concern for validity in narrative inquiry involves the degree of research participant's self-awareness (Polkinghorne, 2007). Simply stated, we are often not fully aware, in the moment, of our felt meanings regarding particular situations. To address this concern, I utilized listening skills and self-awareness to facilitate the exploration of meaning for research participants.

Tools such as open-ended questions: "could you elaborate on that point?" and active listening skills like paraphrasing "sounds like you're thinking that_____" were utilized to draw upon the depth of meaning for the research participants. I established as best I could, a warm and comfortable atmosphere with the subject participants, utilizing coffee and snacks. Interviews were conducted in settings in which the research participants were familiar and comfortable. I was conscious of the use of space and pacing during the interviews and paced these interviews in such a way as to enable research participants to feel comfortable with taking their time in providing responses to my inquiries. Research participants were aware of the research question that guides this inquiry and were aware of my interest in their narratives of experience at the "intersection" of competing discourses of Child and Youth Care practice.

Focused listening and exploration can bring forward the detailed intricacies of a story. Concern for the interpretation of these narratives was also addressed by a two part interview process. In interview two, research participants had the opportunity to follow up their comments from interview one and this was how each of the second interviews began. I prepared questions

in case the narrator had little to say, however, I used broad and open-ended questions whenever possible. The value of this process was confirmed by comments from each of the research participants who stated that they appreciated the opportunity to answer reflective questions and to be given time to think about their practice between interviews. The research interview was a type of conversation that was unusual to their day-to-day practice.

A third concern for validity I raise is that of the potential reticence research participants may feel in revealing their inner feelings to others with whom they are unfamiliar. To help ease this tension I had three and in some instances, four contacts in total, with the research participants. This included my first contact with the entire staff of the *Kids Place* program in the process of research participant recruitment. During this recruitment stage the research participant's in this project were freely able to decide for themselves whether they wish to be part of this project. Any contact I had with any staff interested in this project, beyond our first group contact, was in confidence. Research participants were assured anonymity should they decide to participate in this project, but it is noteworthy that these narratives are from those practitioners who were willing to engage in this research. The narratives of the research participants in this study may be similar or distinct from narratives of those who did not want to engage in this study. Each research participant was motivated by his or her own narrative concerning what it meant to be involved in this project.

During my initial recruitment meeting for research participants I explained the research process and expressed my beliefs concerning the value of their experiences to understanding practice at "the intersection" of distinct discourses. In an attempt to establish a greater likelihood for the expression of the "dirty laundry" side of the story, if in fact this existed, I stated that distinct discourses of practice are in play in that each has a function within this setting. It was

especially important for me to express curiosity towards the open-ended exploration of the stories of experience.

Concerns for validity and narrative inquiry also raise the issue of the interviews as co-constructions between researcher and research participant (Kvale & Brinkman, 2009; Polkinghorne, 2007). It is possible that an interviewer may simply replicate his own beliefs within an interview through use of selective questioning. In the interview process, each of the research participants is placed within a designated role in which the researcher is implicitly in charge of the direction of the interview. During the interview, the researcher is required to make choices concerning what content to attend to and to explore, for further elaboration. This is a natural part of any interview process and is unavoidable.

To address the concern for the research outcome as simply a reproduction of my own belief system, I adopted the open listening stance previously mentioned. I have also attempted to intentionally take a position of "not knowing" (deJong & Berg, 2008). Not knowing is a technique in which the interviewer makes effort to present themselves with an “uninformed” curiosity. I am not suggesting that one’s presuppositions can be set aside, but taking efforts towards not knowing with certainty what the other means results in a tendency for the speaker to elaborate and expand upon his or her content with a goal of clarity for the “not-knowing” audience. At the same time, in co-constructing these narratives I recognize that stories are replications of experience and not the experience itself. By using Cortazzi's (2003) method of analysis, the stories are written in the voice of each of the research participants.

The Research Process and Question That Guide This Inquiry

What are the inter-subjectively co-constructed narratives of experience for professional Child and Youth Care practitioners in a practice setting at the intersection of two distinct and dissonant discourses of social-care practice?

The process of conducting interviews.

The first round of interviews was conducted in mid-December, 2006. Follow-up interviews were conducted in the early months of 2007. During the candidacy and research proposal process I anticipated what these interviews might be like. In considering possible ways to bring the experiences of the research participant to the foreground, I prepared an extensive list of questions that I might use to draw out each interview into more detailed and protracted narratives. These were included in my research proposal. My concern as researcher was that using only a single open-ended lead question eliciting the "story" of experience at an intersection identified in the research question, may not elicit enough data to complete this project.

In the process of approving my research proposal, my research committee suggested that I reduce my list of questions to a basic few and to use as few questions as possible. With this in mind I let each interview unfold in a relatively unstructured manner.

Each interview began with this question:

- What would you like to tell me concerning your experiences here at the intersection of strength-based and deficit-oriented practices?

I considered the addition of the word "story" to this question and this may have been a useful open-ended means to get to the narratives of experience for research participants. However, I also consider that for those unfamiliar with narrative research the request to: "Tell me your story of experience…" may be confusing. In my experience the word "story," may imply a made up

tale, or in some way suggests a sense of "fiction" in the events told. Keeping in mind that a narrative form seems inherent and natural to the ways we convey meaning in our communities, I correctly presumed that research participants would use narrative to convey their experiences, whether or not they were asked to do so.

At some point during the course of two separate interviews each of the research participants were also asked the following questions:

- How do you describe the work you do here at the agency to someone unfamiliar with this setting?
- How do you understand the problems these kids have?
- To whom are you accountable in your work here for these ways of understanding the youth?
- To whom or what do you look to for guidance in your work here?

For the second interview I asked the following questions:

- Since the time we've last met is there anything you would like to add to the last interview, concerning your practice experiences here at *Kids Place*?

Research participants were also asked to select or to imagine a scene that would convey a sense of their experience at the intersection of strength-based and deficit focused discourses. This question was stated as:

- If you were to select and then describe a single "prototypical" moment or scene that presents your experience at the intersection of strength-based practice and deficit-defined, or diagnosed children, what would that scene be? Who would be there and what would be going on? The prototypical moment question was utilized to

encourage a free narration of experience using metaphor, analogy, or example (Schultz, 2003). This question elicits narratives of experience

- How do you explain the extra measures that are provided to these kids, to provide for their education?

I believed these questions would be helpful to understanding the contexts from which the experiences of the research participants were constructed and I was also interested in tapping into the implicit or underlying discourses that may influence their stories of experience.

Some of the narratives that emerge in the space between the research participant and the researcher had a dramatic or performance aspect. Research participants would on occasion speak for others not present, in the voice of the other – for example as a parent, as a child receiving services, or as a significant other participant in the child's or agencies contact. This performance of others voices, or one's own voice in a previous time frame, is indicated in "quotation marks" within their narratives. Performance of these narratives was also enlivened by vocal tone and intonation, volume, and variation in pitch. Where an excessive pause occurs, this is indicated by a series of three dots… Where a heavy emphasis occurs this word is highlighted by CAPTIAL letters. Some of the interview data consisted of narratives involving conversations between others at some previous time.

The participants.

The *Kids Place* research participants who volunteered to participate consisted of two men and two women from this program, ranging in (estimated) age from the late 20's to the mid 40's. Each participant had been on staff for at least two years and some had been in the program for well over a decade. All participants had achieved post-secondary education, two directly in Child and Youth Care, one in social work and one in recreational therapy. Each performed a direct

client-services role in the *Kids Place* program, but for one who also provided a program leadership role.

Experience

The word "experience" is central to my research question and in narrative inquiry experience is conceptualized in its own way. Narrative research calls into question the possibility of ever capturing or representing original experience[12]. Taking on a post-modern perspective, I understand experience to be like a handful of water; the grasping allows at best a momentary capture. Whatever experience is named and however it is described, words are not fully capable of conveying experience. The words are a partial presentation. We all use analogies and metaphors for our talk about experience, as in our day to day existence we have this same difficulty conveying our own meaning. In this research, I am twice removed from original experience in that it is the experience of another and the co-constructions that emerge in the space between the researcher and the researched, that I am conveying. Given that we all struggle to express ourselves as fully and clearly as we can, conveying the co-constructions of a research interview provides a challenge to the researcher.

Experience is influenced by our physiology and by discourses that contribute to contexts of meaning. We perform actions and construct intentions that derive from experience and which create new experience. At times experience seems to require knowledge of its opposite, or binary to emerge. How, for example can we know a concept without the suggestion of its contrast? How

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[12] Relevant views on the concept of experience can be found in my online dictionary (http://dictionary.reference.com/browse/conjunctive). Here, experience is defined as "the totality of the cognitions given by perception; all that is perceived, understood, and remembered" (n.p.); as "a particular instance of personally encountering or undergoing something" (n.p.) and as "knowledge or practical wisdom gained from what one has observed, encountered, or undergone"(n.p).

do I know the taste of sweet, without knowing the taste of bitter? In order to have “up”, must I not also have “down”; in order to know strength it seems I must also know deficit or weakness.

The research participants in this study often relied on the construct of binaries as they often used a comparison and contrast to tell their stories. The experiences in this setting are framed as constructs at the intersection of dissonant discourses and these discourses may also be constructed as binaries. It is notable that the research participants also moved beyond a binary outlook to foster a “yes, and” approach that enables one discourse to compliment another.

CHAPTER 7

The Story of the Research: The Results Part I

Finally the day came. My research proposal was approved by my committee. Ethics approval was granted. On site administration-approval was granted at *Kids Place*. A meeting was arranged in early December 2006 and I was allowed to recruit my research participants, with no influence from the administration. Eleven months since my arrival at the University of Victoria campus had passed; this project was to get off the ground – presuming that I could find staff participants willing to volunteer to participate. I had one chance to meet this staff and present my case; thirty minutes, to explain the project, and their role should they choose to participate.

The meeting began with my presentation and request for volunteers. The staff assembled along two long rows of conference tables. As the meeting began, the numerous conversations between the approximately 25 – 30 staff assembled wound down. I was a diversion from the typical Friday afternoon staff meeting agenda. The staff was split evenly between men and women, their ages ranging from the mid-20 year olds, to men and women of middle-age. Each was aware of my purpose, having previously received my brief introductory letter.

I described my sensitivity to the newness of the experience of being strength-based practitioners, in a setting where children are diagnosed with DSM constructs. I explained to the staff the nature of my project, my understanding of the work they do and the research question that guided my inquiry. There was no indication of willingness or unwillingness; in this regard the group was mute. My portion of the meeting concluded and I returned home to wait for replies.

Rick

The emotional quality of the setting: Keeping the conversation going.

What is the experience here at the intersection of two distinct understandings of our practice? Well, to start, I'd say that embracing the strength-based model impacts the emotional quality of the [*Kids Place*] setting. Prior to our commitment to a strength-based approach - there was always a sense of commitment to the work - all staff believed the work was important. But, we began to do things differently than prior to when we were solution-focused. Our previous work of trying to SUPPRESS behaviours was frustrating and tiring. We were always in the muck. Now we are building on strengths. Our goals are, globally, the same. But now, we have more options and a more positive feel. In comparison, being strength-based is refreshing.

It feels better and it fits my sense of self better to be strength-based than to be mired in the negatives. The negative focus damages the relationship with the client. We were [previously] mired in a cycle of negativity and being strength-based gives us new options and new undertones. The cycle of negativity is easier to deal with [in a strength-based model]; a strength-based approach removes the logjam of change. You know, sometimes we create logjams in the process of change, with our attitudes.

Being a strength-based practitioner aids building relationships with families and kids. Despite a child's problematic history, the parent often believes that their child is an individual with abilities that are overshadowed. Parents are also often strength-based, but this [strength-based] outlook may be buried beneath the muck. Our being strength-based connects with this part of them, establishing positively-based relationships. We engage with parents because we tap into their own underlying sense of strengths in their kids.

As a result of the pressure we experience to give in to a deficit-focused way of thinking, we establish a shared notion of who we are and what we are. As a group we share a commitment to this view, though there are no absolutes. This is an ongoing process and not all staff members are at the same place in the process of developing a strength-based outlook, but that's okay too. We make efforts in nurturing, supporting, maintaining, and strengthening our strength-based identity.

We are an eclectic crowd at this agency, unlike other settings. We don't think kids will change because WE have the right way to intervene, but we think kids need to see themselves differently in their relationships and in their world. We work to create THIS type of [identity] change and we also have to face the practical day to day issues of behaviours and structures and management and finding some sanity.

My experience of being here and being strength-based is that while it is a struggle to keep doing strength-based, we nurture and support one another as a team. We have a shared notion of how and who we are and this is our identity. We practice being strength-based amongst ourselves. For example, I was at a case conference recently and one of our staff was engaged with two parents, and their child is a handful. The staff member strongly reinforced the parents change in approach with their daughter, asking them to reflect on what is going well, and how they did this and so on. I reinforced this same approach with the staff member, how nurturing and supportive he was with the parents. In terms of supporting one another we try to provide very specific feedback to each other about things that go well. Along these lines we are quite specific about staff training.

Staff training brings people up to speed with the program in terms of its thinking and orientation and we have developed modules that are a part of this. This is an organic

development, its okay for our staff to have a variety of integration levels of this model and this provides comfort and safety and allows the staff to explore what this approach might mean for them. Being strength-based is a GREAT way to build a team. We work cooperatively; being strength-based is NOT forced on anyone. We give staff time to engage this outlook and some move faster than others, but this is how we define ourselves. We categorize the work here as being leading edge/cutting edge and encourage this view with staff. When staff embraces this model they view it as cutting edge practice. This view aids motivation and reinforcing the outlook. Our staff develops a sense of pride that follows this outlook.

We are different than a deficit-focused setting because we see change coming about from being strength-based and from being a democratic team, with a sense of community, identity, and shared purpose. The staff here like the sense of community and get attached to it quickly. For example, we had a staff leave here after 6 or 7 years and she left to go to children's [inpatient] psychiatry. I bumped into her recently and she informed me that in her new setting things are less democratic, more rigid, and hierarchical and no one talks the same [strength-based] language. In a sense the deficit model smacked her in the forehead!

As a result we establish a shared notion of who we are and what we are; we share [as a group] a commitment to this view, though there are no absolutes. This is an ongoing process and not all staff members are at the same place in the process of developing a strength-based outlook, but that's okay too. We make efforts in nurturing, supporting, maintaining, and strengthening our strength-based identity.

Being strength-based, it's a different kind of work. To sustain oneself over six hours every day, to sustain a focus for that kind of time frame, this is a different way of being. It requires an ingrained [thinking] – by practices and structure – to be strength-based is infused

[otherwise] you get ground down. We have to make a big effort and individual resources are just not enough, we need the institutional support to maintain our strength-based perspective.

Changing identity and getting out of the muck.

To provide a little background context for our experience here at *Kids Place*, there is often a history of antagonism between parent and child at the point of the child's arrival in our program. Aside from a DSM diagnosis, the label the child often comes with is "he's a little shit!" He is a "bad kid." The parent problematizes the child, they don't accept the DSM label [as a valid form of illness] and in cases where there is a real intense conflict [between parent and child] labelling occurs, but it is much less benign than the DSM label. The DSM label may have little or no impact in an antagonistic relationship of this type. The problematic behaviours the child presents are seen as more personal, more intentional, and perhaps this is where the DSM label could really be a positive. In spite of a DSM label the parent feels the child is intentionally antagonizing. With a strength-based approach we have a more positive feel and we have more acceptance by the parents for what we are doing, yet it's a struggle to keep the [strength-based] energy going.

Being constantly in trouble with someone makes it hard for kids to see themselves differently. Being constantly in trouble makes it hard to feel a sense of confidence, or success, or even secure in one's self. The client's issues are really outside of any categorization. The DSM is of limited value at times like this. The bottom line is: we need to figure out a way to move forward and DSM does not tell me what to do in these moments either.

The work we do here is REALLY HARD WORK. But, in spite of this when the staff leaves employment here, they are routinely positive about the climate, the teamwork, and the democratic approach. There is nothing easy about working with someone who would assault

you, or call you every name in the book. This is the muck. We continuously need to support one another [with a strength-based philosophy of treatment] around resisting getting pulled into the negatives these behaviours can bring forward. It's amazing to see someone who is emotionally battered and bruised and maybe even physically battered and bruised, who then walks into a case conference and be positive. Our staff recognize the positives in the child, in spite of these extreme negatives and the parents are aware of the negatives anyways, this is not something that is new for them. We continuously focus on: "Here's how we can work together with Johnny." It's amazing to watch where a staff has been verbally, physically, and emotionally abused by that kid, then they tell me: they get the strength-based model! These are exceptional people.

Kids will say: "If I cannot do this [school work and meeting in-school behavioural expectations] then I am no good." Many kids would choose to be bad rather than appear dumb. Kids therefore do not want to try hard because it's safer to get kicked out of school and stay home. This is pretty typical; a number of our kids would rather not be in school, so a few small changes to things in school can make a difference. One little guy [diagnosed with a school phobia] we had - his history had been to be in school an hour a day. This came from his previous [in school] experience; he came in the morning and would last until the first recess. His way of dealing with stress was to get sent home. He became very skilled at this. It started with the later recess and he managed to get kicked out earlier and earlier each day. We see this pattern all the time, kids seem to ask themselves: "What do I need to do to get kicked out?" Our kids tell us this! In their previous experience there was a well defined path to get home earlier and earlier each day.

So, we work with the diagnosis of oppositional-defiance and conduct disorder a lot, and you may ask yourself, "What is oppositional defiance disorder? How can this be an illness?"

These kids continually fail in school, they come to school with a failure identity and often the school itself contributes to this. Their opposition to school makes sense. These kids have difficulty in primary relationships at home and then suddenly in school they have 20 or more new relationships they have to manoeuvre. This pattern results in an O.D.D. diagnosis.

Most or all of our kids have trouble with early attachment. This leads directly to social and problem solving difficulties. We are trying to create an environment that is corrective of this, but change is slow and the history that we encounter is large. We are not the people that are all that important. We are not as important as the primary caregiver and therefore our potency is limited by the fact of our limited contact. We work in identity change and relearning and the kids really want positives from their most significant others. Our work is slower going because we have less potency in this way.

Being in two worlds: Working with parallel discourses of practice.

Strength-based philosophy is an easy philosophy to support. My interest is where we put our energy towards change. I readily adopt this outlook, but am not so clear about how it is operationalized. It is a struggle to keep the strength-based energy going. We need to have our foot in the other world, the world of diagnosis and problem behaviours. We need to face the reality of kids with diagnosis and medications. Medications do supplement the work. By virtue of previous trauma or organic-based deficiencies, medications are anchored to the diagnosis. The two systems: education and mental health demand of us the knowledge of and paperwork around the diagnosis. We need to do this continually to demonstrate the need for the child to be in this program, that Johnny deserves to be here. We need to go back to the problem-focused descriptions of kids over time to report and justify the need for this placement.

Being in two worlds [deficit-focused and strength-based] is a disconnect with real conflict potential. We are strength-based but must negotiate the landscape of deficits and DSM. It's not an either/or approach, it's "and," it's both. We need to learn how to behave in different systems. Each world impinges on another and we learn how to behave in different systems. The strength-based and deficit-focused interactions go two ways and diagnosis sometimes slips in to inform our work, in having a complete understanding of the child. It [diagnosis] does not drive our intervention strategies, but contributes to an overall understanding. We need to be bilingual and the influence of DSM deficit-focused is never ending. There are CONSTANT invitations to be part of this way of seeing things. We need to resist these calls to be deficit-focused. We constantly need to remind ourselves what we believe in. Hallway conversations, staff meetings, training; all are designed to develop the strength-based view. The invitation to deficit is never ending.

The DSM is heavily researched and therefore has scientific legitimacy. We need this legitimacy for being strength-based. Some pockets of staff need the legitimacy of science to be fully committed to being strength-based. A belief system needs its own credibility. So, we have looked hard for scientific support for this view. *Hxxx* [another local agency working with DSM diagnosed youth] for example, has a highly structured behavioural approach and other programs [also] take a more applied and prescribed theoretical approach. The strength-based model really doesn't tell us how to operationalize; it's not prescriptive in that way. We sometimes feel we need to know what to do with behaviours to keep sane some days; it's like we need structure and limits. We as a staff need to create a sense of structure and security in working in this way.

We do bump up against the need for scientific legitimacy. We attend workshops on strength-based practices both locally and internationally. We are gearing into the science that

supports a strength-based approach in conjunction with brain development. We straddle both worlds and come to view diagnosis as simply a descriptive label that captures a collection of behaviours. The diagnosis does not influence us that much. We use diagnosis to the extent it brings in money, it's a tool, and it's utilitarian that way, descriptive but not prescriptive, though the organic labels have more certainty to them.

The DSM label is of really limited value, but it can be more prescriptive in that you have to do THIS with THAT. In a strength-based approach we go back to a more fundamental way of moving with the kids. We need to build relationships that are meaningful. We have to establish a foundation of trust and then we can create an opportunity to mirror back to the child a different picture of who they are in the context of their experience. The relationship is the most powerful vehicle for this to occur.

The kids don't see the DSM label as meaningful anyways. They see themselves and others see them as "bad kids." It is a lack of self worth; the DSM diagnosis is not of value to the parents either. But the parents do reflect on how the label reflects on what kind of parent they are. The diagnosis is a hoop really, a hoop that people need to jump through in order to get into our program. The school system needs a code, a code 42, to provide access to our services. Ethically, this is REALLY in doubt, you see the diagnosis and have real doubt about their validity. Often we just don't see in these kids, what the diagnosis supposedly tells us.

