INTERVENTIONS WITH ADOLESCENTS
IN OUT-OF-HOME CARE
DIAGNOSED WITH SEVERE CONDUCT DISORDER

A thesis submitted in fulfillment of the requirements for the degree of
Master of Social Work by Research

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DECLARATION BY THE CANDIDATE

To Whom It May Concern

This is to certify that the thesis comprises the work of the candidate alone, except where due acknowledgement has been made in the text. The work has not been submitted previously, in whole or part, to qualify for any other academic award. The content of the thesis is the result of work which has been carried out since the official commencement date of the approved research program. Any editorial work, paid or unpaid, carried out by a third party is acknowledged.

Signature ..............................................................................................

Date .................................................................................................
I would like to express warm and sincere thanks to the many people who assisted with this research.

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DEDICATION

To my wonderful wife Rachel and our new darling daughter, Anaya.
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SUMMARY

This research examines interventions with adolescents in out-of-home care diagnosed with severe conduct disorder. Interventions from the service sectors of mental health, juvenile justice, child protection and welfare are reviewed and discussed. The research centred around three hypotheses. Firstly, that adolescents in out-of-home care diagnosed with severe conduct disorder have poor treatment outcomes. Secondly, that adolescents in out-of-home care diagnosed with severe conduct disorder are a particularly difficult client group to work with because of issues of attachment. Thirdly, that a diagnosis of severe conduct disorder negatively impacts upon the work professionals undertake with these young people. These hypotheses were considered in the context of an extensive literature review as well as findings gleaned from interviews and questionnaires conducted with research participants drawn from the abovementioned service sectors. Research participants were senior practitioners and managers with many years of practice and experience working with adolescents in out-of-home care diagnosed with severe conduct disorder.

The main findings from the research were that all three hypotheses appeared to be supported. These were that adolescents in out-of-home care diagnosed with severe conduct disorder have poor treatment outcomes and that one of the particular difficulties of working with this client group is the issue of attachment. Also, that the diagnosis of severe conduct disorder negatively impacts upon the work professionals undertake with these young people.

These findings are discussed within the theoretical frameworks of attachment theory and critical theory, which are utilised in exploring the alienation and oppression of these young people on
intrapersonal, interpersonal and societal levels. Finally, implications for social work research and practice are considered.
The genesis of this thesis and its research content is something I recall vividly. It was the late 1990s and I was several months into my first full-time job as a social worker. I was employed in a large community service organisation as a case manager of adolescents residing in out-of-home care. Nearly all of my clients were classified as ‘high-risk’ adolescents by the child protection branch of the Department of Human Services (DHS).

In my case load, there was a young man who was particularly confounding for many of the workers involved in his life – including me. This client had a variety of presenting concerns; however unquestionably the most concerning were his anti-social and aggressive behaviours. Moreover, he did not seem to possess any sense of empathy or compassion for any of the people he assaulted in various ways. I guess you could describe him as ‘cold’ in regards to these matters, as if something vital and really important had been ‘switched off’. It would be fair to say that virtually all of my clients had profound difficulties in relationships, connecting, trust and socialisation; however this young man somehow seemed even well beyond them - beyond reach.

During the first six or so months I had been working with him, I and the other workers around him had ‘launched’ many of the interventions believed to be useful and helpful for a client in his situation. However, it became clear that the young man concerned was not finding these interventions particularly useful or helpful. Fundamentally, I observed that nothing was changing in the life of this young person. I mean, process outcomes were being ‘ticked’ but the really important qualitative changes in his experience were not occurring. Worse still, some of this
young man’s difficulties in being in the world appeared to be becoming more entrenched and intractable.

Eventually, as his case manager, I decided to convene an extraordinary meeting of workers to conduct what was essentially an afternoon ‘think tank’. To this meeting, I would not only invite the usual people that met on a weekly-fortnightly basis to review the client’s progress, but a cast of some of the most senior and ‘expert’ practitioners from the welfare, juvenile justice and mental health sectors. Probably in my mind, the most capable of the assembled throng was a senior clinical psychologist who happened to be from the mental health sector. I had come across her in other settings as a consultant to services working with young people and found her to be consistently erudite. She was rigorous without being pretentious and always possessed a healthy dose of common sense.