Being deficit-focused means you are unlikely to make a fundamental change in the perspective of the client. Change, with a deficit-focused outlook, is not long term and cannot be sustained. Its external that way and the change we are interested in HAS to occur at a deeper level. Sometimes with the DSM there may be some valuable information there, say with F.A.S.D. for example. But its strength-based that gives you different things to try to focus your

energy on. If you get caught up in the deficit perspective with all the things that are going wrong, you get totally focused on what's going wrong. You begin to focus on correcting problems.

The flaw of the deficit view is it doesn't work. If I get stuck in stopping negative behaviours, I am stuck. Some people see strength-based as Pollyanna-ish. Strength-based is about creating this new sense of self. THIS [creation of a new sense of self] is the PRIMARY PLACE and task for real change. I need to work with behaviours but I also need to foster the other side. Yet, it is easier to get sucked into a role of behaviour management exclusively. The more structure that you can bring that focuses on second order change is critical. We want negatives to stop and can default to this; frustration over day-to-day behaviours beckons you, it is far more visible. Frustration pushes people's feelings around. Working with two parallel dimensions is a challenge to staff and we do get frustrated. Kids seem more comfortable acting out sometimes, it creates an internal/external congruence for them. When we challenge the self identity it raises suspicion with kids sometimes.

We sometimes wonder why this coding system [DSM diagnosis] is necessary. What we come up with is that this is an expensive program and in the absence of any alternative for accountability the medical model prevails. We need an accounting system and the medical model is just that. I believe that we are NO MORE expensive that more traditionally oriented programs, and we are more cost effective. We believe that we ultimately save the system money with this approach but we don't really know. There is notably, a great deal of momentum in the deficit-focused outlook. By the time the momentum gets to the individual program there is a HUGE momentum to be deficit-focused. We need to build dams up around that momentum.

Typically, the medical model psychiatrist providing the diagnosis does have a larger picture of the child's social situation. But the diagnostic approach seems to be the path of least

resistance. This is what we can control, what we have access to. By default, what you can more easily control becomes the point of intervention. The kids are an easier target of intervention; we can make them come in every day. We have to dance around a lot to get the parents to come in two or even three times a year. The kids are the target for the intervention simply because they are more readily available for intervention. There is a bus coming to their door every day with the expectation that they are on it and come to our program. While at the same time we are dancing all over the place just to get our parents to come in two or three times a year. We have an opportunity to influence that becomes, by default, a place where resources are focused. It's far more challenging to engage in and do quality work with the family system, so we work with the individual kid.

The legitimacy of strength-based practice.

We have outside legitimizing bodies that also give us [our treatment practice] credibility. The Canadian council for Health and Social Agencies (C.C.H.S.A.) is a national accrediting body that sees programs all over the country. It is very reinforcing that a national body with lots of exposure to other programs has described us as a "leading edge" [indicates scare quotes in the air with his hands] practice. In the absence of hard science that supports our practice model, this [accrediting agency] supports our outlook. We do not see the path where being strength-based will take us as this approach is new for a program like ours. There is a comfort in clarity and we don't know where this will take us or even if it takes us anywhere at all. The comfort of clarity in practices supports our philosophy and the lack of day-to-day procedural clarity sometimes leaves us wondering "where are we going with this?" [indicates scare quotes in the air with his hands], and this may be uncomfortable for some staff. The absence of procedural certainty cuts two ways as it [our strength-based practice] creates an environment in which we expect growth, change,

and evolution. This [strength-based] model allows for a creativity of new ideas and is not totally prescriptive.

Personally, I am comfortable with being on a path that does not have an ultimate destination. We are open to influence from the outside world and this is different than, say, behaviourism, where the outcome is clearer. The strength-based approach does not have a level of clarity to its practices in this site. The program leaders do not have all this nailed down. We are in this together and we are invited to experiment. This means in part, that they don't come down on us for fucking up. In fact, they celebrate that we've tried something new, something different. My experience of being a strength-based practitioner in contrast with a DSM and deficit-focused orientation is being strength-based is a more collaborative and democratic approach to the work we do.

In the day to day work it's possible to develop a cynicism about the strength-based approach. It's a very individually oriented system. It's so individual that you can't map it out. We have doubts and ask ourselves, "Is this the right route?" It's not really like any other way of working and its not always going to result in taking you to the place that you would hope it would.

Day to day challenges: The experience of pragmatic practice.

I am a pragmatist and for me that means that models are helpful when they give direction. In my role it is important to take the strength-based values and build practices and programs around that. This seems so obvious, but there is not a lot said on how to do this; it's one thing to say let's do this, but getting people to move with this is hard. The emotional intensity and conflict that accompanies our kids makes this complicated. We have to build in (structurally) activities that drive these values, this model, into reality.

We are an eclectic staff and it's not so important that we hire staff that are already on board with a strength-based approach. The people we hire are going to get this approach when they see how it works. When they are immersed in an environment that is full of it [strength-based philosophy] they are going to get this approach. But we need more direction and leadership on how to operationalize this approach in those mucky moments. I do like this aspect of the work, it's very interesting and it's a nice merger of theory and practice. So this is where I am as a program leader, working to capture practical activities for back in these mucky moments. I have been working to develop really practical activities that bring those [strength-based] values to the surface. This operationalizing is an ongoing thing.

Pragmatically speaking, we need to figure out how to work with behaviours that are problematic. We use these behaviours as a spring board, as an opportunity to help cast perspective [of the child in treatment] in a different light. Change in perspective enables the child to move to a different level, to work with us on changing self concepts. We move to a deeper level of change; the child's self-concept, the sense of the core self. Our kids have developed pictures of themselves that are quite negative. Abuse, attachment issues, whatever, you pick your trauma, some real damage occurs to their [our client's] sense of self and the world. We need to rework their views of the world. Our kids need support so we say, let's do this together. Otherwise, I can spin my wheels all day getting behaviours to stop.

Swearing is a good example. If I pour all my energy into getting the kid to stop swearing, we are not going to get too far with this approach. If I can get the kid to see himself differently, he will quit swearing on his own. The challenge is to do both at once, to be strength-based and to manage behaviour. I need to work with both pieces a little bit at a time. I can only tolerate so much. Sometimes I have to respond authoritatively to a kid calling me a "fucking asshole."

The prototypical moment: The art gallery.

I think the best example I can think of for my experience at the intersection of strength-based and deficit informed practices is what we are trying to promote with kids and families. There is an artist in residence program here in Alberta. We had a visual artist come in and work with our kids for a week, paper mache, drawings, etcetera. At the end of this week we had an art display at a local art gallery here in Calgary. Two TV networks came down to see this. It was a big deal; there was a kind of status about it. I remember one of our grade 6 kids being interviewed by one of the TV guys. It had a real feel of normality to it; this was a REALLY POWERFUL moment for all of us. The kids still talk about this; it helped them feel normal and removed from the other complications in their world. This [are event] had a real positive impact. The kids felt competent, productive. The families came by and they too felt proud and involved; the community too was involved [by way of the television coverage], so this amplified this positive dynamic. This art event we held was something we really celebrated. You're never quite sure how these things are going to turn out. This was really affirming for us. The work we do, the beliefs, the values, we are really looking for opportunities to move forward. It worked. This helped the staff feel that the work we do is effective and it was very affirming.

A primary goal in this practice is to create positive identities and this makes the work easier. Strengths are always there already. For example, we had a foundation fund raising event and we needed testimonials from our kids. Well one of our kids "Johnny" leapt at the opportunity to speak. This would be unlikely to occur in a problem-based relationship. We helped him increase his sense of competency as a leader. At age 14 he spoke to a large audience in an auditorium, about his experiences in our program. The positive qualities are already there, but are hidden by the more colourful behaviours.

What we are doing is we are trying to create a new story for our kids, an alternative version of how things are - a different vision for the client of how things are. We need to create a belief that change IS possible. That hope exists to move forward, that the necessary energy to create movement can be… IS there. But this new story HAS TO develop from experience. The reconceiving of this is literally through new opportunities. Change in identity has to be sustained through real experience, it's not just a sales pitch, and relationships are the mechanism to move forward in this way. We ask: "What can we do together, as client and helper, to move you forward into a better place, to a more positive view of who you are?" Both DSM and strength-based models are sources of information. This is where we are hoping to go, to work on changing the outlook. A deficit focus is a real resources trap.

This art event that I speak of was not a turning point. We are not looking for turning points; we are looking for an accumulation of moments. The work we do is not about conversion experiences. But the art event supports the change in identity we seek. It had an impact as part of a chain of other things for these kids. Our kids look to the external world to know who they are, to define themselves. There are a variety of people who can define these kids and we see ourselves as one of that group. It's the day to day events that make a difference. For example, the other day was a moment where this really came together, it was really cold outside so we had recess inside. Many of our staff are musical. I saw (through the outside window as I walked by the classroom) the teacher, student, and Child and Youth Care worker playing instruments, jamming. That moment too was representative; it's that feeling, kind of that positive rhythmic feeling, that connection of being together and acquiring that experience again, of redefining things, individually and relationally. There was a real connection there [Rick smiles broadly].

We have a gap in our program with how we are able, or not able, to engage or invite families in a deeper type of work towards this end. The family is far more important in terms of influencing the identity narratives of the child. This continues to be a challenge to help the families see the world differently, maybe in terms of their child's point of view. Home has a much different feel than the school; we can only hope there are consistent messages. The kids experience almost two different worlds, where home can be a dramatically different kind of place.

We want to find a way to support families to move forward positively in a more focused way. At the art gallery, we could see the difference with the families. The art gallery experience made for a change in the way they were seeing their kids. Yet the child wears the diagnosis. The child's social circumstances have a great influence on the diagnosis and seeing the kid as the problem is short-sighted.

Preamble to discussion

The reader may note many content theme and holistic analysis similarities in the narratives of the four research participant's involved in this project. As a researcher I will take up discussion of content and holistic story themes as they arise within the discussion that follows each narrative. In order to avoid repetition of content I will try to avoid discussion of content and holistic themes in subsequent narratives if they have been considered previously.

Discussion of Rick's Narrative

Getting out of the muck.

For Rick, a strength-based model of practice offers a way out of the ethically disquieting coercive traditions that are in evidence in some, perhaps many, Child and Youth Care practices settings (Brendtro, 2005). Rick alludes to his history of practice spent "suppressing behaviours"

and he characterizes both these actions and the behaviours he works to suppress as "the muck". The muck is more than negative behaviours – it represents a gestalt of negativity that surrounds the child at the time of admission to this program. Being in the muck covers over the strengths he believes are found in all clients; it is a "log jam" of pessimism that restrains a change of outlook and practice. For Rick, there is much more going on for the child than being in the muck, but this "muck" represents a typical part of the child's life and a typical beginning to treatment at *Kids Place.* What he does with the muck within the treatment process is highlighted for its importance in how it influences the emotional milieu of practice at *Kids Place*.

Getting out of the muck is a shift towards a broader and reflective consideration of the child's and practitioner's contexts of being. It suggests sensitivity to and a scrutiny of the contexts and discourses that try to define both the client and the Child and Youth Care practitioner. Getting out of the muck represents movement from a pre-occupation with the certainties of diagnostic constructs and behaviour management towards thinking that centers the child and his or her contextualized needs as a cornerstone to treatment. Ungar (2004a) suggests that this client centering is a critical component of the construction of resilience in high risk youth. This shift in thinking represents a reconfiguration of the concept of care. This shift moves individualized treatment to the foreground and relegates hierarchical expert theory and knowledge that determine client needs to a secondary position in treatment. This shift also aligns Rick's practice at *Kids Place* in a value base that reflects "the nature" of Child and Youth Care practice (University of Victoria, School of Child and Youth Care, 2008b).

Rick narrates his role as that of a therapeutic agent with a distinctive and relatively new form of "cutting edge" practice; his strength-based model is framed as a fresh and contemporary model for treatment. Rick believes that he and the members of this program have unique insider

knowledge; they "get it" while those outside this paradigm of practice do not. An identity as an agent of change who understands and sees what most others do not situates this practitioner in the role of an elite, a member of the select few on a quest for practice-excellence, framed as a heroic and noble cause. A strength-based practice enables Rick to "see" the client differently, just as it enables him to see new possibilities for his identity as a practitioner.

Being an agent of change rather than a manager and suppressor of the symptoms of mental disorder facilitates movement towards overcoming a second form of attitudinal and behavioural "muck" within the Canadian social care system. Historically, Child and Youth Care practitioners have struggled to gain professional recognition as equal participants in social care treatment, in relationship to other professionals (Dunlop, 2004; Krueger, 1986; Phelan, 2005; Trieschman et al, 1969; Ungar, 2004a), in spite of their closeness and familiarity to the client populations they serve. As Kruger suggests our social care system for children is patterned after the adult mental health treatment model. Herein, "those furthest from youth still wield the most influence in the system" while those closest to the youth are of "secondary importance" (p. 37). Kruger also notes that a hierarchical model of professional influence in children's social care reflects a construct of Child and Youth Care identity as that of mere "care providers", reviewed in Chapter 2. In Kruger's view the medical model predominates the delivery of social care services in which the disciplines of Psychiatry and Psychology "still have the most influence" (p. 38), followed in descending order by Social Workers, Teachers, and "other specialists" with Child and Youth Care practitioners having "the least influence in the system" (p. 38). Kruger adds that Child and Youth Care practitioners "must continually take a back seat to other professionals" (p. 38).

The effort to define Child and Youth Care as a discipline and as an emerging profession is reflected in my interpretation of the holistic story Rick presents in his narrative. I suggest that this story takes one of the traditional story forms in Western culture, that of a "quest" (Booker, 2004) for excellence in practice. This narrative makes possible an alternative construct of *Kids Place* Child and Youth Care practitioner identity to that of the "secondary" role at the bottom of the hierarchy of disciplines that Krueger (1986) refers to above. I suggest that "the quest" as a narrative shifts the practitioner role from "the muck" of a para-profession status Dunlop suggests as characteristic of Child and Youth Care as a "craft" (2004), into the legitimacy of professional practice. I also suggest the story of each of the practitioners in this study reflects a desire to define their own uniqueness and in turn the uniqueness of Child and Youth Care, by claiming a space for Child and Youth Care as a professional practice that is valued in the hierarchy of social care services.

Issues of identity re-construction are pertinent for both the clients and practitioners of *Kids Place.* An identity-based commonality between the *Kids Place* practitioners and their clients may also influence relational processes in treatment, as practitioners may "identify" with the experience of the one-down position their clients hold in relation to the authorities of power that influence their lives. A portion of the holistic experience of this story, for both client and practitioner can be characterized by the notion of gaining power through identity re-construction. However, the muck of the difficult work, the low recognition at the multi-disciplinary and fiscal levels, and turf battles over meanings and treatment processes continues. Rick at times gives in to get along with outside factors, while constantly promoting the value of this work.

The question of whether Child and Youth Care is an emerging discipline or profession is an ongoing debate in the Child and Youth Care literature. As mentioned above, Dunlop (2004)

suggests that Child and Youth Care is a "craft" and not a profession. Others (McDermott, 1994; Phelan, 2005) suggest that Child and Youth Care will only gain recognition as a distinct profession in the landscape of Canadian social care when those within the discipline are able to articulate the values and beliefs that make Child and Youth Care distinct from other discipline. Rick's narrative exemplifies a practitioner who is equipped with the language and values necessary to describe Child and Youth Care practice as a profession. I suggest that Rick's narrative, when considered in its entirety, is characteristic of "a branch of knowledge with a specific focus and orientation to the world in a particular subject area" cited by Stuart (2009, p. 116) as the criterion for this distinction.

I noted in Chapter 2 that historically, the Child and Youth Care practitioner, has often been relegated to a secondary position as an afterthought in the schema of social care provision (Krueger, 1986; Linton & Forester, 2003; Phelan, 2005). I suggest that this identity is an implicit portion of Rick's experience, given his expression of a continual need to protect his own preferred model of treatment and his need for bi-lingual fluency in knowing the language of the "other" model as he "straddles" two worlds of experience. While a strength-based model of practice is not unique to Child and Youth Care, what is unique at *Kids Place* is how the espoused value-base and nature of Child and Youth Care practice appears to seamlessly join with the *Kids Place* strength-based practice.

Being in two worlds: Working pragmatically with parallel dimensions of knowledge.

Rick tells a story of the consequences of a strength-based practice model in his efforts to find value in, and manage the expectations of a medical model for treatment of mental disorder. He conveys a sense of practice in two distinct worlds of experience that reflect the discursive distinctions in play at *Kids Place*. Rick describes distinctly positive outcomes that he believes

emerge from the intersection of two models of practice. In this regard Rick's practice is a confluence rather than an intersection of experience. A confluence suggests a process of joining where there exists a potential for turbulence and an enlargement of inclusiveness in the content of the flow. In this sense, a confluence has the power of greater inclusiveness than two single streams flowing apart for one another.

Rick speaks of unexpected challenges and conflicts that arise in his practice and about the necessity of maintaining a collaborative stance in his attempt to manage the discursive turbulence that emerges in this setting. In Chapter 2, I referred to how Agnew (2008) conceptualizes positivism and social constructionism as distinct paradigms; each a separate "solar system" of knowledge, each apparently complete unto itself and independent of the other. These paradigms are brought together at *Kids Place* and Rick notes these as two "parallel dimensions" of knowledge. Turbulence arises as these distinctive understandings of the treatment of mental disorder intersect. Medical model and strength-based understandings each offer their own views of the nature of reality and at a distance each appears incommensurable with the other. A strength-based practice reflects a social constructionist orientation that moves past the emphasis on the construct of the individual mind and an objectively knowable world. As a pragmatic move Rick feels obliged to serve as a go-between and balances his strength-based beliefs with "a foot in the other world" to maintain a form of commensurable-coexistence between these discourses in his pragmatic practice. Each discourse has the ability to move the practitioner in a particular practice direction and Rick is interested in utilization for the purposes of client movement. Rick accepts that he has to live with the expectation of bi-lingual knowledge.

Rick values theoretical knowledge but this knowledge must be enacted in a pragmatic manner and be seen as productive. This program is both costly and closely scrutinized by its funding bodies. In reference to social constructionist positioning Gergen (2009) notes that when it is socially useful to do so "utility precedes essence" (p. 31) suggesting that when practical and expedient, Rick will pick up the tools of the "other" model for his own purposes. Rick feels the impact of each discourse and notes distinctive possibilities regarding how they call upon him to practice. One prospect is focused on surface level acts of "correcting problems" or controlling the symptom(s) of mental disorder. Ungar (2004a) refers to this role as one derived from positivist definitions of troubled children and from controlling and oppressive social care processes that include "stigmatization, placement, incarceration, treatment and most often, exclusion" (p. 14). Brendtro (2005) and Szasz (2007) refer to this position as a "coercive" treatment practice based upon a hierarchical and dominating outlook towards treatment of mental disorder.

Deficit-focused thinking and practice is represented as the "other" in Rick's narrative, indicative of an in-group, out-group evaluation of strength-based and deficit-focused discourses. Rick is uncomfortable with an "either or" stance towards practice, yet his narrative occasionally reflects an insider-outsider us-against-them view of his experience of deficit-influenced practice. A medical model discourse is discordant to his preferred way of understanding.

At *Kids Place* Rick blends these two models of knowledge, but Rick acknowledges the short-comings of each model. He speaks of the difficulty of getting sceptical Child and Youth Care team members "onboard" as strength-based practitioners and of "operationalizing" a model that falls short on particular techniques. He also mentions his doubts about DSM diagnostic constructs that he understands as descriptive and not prescriptive. Rick views anger and

resistance to treatment as purposeful and positive forms of self-preservation for the child. This view reflects Rick's ability to see beyond what he understands as traditional and prescriptive concepts in treatment.

Ungar (2004b) states that "for many children, patterns of deviance are healthy adaptations that permit them to survive unhealthy circumstances" (p. 6). Meaning is derived in relationships between individuals, groups, and discourses, and Rick chooses to collaborate with a strength-based discourse that is in keeping with his preferred identity in practice. I also note that the DSM is a classification tool that is based on descriptions of symptom clusters and the DSM is mute regarding what methods should be used to treat its diagnostic categories. None-the-less Rick's narrative suggests that he views the DSM as calling upon him to understand mental disorder as within the individual, and to perform his therapeutic work in a manner indicative of mental disorder as an individual and biological dysfunction. While the DSM is not prescriptive about treatment methods, the suggestion of mental disorder as a form of biological dysfunction is noted in the DSM and is widespread in popular discourse. It is likely Rick draws upon this discourse to liken a DSM diagnosis to a particular form of treatment for mental disorder. I turn to Szasz (2007) for examples of the discourse surrounding concepts of mental disorder:

- *White House Facts Sheet on Myths and Facts about Mental Illness* (1999): "Research in the last decade proves that mental illnesses are diagnosable disorders of the brain."
- President William Jefferson Clinton (1999): "Mental illness can be accurately diagnosed, successfully treated, just as physical illness."
- Tipper Gore, President Clinton's mental health adviser (1999): "One of the most widely believed and most damaging myths is that mental illness is not a physical disease. Nothing could be further from the truth."

- American Surgeon General David Satcher (1999): “Just as things go wrong with the heart and kidneys and liver, so things go wrong with the brain.”
- Nancy C. Andreasen, professor of psychiatry at the University of Iowa (1997): “What we call ‘mind’ is the expression of the activity of the brain.” (p. 89)

Rick describes his ideological divergence with outside practitioners, consultants, and overseers from outside agencies who are aligned with deficit-focused thinking, but who are peripheral to his day-to-day practice. Rick’s fluency in the language of a medical model of treatment enables him to maintain a collaborative stance with these practitioners and he considers himself “bilingual” in this regard. Rick believes it is in his best interests to learn their language and I note that these outsiders support the diversity of his practice. Rick’s narrative suggests his deliberation and uncertainty, concerning how best to manage the expectation of others’ divergent constructs of Child and Youth Care practice.

Adopting a strength-based outlook for practice also represents a letting go of the certainty of concepts and beliefs for treatment practices within the predominating medical model. The adoption of a new practice model feels tentative and fraught with risk, like walking on thin ice; one may never know when that which supports gives way. In adopting a non-hierarchical model of treatment, Rick negates what Fulcher and Ainsworth (2006) note as a “traditional expert model that assumes an inability on the part of children, young people, and their families to participate fully in care and treatment” (p. 29). Stuart (2009) adds that this traditional top down model of treatment has “no place in responsive Child and Youth Care practice” (p. 117). Rick represents his experience at *Kids Place* as a non-hierarchical process of change and states “we don’t think kids will change because WE have the right way to intervene.” This notion of a lessening of the hierarchy in the treatment process has a longstanding history and is not exclusive

to strength-based practices (Banmen, Gerber & Gomori, 1991) but it is cited as a fundamental component of social constructionist therapies (Gergen 2009; Ungar, 2004a). Rick believes that the work of re-constructing identity is a fundamental focus for treatment and he rejects an approach to treatment where change is orchestrated from external sources.

The world of deficit-focused social care practice is narrated as a pervasive "juggernaut" of discourse. Its power "demands" acknowledgement, attention, and active resistance. The outsiders who engage deficit-focused constructs of knowing insist on being heard; its proponents will turn up the volume if strength-based practitioners do not recognize the validity of deficit-focused narratives. As Rick states "There are CONSTANT invitations to be part of this [deficit-focused] way of seeing things." Rick accepts these voices as distinct from his own and reluctantly accepts their presence as they are the overseers, consultants, funders, and referral sources of his program. As such, he acts "as if" they have a rightful leverage of influence.

The need for a "foot in the other world" and fluency in the language of deficit when called upon for funding and placement review is a pinching ethical concern for Rick, as he takes up the ideology of "the other" model. Rick's narrative suggests he recognizes his own complicity in his cooperation with a social care system that supports the "individualization" of social problems rooted in structural and systemic inequality and framed as mental disorder. He recognizes that he is complicit in a social order in which poor, maltreated, and vulnerable children are often the most likely to have difficulty negotiating the needs of the C.B.E. and therefore be identified as deviant. Yet social constructionist epistemology is concerned with taking up positions as determined locally and in the moment, on a case by case basis. As Gergen suggests "all that is solid need not melt into the air. Rather theoretical constructs are [useful as]

discursive resources" (p. 809). Rick uses a strength-based outlook to see the positives and value in deficit-focused thinking.

Rick, at times, acts as if he is in accordance with the legitimacy of deficit-focused constructs as he describes children to outsiders in ways that will enhance the likelihood of continued funding. In some instances problems are represented to program overseers as severe in nature to enhance the likelihood of continued funding. In the face of ethical challenges, Rick justifies his "foot in the other world" actions by the necessity of managing systems of social care to ensure continued program existence. He speculates as to what needs are being met in the coding system of "accountability" that the medical model represents to him; yet he acknowledged that, by default, some "accounting system" must be in place to coordinate funding expenditures for his program.

Rick acts within the deficit-focus world in a way he would not act in good conscience in the strength-based world in order to maintain children in this program who might otherwise be removed. The need for fluency in deficit-focused language suggests the importance of maintaining and strengthening the narrative of strength-based practice on the inside, within the team and Rick states "we constantly need to remind ourselves what we believe in."

The emotional quality of the Kids Place setting: Keeping the conversation going.

Rick's narrative suggests he desires a tranquil implementation of a strength-based practice model, but this model is not accompanied by a template for its implementation. It takes exceptional practitioners to focus on client strengths in a context where their own physical and emotional wellbeing is at risk, as a result of their client interaction. The experience of creating a local milieu to counter the effects of deficit-focused thinking suggests an on-site "sales job" is at times needed to "aid motivation and reinforce the [strength-based] outlook".

The concept of creating a milieu is common to Child and Youth Care practice ethos (Burns, 2006) and aspects of *Kids Place* are reflected in the elements of milieu Burns describes, including using the physical, emotional, social, cultural, and ideological dimensions of milieu to create a sanctuary for strength-based thinking to come to fruition. Clearly Child and Youth Care scholars and practitioners have had a significant impact on the practice ideology of this setting and in establishing a milieu where practitioners feel valued and connected to others and place. Predictably, this results in an "attachment" to programs for both client and practitioner (Heydenberk & Heydenberk, 2006).

The legitimacy of strength-based practice.

Rick's narrative relates his concern for the stamp of legitimacy and approval of positivist science of the strength-based model and its operationalization in practice. He states that "in the day to day work it's possible to develop a cynicism about the strength-based approach." This concern for legitimacy and day-to-day operationalization of a strength-based practice results in personal doubt and at times, outright exhaustion. It also places strength-based practice alongside deficit-focused discourse as an imperfect model of practice.

Ironically, Rick turns to positivist science to judge the validity of his social constructionist practice. To be strength-based at *Kids Place* is constructed as unproven by science, yet paradoxically, DSM diagnostic constructs that are derived from "legitimate" science are viewed as lacking credibility. In the absence of legitimizing positivist science**,** what remains are pockets of scholarship that support a strength-based model and an intuitive sense that the goal of inviting and accomplishing identity re-construction enables children to succeed in school and beyond.

The prototypical moment.

Rick's narrative of a prototypical representation of experience at *Kids Place* again suggests a primary goal of treatment at *Kids Place* is the re-construction of the child's identity and experiences of others through day-to-day activities. The event he describes is a form of "definitional ceremony" that Gergen (2009) suggests is critical to the process of changing one's definition of self. Much effort in treatment is focused on inviting "2nd order" change in the child's narratives of experience. This is change from the inside and is child-directed; it represents a flattening of the hierarchy between practitioner and client that Ungar (2004a) suggests is characteristic of constructionist therapy. The child is invited to examine his or her relationship with the world and Rick states "we are in a process of redefining, a process of helping the kids see themselves differently in relationship contexts and how they move in their worlds." As a practitioner Rick has worked to coordinate his actions in practice with his client's actions, using conversation and day-to-day activities as valued resources. His practice requires a capacity for fluidity and "moving with the child" in treatment. As a post-modern therapy, a strength-based practice attends to the power imbalances evident in the lives of traumatized and DSM diagnosed children.

Practical day-to-day experiences drive the opportunities for co-constructing more favoured client identity. Client change and positive growth is facilitated through daily opportunities to try on new skills and identities; the treatment process is conceptualized as a fluid, always in motion succession of accumulated events. There is little interest in "aha" moments of sudden insight in this treatment process and Rick disclaims any sense that he holds the answers that are the key to change in treatment. His position reflects a construct that Maier (2002) notes as the "transformative" moments that occur in the minutia of day-to-day experience

in the child's living milieus. Maier suggests that when a particular and positive interaction is brought to consciousness, a potential for change occurs; herein "noticing" is a significant aspect of strength-based practice (deShazer, 1994); noticing is considered an important technique for re-constructing the narratives of self and surroundings.

Rick narrates an experience of a co-constructive process of meaning-making in treatment, where his thinking aligns with the nature of a constructed reality, but he does not embrace a social construction epistemology. Others (see for example deShazer, 1994; Ungar, 2004a) clearly situate a strength-based practice and the concept of resiliency, within a paradigm of social constructionist epistemology. As Rick states "It [identity change] has to be sustained through real experience, it's not just a sales pitch, and relationships are the mechanism to move forward in this way. We need to build relationships that are meaningful. We have to establish a foundation of trust and then we can create an opportunity to mirror back to the child a different picture of who they are in the context of their experience." This is a concept that is well described in the Child and Youth Care literature. A concept that Lundy (2006) describes as the "heart" of change and Fewster (1990) describes as a "journey into self". Herein, the use of self is interactive, immediate, and child-centred (Stuart, 2009). The standard of mirroring self back to self may equally apply to Child and Youth Care as a discipline and its relationship with other professions.

CHAPTER 8

The Story of the Research: The Results Part II

Monique

A difference that makes a difference: the boy who learned to speak.

What I would first like to tell you concerning my experiences here is that I find this experience of being strength-based very different. This is the first place I've worked where being strength-based has been promoted. I do find it quite different from other agencies where I have worked. I come from a background [an inpatient psychiatric setting] of understanding the child based on the diagnosis and learning about the criteria and the characteristics that make the diagnosis, and working with them [patients] in that way, with diagnosis as a forethought as a foreground consideration. Therefore, I find it challenging to really go strength-based one-hundred percent.

At the same time I don't necessarily look at the diagnostic pieces as a negative. I use a strength-based approach to bring out the positives of what these kids are able to do. So in this way I do not focus on the negatives. For example, working with a child diagnosed with Aspergers syndrome, I understand the child may have a hard time with transitions. This is important to know and I use the diagnosis as a guideline. At the same time this [strength-based] approach is very different, for each individual, and I use the diagnosis to individualize treatment. A diagnostic piece is important to know for [how it names] what challenges that there could be for that child. At the same, I use a strength-based approach to bring out the positives.

In my previous experience [in an inpatient hospital psychiatric setting] a child would be described to me diagnostically. Therefore my first interaction with a child would be to know the diagnosis [from the case file]. I am already going in [to the first client contact] with the attitude

that I'm working with the diagnosis. For example, this [prescriptive intervention] is how you work with autistic people; this approach really limited me. Being strength-based really sensitized me to the expectations that accompany a diagnosis; you're constantly looking at deficits in a diagnostic approach and not at strengths and abilities. There's not much individuality in this type of approach or individual personality involved. The child IS the diagnosis and this [deficit-focused treatment protocol] is what you do with someone with that diagnosis; this was a very prescriptive approach. Their personhood was left out [in her previous practice setting] and there is not much individuality in the equation. Diagnosis asks me to leave out individuality; it's like being assigned a number. I found this very restricting and limiting in my previous work setting. It resulted in me lacking a lot of motivation and initiative on what to do with my clients. The diagnostic approach for my previous setting was quite rigid in how to work with these kids. It was quite frustrating and against the values and attitudes I had about kids with special needs. Working [in a previous psychiatric setting] from a diagnostic perspective lacked spontaneity with kids and with me as well. There's not much relationship building; I would go and do my job and leave.

I was in conflict with others over case plans. For example, a Speech Therapist told me the child I was working with would never speak. I was shocked! The diagnosis says this child will never speak and this was what was expected by this Speech Therapist in this setting. This three or four-year-old child has Aspurger’s syndrome and this Speech Therapist told me this child will never speak. I thought “How do you know this?” So I used this as a challenge and I thought "We'll just see about that." In five months, with me working with him, he learned four words he could speak and four more words in sign language.

The impact of this [teaching an autistic child language] resulted in a mom who discovered hope. This mom had a four-year-old with Aspurger's syndrome who is mute and she was told he will never speak. I began constantly challenging the other professionals [in her previous setting] not to say: "I don't", I can't", and "You'll never". After five months of hard work the child began to learn language. When his mom saw her child and I said look at what he can do, she cried. This was a huge aha-moment for me, a huge moment in being strength-based in a deficit focused setting. I worked with a four-year-old boy whose diagnosis stated he could never speak and can you imagine how his quality of life would be severely limited as a result? He could not communicate hunger, the need to use the toilet, or even say yes or no. So, I took this speech therapists' diagnostic certainty as a challenge. The child spoke after five months of hard work and this was a huge moment for me: to realize that even professionals like speech therapists, psychiatrists, and whoever they may be can diagnose and set such limitations to what a child can be capable of [and be wrong].

Trying to find a shift: Getting out of the box.

Helping a boy to speak, where the experts said he couldn't speak left me questioning the training and the knowledge of the experts. It's really important to keep hope. If you say a thing is not possible to accomplish, I do not have hope and therefore I do not advocate for change. Where there is no possibility of trying to find resources for change, then we don't try to find change. It was just a single person saying he cannot do this when in fact he could and so we must keep hope. I am much more motivated now to do things that are a bit more extreme, to think outside the box. There really is this box, the diagnosis is a box and in order to be here in this program they [the client] must have a diagnosis. I say okay but the reason they're here is not for that [diagnostic] reason. When I am working with what's going on with them, it may be behaviour;

you may have a behaviour problem. But if I focus all day on: "you have a behaviour problem" [indicates scare quotes in the air with her hands] then that's all I'm going to see, all day long.

My purpose is to show kids and families what they can do if they work at whatever they need to do to meet their goals. Rather than focusing on “you have done this and this and this and this is the reason you're here”, we already know what your bad days look like. Changing focus [by focusing] on what you can do differently. That means I want to know what you [the client] want tomorrow to look like. I ask a lot of questions and they are very future focused. How do we get to where we want to go? For me that part is the strength-based part, looking at capabilities and what you can do. These kids know what they cannot do because they've been told a million times what they are unable to do.

I am looking at where the shift needs to be. Not necessarily looking at changing behaviour, but what we can find in a behaviour that is positive. The DSM places these kids in a box. They are sitting in a box, this is what they're diagnosed with in order to be here, but they're not here for that reason. I come from a life skills background where we looked at teaching and looking at what is creating negative or helpful responses in other people. What is it in the child's behaviour that we can use to create a shift in reaction from other people? What is it that's a good characteristic about this behaviour? We reframe and redirect behaviours; what is it that you're really seeking and how can we get that in a positive way?

I don't get stuck on why questions and am not that concerned with causes of behaviour. I may never know why, the child may never know why he did certain behaviours. But because we don't know the cause of the behaviour doesn't mean you can't make a shift [to a strength-based practice]. It's okay that we don't know the cause. But it was a challenge to become more strength-based after working in more deficits oriented environments. It's terrible to say, there was… I was

stuck trying to figure out what was wrong with this child [in her previous psychiatric setting], I looked to the diagnosis to tell me what to do. Coming here, I would see the kid in the classroom and I thought everything I knew just went out the window. I have to deal with personalities! I had to learn to look for the positives.

Being deficit focused led me to burn out in my previous [psychiatric inpatient] setting. I was told repeatedly about the limits for the kids I worked with and I was very frustrated and eventually quit. My skills and my belief system were not utilized to their capacity and I was just as rigid as anyone else there. Coming here, I was thrilled, this is like freedom! Coming here was a really nice shift, but I had to get out of my old routine. Relationship building was a very good piece of what attracted me here in the first place.

Having a disconnection from the kids worked well for me in my previous [practice] setting. Often I was performing a parent-like role, helping with the basic needs of these kids. There were many complexities with the kids in the previous setting including times where they would die. So I was afraid of relationships and attachment for this reason. Taking on the DSM type approach enabled me the protection of not forming close relationships. This protected me from hurt, it isolated me from loss and the hurts of the child and also from knowing that not much change would be happening for the child. Treating a child like a diagnostic category protected me. The strength-based protocols ask me to engage with clients at the relationship level. I don't find it a challenge to develop those relationships with the kids anymore. The child can only go so far without developing an attachment to an adult and good working relationships result in our exceeding expectations. Every relationship with each kid is different and they all may have the same diagnosis!

What happens when we make the shift to reframe behaviours as positives with kids is that we get resistance. A reframing doesn't match the template they already have of what they are, the template they hold of themselves as what they are. These kids are told from age 0 to whatever that they are a "bad kid". It doesn't matter much what I say, maybe they get comfortable with the positives but then it [the deficit message of self] gets to be too much to resist. The work here is a matter of continuously to try to change the view of self [for the client]. We are working to change the template [of the child's self-identity] absolutely to the core. You can change behaviour all you wish, you can modify behaviour and do it in a million ways, and it's not going to last. The next time someone says "you are a stupid kid" they go right back to the template. With a behaviourist approach, one negative comment and the child is back to saying "I am a stupid kid." Simply changing behaviours is not enough.

Telling our clients "you're a good kid" is automatically rejected because it doesn't ring true. There's a piece inside all of my clients that is not about behaviour per se, it's about how they see themselves. They believe the negatives they've heard resonate with truth and telling them they're a good kid is rejected because it just doesn't fit with how they understand themselves. How do we change the template [of self identity]? This requires a lot of hard-core experiences and a lot of not giving up. It's hard to stay motivated to continually find the strengths when they're rejecting that. I know why they are rejecting my views; that they reject my views makes sense, but this still hurts my feelings. I still offer compliments and reflect positives in spite of being rejected.

I see myself in this work as being accountable to the child first, then to those attached to the child, and then the supervisor and my team. We have to stay close as a team, connected. I am also responsible to myself and my own beliefs. I cannot, therefore, do the mechanical work of a

problem focused approach as it does not account to myself. But, there are also times where I need to be accountable to me and to my own need for a break from these kids, and a lack of progress can be most frustrating. Sometimes it's very slow going here, we work hard and conditions are tough, including name-calling, threats, and physical acting out. There are times when they've [the client] worked hard and then they throw their shit [intolerable feelings of anger, hurt, rage, sadness, disappointment, frustration, etc.] at me. Sometimes I don't get it. I'll say "Why are you mad at me?" It typically turns out something happened at home. I stress the relationship between us and this [acting out] hurts me. This is a reciprocal relationship, the trust I have built allows them to deal with their pain with me and I have to remember not to personalize this [acting out].

From a strength-based perspective I ask, “What is the problem?” The problem is not the diagnosis or the family; rather the problem is what we are going to do with this information to get to where we need to with this child. The situation is just the facts; we need to look at where we go, how we involve the child in this [treatment process]. This is distinct from a deficit focused present and past orientation. The past is this information but cannot be changed, in a deficit model the conversation would sometimes end there. The deficit focus is far more likely to encounter: "This is how it is and nothing can be done". The parents then wonder “Why should they get involved?”

I had a child I work with who could not talk and in the previous setting the experts said he is “blank” [referring to the diagnostic construct], therefore he cannot talk. In a strength-based approach we looked at, if this is true, what can he do instead? The point being is to offer something towards making a difference; otherwise we are just glorified babysitters.

Trust and relationship as a pre-condition and a tool.

Trust, safety and security, these are the issues that for the children who come to this place have quite a problem with; they are resistant to trust. Trust looks like sharing, like when a child comes up to you and says "can I talk you?" and then just dumps this gross ugly thing on the table, and says "this is what happened to me yesterday". It's embarrassing and humiliating or fearful and they dump it all out on the table, and we just leave it there and we walk away from it. I have to deal with this in a respectful way. My kids know they can dump it and we can go over it one more time; that it might not be fixable, but they [the client] were able to let it out. This takes a lot for the child to tell you what's going on [in their troubled worlds].

When I feel trusted then I feel more successful and energized and hopeful. I think the kids begin to think things and see things, and find things out about themselves that they may not have seen before. Being able to trust another adult is a big thing and with this comes the means to take care of themselves, respect themselves more. This can snowball into a continuing positive thing. The kids take care of themselves with more respect for themselves and advocate for themselves.

Without trust I could not use the diagnosis in a helpful way. When I explain a [personal] problem [to a client] without trust he would see that as a putdown, as a negative. In fact it's an attempt to be helpful, so the client conditions [trust, safety, security] must be in place for him to hear this message. However we have to be careful that this does not become an excuse for lack of performance; what a diagnosis really means is that the child has to work harder than others.

The value of DSM diagnosis.

The diagnosis is helpful in certain ways. I've seen when someone doesn't understand the diagnosis of the child they are working with and they work with the child differently than I

would. I share the diagnostic information with my teammates by saying "try to understand that he will have difficulty in certain areas". People get frustrated if they don't understand some of the child's limits. We continue to work in a strength-based way but we also need to understand the impact of his diagnosis on his performance.

I use the diagnosis to help kids understand their own thinking sometimes. For example, working with an F.A.S.D. diagnosed child recently, I drew a picture of his brain to help him understand why he forgets, why he gets frustrated. I used the diagram to say sometimes information connects and sometimes it doesn't, it's hit and miss. The diagnosis helps him understand himself and not be so frustrated [with his own cognitive difficulties]. What being strength-based really means is that we [practitioner and client] have to work harder sometimes.

I do see kids using their own diagnosis as a copout. "I didn't take my meds today." They use the deficit language too; they've been to a million doctors. They've been to this doctor, that and the other; they've been to more doctors in their short lifetime than I have. They know their diagnosis, they know the medication, they understand themselves as having a "medical condition" [indicates scare quotes in the air with her hands]. They see themselves as having a medical condition and often give up hope as a result.

Sometimes the diagnosis takes away hopefulness, but sometimes the kids simply understand themselves as bad kids. I have an 11-year-old, who says he knows the future. I say "What your future?" This is someone who's very depressed and he says "I'm going to jail. My mom's been to jail, my uncles' in jail, everyone I know has been to jail." I say "You haven't lived long enough" - he's 10 years old – "you haven't lived long enough to give up hope". This is shocking!