At the case conference, I provided a thorough presentation regarding my client and his many difficulties. During this presentation, attendees would frequently interject to ask clarifying questions or seek additional information outside of the format I was using. It would be fair to suggest that after about a one-and-a-half-hour-plus presentation provided in this way, all those gathered had all the necessary information at their disposal to shed light on future directions. However, when I opened up the floor to invite the expected cascade of suggestions to flow forth, there was silence. I think perhaps a stunned silence. To some extent, this silence was probably an endorsement of the expertise of those assembled rather than an indictment. Clearly, they had grasped the extent of the difficulties in assisting this young man to change when he had experienced such a ‘de-humanising’ infancy, toddlerhood, childhood and early adolescence. It was as if his humanity had been permanently stripped from him.
The woman I mentioned earlier from the mental health sector, in whom I placed the greatest sense of hope, took several minutes before finally uttering in a quiet almost despairing voice, ‘I think he needs a new soul’. I thought ‘what - is that all you’ve got’? Are those seven words going to be the sum total of our gathering today? After getting past this brief sense of exasperation and frustration, I was left feeling somewhat in despair. The task of assisting someone to acquire a new soul or regenerate an existing one is difficult and vexed indeed.

This experience was deeply affecting and caused me to reflect that somehow, we needed to do better than this. For adolescents in out-of-home care diagnosed and/or presenting with severe conduct disorder, we needed to develop better understanding and comprehensive interventions that could actually assist young people in re-building their souls. I chose to begin my contribution to that project by undertaking the research included in this thesis. At the end of it, I hope to have contributed in some way towards developing interventions that could assist young people like the one mentioned above. In particular, to re-build their sense of hope, faith and trust in themselves and others. Also, in the possibility of a life spent outside the juvenile and adult prison systems. My passion for this client group has helped sustain me throughout the research and thesis writing process. I have found this process stimulating, challenging and highly rewarding. Currently being employed as a project consultant to an agency working with young people like the one discussed here, I hope to make some positive difference to the type of interventions they receive and outcomes they experience.
Chapter One

Introduction

The following quote from a police officer in Hamilton-Wentworth, Ontario, Canada describes an adolescent diagnosed with severe conduct disorder (Waddell et al., 1999:35):

The youth who sprang his girlfriend from Arrell Youth Centre has a record many career criminals would envy. Unfortunately for society, he just turned 15 and has discovered an interest in illegal handguns. This is a one-kid crime wave. He’s not like other child criminals – not even close. He’s a bad kid.

Helen Thomas (2003:1) usefully depicted the situation for such adolescents when placed in the out-of-home care system in Australia during an introduction to the expert panel discussion on ‘High Risk Kids’ for the Background Briefing program on ABC Radio National, October 19, 2003:

They’re the kids with nowhere to go, bad girls and mad boys we don’t really have a place for in our community. They live at the ‘hard end’ of Australia’s child Protection system, ‘kids from hell’ with such serious behavioural problems they can’t be placed in foster care.

1.1 A Case Study
The hard end of the Child Protection and adolescent Mental Health systems is where I found myself not long after beginning my social work career. My first full-time job was working for a Community Service Organisation (CSO) in Melbourne in the role of case manager for adolescent clients aged 12-17 who had been determined by the Department of Human Services to be high risk and in need of specialist, intensive case management. (The term ‘Community Service Organisation’ is equivalent in meaning to the previously used term ‘non-government organisation’). Our clients remained wards of the State within the Child Protection system; however the agency I was working for was one of two in the Region at that time that had such clients tendered out to them for day-to-day case management. After having worked for this CSO for about three months, I soon came to hear of a particular client, let’s call him Billy.

Billy was fourteen years old and imprisoned in a Juvenile Justice centre. He was serving a 12 month sentence for having committed an aggravated assault. Now, it is not uncommon for a young man to be concurrently in the Child Protection and Juvenile Justice systems and been charged with a serious assault charge. However it soon became clear that there was much more to this sentence and young man than first appeared.

I soon discovered that the well worn adage in this field, ‘his reputation precedes him’, applied to this young man in a powerful manner. The nature of the aggravated assault sounded far more like attempted murder. However, various colleagues informed me that that particular charge had never been laid. No-one was particularly clear why, either, other than some comments that such a charge would have been unfair at such a young age and may have destroyed his life at fourteen – a view which police, reportedly, did not share. Other colleagues stated that the charge of attempted murder was not pursued as it was unlikely any magistrate dealing with juveniles would allow it, magistrates being seen as bleeding hearts on most occasions when it came to sentencing.
young people for criminal activity. There was also the view that if Billy was charged with attempted murder he’d receive a substantial custodial sentence and that this would only hinder attempts at rehabilitation. And then, there was the victim – so traumatised by Billy’s sustained beating of him that he had indicated to others that he ‘just wanted the whole thing to go away’.