I think these kids solicit positives sometimes, even if they do not fit with their own experience of themselves. They call on us to respond when they say to us "I'm no good." Of course they know they'll get a response from saying that and it's manipulative, but even so I'm okay with this, to a point. I see these manipulative behaviours as forms of hope. The child manipulates positive comments from me through saying "I am no good, I am ugly, etcetera." This is okay, as she is open to something, or trying to create an opening, and this seems to be what she needs at the moment.

Medication can be helpful, or not, and it can certainly be a crutch. It's just a piece of what's going on and I feel 50-50 about meds. I have seen benefits and I have seen no benefits. [Sometimes] it's used as a crutch: "Excuse me I didn't take my medications." They [clients] see meds as a crutch and so do the parents. The parents will quickly run to the doctor to get a new prescription and for many parents it's a place to start. Medications tend to excuse and confuse the situation, with or without meds other things need to change, but a dependency [on medication] does occur. Kids can be just as reliant as the rest of us about their medications. So medications are double-edged sword. I've seen kids who would crawl out of their own skin without medications and others who sleep 14 hours a day and be zombies on their medications. I play this by ear, one person at a time.

People typically want a fast fix, they think "if I can use a pill to change behaviour I will do it". I run into a lot of quick fix attitudes in this work, especially with medications. I worked with a young man who the teachers and school system wanted to medicate. His family did not want to medicate him, they said teach him and help him learn how to behave. The teachers did not know what to do and so this is the Band-Aid, the medication is the band aid. If it wasn't for

the parents advocating for him, and having the skill to do this he might still be on meds, in a day program; but he now has a job and works in the community, independently.

We work with traumatized kids and change is necessarily slow with this population. We are quick fix society, if I get chronic headaches I take a pill - that is the preferred approach versus fighting the source of the problem. In the end, the slow route is better but it takes too long. We do not take the time to teach skills because this involves establishing relationships of trust with traumatized clients and this is time consuming. Relearning is growth and takes time, its two steps forward one step back.

Where the quick fix is utilized, what we create is sometimes sad to see. I've seen a child go from a really happy excited child to someone is just sitting there looking like they're sleeping. They're not sleeping, yet they are not even aware they are drooling; you have to tell them they are a mess. This is the Band-Aid - putting a Band-Aid on a problem without looking at what's really going on. We often work with kids who have been through trauma, which may not have concluded. We define the problem as within the individual, it's cheaper and less trouble to do so.

Our job here is to empower change. I've seen many family members live the deficit, live in relationship to how people react to their deficits, living in deficit-focused ways. Families may lack the skills and abilities and understanding to do the change. They do not want to be bad parents and with empowerment, with strength, change can occur. A permanent condition is only one factor of life it is not the only factor, the chronic condition, for example F.A.S.D. is not going to be all that person can be. The diagnosis is a factor to deal with; it means you have to work harder in some areas. We have to, in this work, put aside the limits you feel from the diagnosis. A diagnosis simply means you will have to work harder in some areas than others do. We focus on the strengths, this is not impossible.

The prototypical moment: The case conference.

If I was to select a moment that represents the experience of being strength-based in this setting I would choose a case conference. I have been to MANY, MANY, case conferences over the last 10 years and it's always a struggle to describe to parents what's going on with their kids. Previously [in her psychiatric inpatient practice] the parents were bombarded with information concerning needed meds and what's wrong. The school is saying the same thing and the parents are EXPECTING things to be really negative. After all they never call us when things are going really well, so negatives are normal and anticipated.

I was at a recent case conference here with a lot of participants and this is potentially intimidating for the parents. But in this instance the parents were on side, the picture at the end was of everyone being on side. This is so different than previous meetings the parents have attended and they said so. [Parents say] “It's so nice to come in and not just hear the bad. We didn't end up feeling like we're rotten parents. We've experienced this for years and years and years. We just dread these meetings because they are so negative. It's so nice to be enveloped by people who are on our side. And the way the information was presented it wasn't chocolate coated or anything."

This is a new experience for me, a unique experience, to have parents on side and truly appreciating the work we do. I have never heard that in another agency. It was empowering. It really struck me to hear that from them. The parents and significant others have to be involved. Having parents involved in what is going on is strength-based; we alone are not the experts. We only see the kids eight hours a day, our work won't have any lasting effect until we work with the broader environment, so follow through at home is critical.

I assume the best of parents, though some do not get involved with us. This is a matter of a glass half-full or half-empty and I choose half-full. If they lack skill or confidence, no one wants to be a bad parent, but sometimes they're not able to be involved. Motivating the parents to be involved makes a big difference. Not everyone is on board with being strength-based, even during these case conferences, as they are also attended by outside professionals. We do discuss diagnosis and things like that [at the case conference] and that's okay - we work with this information and reframe it and it becomes something we can use in a positive way. Even negative information creates motion and therefore is not negative.

The prototypical moment feels like a job well done, like satisfaction from accomplishment. It feels good knowing that the parents walked away from this case conference feeling good. I work hard at this and it's frustrating, difficult, and challenging work. The child may not show appreciation, but the parent certainly does, and a happier parent equals a happier child. At the end of the case conference in this setting, parents did not go home with discipline issues on their mind, and anger. Kids are not afraid of parents when they return from this meeting. In other settings I've seen kids afraid to go home after a meeting like this.

This [prototypical] moment means success, and it is difficult to keep strength-based energy going all day. This result keeps me motivated as you can see the outcome for your effort. The parents walk away taller and stronger. Kids are sometimes a difficult barometer by which to judge their own improvement. This work is hard work. You have good days and we have really frustrating days. It's not easy and can be physically dangerous. I would be safer working in a jail!

Discussion of Monique's Narrative

A difference that makes a difference: the boy who learned to speak.

Our patterns of understanding and roles of performance of both our personal and professional self are culturally and discursively situated. Leaving a culture and the norms that exist within a culture often enable us, like travellers in a foreign land, to see our original culture through new understandings. Monique's experience at *Kids Place* enables her to consider her previous practice in an in-patient psychiatric setting through the eyes of someone who has relocated to a new and interesting culture. Monique reflects on the ways she knew herself and her previous practice from the vantage point of experience within a distinctly different culture of practice.

Monique's narrative suggests she felt cast into a subordinate role in relation to other disciplines in her previous practice setting. Her previous treatment experience was characterized as "expert" driven and diagnosis was understood from a positivist epistemological outlook. As I discussed in Chapter 2, there is at least a trace of Child and Youth Care history in this disempowered position (Charles & Gabor, 1991; Dunlop, 2004; Linton & Forester, 2003; Ungar, 2004a). Monique's use of language suggests she has become accustomed to a secondary role in relationship to the expert knowledge in her previous practice setting, one characterized by professional hierarchy. Monique's acquiescence to these authorities of knowledge suggests receptiveness to others who define treatment conditions and factors within her practice circumstances. Moving to *Kids Place* reflects an experience of moving beyond a role she describes as little more than "glorified babysitting". Monique does not want to be a "manager" of "difficult" "special needs" children and narrates her identity as an agent of change.

Blundo (2006) refers to the changes Monique experienced in coming to *Kids Place* as a "de-centering" of the traditional framework for understanding. This "de-centering" is laden with surprise and disquietude. The experience of teaching a four-year-old Aspurger's syndrome child to speak and to overcome the prescribed limits of his diagnosis is moving for Monique. It has confronted her faith in the positivist system of knowledge that informs DSM based practice and moves her to challenge her own disempowered position. Monique questions the authority and superiority of the medical model of treatment and is reconstructs its value to her current practice. Monique is "shocked" that a speech-therapist, as an "expert" representative of a system of objective knowledge, could be mistaken about a child's ability to speak. In this event she experiences a realization that what she thought of as an objective and certain fact was not. This event was highlighted in two separate interviews, for its significance in Monique's narrative of practice.

Monique continues to hold faith in the diagnostic constructs derived from positivist science and describes her comfort with two distinct discourses for her practice. Her relationships with the discourses that influence her practice have shifted, but she does not feel compelled to set aside previous constructs of practice. Monique does not deny previously valued ideas and practices; rather, she incorporates these when it is judged useful to do so. The choice between strength-based and DSM informed practice provides her greater flexibility in practice. She does not challenge the validity of DSM constructs, but feels greater confidence in her ability and judgement for having previously been sceptical about their certainty. She has not abandoned the tradition of positivist medical model practice but now places it alongside strength-based practice as one tradition and not *the* tradition. Her focus in the treatment process has shifted to a concern with constructs of meaning and identity. Monique is convinced of the need to be future-focused

in her practice. Her experience of *Kids Place* is one of continually asking: "What do you [the client] want tomorrow to look like?" and "How can we create a shift?" in meaning and identity utilizing grounded activities that enable an identity shift to have credibility.

Getting out of the box and the value of DSM diagnosis.

Monique's narrative frames a diagnostically driven approach to treatment as a "box" from which she has gratefully escaped. In her previous setting the use of medication, even when effective at symptom alleviation, was characterized as a "band aid" that does not get to "what is really going on." For Monique, medication serves a covering and constraining function. Medications offer hope, but may create dependency; their misuse may also serve to excuse poor performance. Yet Monique also recognizes the utilitarian value of a band aid, in stopping the bleeding and protecting a wound.

Each of the identified discourses reflected in the research question that drives this inquiry draws Monique's attention to distinct aspects of the treatment process for mental disorder. Each of these discourses brings about a different role and a different way of thinking for Monique. Monique narrates the DSM as asking her to focus on "what is wrong" with the child, while in a strength-based practice she is drawn to "what is right" with the child. Monique considers both as relevant but notes that strength-based practice leads to preferred client relationships. If her constructs of her professional role and her way of thinking are significant parts of her identity, then Monique's identity shifts as her constructs shift. Monique is a different kind of practitioner in each of these distinct practice settings she discusses and her preferred self is realized in a blend between each form of practice.

The contrast between two distinctive cultures of knowledge is reflected in the comment that coming to *Kids Place* meant "everything I knew went out the window." Monique sees *Kids*

Place as calling upon her to be inventive in her engagement with her clients; she exclaims that now she has to deal with "personalities!" A strength-based model of practice for Monique, "means that we have to work harder" to create change rather than "fixing" the individual or aiding in their adaptation to their social circumstances; this is a role Stewart (2009) notes as inherent to "mature" Child and Youth Care practice. At *Kids Place,* the circumstances of the education process have adapted to the needs of the client/student.

Previous to her arrival at *Kids Place,* Monique made an effort to be a strength-based practitioner in the psychiatric setting where she practiced. This was a frustrating experience as her skills were underutilized and led to "burn out". Her frustration resulted in her decision to leave this practice. As she reflects on two systems of knowledge in play in her practice Monique's narrative suggest an experience that is characterized by feelings of astonishment - the classic therapeutic "aha" moment Brendtro and Ness (1983) characterize as an astonishment of insight. The energy of this emotion embedded in her narrative suggests the importance of this event to her experience. Monique's aha moment reflects her turn from unquestioned acceptance of the construct of diagnostic certainty that until this point had characterized her relationship with DSM diagnosis.

Monique believes that her previous psychiatric in-patient experience has constrained her efforts at becoming a fully committed "100%" strength-based practitioner. Just the same, Monique's narrative suggests a sense of professional growth in coming to *Kids Place.* This forward movement is an opportunity for Monique to bring a fuller complement of her professional skills to her practice yet this was not an easy transition.

At *Kid's Place* Monique takes on the "yes/and" position that recognizes the value of multiple and circumstantial truths. She challenges the validity of DSM diagnostic labels yet she

also defends the value these diagnoses lend to treatment practice. Throughout her narrative DSM diagnoses are portrayed as informative but distracting. She states "the situation [diagnosis] is just the facts; we need to look at where we go, how we involve the child in this. This is distinct from a deficit focused present and past orientation." Monique values the medical model diagnostic constructs, as a means for troubled children to gain access to *Kids Place* School. Here DSM serves a role as the ticket for admission. She highlights the needs of the client as driving her practice as she, her client, and her agencies' treatment discourse co-construct these needs. It seems contradictory to Monique to try to apply a deficit-focused treatment strategy that dominates the client's narrative of self in a process designed to facilitate recovery from mental disorder. Yet, strength-based strategies in treatment also may be seen to dominate the client's experience of self, albeit in a more benign manner. Monique's ability to empower others empowers her own belief the efficacy of a strength-based practice model.

Monique's future-focused outlook frames the goal of change and identity re-construction in the forefront of her practice. A strength-based practice guides her to place client collaboration at the centre of her thinking and to ground this practice in the activities of daily living and this reflects a Child and Youth Care positioning (Stuart, 2009) typified by finding opportunities for change in the moment within the child's natural milieus. As Stuart suggests, the practitioner "maximizes the opportunities for change that are present within that milieu" (p. 16).

Trusting relationships with clients enables Monique to use the DSM concept of "disease" to "externalize" a child's condition, in her example of a client with an F.A.S.D. diagnosis. This experience reflects a mutually complimentary use of distinctive treatment models, where the diagnosis is used as a teaching tool in conjunction with the therapeutic alliance. This alliance derives from caring and trusting individualized relationships with her clients characteristic of a

strength-based practice model and characteristic of the essential "ethos" of Child and Youth Care practice.

Monique's *Kids Place* practice experience is also characterized by flexibility. For Monique working to coordinate her practice with her understandings of the expectations of the medical model in her previous in-patient psychiatric practice resulted in what she describes as a fixed, habitual, and mechanical experience that lacked personal self-involvement and genuinely-caring relationship with clients. At *Kid's Place* Monique feels the experience of "the envelope" of strength-based thinking, as personally empowering and satisfying. Monique's narrative suggests that at *Kid's Place* she has integrated the Child and Youth Care practice values of a non-pathological, growth-focused and relationship-based practice, recognizing these as aligned with the values she prizes. As "Rick" earlier stated, "the people we hire are going to get this approach when they see how it works."

The impact of trust and relationship.

Kids Place offers Monique an opportunity for meaningful individual relationships with her clients and it was "relationship building [that was] a very good piece" of what attracted her to practice at *Kids Place.* Her example of a representative prototypical experience reflects her appreciation of the relationships that develop from a strength-based model of practice. Monique steps "in" to a strength-based relational space with her clients and in doing so she loses the insulation from relationship that a DSM diagnosis previously offered her. She is personally vulnerable to the hardships her clients encounter within and outside of her practice. DSM diagnoses provided Monique with a form of emotional protection from these hardships.

For Monique, "taking of a DSM-type approach" was not a practice devoid of relationship; rather, I suggest that she was in relationship with her own constructs of mental

disorder. Her previous practice was predominately one of treating constructs of biological dysfunction and not individuals. As Szasz (2007) suggests the "assumption that mental illnesses are as yet undiscovered brain diseases liberates [the social care practitioner] from having to know his [sic] patient as a person" (p. 89). A diagnosis of an objectively known physical condition of the brain may be used to rationalize treatment without personal involvement and client consent in decision making; the presumption of a dysfunctional brain suggests and an incapacitation in decision making. And just as a surgeon does not need to form a close relationship with his appendectomy patient, so too, a biologically known condition of mental disorder becomes a condition of objectified medical illness justifying this position. This protection from forming close personal relationships with individual clients is set aside at *Kid's Place;* Monique now acknowledges the importance of the personhood of each individual in her current practice. The cost of caring in her professional practice at *Kids Place* includes emotional involvement with the care recipient. The vicarious experience of both a client's joys and failures is both exhilarating and wearing.

Monique also notes the impact of hope in the treatment equation. Typical of strength-based practice, Monique narrates hope as a corner-stone to her experience of a strength-based practice and as vital to the process of change (Duncan & Miller, 2000). Hope precedes future-focused client movement. It is a fuel she believes necessary to drive the client's hard work in the process of change. Hope centers the client in the treatment process as a tacit recognition that the client is the central figure in any efforts towards change.

Monique's practice at *Kid's Place* is a contrast between experiences of satisfaction and deeply committed involvement, juxtaposed against the stress of her concerns for safety and her identity as a practitioner. Much of the scholarship of Child and Youth Care suggests that "the

relationship is the intervention" (Stuart, 2009, p. 131); a place where a different understanding of self and identity can be nurtured (Garfat & McElwee, 2004). Monique's narrative reflects the Child and Youth Care "relationship as intervention" sub-domain identified by Stuart including use of caring, engagement and activities to facilitate change. The strongly caring and positive relationships Monique described are highlighted as that which attracted her to *Kids Place.* Yet this relationship quality contrasts with occasions of fear for her psychological and physical well-being. Monique states emphatically that she would be "safer in a jail!" Her practice relationships and diminutive stature place her well-being at risk and this experience is a dilemma found within her strength-based practice, where relationship is highlighted as a vehicle for change. Her closeness to her clients is prized, yet this closeness also results in a greater likelihood of her jeopardizing her safety. This closeness makes her a target for children in treatment who "act out" their emotions. Taking up Gergen's (2009) view that all emotions are a form of inter-relationship communication I suggest that Monique's interest in relationship with her clients makes her a vulnerable target for these difficult emotions as she serves in the role of a conduit for her client's need to communicate their state of being to the world at large. Monique's dedication to client change in the face of personal danger suggests she constructs her identity in practice as a heroic practitioner, who understands her own practice as a calling. Child and Youth Care practice as a calling is a common theme in the literature surrounding Child and Youth Care practice.

CHAPTER 9

The Story of the Research: The Results Part III

Ray

The experience of strength-based practice.

What I'd first like to say about my experience at *Kids Place* is that it's tough sometimes to be strength-based in this place. Sometimes I don't know what I am doing, I run out of ideas. Everyone here is strength-based and there is a lot of support [amongst the practitioners] and it can be free flowing, but it's not always like that. There are frustrations and hurdles. This [strength-based] approach has an allowance, to make things better without going backwards; it's somewhere you can be without going backwards. Growth can happen in a strength-based model without too much gravity or personal history bringing it down.

We get more honesty with this approach. Honesty goes hand in hand with the positive relationships we establish. We are not looking at the problems and we are not necessarily looking at the past. Deficit is the stuff that slows you down, it's important to be aware of it, but it's part of life. We look to where our clients want to go. We all have history and it may often be that it's problematic, but that's life! When we get focused on these negatives, it makes the mind focus on that and then it's harder to do other things. This is what it's like to be solution-focused. Sometimes we as a staff fall short, even being strength-based. But taking on this [strength-based practice] approach formally pushes you to do this, to be focused on strengths. The kids pick up on us being strength-based too. It helps us establish good relationships, it creates a more level relationship with our clients and it seems to mean that they cut us some slack. I try to stay positive and sometimes fall short, even being strength-based. The kids accept this; they cut me some slack sometimes.

Being strength-based allows for the development of a more real relationship. The kids know that you are a positive force in their lives and that you recognize that in them which is good. Being strength-based has allowed for so much. The kids understand this and are more positive as a result and there is more honesty, progression and trust, you can speak to kids more frankly, of course keeping in mind what they [are able to] understand [considering] their age.

I stay accountable to being strength-based and this means I am trying to do my best rather than give up halfway through the day. If things get to me I may say "screw it" then the focus changes and I become focused on managing [behaviours]. Quite often frustration will pull you into the blame game. Then, I have to go home and remember the focus. At the beginning of a day I remind myself what the focus is - it's not you, it's the child. As frustrating as it can be here, I have to remember that the kids for the most part are not to blame. They are just amazing kids. There are some pretty crazy kids here. We keep our strength-based energy going using the team and if you come into a good team, stick with it. The team helps you through and are so important …and I've got the best team! But everyone here would say that. But, I DO HAVE the best team! [laughs].

We stay strength-based as its part of all our discussions. The thinking behind being strength-based is part of all our discussions. Most of the staff here has a history of being strength-based, but it's not forced upon us. We are hired for our beliefs in this area.

My education in Child and Youth Care contributed to my strength-based outlook. I am not fond of school and struggled with the work, but my education gave me a base, a foundation of understanding. I was taught to be strength-based without even realizing it. Those ideas and values were being passed on and you have to live it.

It's easy to come here and answer these questions and sometimes forget the tough side of things. There are days, I don't feel like I am strength-based. It's not easy to be positive 100% of the time. It's not reality for us either. I love the work, but it's so hard sometimes. We have to be perfect and this is not perfect for the Child and Youth Care staff either. There are times I want to give up. We have to be positive examples for the kids and the reality is we are not always that way all the time. Sometimes I will just go through the motions. I will go home and pose a lot of questions to myself: Why am I doing this? How real is this? If I can't be 100% strength-based in my own life how real is this? Yet, I don't see a whole bunch of options right now. This seems to be the best approach I know.

We have these days where things are not always strength-based. I have been sick for a week now, headaches, not feeling well. At times I do not have the patience. We have one fellow who cries at the slightest touch, over anything at all. One day he was just bawling away, over a touch on the shoulder. I gave him the tough love approach, but always, always, follow it up with understanding and love. We are always building, not tearing down.

For me to be strength-based is that quite simply, I recognize the strengths in others and build on those; it's helping the client see their own strengths. We do this is so many unorthodox ways. We help our clients recognize their own strengths, whatever they have we go with and that means, in part we build relationships to help kids feel good, feel happy with what they are doing.

I wonder if being strength-based is a fad. Yet, being strength-based fits for me. It fits with how I perceive things, how I would like the world to be. You look at child-care practices thirty or fifty years ago. What care providers did then seemed to do more damage than anything. We ask now: "What were they thinking!?" We only know what we know, but I wonder if we're going to look back is twenty years and say the same thing about being strength-based. Being strength-

based fits for me because this is how I would like to treat others and have them treat me. This model fits with me as the possibility seeker, the dreamer.