The aggravated assault took place in a rumpus room at a residential unit owned and operated by the Department of Human Services. Apparently, Billy had asked one of the residential workers/carers for a cigarette on several different occasions one day. The worker, let’s call him Jack, steadfastly denied the request in accordance with a range of organisational and procedural guidelines. Finally, Billy completely lost his temper and charged the worker, jumped at him and forced him to the ground in doing so. Billy then immediately landed a number of damaging punches to the worker’s face and head, drawing blood.

Billy then quickly stood up and proceeded to kick the worker in the head and all over the body, verbally taunting him. Jack, by the way, was a very experienced residential worker in his early thirties, approximately 6 feet 3 or 4 inches, of a large, muscular build and had received extensive training over many years in the customary techniques of self-defence and physical restraint for working with high-risk young people. Billy was about 5 feet 9 inches and had quite a wiry build but certainly no physical features by which to distinguish him. Two female residential workers entered the room to try and restrain Billy at this point during the attack. However, Billy was able to assault each of them and get them out of the room – all the while Jack was on the floor wishing he hadn’t come to work that day.

With the two female workers (also very experienced and of a fit and sturdy stature) successfully warded off, Billy continued to assault Jack. Billy continued to kick, punch and strike Jack with a
pool cue. These acts were interspersed with laughter and verbal taunting by Billy including comments recounted later by Jack such as ‘I’m the last person you’re ever gonna see’, ‘You’re gonna die’. Jack cried for Billy to stop, but he didn’t. The two female workers had been locked out by Billy and could not re-enter the fray. However they did call the police.

Unfortunately for Jack, by the time the police arrived, 45 minutes had passed since the beginning of the attack. When they arrived, Billy ignored their presence and was still taunting and assaulting Jack who by this time was coming in and out of consciousness. The police then broke into the room and apprehended Billy. Jack was nearly dead. The residential staff and police involved strongly believed that Billy would have kept going and murdered Jack had police not attended.

After going into a coma for just over a day, Jack survived and recovered – very slowly. Jack’s physical injuries and facial disfigurement would require months and possibly years of surgery and treatment to heal. The psychological scarring was possibly permanent. Jack was sent home to his wife and two young children and became clinically depressed as well as suffering from all manner of anxiety and post-traumatic stress. He could barely leave the house for fear that Billy would suddenly appear and ‘finish the job’ and any male Jack saw who bore the slightest resemblance to Billy would cause him to have a panic attack and/or faint. Jack stated he would never work in residential care again, ever. Billy was not known to be remorseful at any time following the incident.

I ended up researching and knowing so much about this incident because a few months into my first full-time job, I put my hand up to become Billy’s case manager and key point of contact within the out-of-home care system. Prior to the abovementioned incident, Billy had been placed
in out-of-home care due to the substantiation of extreme, long-term parental and familial abuse, particularly physical violence and beatings. Billy was diagnosed with severe conduct disorder.

1.2 Some Terms of Reference

This thesis will indeed examine the very specific group of adolescents placed in out-of-home care with a diagnosis of severe conduct disorder. Within this field of research and practice, terms of reference are sometimes poorly defined and so I’d like to provide some working definitions of the key terms that will be referred to. Within the out-of-home care system, adolescence refers to young people between the ages of 12-18 years (Department of Human Services, 1998:9). While the term out-of-home care may refer to a number of different placement types within the community, adolescents in out-of-home care with a diagnosis of severe conduct disorder are generally only able to be placed in a residential unit with 24 hour rostered staffing (Barber et al, 2002:34; Bath, 1998:23; Delfabbro et al, 2001: 789). Indeed, Barber et al (2002:34) state that ‘some children are unsuitable for conventional family-based foster care and should be screened out. Adolescents with Conduct disorder and/or other mental health problems are particularly (my emphasis) poorly suited and require more intensive or residential options’.

The only other viable, intensive placement option is a ‘One-to-One’ highly specialised foster-care placement (Department of Human Services, 1998:35). Such a placement markedly differs from other forms of foster care in that the carers (often former residential staff) are specifically recruited to work with high-risk young people, receive compulsory training and receive significantly higher levels of reimbursement (Department of Human Services, 1998:35). Also, the level of general financial support and professional services attached to the placement is much higher (Department of Human Services, 1998:35). Finally, there are no other young people in the
placement at any time as the carers are reimbursed to a level that aims to enable care-giving to be directed towards one high-risk adolescent on a full-time basis.