But too much strength-based can be an overload. It's like a favourite song you hear too many times on the radio. You need a break, it gets a little tired. At the same time, the staff's approach is balanced. There are times when we have to say to the client, "toughen up!" These are the realities of life. Even if yours is not the best reality – we know there are better ways – all the people around you out there are not going to be strength-based. On the other hand you don't want kids to get used to that negativity. They have an over abundance of negativity in their lives. I don't see this approach as having an end goal. I am constantly growing and learning in this model. I pause to rest; I don't know where I am going as far as growth goes [in this strength-based practice].

Using the DSM to advantage.

The role for the DSM here is to help us put a finger on things and you certainly run into labels here. There are so many of them it's really hard to sometimes believe all of them. The labels make it easier to see deficits, that's for sure. But, you can use D.S.M. labels to your advantage. You talk with the kids, about, say, autism and use this to your advantage. I use the label to externalize the problem somehow and to help the kid understand, and to get around certain reactions they are likely to have. When you anticipate behaviours, you can direct them. A lot of times the kids don't understand the label and I don't get it too.

The influence of labels is simply that they think they are bad or stupid and they don't understand how they got here. We are sometimes baffled by where this thinking comes from, we think [it comes from] peers, teachers, parents. A lot of kids simply understand that they are bad.

Telling them they are not a bad kid is tricky. They often don't believe it, its like "who are you to say so?"

Being strength-based is more effective and it's more pragmatic. Working in the negatives takes twice as long to get something done, sometimes it never gets done. Yet, there are so many people who come through here: parents, outside consultants, and agency personnel, teachers, etcetera, that come from the outside. Sometimes the outsiders come in here, not with the same beliefs and practices, where the focus is strictly on the diagnosis, you know, the problem kid. I have that [diagnostic] information. It's what you do with it that is important. There are people who are deficit-focused that's for sure, in my experience MOST people are like that, but for me its what you do with it [the diagnostic information].

I think that the DSM tells us that the diagnosis is equivalent to some other type of physical condition, others seem to act that way and this SEEMS pretty clear, but this is a cover up for something deeper. We are putting on a band aid on sometimes. Diagnosis and medications are tools; they are all tools that help out. If a kid is, say, bipolar, then if he can gain some control while his life moves on, their use of medications is fine. If you are diabetic you need insulin. With certain conditions you have to take something to stay alive so you can function. But medication is just one direction, there are a million other ways that may be just as effective. People with influence in this process may say: "the child needs to be on medication" and then I have to accept this as given. So then you try to do your best and I am only one part of the whole picture. I come in with whatever skills I have and if their path has led them to take medication, I work with that.

Sometimes I may advocate FOR a child to be on medication and get resistance from a parent. You try to get the parents to understand, for example, here is a boy really struggling to sit

still. He's reactive and with too much stimuli he's off his rocker. Yet his parents do not want him to take medication, but if he did, just for the time being, he could at least focus. I don't like to go this way but you know his grades are failing because he can't sit still. Medication can be quite positive and it can be quite negative too. I have seen some extreme cases where it is used regardless of the child's condition. In previous treatment settings I have seen clients that are doped up so much they can't move. This doesn't happen here; if we use medications, it's as a last resort.

The problem is not just in the child. What I would like to see is the people surrounding the child being more involved. If things were perfect we would have the time and energy to not be just with the child as the identified problem, but we'd be with those people BEHIND the client. We don't have the resources for this and it's a struggle to find the time or the skills to do all that needs to be done. I rely on medications… yes sometimes, but medication is never enough on its own.

What we really do is to work to change the child's view of himself and the views of those in his contexts of living. Sometimes others in the environment continue to hold a negative view; this is a bad kid, a rotten kid, instead of an understanding approach. Medications are only one thing; they do not put the skills in place. We need skills, practice, and identity. Medications cover only one little area. It's like a sore throat, you can take something soothing, but, where do you go from there? And so I believe that medication will only cover one little area. There is compatibility between a DSM and a strength-based approach but I wish it did not have to be deficit-focused; we have to work with the constraints we face.

The personal and professional mix.

I've come to be strength-based from my own life experience. I know in my life I have run into obstacles; I was a rowdy kid, sometimes a bad kid. Then I realized somehow that I have good, other people recognized it. Maybe they too, that is, the others who recognized my strengths, had similar problems that led them to this same place. Eventually, you walk a path that includes being strength-based and maintaining a strength-based outlook relates to my identity. This is who I see myself as being but it takes work to maintain, just as my identity takes work to maintain. Going back to school to become a Child and Youth Care worker helped me realize a few things about myself. It was a long process, giving my "self" [indicates scare quotes in the air with his hands] thought and realizing things. Now I am surrounded by like-mindedness and we pool our [practice] ideas together.

Part of being strength-based is being a dreamer. I am a dreamer and when you dream, you think of things that could be, there's more out there, I dream for greatness and beauty. I know just about anything is possible. Trying to reach those dreams can be tricky; you have to figure out ways to get there. Looking into these kids eyes, I know there is something there. What comes forward at that moment? Love. When I look into their eyes I see love and it helps me be grounded and connected. Love helps me get past the things that are hard and to remember my focus. Love helps me relate and to join with my clients so we can do things together. Love helps me create change.

I could work in a more deficit and behaviour management oriented setting, but would it be satisfying? That is the key, it would not be satisfying. Now I have been exposed to a strength-based outlook to Child and Youth Care practice and because of this practice … it's been a real eye opener on how I would like to live my life. I have seen how we build on positives, directing

yourself not to the negative side of things; you know building on positives works MUCH BETTER. It is much more effective to focus on the positives; it's much better, as opposed to working backwards, looking backwards.

I keep strength-based energy going by utilizing the team. We are all a team, individuals with a common direction. The client's positive energy is supported by the team – everybody here has had training, schooling to do this work and an aptitude towards it. The people here fall into the touchy-feely category. If the whole world was run this way, things would be better. I am a dreamer and when I dream, I dream about: "What is it we need to be doing with these kids?"

The tough times help us too. I used to run a lot, do triathlons and I used to hate hills. So I would be running up the hill and thinking: "Why do I do this? This sucks. This hurts. I am tired, it is all in vain." So I decided this wasn't working for me, I needed a new strategy to get my mind through the tough times. I started thinking that the hills are my friend. At first glance they appear as enemies, but now I see the hill as my friend, because when I get to the top I am going to be stronger for it and then it will be clear sailing. I used to think the hills were my enemy because they were breaking me down and making me tired; I changed my train of thought.

I hope we as a community see these kids as the future. I see the world falling apart around us, I hope that people make changes, we need more investment in people. Sometimes I think we as a community do this work to help, but other times simply to fulfill a perceived moral obligation. We as a community have to do something, we want a child's situation to look better, but what we do is not necessarily from the heart.

I wonder if I feel this way because I do this work and I am selfish, OR is it because I am in it and see what I see. As a kid growing up I wish there had been programs like this for me. I wish someone had been there in this way for me. I know these kids we work with are the ones to

take us further down the road. It frustrates me! These are kid's lives! We can, we could do more to help.

The prototypical moment: Trust and the playground crisis.

The moment that captures the essence of my experience with the strength-based approach was a year ago, a nice spring day. The kids were playing on the playground and like that. One of the boys was having a really off day. He was off to the side on the edge of the playground and he was angry.

I had been working with this boy for many months – and I work in a medium using photography – with his permission. This has been debated amongst the staff - is this okay? In this one moment, my client had been having a bad day. He was off to the side on the playground, on his own, isolated, and withdrawn. There had been a lot of turmoil in his life. He was moving from one [foster] home to another and he did not know what was stable in his life. It was a day when things were too much – all these things going on in his life – and he just withdrew. I took some photos of him at this moment. No words were spoken.

I am a photo geek you know, so I start to take shots from about 50 feet away. He knew I was doing this – all the kids are comfortable with this – used to it. He let me get very close while I continued to take shots. I didn't realize until I got home what he had allowed. He'd allowed me into his world of feelings – seeing the words, the expressions, the moves, the feelings come out. This was trust. I didn't say anything to him. He just allowed me to do this.

Trust is so moving, when the client trusts. From the moment we started building relationship, I have always seen trust as something that builds. We had trust. He looked directly into the camera and a picture tells a thousand words. There was so much pure emotion there…He opened himself to me, he became vulnerable to me, he allowed himself to be vulnerable and

unprotected, he showed me this and trusted me. The prior experiences of these kind [changing foster homes] mean they learn to protect themselves…It was a perfect moment… When you have openness like that or you're developing things… its closeness together that lets you be close and open up to each other. This complete trust just allowed us to be whoever we wanted to be – with no expectation that he had to do something different. He felt the trust and acceptance that allowed him to be just who he was in that moment.

After I was done taking pictures I just sat and chatted with him. It pulls you together – this event allowed us to trust one another further. I knew what we were doing was going well. You know that when you build things – you are able to move in and you are going to make changes.

The kids that come from here are the purest. They are hard to work with and everything like that… But for me it's HARD to focus on the negatives. It's because so much good comes from a positive focus; and yes there are frustrating days. A kid may fall short in some things, but he can really excel elsewhere. It's a balance, there has to be another side, and relationships are one thing that will help everybody. A lot of these kids have NO OTHER positive relationships, than the relationships they have with us.

Our goal in this program is to get kids back to a mainstream setting. Many things have to change for this to happen. The way they interact with each other, the way they view themselves, the way others see them and the way teachers deal with them in the mainstream setting. We try to do all of this, to work on all of this. These changes are a HUGE part of the change process. This is my belief, this is what I do.

Discussion of Ray's Narrative

The experience of strength-based practice.

Ray's narrative expresses his concern and frustration in trying to operationalize a strength-based approach to treatment of mental disorder. His experience of *Kids Place* requires his highly active and creative participation in the effort to structure the treatment process. He corroborates Rick's narrative that a strength-based approach creates a unified team of practitioners but he also conveys a sense of obligation to adopt this approach; I sense a hesitancy in Ray's commitment to strength-based practice.

A strength-based model fills a void in the need for a model to drive treatment activities. Ray lacks a better alternative to treatment. Adopting a strength-based model involves a constant building and unfolding of the meanings of strength-based practice. He is aligned with strength-based thinking philosophically but like a favourite song played too many times "it gets tired" and disingenuous. Ray is weary of the melody of "constant positives" on a daily basis. This experience of weariness skirts ideological concerns and reflects the day-to-day difficulties of daily contact with a hard to serve and involuntary client population. The practitioners at *Kids Place* cannot ignore the performative expectations both they and their clients face in their mandate to facilitate a successful return to the mainstream school system. Feeling good must be accompanied by tangible behavioural outcomes in the classroom.

Using the DSM to advantage.

For Ray and like Monique, strength-based practice is an approach that he can add to his pre-existing understandings of treatment processes. Ray makes use of what a DSM understanding of treatment offers, which is of pragmatic value to a strength-based treatment model. Ray resists the DSM diagnostic construct of pairing mental disorder with a perception of

inherent individual deficiency through normalizing his clients' weaknesses. His clients are not "lesser than" beings in Ray's eyes because of a diagnosis or because they have trouble meeting the performative needs of the C.B.E. school system. He views his clients as capable, or as being able to develop capability in spite of their unique needs.

The epistemological conflict of practice that I construct as emergent at Kids Place is not an immediate concern for Ray. Rather, his desire is for a just society, and more attention of any kind for the kids in this program. Ray hints at the value of this work in assisting his own healing process. He wishes to make a significantly positive difference in the lives of children and this suggests that he is well suited to this work; his vocation and his avocation are entwined.

The personal and professional mix.

Ray believes a strength-based treatment approach contributes to his client's openness to relating to him at both a professional and personal level. As a result of their sense of his fallibility and humanity they "cut me some slack sometimes." This personal-professional mix arises throughout Ray's narrative and raises interesting questions concerning the use of relationship and related professional boundary issues in Child and Youth Care practice. The "inter-personal-in-between" as a way of "being in a state of co-created connected experiencing with other" (Garfat, 2008, p. 14) is a relational position often promoted within Child and Youth Care discourse. The interpersonal in between represents the importance of close personal client-practitioner relationship; it is the relational ""bubble" that "surrounds the relationship and the people" (Stuart, 2009, p. 78) who are joined together as service provider and recipient. All the research participants in this study note the importance of reciprocal care between client and practitioner as a primary goal and as a vehicle in treatment. Strength-based relationship becomes

a form of intervention, as these practitioners create relational attachments to a client population that is typified as having difficulty with attaching to others.

Ray narrates his clients as "vulnerable and unprotected" in the treatment process; their openness to establishing close relationships with significant adults in their lives is influenced by a history which makes them relationship-adverse. Brendtro et al (1998) connote "belonging" as an essential human need. If this construct holds truth in this context, these vulnerable clients may be drawn to relationship based in the positive esteem expressed by *Kids Place* practitioners. A strength-based practice is constructed as enhancing the practitioners' ability to form this intimate relationship. Ray's attractiveness as a practitioner is enhanced by his attraction towards his client's and a strength-based practice is noteworthy as a tool for enhancing relationship.

Ray describes his experience with clients as characterized by constructs of "love" and his use of this word speaks to an overriding sense of deeply felt compassion that characterizes Ray's narrative of relationship with his clients. He uses a crisis on the playground to illustrate his construct of trust and his feelings of compassionate "love" for his clients. Ray works in an ideological and an emotional milieu at *Kids Place* that he first constructs within himself. His worldview and his professional practice combine, reflecting White's (2008) views of Child and Youth Care practice as a combination of personal-professional being and Smith's (2006) belief that care is a moral duty that all people are obligated to perform. Ray has incorporated an intuitive sense of this moral obligation to care into his practice. For Ray, Child and Youth Care practice is a passion that reflects his desire to serve others.

In an earlier time in Child and Youth Care history Ray's commitment to bettering the lives of others may have been labelled as a "calling" with a suggestion of the spirit of Christianity though spirituality is now judged as "inappropriate within the diversity of modern

society" (Stuart, 2009, p. 7). Stuart's comments suggest a discomfort within secular professionals with the religious or meaning-based overtones in this position. Ray's "calling" also reflects a narrative and an identity construct of a personal commitment to social justice.

Many scholars within the Child and Youth Care community support the notion of Child and Youth Care practice as a calling (Austin & Halpin, 1989; Garfat, 1991; Stuart, 2009; Thomas, 2004); Fox (2010, personal communication) comments that Child and Youth Care Workers "have their primary credentials in their hearts". Scholars in Child and Youth Care (see for example, Maidment, 2006; Skott-Myhre & Skott-Myhre, 2007) describe "love" as a common characteristic of Child and Youth Care practitioners and suggest Child and Youth Care intervention must be characterized by more than a skill set and an overarching treatment model.

Ray narrates his "dreamer" identity as a comfortable fit with a strength-based practice. He reframes the difficulties of the onsite tensions in his experience as a means to create greater strength in his practice. Operationalizing a strength-based treatment model in a challenging practice setting is parallel to Ray's triathlon experience of hill climbing. Overcoming the difficulties he faces as a practitioner will make Ray a stronger practitioner. Ray's desire to become significant to the child and to make a difference in the child's life, becomes a test of his commitment and determination to practice in a way that is compatible with his personal constructs of self.

The shift from a deficit-focus to strength-based focus of practice has challenged Ray's personal values and the result has been his growth to a more satisfying alignment between personal and professional outlooks. His *Kids Place* experience has called upon him to examine his beliefs about his work, the relationship between his personal and professional beliefs, and his life as a whole. He has determined that his personal and professional identities are more closely

aligned as a strength-based practitioner, but this process represents an ongoing struggle to define experiences through the lens of a strength-based practice and Ray admittedly fall short on some days in this effort. It seems disingenuous for Ray, to always be focused "on the positives."

The concept of care suggests a cornerstone construct of Ray's experience in this intersection; his identity and role emerge from his belief in the importance of genuine care and from the constant conversation that occurs amongst *Kids Place* practitioners regarding what it means to be strength-based. He believes *Kids Place* is a unique treatment setting and that his work is significant. Ray alludes to his own troubled history – a time when others' supported his strengths and abilities. All people, at some point in their lives, and often daily, rely on the care of others to help meet their needs and to develop their capabilities. In some form, care enables all people to make their lives possible (McDermott, 1994). Being a care provider is a matter of ethical balance for Ray; as he expects care from others, so too, he provides for the care of others. Care represents a sense of social obligation towards others for Ray; it can be framed as a moral duty or as a form of paying back or giving back to the community (Austin & Halpin, 1989).

The experience of once being a care recipient may serve to connect Ray to the children at *Kids Place*, through his personal identification with their needs, and with his sense of moral obligation to provide care. Ray states: "being strength-based fits for me because this is how I would like to treat others and have them treat me." Ray constructs his *Kids Place* practice as motivated by factors beyond his own immediate self-interest. His narrative suggests that looking after children in their immediate environments will result in the betterment of the community as a whole. My holistic interpretation of Ray's narrative as a story form suggests Ray sees his own identity as that of a crusader on a holy quest in a noble cause (Booker, 2004).

Ray's narrative includes an anguished plea for understanding of the importance of the work he does in the lives of the children he serves. He comments on his need for social justice and is dissatisfied with the community's efforts in addressing the needs of children with diagnosis of mental disorder; his treatment experience at *Kids Place* suggests that treatment efforts could be more comprehensive and not primarily focused on the individual child; herein both deficit-focused and strength-based treatment models fall short of Ray's expectations. His plea holds an underlying distress and frustration, where Ray judges that the community does not understand the needs of the children in this program.

Using DSM to advantage.

Ray's narrative reflects an integration of the dualistic notions of mental disorder reviewed in Chapter two; he is ambivalent and uncertain concerning the available constructs by which to understand mental disorder. He is uncertain about exactly what is being treated, in the treatment of mental disorder and his narrative suggests a comfort in treating mental disorder as a chronic physically known condition akin to diabetes.

The discourse of the DSM provides value in use for Ray but its diagnostic validity is in contradiction to his own experience. Like Rick, he understands DSM influenced practice as concerned with the management of a client's symptoms; while he is sceptical towards DSM constructs, he also acknowledges that biological intervention for mental disorder holds utility and value in practice. Ray, like Monique, recognizes DSM diagnosis as an effective teaching tool for some clients but this tool cannot be utilized effectively without trust from the client. Ray's narrative suggests he often side-steps DSM constructs, in his work and thinking, when he can. Its discourse directs his practice focus to the historical "gravity" of past trauma; for Ray this is "going backwards". The bond Ray constructs between practitioner and client enables a level of

intimacy he believes necessary to accomplish the intensely personal work of overcoming a DSM diagnosis. Ray's suggests that treating symptoms may benefit from medication, but treating the cause of a disorder is also about addressing identity constructs that surround the child (Ungar, 2004a) and adapting the environment to meet the needs of the client.

Ray makes effort to structure the interactive in-between space, as a caring relationship; like Rick, he narrates change as something invited but not demanded of his clients. Ray's practice is attentive; he combines individual attentiveness with "no expectations [for the child] to do something different" and this position reflects a strength-based view for relationship with an involuntary client (deShazer, 1994). Ray is aware of the primary goal for treatment in this setting [return to the mainstream C.B.E. classroom] yet his narrative suggests letting kids be however they may be without expectation for change, as a starting point for therapeutic contact. Attentiveness to his clients entails his ability to anticipate the needs of the client through his sense of empathy. For Ray, caring is also characterized by respect as he sees his client population as capable of understanding and of expressing their own needs.

The prototypical moment: Trust and the playground crisis.

In the example of the playground crisis, Ray suggests he recognizes his "intervention" as unorthodox but effective in the moment. Ray's goal in this process may have been to establish a unique relational space with this client and in a sense there was a coordinated interaction that occurred as Ray photographed his client in crisis. An alternative construct of this example is one in which he pursues his personal interest in photography while setting aside his compassion for the difficult moment the child experienced as he moved to a new foster home. The interpersonal nature of Child and Youth Care practice may blur the boundary between personal and professional intervention (Fewster, 2005; Stuart, 2009) and how the practitioner separates the

personal from the professional in a relational practice remains an ongoing academic concern (Charette, 2005).

An outside observer could construct this example as exploitive of the child, at a time the client is highly vulnerable and unprotected. In this instance the critical observer may describe the relational space between practitioner and client as characterized by the unequal power held by the practitioner. Ray's client was in need and the influence of a relational differential of power and the child's needs to connect to others are constructs that explain the client's compliance with this intervention technique.

Ray's crisis intervention raises questions about the professionalism of this practice and the objectivity of practitioners who are professionally enmeshed in the lives of their clients. Where the professional/client boundary is drawn in Child and Youth Care and in fact, if Child and Youth Care itself is a "profession", is an open and ongoing discussion in Child and Youth Care academic literature (Dunlop, 2004; Richmond, 2006; Stuart, 2009; Thomas, 2004). Relationships of trust are an essential component of Child and Youth Care practice but like a strength-based model of practice, this is not exclusive to the ethos of Child and Youth Care as a discipline. What distinguishes Child and Youth Care from other disciplines in social care is the amount of time a practitioner may have to devote to relationship building, a practice that occurs in the child's natural environments and the primacy of relationship focus intervention, within the academic and practice communities. Though for some, this quality of close relationship negates efforts to attain professional status (Dunlop, 2004). For Dunlop "professionals don't "get their hands dirty" — there are intermediaries [Child and Youth Care practitioners] that insulate them from those they serve and who act as gatekeepers limiting clients' access to professionals in practice" (p. 259). Dunlop frames the role of the Child and Youth Care practitioner as that of the

gate-keeper; a group of care-providers who serve a go-between function between the client and the professional.

Client-practitioner relationship at *Kids Place* serves as a vehicle to performative expectations; relationship represents a means to accomplish a particular goal. Regardless of how the goal is framed through our discursive constructs, relationship is a means to accomplish the externally imposed goal of treatment which is a return to the mainstream C.B.E. school setting.

Ray's narrative of experience concludes with constructs of the importance in establishing relationships of trust with his client's. Trust is a cornerstone of his experience and is considered vital to a practice in which collaboration is highlighted as a means to engage and centre the client in the treatment equation. Client collaboration involves reciprocity; it is following as well as leading. It also includes finding ways to cooperate with other significant people, to establish a balance between conflicting systems and discourses while remaining within one's own preferred treatment model. Ray's goal appears to focus on establishing client trust as a means to become a person of significance in the child's life; once significance is established the very personal work of change in treatment is more likely to succeed. Trust in relationship is a learned skill and this client-learning requires patience and predictability from Ray as a practitioner.

Ray alludes to being strength-based, while surrounded by constructs of deficit as a part of his personal identity and experience. His commitment to strength-based practice draws experiences from his own history; at some troubled point in Ray's past he has experienced the value of strength-based thinking in a deficit-dominated environment. Ray has apparently found a strength-based view of experience as a powerful alternative to a deficit-focused outlook. This commitment is tied to his personal narrative of "love" for his clients and the narrative of a "calling" within the Child and Youth Care scholarly conversation. Ray's statement concerning

his needs as a child suggest a sensitivity and empathy towards children whose needs were like his own; his personal narrative for social justice drives Ray's commitment to his clients and to his practice as a Child and Youth Care practitioner.

Ray is committed to a strength-based identity and constructs his experiences through this lens, yet Ray acknowledges that a deficit-focus is a common way of being; of the tendency for others to be deficit-focused, he suggests "that's life." He experiences his life, professionally and personally, through strength-based constructs, and this represents a way for him to be caring for himself. Ray narrates his practice as a form of mantra: "Hi, I'm Ray, and I am a strength-based Child and Youth Care practitioner" and this mantra serves to help sustain his commitment to strength-based thinking, identity, and practice.

The importance of the over-arching team commitment to this model is also supportive to a strength-based identity construct. The experience of "team" aligned with a common model of practice, constructs an inside-outside or them-versus-us feel to this setting. Ray constructs his experience as one in which he is surrounded by "likeminded" thinking. His colleagues and he are unified in common goals of refining their strength-based practice as they gently resist the DSM as a form of counter-culture. Ray's mild opposition to the DSM takes the form of a quest for a better method of practice.

CHAPTER 10

The Story of the Research: The Results Part IV

Shandra[13]

Practice on the inside.

I work with quite complex kids and it's hard to explain to the community what it is that we do. We work with kids whose issues are really quite often outside of themselves. Their issues are in their family situation. Being strength-based for me means that we extend what we do outside our immediate environment and have the family involved. We have to remember that these are children.

I would add that there are a lot of strengths within this agency. We are quite coherent as a staff unit in this approach. We adopt this belief system across the board and it benefits the kids in a lot of ways. We are not focused on the deficits or diagnosis. We look at the kids individually. Even if they have the same diagnosis, we look to each individual kid, to understand how to work effectively with that kid. Then we work to find opportunities, we create opportunities for success for each individual, not for what the diagnosis tells us. This approach is embedded in the program, but there are always opportunities here to bring forward ideas about how we can actualize being strength-based. This program and this philosophy are evolving and we are always looking for new ideas and ways to be creative. New approaches engage the kids and we work day to day to be creative.

Working [previously] in a treatment centre that was deficit focused was a conflict with how I am and what I believe. But I found like-minded people there to support my ideas of

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[13] Part of Shandra's work involves liaison between *Kids Place* school and various mainstream C.B.E. schools.

change and growth and hope. It's important to find people in the environment who are aligned with my understandings of change and this is what helps me to work here every day. Its interesting work, the kids are energizing and they keep me coming back, but I do go home exhausted. The kids here are themselves and they are in relationship with us but sometimes we are the targets of their past trauma. Being the targets of past trauma, it's hard not to personalize this sometimes and take it home with you. I worry too about what the kids are doing at home when they're out of school.

We have positive moments too. It's satisfying when kids trust us; I had this fellow in class who has this video system he brings to school every day. We agree to keep it in my desk; this is our agreement for its safe place during school. This is satisfying, its trust. This is one of the most important things he has in his life and he trusts me with it. When the kids leave us at the end of the day, when they've had a good day and are feeling proud of themselves, it's [the positives] attributed to what we do together in the course of the day, this is what keeps me coming back. It's nice to watch staff have good relationships with kids in the class.

Practice on the outside.

From a strength-based perspective I do a lot of interpretation for teachers and administrators, especially in the mainstream school system. From a strength-based perspective we try to think about things differently and for every behaviour there are positives in what is happening. We try to shift from a negative to positive perspective. We wear rose coloured glasses; it's not that we don't realize the problems and aren’t dealing with them; we are just dealing with them by focusing on building strengths rather than on focusing exclusively on eliminating negative behaviours.

I work in a variety of schools, I'm not always surrounded by colleagues who believe in a strength-based approach, but this year I'm working with a principal in one school who's also strength-based and this makes a great change. It's possible to be strength-based without even knowing it; I see it as a personal philosophy. This means making children feel good about themselves rather than being punitive. I worked with a traditional principal last year and she was very much “in the box” [indicates scare quotes in the air with her hands] about how she dealt with behaviours in situations. She did a lot of consequencing and she did not focus on how to change behaviour. As a result we couldn't come up with ways to compromise on how to work with my students.

I have a friend who works with the deficit model in children's psychiatry and she says similar things. She has to fight, fight to be heard; the belief system at the top of the chain is a medicalized understanding of behaviour with doctors and nurses in charge, which makes change and being strength focused very difficult.

Another experience that comes to mind for me, being in these two worlds, was a time in which I was working with a group of grade 6 boys, who were identified as the school bullies. They were terrorizing the school and they were referred to me for some group work. We literally did not address the bullying; we never addressed their behaviours in this group. On the first day they walk in and said, “Why are we here?" I said we see you as potential leaders, that other kids look up to you and we want to build skills to go along with your leadership. Now these same kids are running intramural sports and helping younger kids in the school to read. There were no more bullying incidents. We have to earn respect for this approach in the C.B.E. and this is how we do it, by showing people it works.

An important part of the change process in being strength focused is changing the story of the youth. The kids we work with have negative images of themselves; they have negative images of other people, and of how other people understand them. When it was announced to school staff [in a staff meeting] that I was doing a bullying group, I said “No I am doing a leadership group." A teacher in this meeting rolls her eyes with sarcasm. Six weeks go by and they haven't had any problems in class with the kids from my group. Being strength-based we work with the individual to change their story and we work with the people in their context to loosen up their definition of the individual [student]. We work to change roles; everyone has a role in life we fall into.

The day to day grind: Life in the infantry of social care practice.

Our role here is VERY broad and we work SO CLOSELY with these kids in a wide range of capacities, all day long. We tie shoes, we deal with problems on the play ground and we deal with families and family problems, school problems, and internal issues with the kids. We are often a target of these internal issues. Our kids are overwhelmed with their own situations and end up feeling aggressive and confused by all their different feelings. Part of this experience is that we end up as advocates and supports for these kids.

We want to ensure success on a daily basis and help them feel like they want to be at school, doing activities with other kids, making friends at school. We try to enhance their connections to others even outside the school, with how they talk to their parents and connect to other service providers. Whenever we have an opportunity, we do advocacy. We also suggest avenues for the parents for referrals to other resources. We know the children sometimes as well as they do, we are with them more often, for longer than the parents might be, due to their work or other pressures of daily life. Together with the parents we have a common ground of knowing

their child well and our closeness allows us to be an ally. This is complicated and sometimes this closeness puts us in opposition to the parents over something that is happening at home [Shandra is referring to a concern for abusive treatment of the child]. Sometimes we need to keep an eye on what's going on at home.

Our kids are quite volatile. One moment we see kids in crisis ready to lash out at whoever's there; then, maybe the next day, or even in a half-hour they're smiling and joking with us; I find [resolving] this satisfying. We are often the target of their crisis [reaction] and of the kid's strong feelings and this is hard. I have to understand that it's coming from a different place and though it's not directed at me I may happen to be the one standing there in the way of anger or blame or whatever is taking place. This can be difficult.

There was a situation earlier this year where I was assaulted by one of the girls in our class who targeted me specifically. Now that was really hard. I had to step back, to step out of it for a while. It was just before spring break and I took quite a lot of that break to remove myself emotionally from her. I was really taking this one incident personally, you know… "You attacked me" [I thought]. This can really affect the relationship if you do not step away from it and put it into perspective. I'm usually good at not taking this personally but it's not always that easy to brush off. I talked with the team and discovered that her history was to target females that she feels really close to, so in a sense this was a compliment to our relationship. THAT is putting it in perspective. In processing this with her I tried to make clear that this is only one incident and that our relationship would be okay. I wanted her to know I wanted to move on. This is one of my biggest struggles, I have trouble letting go of this and it's not beneficial thinking about this too much. I am still working on it [letting go of this incident].

During stressful times it's easy enough to fall into this label of "you're just a bad kid." I know better than that and it's just not satisfying to think that way, it's not a satisfying explanation for what's going on with these kids. You just have to think about it. Being strength-based is not something you can put onto someone, it's something they have to get on their own, something they have or are working to have. I can default to the deficits and anyone here can. Like any other place we have our challenges, we have our difficult incidents.

I enjoy the work here and that keeps me going. But there are days you go home and say "I don't want to go back on Monday." Then the next week, you'll have a good week; some days are great, others the total opposite. We try to keep the environment interesting and we have a lot of opportunities for hands-on things that can contribute to success. We swim, we skate, sometimes we don't know how things are going to turn out, but we hope it will be one of those valued things that stick out for the kid down the road. Sometimes our projects are nuts because it's difficult for supervision in the community, much more so than in the closed school setting. But we live in the community and we need to take these kids into the community, regardless of the [behavioural] challenges around doing so.

This is school after all; the students do receive education as well as working on their behaviours and learning new skills. Sometimes it really is a challenge to be strength-based while doing all of this and some things happen here that would NOT be tolerated in other schools. I do wonder: "Am I setting the child up for problems later if I tolerate something that would not be tolerated elsewhere?" This is a conflict that being strength-based creates; I am torn by doing what would be beneficial versus what a different school might or might not tolerate.

Sometimes I question "does this strength-based approach make sense?" But, with any model you still have to work somehow. We need cohesion, as a whole unit, as a staff, and we are

always asking “how can we put this philosophy into practice?” I think of it as a belief system, as a way of believing. It doesn't say you don’t have consequences, but I first thought when I came here: “does this mean anything goes?" It doesn't mean anything goes. You don't need to go to the deficits, but there's no manual on how to do this [strength-based practice] on a day-to-day basis. We need to learn to use the strength-based skills we have and it's not anything goes.

It's hard to operationalize a strength-based practice, there's no manual and there are gray areas. Yet, when I see other staff working through a crisis with the child I can see a big difference in the approach, it’s a different way to be, different than a more militant and authoritarian approach. These are really neat kids. They are really unique characters, they’re a lot of fun, they can be a lot of fun, and it can be very challenging too. It’s like a balancing act. We have to find a place between fun and work, which helps us recognize the childlike qualities in the kids.

The impact of these conversations [with the researcher] does raise my awareness of what I'm doing here and it’s nice to reflect on experiences and where I sit with them. I was thankful [for the chance to be interviewed] and it was beneficial to put this in context. It [these two interviews] made me reflect, it's hard to summarize during the day, there are so many things going on and we get caught up in the moment. It was good somehow, to talk about this work in this way.

The ideal intersects with the practical.

We are always taught coming into this field that you do four positives for each negative. In certain frameworks of working this really isn't possible. I have always struggled with this and my deep down philosophy has been that to promote change you have to make people feel good about themselves. If they don't feel good about themselves, they have no hope, with no hope

there is little desire to change. Without hope the child says, "Everybody always thinks I'm stupid, so why should I bother to make a difference to try to think differently." When we change people's thinking about themselves we create hope. A change of thought patterns requires changing understanding of one's self.

My findings in the real world working in an alternative program is that they [other programs and practice] are more interested in the problem, the assessment, and what the experts say, and that things tended to be the opposite of what I was taught. What I actually experienced [in prior settings] was four negatives to one positive. If everyone around you is in a negative frame within an agency, it is very easy to get pulled into that negative approach. Being behaviourally focused, focused on behaviour management, is a focus on the negatives. My work in this program, as a strength-based program started around 2002 [this was when *Kids Place* program adopted a strength-based philosophy of practices]. The children we work with have significant difficulties and for the C.B.E., they believe that "this child has a problem, you deal with them."

Narratives of the medical model.

I am neutral to the use of medication, but what I really focus on is the big picture. Being strength-based means I am interested in the bigger picture and the diagnostic orientation is more linear and immediate. The medical model approach seems to try to fix a small piece without really knowing what it is they're trying to fix. This is an expedient model but narrowly focused. Doctors are too quick to head to the medication. I see children go to a psychiatrist they've never seen before, for a 15 minute examination. They [the psychiatrist] do not know anything about the child's life beyond what the parents are telling them. Keep in mind these are parents who are

stressed by the child's behaviour and want something to be different. I think this is wrong and it makes me question the [social care] system.

My opinion of psychiatry has been changed as a result [of these diagnostic practices]. There is a need for psychiatry and there are very good psychiatrists out there and of course there are many individuals who benefited from being on medication. But because of a lack of time and a rushed pace the psychiatrist is often not getting the whole picture. So I often tell the parents we work with to question the medication. I think we have to rule out other things before going for the medication. We need to treat the individual and not the diagnostic category.

I'm not against medication and I think children experience stress because they cannot control themselves. I work with a little boy who really was a walking poster boy for A.D.H.D. and he was put on Ritalin and his behaviour worsened. So, we watched for a pattern. We asked ourselves, "When does he become more impulsive, out of control and hyper?" We realized his behaviour escalated after he ate and after he took his medication. It turns out he had an allergy to certain foods and to the ingredients in Ritalin itself, so taking the drug simply made things much worse for him. In a short time he was removed from that medication and his food allergies were controlled and now he has fairly quickly returned to the community school where he is now very successful.

A search for the root cause is not always fruitful. Things happen in a child's life, like abuse, that has significant impact on day-to-day experience. A child who has experienced abuse will not benefit from medication. Medication cannot solve this problem, but medications produce SOME benefits. Sometimes it allows the kids to be more task oriented, but I have also seen the reverse where kids are numbed out and I wonder, “What are they losing?” From a classroom management perspective, it's an easy thing for sure, to have the kid medicated, as they certainly

become easier to manage. We have situations [in a mainstream school] with one teacher and 25 students and with one kid off task, this presents very difficult challenges for the teacher, so it is convenient where individual attention is not possible. In other instances, the A.D.H.D. can be severe, so much so that a child is not going to overcome it no matter how much attention he received. Sometimes a child returning to the community school is set up to fail without medications, so I have in some instances advocated for this [use of medication].

The use of medication is complex and often it is not used consistently. I believe if we are going to use it consistency of administration is important. Parents are often not on board with this [use of medication] and do not administer them [medications] consistently. They don't even eat at the same time each day, let alone take their medications on time. This [medication] should not be the treatment focus. Meds are only a small part of the solution and there is way more going on for these kids than simply behaviours that are unacceptable. I have to admit that when behaviours are not so problematic, we do better relationship building, and relationship is critical no matter what, meds or no meds. Through relationship, this is where change is going to happen. We need parents to understand this too; the relationships they have with their kids will make a much greater difference than any medication.

Medication is never enough on its own. If you have a persistent headache and all you do is take Tylenol, you can never find out what's causing the persistent headache. Medication is a fix, but there is still an underlying issue. There needs to be much more work with building the child's skills, working at communication, trying to find out what's at the root of these difficulties and building skills to promote change. Medication may enable the child to tread water, but we also want to teach the child to swim. So we are advocates for these kids too [around the use of medications].

A lot of our kids experience trauma and neglect and this can change brain functioning and brain development. This trauma can present itself in many ways behaviourally and victims of abuse do not fit specific categories. Behaviour is often a by-product of an identity and the aggression we experience with these kids comes from past experience. A child needs to survive the situation they find themselves in. But as far as finding root causes, well, we can teach coping skills without knowing the reasons for extreme behaviours.

These kids need additional support because they need a chance [for school success] like any other kid and the traditional means is not working - the community school does not meet their special needs. Our kid's families face significant challenges too, financially, emotionally, with their own mental health. It's difficult for some families to manage on a daily basis considering just the basics, let alone when their child needs special attention too. In these families, kids often lack many opportunities and then fall behind and slip through the cracks, based on their behaviours, based on how they manage to learn and survive their circumstances. They fall behind and then they hate school, because it continually tells them a message about who they are, and it's not a good message.

I don't know the origin of the problems with these kids. I believe that kids need a lot of support growing up and family has a huge role to play here. Sometimes families are not able to provide them with these supports and need. There are a lot of barriers for families to overcome and providing extra support to a weaker member of the family is difficult. Some families we work with struggle just to get dinner on the table, but I think the support kids need begins with the family.

I had a lot of support at home and this was a key factor in my success as a person. On some level there is a connection between my family which was a healthy family and my being

here, but I can't tell you what is. My being strength-based started in college where an instructor I had was very strength-based. It was modeled and I think modeling is important…I had an early residential experience that was in a setting that was highly strength-based as well. Being strength-based fits with my own beliefs anyways, it's easier to do things this way. Being deficit focused does not really feel like it's solving anything.

A deficit focus does not answer a lot of questions [concerning treatment practices]. I have worked in the justice system and this is a good example of a consequences-oriented approach. To prevent kids from involvement in the justice system, I have a belief that ultimately they can go a different route, but they need some other intervention. I don't focus on the deficits and the consequences in the same sense and hope I'm more likely to prevent the justice system as a final destination for our kids. I'm an agent of change and do not wish to focus simply on coping or just getting through the day. People are where they are for reasons and can get to where they are going in a positive way. It seems pretty dismal and hopeless to work with a deficit mindset. When I was working in a detention centre, it was hard to find hope for change.

Our kids, at least our older kids, are aware of their diagnosis. With the kids in grades five and six I tend to be a little blunter. They know their diagnosis but I say "That's not who you are. We're going to find ways to develop who you are." They [our clients] don't have to be the child with the deficit label.

Sometimes, diagnosis may be used by the kids for leverage to be excused from certain activities. For example a kid might say "I have to go for a walk right now because I can't sit still because I have ADHD." Even though there's a math test in a moment. We find pragmatic ways to address this. I will say "We will find you a quiet room to work in and you don't need to use that

excuse, I have confidence that you can do this test." With my work in the public school system I have a very different relationship with the kids than do the teachers.

The DSM asks me to think that the child is the problem and that the problem is within them. It sometimes also gives me a framework for what's going on with the child, but usually not the whole picture, just a starting point. The DSM gives me a baseline, not really a foundation, but a baseline to start understanding. My work is to create change and I tend not to focus on the diagnosis. For half the kids I work with, I don't even really know their diagnosis. It's not very useful unless there is something specific about their medical condition such as seizures that I need to know about. To me the diagnosis is not who they are and the child's file is not the whole picture. I read a file with an understanding that this is just one piece of the child. Typically, my sense of the file is that it represents itself as the whole picture. There is limited value in the file and it colours my perception. I want to be a blank page when I meet someone and make my own perceptions; I can be wrong but also have been very intuitive.

Seeing the strengths: Constructing the strengths.

I see things differently than others and I experienced resistance from others in being strength-based in my work in the public school system. I have to be stubborn and I will keep working away until you hear what I'm trying to say. People change to a degree, but the C.B.E. is a very big system. Change happens gradually and often in local environments it’s [change] one person at a time. I would like the C.B.E. and the whole world to be strength-based!

Trust and acceptance go both ways and if I expect the kids to trust me then I’ll have to trust them and accept them no matter what. I had one boy who had a real problem stealing and no one trusted him, he had a bad reputation. The first thing I told him was "you've never taken

anything from me so right now you have my complete and utter trust, if you break my trust we'll have to deal with that." I never had a problem with him taking my stuff.

Being strength-based asks me to be open and accepting and not be clouded by the negatives. I worked with a little boy here from another province, he was in grade 3 but he'd never really been in school and was extremely volatile in his behaviour, quite aggressive. He moved here to live with his Dad and up until then had lived with his Mom in another city. His Dad and step-Mom were a pretty stable environment for him and his birth Mom had given up on him. Prior to his arrival in school, the school did not want this child, but working from a strength-based perspective, we worked to put the supports in place for him. We knew this was going to be a challenge. But he has not been suspended once between September and Christmas [the time of the interview]. His behaviour is still unpredictable and can be violent, but he sees school in a different way now and prior to this he thought of school as a horrible, horrible place and we changed that perception. We wanted to make a successful experience for him, a slow integration. He did not understand how to do things differently, but through advocacy with the teachers they understood and then accepted his lack of knowledge and so they approached him with more understanding. I should mention that in this instance the parents here were really on-board and this makes a huge difference too.

The prototypical moment: The Christmas assembly.

The moment that captures the experience of working in this program for me is represented by our school Christmas assembly. We have assemblies just like any other school and assemblies are typical of all schools. This SOUNDS like a simple thing and is especially important at Christmas, Easter, and times like this. It's so neat at our school in particular because it's just those sorts of normal everyday things that take so much work, just to see the kids get

really engaged in this. The assembly is a really neat thing these kids to do and often they go very well. I find this kind of cool. Kids are not asked to leave assembly [for misbehaviour] and WE [staff] come together and get involved and the kids are really into it. All our staff are involved in this scene, planning decorating and prepping for something for the kids to participate in. Our clients are comfortable enough to do public speaking at an event like this. This is a huge feat; the kids are secure enough and confident enough to do this public speaking in front of a large audience. It's not likely they would be able to do this sort of thing elsewhere.

We provide a setting where kids are comfortable with themselves, whether it's public speaking or talent shows. The kids are able to step out of their own comfort zone to do this and to present themselves to the school. It's a huge kind of thing for a lot of these kids. We celebrate this by getting everyone involved and we invite administrative staff, parents, and significant others to check this out and they see the success. The Christmas assembly stands out for me in this way. This is a very open, positive and encouraging time. When you can see the work you are doing every day, the work you're doing is paying off. The kids are almost showing…PRIDE. They are accomplishing things just like any other kid. They overcome their initial embarrassment and fear.

The *Kids Place* program (and this assembly moment is symbolic of this place and its work) is really helping the kids feel successful in a lot of ways. You can see how overwhelming this assembly would be if they did not feel that they belong, if they did not feel part of the community. This is a safe place for these kids; they are attached to this school. Success allows them to like being here. They feel like they belong here and even if they have to leave the assembly they know that it is OKAY, [they know] that we won't be angry if they can't handle it.

The assembly is safe and predictable. The belonging and trust in our school community is HUGE.

We create a sense of community with their daily actions with the kids and with one another. The kids see that we have a community and the kids know this, that this is a different place, a different kind of school. I suppose this is a special school in a good sense of what that means. We do things here that other schools would not do, to encourage involvement. Parents are invited to this assembly and this helps them feel part of the community too. It is ABSOLUTELY helpful when parents are involved here. Then the kids get good messages, they're being supported from a couple of different angles. Getting the same message at home as here helps the kids in feeling more secure and really supports the internal changes were trying to make. The parents that are not involved are the flip side of the parents who are there for their kids. When the parents are not there, this is painful [for the client and practitioner].

This kind of event, the assembly, changes how parents see their kids. In a different situation or in previous experiences the assembly was a time when their children were acting out during assembly. They were not able to participate and they would act out and be removed from assembly, so in this way assembly was a negative. The assembly reminded everyone that they [the client now at *Kids Place* School] were different. Some of the kids would have trouble just sitting still for that long for instance, so here, this change is huge. The parents can have a sense of pride and accomplishment for their kids in this school.

We do things in our assembly (they're shorter for instance), that enable success. Something as simple as a shorter assembly [makes a difference]. The kids don't even realize the change in themselves, we have to point this out, we have to bring their own accomplishments to their attention. We create a new way of looking at things for both ourselves and for our clients

and for those in their environment. The kids don't even necessarily know they're doing well when they are doing well.

The kids will not be here forever, this is a temporary setting. We need to prep them for the next school experience, but they need to establish the skills that will take them to the next school successfully. We want to establish success and change how these kids feel about things so that we can transition from here [to a mainstream school] successfully. The staff make participatory contributions to the assembly too. Lots of people play music, we have a mascot, and we create a fun place to be. It's really important that we have fun at work and the kids enjoy assembly because it's fun.

Discussion of Shandra's Narrative

Constructs of practice: Seeing the strengths and constructing new narratives.

Shandra introduces her stories of experience by explaining that her client's "issues" of mental disorder as often found "outside of" the child; a "search for a root cause" of mental disorder appears to be a pointless effort. Shandra's interests in relationship and meaning draw her attention towards working to alter the social constructs surrounding the child that she judges as interfering with a child's success and identity of wellness. Shandra describes movement in her thinking and practice towards a relational understanding of human actions where meaning exists in the space Garfat (2008) identifies as the "interactive-in-between", the space where meaning is co-constructed between self and others.

Shandra's view suggests a social constructionist outlook to her practice in that she believes it is history in relationship, past trauma, and the narratives that follow from this history create identity. She suggests that if the client is locked into the past, these historical discourses dominate one's identity; she notes that "everyone has a role in life we fall into." For Shandra, to

remain in relationship with the past is, as Gergen (2009) suggests "to participate in some scenario that privately maintains itself" (p. 294). If the DSM casts Shandra's clients into a "fallen into" role, then Shandra works hard to find a way out of this (w)hole.

Shandra has set aside many but not all individualized understandings of the aetiology of mental disorders to adopt a contextualized and relationship-based narrative in its place. Shandra pays attention to the form of her collaboration with other professionals. The form of collaboration available may reflect either a problem-saturated or strengths and abilities-saturated narrative of meaning surrounding the client. Shandra prefers the latter but also uses the former to construct a narrative of understanding and sympathy for outside professionals aligned with positivist understandings of mental disorder. Utilizing the discourse of mental disorder enables Shandra to create leverage to remove blame for the "bad" child, as one cannot easily blame the child for "having" a disease?

Ungar (2004a) notes that mental health treatment outcomes are "closely linked to the control high-risk youth exert over the labels that define their health status, a control largely denied them in mental health discourse" (p. 6). Ungar's views are similar to what Gergen (2009) refers to as "relational recovery", where problems are not seen as possessions, but rather are identity constructs generated by the narratives the child lives within. Shandra de-constructs these narratives to re-construct preferred identities.

Shandra's prototypical moment reflects a view that mental health involves a process of creating an image of oneself as healthy through constructing concepts of resilience in day-to-day activities. The notion of resilience as "constructed" or as "hidden" suggests the interplay between an understanding of resilience as a core essential characteristic lying within the individual (Masten, 2001) or as a form of social construct based in language (Ungar, 2004a).

The experience of *Kids Place,* as an intersection of Child and Youth Care practice reflects an intersection of these concepts of resilience. Masten refers to the concept of resilience as "in" the individual, as a demonstrable set of "personal" characteristics that leads to "good outcomes in spite of serious threats to adaptation" (p. 228) A significant portion of the literature on resilience reflects the discourse of developmental psychopathology (Stewart, 2009; Ungar, 2004a). Problematic to an essentialist notion of resilience as "in" the individual and not "in" the interactive relationship is the concern that the construct of "good outcomes" that accompanies the positivist view of resilience is a difficult concept to define. This construct reflects a vague and epistemologically questionable set of socially determined results.

From a positivist perspective, resilience is defined according to a particular standardized model of resilient functioning. This model is embedded with the positivist presumptions found in predominating mainstream discourses surrounding mental disorder (Lesko, 2001). As Rick stated in his earlier narrative, what positivists define as pathology, may also be understood as a purposeful form of self-preservation from within the clients narrative. His story of the boy diagnosed with "school phobia" illustrates this point. Like Rick, Shandra understands client actions in distinctive ways when compared to the understandings of the medical professionals who diagnose her clients. Ungar (2004a) also demonstrates how what may be considered as a "bad" outcome, for example a suicide attempt and ensuing hospitalization, can also be constructed as a positive move in the narrative of the individual adolescent.

Reflecting upon the historical and cultural constructs that surround the child Shandra considers the political, community and family environments as systems at play with the power to define the child. Like Foucault (2006) and Gergen (2009) she advocates in order to erode the certainty of others' realities, to shake up what is known to make room for alternative views. She

also wishes to provide emotional and relational support, and to develop skills for children in her practice so they may re-create compelling alternative narratives to live by. Through developing new skills and understandings, new paths are made available to support her constructs of change. Shandra's consciousness raising "broadens the circle" to bring the child's daily environments on-board with strength-based thinking and a goal of identity change for the client. Significant others are critical to the process of identity re-construction and it is important for Shandra that professionals who surround her practice are in sync with this goal of change and movement in identity. Her practice is concerned with co-ordinating efforts to aid others in constructing alternative meanings for their understanding of their clients or students.

Alongside the treatment goal of identity change described by all the research participants in this study, Shandra adds that "feeling good about oneself is a counter weight to feeling bad about oneself". A strength-based practice model is credited with the potential to create the hope needed to initiate the momentum for this change. Hope is cited by Duncan and Miller (2000), as a significant component of all processes of therapeutic change and reflects a value of inclusiveness. Feeling good about oneself contributes to creating hope for the child and hope is increasingly recognized as a construct (Cheavens, Feldman, Woodward & Snyder, 2006; Duncan & Miller, 2000), that is likely to facilitate a desire within the client to engage in a treatment or a change process. Successful treatment is synonymous with this change in outlook and the development of a skill set necessary to succeed in the C.B.E. mainstream school system; an ability to do so is the definition of treatment success. Relational recovery is a goal that seems prescriptive for its suggestion of a fixed end, but the co-active process of relational constructions continues indefinitely as an ontological foundation for human kind.

Hope is a construct that emerges through collaboration between the client and practitioner (Stewart, 2009; Ungar, 2004a). Practitioners who recognize clients' abilities create a sense of hope in the character of their relationship with the client. This hope is understood to contribute to the client's gaining a sense of power and control. Shandra views hope and client collaboration as components of a strength-based practice model that draws the child towards a sense of inclusion, belonging, and to a personal sense of mastery. These are characteristics Brendtro et al (1998) name as essential and basic human needs.

Conversely for Shandra DSM discourse is thought to set the child apart from the others as different, needy, and biologically flawed; it contributes to feelings of ostracization for children who are already having trouble meeting others' expectations and who already sense their own differences. A deficit-focused construct saturates a client's identity with the discourse of individual pathology and contributes to alienating the client from a treatment process where the client perceives that "others" simply do not understand. Shandra utilizes DSM constructs to create momentum needed for change to occur.

The ideal intersects with the practical: Narratives of the medical model DSM discourse and pragmatic practice.

Shandra narrates her experience of the DSM medical model orientation to practice as an authoritarian "top-down" expert driven model (Fulcher & Ainsworth, 2006) that is often ineffective for the goal of change. In spite of this, like Rick, she values its discursive authority in re-defining a child as "disordered" and not as simply "bad". Reflective of a social constructionist and narrative understanding of the value of language and meaning in practice, DSM labelling can be used purposefully to marshal resources, and to create a localized climate of understanding and support for children in transition from *Kids Place* to a mainstream school. The practitioners in

this study are guided by the constructed practices of their strength-based model and the ethos of Child and Youth Care. Their theory in practice is synonymous with a pragmatic and utilitarian philosophy in that any tool at hand or any version of Truth at hand will be considered for its value in the moment if it is aligned with the ethos of her practice. Some of the tools of their opposition will be taken up, in spite of the distaste of having done so, but these tools are used creatively and for distinctive purposes. It is apparent that the ends are used to justify the means in this instance. Shandra values the medications that accompany diagnosis, but like all the participants in this study, believes that they are a "last resort" in treatment. In some instances medications are cited as aiding relationship building and helping the child "tread water" while the child learns "to swim". Shandra's stories of *Kids Place* suggest an experience with the constructs of knowledge in play whose blend is more akin to a confluence of practice than an intersection of practice.

Shandra's narrative describes her experience of a DSM medical model approach as a way to compartmentalize and limit the client; as she states of the diagnosis "they know their diagnosis but I say that's not who you are." The story of the child's deficit-saturated self is incomplete. It is suspended so that the client and practitioner may return to the past to write conclusions to stories that are more satisfactory to their preferred identities. The drama of the past holds the client and others in its grip – as it reminds those surrounding the child of their flaws and inadequacies; often this is the voice of authority. As Gergen (2009) suggests, a story is never simply a story; rather, a story gains its significance through interactions as the client and others are "immersed in the confluence of relating" (p. 304) to one another, within the context of a particular narrative.

Shandra's practice is characterized by Gore (2007) as an "anti-oppressive" stance to youth work. Anti-oppressive practice works to "extend young people's understanding of the

world…and how oppression limits their opportunities" (p. 68). The DSM is a form of narrative oppression that Shandra rallies against. Like Gore, her anti-oppressive practice "identifies opportunities to engage young people in finding the tools to challenge their own oppression" (Gore, 2007, p. 64). While working to engage children and youth "in building their self-esteem and pride in who they are, through celebrating" (Gore, 2007, p. 68) their identities.

Shandra's suggests that DSM diagnosis contributes to a fractionalization of the person where the person is reduced from a whole into components in a process of objectification. The component of interest is dependent on the specialization of the expert who is focused on narrowly defined aspects of the person. The education system is interested in delivering education services; this is their component of interest. There are mandated to provide this service and expect particular kinds of behaviours in their classrooms in order to provide this service efficiently. The psychiatric system is interested in the mental health of the child. It is as if for Shandra, the DSM suggests a useful but singular way of knowing that surrounds the client, and Shandra, like other participants in this research, rejects this singularity to adopt a complex understanding of her clients' actions, contexts, and her role in the treatment process. "We're going to find ways to develop who you are" she states. Shandra's model for practice is valued for how it enables the client to define and be experts upon their own problems (Anderson & Goolishian, 1992).

The tendency for positivist reductionist compartmentalizing is in conflict with Shandra's preferred practice of considering the "big picture" and treating the whole child. The compartmentalizing experience may be conveyed in the analogy of how a strength-based practice model and the ethos of Child and Youth Care practice "concerned with the totality of a child's functioning" (University of Victoria, School of Child and Youth Care, 2008b, n.p.) understands

DSM discourse. If we consider the DSM as like a singularity of light, when DSM discourse filters through the practitioner as a metaphorical prism - it is transformed into a multiplicity of hues of understanding. Its original light is fractured into an array of new meanings, each derived from the original light. A "yes/and" construct of practice recognizes a singular part as a component of a bigger and ever evolving "multiplicitous" narrative whole.

In Shandra's narrative we again see the use of the metaphor of a "box" to describe her views of both thinking and practice within a medical model DSM orientation to care. The repetitive nature and similarities of these narratives is not surprising given the closeness of the treatment team at *Kids Place* and the constant conversations they describe that construct their strength-based model of practice. Reader's privy to these narratives have commented on how they were struck with a sense of the ordinary, through the similarities of experience across these narratives, suggesting a sameness in the day to day experience of the research participants in this study.

Shandra, like each of the other research participants in this study, works hard to be "in" the model and though Rick earlier stated that being strength-based is "not a sales job" for the clients of *Kids Place*, the practitioners themselves engage in conversations that resonate with a sense of creating a strength-based hegemony in support of their own practice. The importance or perhaps the necessity of creating a way of being suggests that this process is not dissimilar to a sales job. Its purpose is protection against the "default" language of deficit-focused thinking. Strength-based discourse represents the use of emancipatory language to create what White (2007) refers to as an emancipatory narrative surrounding the client. This is what Gore (2007) defines as non-oppressive practice. As Gergen (2009) suggests "if I had another way of talking, a new story line by which to know and explain and be myself in interaction with others" (p. 301)

then recovery from mental disorder is possible. Herein, "bullies" become "leaders" and no single label can define the individual with certainty. This is in contrast with the discourse of DSM and the potential for its language to repress and limit clients' narrative possibilities; for Shandra the DSM constructs a role the client "falls into". For all the research participants in this study I note the analogy of deficit-focus thinking as a powerful force, having the ability to "pull in" the practitioner, particularly in times of stress. One could also argue that strength based approaches may deny the existence of a client's difficulties and struggles, and in some manner invalidate the clients' experiences of hardship.

Getting out of the box.

Part of Shandra's practice involves liaison between *Kids Place* School and mainstream C.B.E. schools. She tells the story of a frustrating experience of trying to find common ground and failing to do so with a "traditional principal" who was "very much in the box". The use of this comparison suggests a sense of practice as contained, boxed in, and limited; the definition of the individual is standardized and concerned with efficiently controlling and processing the disorder, within this metaphorical box. Conversely, being in the box may provide practitioners with sense of comfort and safety. The certainty of DSM constructs, supported by the authority of positivist science, represent a box that contributes to a sense of security in the meanings and methods that surround treatment practice. There is a historical pattern for Child and Youth Care as a discipline to turn outside of its own experience and towards "legitimate" and authoritative discourse in seeking understanding of practice experience. To turn to outside disciplines to define experience has been, at times, a historical necessity, but it also suggests the insecurity of a burgeoning profession. To remedy this Anderson-Nathe (2008) suggests that the discipline of Child and Youth Care must continue to construct its own narratives of identity and meaning

through finding communities of practice within which we share the stories from the front lines of practice. At times these narratives serve as a counter-balance to those narratives that are constructed for the discipline by others; the tendency to acquiescence to the others' definitions of Child and Youth Care identity and experience are a form of "box" for the discipline as a whole – this is a box of our own making.

Shandra suggests that as a strength-based practitioner she has found a way out of "the box". Shandra experiences a strength-based model as giving her freedom to explore creative methods, relationships, and identities with the child in treatment. Getting out of the box of traditional practice methods and taking the child out of the box of diagnostic constructs, is potentially fraught with risks. Shandra's narrative suggests she is not averse to risk taking, conflict, and client advocacy.

Shandra believes her strength-based practice is divergent from that of a "behaviour management" and medical model understanding of treatment. This divergence results in a close scrutiny and external scepticism by outside professionals, upon her alternate practice model. A practice that is newly divergent from a mainstream tradition of treatment implicitly suggests that the divergence is an improvement in methods. It follows that Shandra states she continually has to prove herself in each new location of practice as she encounters external scepticism for the way her program engages with and represents its clients to outsiders. In this sense, Shandra's strength-based practice is suspect by outsiders, for its difference.

The day to day grind: Life in the infantry of social care practice.

Shandra's experiences at *Kids Place* are characterized by intense emotional interactions with her clients; the onsite cohesion amongst Child and Youth Care practitioners and their commitment to a strength-based philosophy is noted as maintaining her strength-based energy

flow and providing support if she is verbally or physically confronted by clients. Staff cohesion is "what helps me to work here every day." Shandra views physical confrontation by her clients as a highly distressing aspect of her work and she tries to minimize and set aside the impact of this characteristic of her work with reframes and preferred narratives that explain the motives behind violent client actions she describes, in a manner reflective of strength-based practice. Her story concerning an onsite assault attempts to convey a sense of optimism and overcoming, but her hesitancy in relaying this story suggests it is incomplete.

Okamoto and Chesney-Lind (2000) note a relationship between female Child and Youth Care practitioners and fear of physical confrontation. Findlay (2005) notes characteristics of a relationship characterized by bullying to include "physical, verbal or psychological assault", "repetition of [bullying] behaviour by the perpetrator" and "an intention to cause harm or fear on the part of the perpetrator" (p. 34). The experience for Shandra of a "targeted" assault appears to meet these criteria, but the bullying construct does not emerge in Shandra's narrative, as it applies to her interactions with her clients. When the story of an assault is told, it is reframed as an indication of a special form of closeness between client and practitioner and as a means for her client to communicate her needs in the treatment process. As Rick stated earlier in reference to the *Kids Place* practitioners "these are exceptional people"; Shandra's re-narration of this targeted assault reflects how her model of practice borrows the techniques of other treatment models, in this case her re-narration is a skill a Cognitive Behaviouralist or a systemic Family Therapist would call a "re-frame". Shandra's exceptional ability to be strength-based in her practice outlook in the face of physical harm suggests the importance of an under-lying philosophy of practice that distinguishes strength-based practice as more than simply a collection of techniques.

Shandra's experience of a targeted assault is confusing and unsettling. The assault moves her beyond the strength-based narrative to a place of not knowing (Anderson-Nathe, 2008). Shandra wants to see this incident as a form of closeness, but an alternative voice within her is not fully at ease with her strength-based narrative of this incident. Her professional practice in Child and Youth Care is closely aligned philosophically with her personal stance, a practice she characterizes as building positives in the other, based in caring relationships. She also alludes to a sense of calling in her practice that is characteristic of Child and Youth Care as a discipline. The assault suggests a shakeup of her "calling" narrative of work to help support others.

From a critical perspective I view the construct of the experience of a strength-based model of practice as another type of narrative "box" or paradigm of knowledge that also structures and delimits Child and Youth Care practice. A strength-based model is noted as difficult to operationalize and this model requires a particular way of being for its adherents. Monique, Ray, and Rick have also alluded to their experience of the difficulties in operationalizing the strength-based model and of consistently being the kind of practitioner they believe the strength-based model calls upon them to be. As Monique stated in an earlier narrative "I find it challenging to really go strength-based one-hundred percent." The strength-based model is a preferred way of practice at *Kids Place* yet both a deficit-focused and strength-based model represents a search for excellence in the treatment of mental disorder. Each model is intended to answer questions of how best to serve the needs of the diagnosed client, their significant others, and the systems that surround the diagnosed child. Each model serves as a resource that is called upon to understand and to create experience, to ameliorate suffering, and accomplish change.

In the most difficult moments of care and treatment, in the daily grind of practice, the stress of the moment is difficult to manage. Theory is a much needed resource for the needs of both the client and the practitioner, but at times practice at *Kids Place* and the demands of the immediate moment seem beyond the theoretical constructs of treatment of mental disorder. Shandra's experience highlights a distinction between academics who theorize and value the construction of alternative narratives of self and experience and the practitioners in the infantry of social care practice who must somehow accomplish this goal on a day-to-day basis with young involuntary clients who are prone to violence. At times these practitioners are burdened by the expectations placed upon them and placed upon their clients. These foot soldiers are not at war with their clients or with mental disorder, rather, they are peace-keepers in the role of negotiating a mediated settlement between their client and others, and within their clients' notions of their own narrated selves. At times they suffer from having internalized expectations placed upon them regarding the need for change; Anderson-Nathe refers to this as "the myth of supercompetance" (2008).

Many scholars (see for example, Brendtro, et al, 1998, Ferguson, et al, 1993, Fewster, 1991; Garfat, 2008; Stuart, 2009) in Child and Youth Care construct a theoretical practice of the client-practitioner relationship as a condition of "being" in practice. Child and Youth Care practice is broadly regarded by both strength-based practitioners and others, in Child and Youth Care academic communities, as a relationally based practice. In other cases (Rose, 2005) relationship *is* the therapeutic intervention. Relationship is a means to accomplish the use of theory and a strength-based focus enables or at least facilitates relationship building. Relationship is both a precondition of effective treatment practices and a tool in the change process.

The Child and Youth Care client population at *Kids Place* is described as those who "will sneer, insult, put down, assault, and constantly test" the practitioner (Fewster, 2005, p. 4) or as simply "unattractive" and "unlovable" (Brendtro, et al, 1998). Holding a strength-based outlook of practice and loving the unlovable in this environment is difficult. The practitioners in this study work actively to find ways to see their clients in the best possible light and this effort reflects a human struggle to overcome the "defaulting" to the simpler labels that accompany these clients; "bad", "damaged", "no good", and "little shit" are descriptors that have been mentioned previously. These labels suggest a human need to have power over that which we cannot easily control. The slow pace of change at *Kids Place* is at times an experience of being stuck and discouraged and this would be likely so within any model of treatment practice. Fewster suggests there is some manner by which we can "genuinely" know and experience the essential quality of a relationship. His position also suggests that a focus on the positives and strengths of a client may deny aspects of the relational experience the practitioner has in the moment with the client. Both Shandra's and Monique's narrative highlight the difficulty in being a target of children's anger and acting out behaviours.

If a deficit-focus orientation is synonymous with labels and blame, for the practitioners in this study, it is during stressful times where they are tempted to react outside of strength-based narratives of practice. The experience of assault suggests constructs of despair, hopelessness, humiliation, and being out of control. The Child and Youth Care practitioner believes that she is the front-line professional who is supposed to be in charge, in control, who is supposed to know what to do. An intentionally directed assault stresses the professional's need for competence. There is very little in the "literature" on how to be a "failure". Shandra relays the very human experience of simply being a person on the scene who is charged with what to do but does not

know what to do. Her personal commitment to the narratives of "meaningful work", "a calling", and "making a difference in a child's life" fall short as she narrates herself as the helper who cannot even help herself. Shandra struggles with acceptance of her own "not knowing" position in regards to this assault.

In the difficult moments, in the grind of a highly stressful psychological or physical assault from a client directed towards a practitioner, there is a need to resort to explanatory theory, but the "mucky" moments in the immediacy of practice seem beyond theory. These are experienced as raw, unattractive, personally challenging, and often unavoidable aspects of practice. These practitioners find a way to get through the muck; beyond the theory base of their practice lays the personal commitment to doing what is judged as good and right, and the calling upon team members for support in order to cope with the conditions of practice. The belief in the work as a calling (Austin & Halpin, 1989; Garfat, 1991; Thomas, 2004; White, 2008), the support received from team members, and the support of an alignment of personal and professional outlooks enables the practitioner to return to work every day in spite of the fear of physical harm. Shandra, like Ray, holds a belief that the work must be done is some fashion and strength-based practice is something each practitioner is committed to in spite of the hardships found onsite at *Kids Place.*

If the DSM is a box that confines, so too, a strength-based practice may also be represented, like any narrative, as confining – more flexible, form-fitted and adaptable to a variety of uses, but still a place of confinement. The pain of an intentional targeted assault undermines Shandra's efforts at establishing relationship and her efforts to genuinely care for her clients. This event is constructed as an experience of sadness, fear, and futility for Shandra that she must work hard to overcome through re-narration. Creating a strength-based relationship in

the “interpersonal-in-between”, being “in” relationship (Garfat, 2008) did not protect her from this hurt and a strength-based practice makes it difficult to represent the full gamut of her experience. Her constructs of the power of caring relationships to facilitate change may have placed her at greater risk for this assault. In this example, getting close means a greater likelihood of getting hurt and trying to make a difference in a child’s life makes her an inviting target of aggression.

Shandra uses this incident to purposefully maintain her strength-based narrative within the treatment process. A strength-based model as a practice philosophy is “easy to embrace”, but in the example of the incident Shandra narrates, the personal and professional narratives require hard work to align. Shandra’s difficulty in coming to terms with this assault reflects an “imbalance” in her “inner stance”, which Hoskins and Ricks (2008) note occurs when one’s espoused values are incongruent with one’s internal intuitive state. This is as if the body is speaking to the mind, when a practice stance or position does not feel like “the right thing to do” (p. 298). Shandra’s narrative suggests that deficit-focused understandings are embedded and inescapable narratives within our culture and within the experience of treatment of children’s mental disorder. At times practitioners in a treatment process must work hard to overcome the domination of a deficit-focused outlook, but a deficit-focused outlook also has value for its utility to define what needs to be overcome, and for its ability to draw resources to children’s circumstances where change and intervention is warranted. Deficit-focused definitions of a child’s behaviour as mentally disordered is of value in aiding the child to achieve the attention of others that is needed to facilitate a change in their narratives of self and in the social circumstances that surround their lives. In this sense, a deficit-focused narrative draws a child into a process of intervention and a deficit-focus is therefore a useful precursor to change.

CHAPTER 11

The Epilogue

Watching new graduates leave my college and enter their own Child and Youth Care practice reminds me of newly hatched turtles emerging from the shelter of their eggs, on a warm and protected tropical beach as they scramble for the safety of the ocean. This is a story with a beginning of promise, but I construct the event of these newly hatched turtles as a somewhat poignant spectacle to behold and I cannot deny that it is a part of nature. Only a small percentage of these turtles succeed in reaching the ocean and growing to maturity. The remainder, before they reach the safety of the water, become life-sustaining morsels for the opportunist predators that gorge themselves.

My experience with Child and Youth Care graduates suggests that it is difficult for newly graduated Child and Youth Care practitioners to negotiate the deficit-focused landscapes that they encounter as they enter their own practice settings. When I am in contact with those practitioners who remain in the field of practice, months or years past their graduation, many are comfortably aligned with deficit-focused and diagnostic thinking. Often a primary concern of their practice is described as the suppressing of behavioural symptoms of mental disorder; occasionally they or their supervisors express a desire for additions of diagnostic course content to our curriculum so they may better know the medications they rely upon in their practice. I also note the high rate of attrition for Child and Youth Care practitioners in Alberta. As Rick stated, they are "in the muck" of a behaviour management orientation to their practice. The contrast between espoused Child and Youth Care theory and practice continues to puzzle me and was a significant impetus to the motivation to commit myself to this lengthy research project.

In taking this opportunity to speculate about the gap between theory and practice I note that the practice landscapes my graduates enter are dominated by traditional positivist understandings concerning treatment of mental disorder. I rarely encounter programs where the administration is populated by senior-level Child and Youth Care educated practitioners who are knowledgeable in the values and nature of Child and Youth Care practice. The senior administrators who oversee these programs tend to steer clear of critically examining their own institutional frameworks for understanding their role in the social care system, their forms of practice, and the nature of mental disorder. They turn to the disciplines of psychiatry and psychology for an understanding of their role in the treatment continuum. Their positivist and status quo oriented practice frameworks limit their ability to "think outside their existing paradigms" (Bellefeuille, 2008, p. 10).

Child and Youth Care practice is often overseen by administrators and managers who face the systemic and structural pressures of limited resources combined with an insatiable demand for service. It is puzzling that a discipline devoted to a specialization of social care of children, youth, and families is often relegated to a secondary position of influence in children's social care practice. Child and Youth Care practitioners are often charged with delivering their therapeutic services without much influence on the process of how the service is delivered. The tendencies I speak of above, combined with my own analysis, suggests to me that the structural needs of the social care system have an implicitly predominating role to play in the experiences of the Child and Youth Care practitioners at *Kids Place*, and in many practice landscapes for Child and Youth Care practitioners.

The practitioners at *Kids Place* constructed and defined success in their own terms. They were committed to their own definition of their own professionalism. They turn to their own

discipline to define themselves and did so in a way that was comfortably aligned with the espoused Child and Youth Care ethos of practice. Their notion of client change through growth was defined as an invitation to the construction of a new form of identity, through experience and language, for their clients. Their quest to achieve practice excellence and legitimacy in the landscape of social care practice within their preferred model of practice suggests that this is an ongoing struggle between the philosophy of practice and the pragmatics of the day-to-day experience in the trenches of treatment for mental disorder. Child and Youth Care as a discipline has articulated a unique and distinct philosophy as the nature and ethos for its practice. While other disciplines are sympathetic to a strength-based outlook of practice, Child and Youth Care is unique in its combined interest in the totality of a child's functioning, in the day-to-day lifeworld of the child's environment, in its focus on enabling a child to gain mastery, in its acceptance of the child "where they are at", and in centering the child in the treatment equation. Child and Youth Care practitioners represent the infantry in the peacekeeping effort to overcome troubled histories and deficit labels.

While I do not claim that the outcome of this study is generalizable to the experience of other practitioners, the story of experience at *Kids Place* suggests that Child and Youth Care faces the challenge of continued self awareness of the ethos of the discipline, self advocacy, and community education. Like the practitioners at *Kids Place,* I believe the discipline will benefit from the continued conversation of what we stand for and how practitioners wish to construct and define their practice in the broader landscape of Canadian social care services.

The experience at *Kids Place* also suggests Child and Youth Care as a discipline will benefit from greater self and community awareness of alternatives to the hegemony of a positivist medical model outlook in treatment of mental disorder. The practitioners at *Kids Place*

have taken steps to define themselves and to establish an alternative treatment method. They faced the juggernaut of a medical model and deficit-focused orientation to social care and have effectively, but always temporarily, counter-balanced its momentum, with a significant degree of support from their administrative overseers. They recognize that a pre-occupation with technological and deficit-focused approaches to treatment cannot effectively create change through growth, solely on its own. Without positive and growth-enhancing relationships with significant others in their daily lives, mentally disordered clients may not overcome their deficit-focused identities or develop the skills necessary to succeed in their social environments. The research participants in this project recognized that speaking of things like compassion, care, kindness, and love are more than simply factors in treatment; these are the needs we all experience in our lives. These qualities should not make a social care practitioner uncomfortable, self-conscious, embarrassed, or "less than" in the eyes of other disciplines of social care.

I believe that it takes skill and confidence to be a practitioner who does not know the answers and who is comfortable developing expertise on the process of change while acknowledging that the professional helper can never really know what's best for another person. Child and Youth Care is unique in the role of knowing the child in ways that other social care disciplines do not and in acceptance of the child's interpretation of their own experience. Child and Youth care as a discipline appears to know what it believes in but often is constricted from practicing within its own preferred value base. I suggest the discipline of Child and Youth Care benefits from knowing the constructs of our own history and the history of those concepts that we address in our social care practice. I also suggest that the discipline of Child and Youth Care benefits from valuing and celebrating our role of "being" with the child and "in" the child's daily experience, like no other discipline. The challenge for the practitioners of *Kids Place*, and

perhaps the challenge for the discipline as a whole, is to continue to push back against the constriction of others' definitions of our practice and identity.

* * *

As I conclude this project I reflect on recent comments I've heard from Child and Youth Care administrators on our local scene, in reference to their practice. One senior practitioner relates his dismay of how 100% of the children in his residential treatment program are medicated. He explains, with what I interpret as a sense of helpless alarm, that it is not unusual for these medications to have permanent and life altering side effects. He also expresses bewilderment about this practice, noting that when he entered this field, some 30 years ago, none of the residents in this same facility were medicated. Another senior practitioner relates to me a story of a local foster parent who recently has repeatedly requested medication for her infant foster child, who at less than a year in age, would not sleep through the night.

* * *

In the midst of writing this story many months after the final research interview I awake to the alarm of the clock radio and hear the local CBC news from Calgary announcing the closure of the *Kids Place* programs – two strength-based programs concerned with meeting the in-school and integration needs of their clients. Concern is expressed by the voice on the radio, for the layoff of 85 staff from these programs. The kids in these programs are described as "extremely troubled" by the media; budget constraints and service re-alignments are cited as explanatory factors for this closure.

The story of my research has found a momentary conclusion, as a tragedy. The tragedy is the loss of services for needy children whose special education needs will no longer be met by *Kids Place*. This tragedy is also personal, for my own experience of loss in empathy for the

practitioners in this research project and their unique commitment to their strength-based model of Child and Youth Care practice.

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Appendix A. Comparative Chart of the Structure of Narrative

The following comparative chart concerning the structure of narratives is used to illustrate the similarity in concepts amongst the authors referenced in the discussion on methodology. While each author uses his or her own language to describe the structure of a narrative, there is a consistency in how each describes the individual component parts of a narrative segment as a stand alone unit of speech.

The structure of a narrative	Bruner (1986, 1990, 2005)	Polkinghorne (1988)	Cortazzi (2003)	Gergen (2005); Gergen & Gergen (1988)
1. Abstract: In initiating a narrative: an abstract or overview is provided that initiates, as a signalling device, the beginning of the narrative.	"The speech act is initiated by giving some indication to a listener or to a reader that first a story is to be recounted" (1986, p. 25). This may include suggestions as to its meaning, or how it is to be evaluated or interpreted.	The beginning of a narrative is signalled through an orientation to time as an event recalled. A typical narrative represents an emplotted series of events; it is a "scheme that displays purpose" (p. 18) organized through plot.	Abstract: The abstract signals the beginning of a narrative or story by providing a statement of general proposition or point that the narrative exemplifies. The abstract represents a point to be made in the narrative segment to follow. It also serves as a signal within an interview that the speaker wishes to have the floor in order to make the point. The abstract answers the question: "What is this [narrative]	Most acceptable stories employ a signal to indicate their existence as stories. "That reminds me of the time when" Concern for endpoint establishes context – selects events. "An acceptable story must first establish a goal, and event to be explained" (p. 100, 2005). This typically takes the form of "how I…". The beginning of a story involves revealing the point or value of a story to be told. These are determined by the teller of the

The structure of a narrative	Bruner (1986, 1990, 2005)	Polkinghorne (1988)	Cortazzi (2003)	Gergen (2005); Gergen & Gergen (1988)
			about".	tale. It is only within a culture of tradition that the valued events are intelligible.
2. Orientation: Orientation data: Information that is needed to understand the point of the narrative.	A narrative told reviews actions in context in a recognizable setting. Employing means to a particular end goal or point. "Narratives start with a canonical or "legitimate" steady state" (1986, p. 16). A narrative describes a "landscape of action" and a "landscape of consciousness" (p. 14).	A story begins in a setting, and the narrator introduces the characters, location and time in which the story takes place. The character sets a goal or goals and outlines a path to attain the goal.	Orientation: the orientation is utilized to provide the listener with "necessary and sufficient" (p. 45) contextual details, both immediate and distant, as the speaker deems relevant to the point to be made. The orientation answers the question of: Who? What? When? Where?	Selecting relevant events. Once the point of the narrative is established, the events chosen for inclusion follow from the point of the narrative. The narrator is not free to include all that takes place in the story, but rather chooses information selectively as it is relevant to the point of the story. The evaluation or "point" of the story drives what details are shared.
3.Complication: The complicating factor that creates a point of tension or interest in the story.	The steady state "is breached, resulting in a crisis" (1986, p. 16). What drives the story and makes it worth telling is "trouble". A	The story involves a predicament and attempts to resolve the predicament	Complication: The complication shows a turning point, or a problem or crisis to be resolved. At the least it presents an event of interest. The	The point of a narrative is goal and identity stability.

The structure of a narrative	Bruner (1986, 1990, 2005)	Polkinghorne (1988)	Cortazzi (2003)	Gergen (2005); Gergen & Gergen (1988)
	misfit between agents, goals, settings, and means.		complication answers the question: Then what happened?	
4. Evaluation: The point of the narrative. The moral or lesson told within the story. Often provided in the form of a summary statement.	Narrative requires a means for emphasizing human agency and a voice that approximates a narrator's perspective. The narrative must "make sense of a cultural aberration by appealing to a subjective state in a protagonist" (1990, p. 82).	The outcome of the predicament establishes the causal links between the predicament, the actors, the setting and the causal relationship among each of the elements in the story. The explanation is represented by the outcome of the attempts to resolve the predicament. The outcome is laden with explanation; "in the narrative schema for organizing information, an event is understood to have been explained when its role and significance in relation to a human project is identified." (Polkinghorne, 1988, p. 21).	Evaluation: Often proceeding the "result" this section indicates the point, the raison d'être of the narrative. The evaluation is a signal to the listener of how the teller intends the narrative to be received.	Narrative requires an evaluative framework. The ideal narrative is one that gives explanation. The ideal narrative links the facts required to make the point of the story, and the explanation resembles Cortazzi's evaluation of the actions involved in the complication. Interdependent linkage of the events results in a well formed story, or makes a well formed point.

The structure of a narrative	Bruner (1986, 1990, 2005)	Polkinghorne (1988)	Cortazzi (2003)	Gergen (2005); Gergen & Gergen (1988)
5. Result: The outcome. The results of the action taken that followed from the complication.	What makes the story worth telling is the point of how the complication is resolved.	The outcome of the attempts to resolve the predicament.	Result: The outcome or resolution of the complication. Coda. This optional component of a speech action as a narrative, and signals the completion of the communication as the turn of the speaker is considered over.	Valued end point – the outcome of what happened within the story.
6. Coda: A signal may occur to indicate the end of the story.	Narrative is justified or warranted by virtue of the sequence of events. It tells about something unexpected, or something that one's auditor has reason to doubt. The "point" of the narrative is to resolve the unexpected, to settle the auditor's doubt, or in some manner to redress or explicate the "imbalance" that prompted the		Coda: Cortazzi (2003) suggests that the coda is optional in storytelling but that its purpose when utilized indicates that the narrator's turn and domination of the communicative interaction is complete. At this point normal interactive turn taking mechanisms are reinstated within the interpersonal relationship. The coda signals that	Gergen (2005) suggests that most stories employ a signal to indicate their endings that resemble phrases such as "so now you know" or "that's what I mean about trust here". This component of the story returns the listener to the present moment and restores the previous interactive context that was present between teller and

The structure of a narrative	Bruner (1986, 1990, 2005)	Polkinghorne (1988)	Cortazzi (2003)	Gergen (2005); Gergen & Gergen (1988)
	telling of the story in the first place. A story, then, has two sides to it: a sequence of events, and an implied evaluation of the events recounted.		the narrator is handing back speaking space to whomever wishes to take it. Most stories that meet the commonly experience cultural criteria as acceptable employ a signal to indicate their endings	audience.

Appendix B: Cortazzi's Method of Narrative Analysis

The following discussion presents the stages of a "narrative unit of speech" using Cortazzi's (2003) evaluative method of narrative analysis used in the research. Each of these stages can be compared to the work of other scholars in narrative research in the chart above. There is consistency amongst these authors in their understanding of the distinguishing stages of a narrative unit of speech.

The Beginning of a Story-Telling Interlude

Cortazzi (2003) refers to the syntactic signal that indicates the beginning of the story as the "abstract". "That reminds me of…", for Cortazzi the abstract indicates the beginning of a narrative or story by providing a statement of general proposition or point that the narrative exemplifies. The abstract represents a point to be made in the narrative segment to follow. It also serves as a signal within an interview or conversation that the speaker wishes to have an uninterrupted time interval in order to make the point. The abstract answers the question: "What is this [narrative] about" (p.45).

The Orientation Stage

Cortazzi (2003) refers to the "orientation stage" of a narrative as giving details concerning time, place situation and actors. The background that is judged necessary to understand the point of the story is provided by the narrator. For Cortazzi, the orientation is utilized to provide the listener with "necessary and sufficient" (p. 45) contextual details, both immediate and distant, as the speaker deems relevant to the point to be made. The orientation typically answers the question of: Who? What? When? Where?

The Complication

Cortazzi (2003) suggests that the "complication" stage of a narrative shows a turning point, or a problem or crisis to be resolved. At the least, it presents “an event of interest” (p. 46). The complication answers the question: “Then what happened?” (p. 45) that follows from the steady state provided by the orienting data. The complication is a device that enables the narrator to present a result or evaluative comment or both, and in this way represents “the bones” of the story for Cortazzi.

Evaluation and Result

Cortazzi (2003) dissects the final portion of a typical narrative structure into two distinct components within the story that he refers to as the "result" and the "evaluation". For Cortazzi the evaluation may precedes the result. This section indicates the point, the *raison d’être* of the narrative. The evaluation is a signal to the listener of how the teller intends the narrative to be received.

The Coda: Terminating a Narrative Segment

Cortazzi (2003) suggests that the coda is optional in storytelling but that its purpose when utilized indicates that the narrator's turn and domination of the communicative interaction is complete. At this point normal interactive turn taking mechanisms are reinstated within the interpersonal relationship. The coda signals that the narrator is handing back speaking space to whomever wishes to take it. Most stories that meet the common cultural criteria as acceptable employ a signal to indicate their endings such as: “So now you know” or “That’s what I mean about trust here”.