The term conduct disorder is a diagnostic classification found in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV), which is the international standard reference for mental health professionals for deciding upon diagnostic classifications pertinent to their clients/patients.

Briefly, the DSM-IV defines conduct disorder as ‘a repetitive and persistent pattern of behaviour in which the basic rights of others or major age-appropriate societal norms or rules are violated’ (American Psychiatric Association, 1994:85). According to DSM-IV, the criteria for a diagnosis of conduct disorder fall into four main groupings – ‘aggressive conduct that causes or threatens physical harm to other people or animals, non-aggressive conduct that causes property loss or damage, deceitfulness or theft and serious violations of rules’ (American Psychiatric Association, 1994:85). The diagnostic criteria for conduct disorder in DSM-IV also allow the severity of the disorder to be specified as mild, moderate or severe. Severe conduct disorder is defined as ‘many conduct problems in excess of those required to make the diagnosis or conduct problems that cause considerable harm to others’ (American Psychiatric Association, 1994:91).

1.3 Research Hypotheses

My thesis aims to address three hypotheses in relation to adolescents placed in out-of-home care with a diagnosis of severe conduct disorder. These are:
1) Adolescents in out-of-home care diagnosed with severe conduct disorder have poor treatment outcomes.

2) Adolescents in out-of-home care diagnosed with severe conduct disorder are a particularly difficult client group to work with because of issues of attachment.

3) The diagnosis of severe conduct disorder negatively impacts upon the work professionals undertake with adolescents in out-of-home care diagnosed with conduct disorder.

These three research hypotheses naturally ignite a number of other related ‘lines of enquiry’ in relation to the research topic. For instance, if adolescents diagnosed with severe conduct disorder have poor intervention outcomes, how might these outcomes differ from those for adolescents in out-of-home care without a diagnosis of conduct disorder or severe conduct disorder? What is the current range of interventions chosen to work with adolescents diagnosed with severe conduct disorder in out-of-home care and how are they working/not working? Who makes decisions regarding working with this client group and what is the rationale for them?

Secondly, if issues of attachment make it particularly difficult to work with this group of young people, what other explanations might there be in terms of understanding why this area of practice is so difficult? Indeed, are there explanations or ways of understanding that implicate broader societal and/or structural issues? Thirdly, if the diagnosis of severe conduct disorder negatively impacts upon the work professionals undertake with adolescents in out-of-home care, how useful/helpful or relevant is a diagnosis? Clearly undergirding these questions are even more fundamental and searching questions relating to the epistemology and ontology of mental health/illness and the ways in which claims to knowledge and truth are established within particular historical periods.
The thesis, then, will seek to explore quite concrete concerns relating to the chosen field of practice as well as broader issues that may in fact lend further understanding and insight to these concerns.

1.4 Background to the Research

For many years now, working with adolescents diagnosed with conduct disorder and/or severe conduct disorder has been considered an extremely difficult task, with treatment outcomes in the Welfare, Mental Health and Juvenile Justice literature being reported as generally poor (Day, 1994; Hemphill, 1996; Leventhal et al, 2000; Penzerro et al, 1995; Shamsie et al, 1994). A treatment called multi-systemic therapy (MST) has been regarded by some as offering hope. MST is a treatment approach based in systems and social ecology theory and is a multi-modal approach to working with anti-social behaviour in children and adolescents who are at risk of out-of-home placement (Henggeler et al, 1998, 2002). It is a family-based, preventative model and emphasises working within and between the systems in which young people are embedded. These include family, peer, school and neighbourhood/community contexts. A range of individual, family and systemic therapies are utilised and intervention is intensive, home-based and generally of three to five months duration (Henggeler et al, 2002).

However, even recent reviews that praise MST as a particularly encouraging intervention still express caution and significant concerns regarding its real positive and practical impact in the lives of young people beyond a reduction of ‘symptoms’ such as re-arrest rates or periods spent incarcerated (Kazdin, 2002:72-80). Furthermore, Morton et al (1999:124) explain that:
Both within Australia and overseas there is a dearth of adequate research, data or analysis directly addressing service provision to young people with a history of severe abuse. The treatment literature has been clustered around particular problem behaviours such as drug abuse, violence, suicide and self-harm with relatively few programs addressing these problem behaviours in the context of understandings of attachment, trauma and emotional disturbance resulting from severe abuse in childhood.

For instance, Henggeler’s much lauded MST consistently describes its ‘participants’ in outcome studies as clustered around the particular problem behaviours of violent or chronic juvenile offending who are at risk of out-of-home placement due to their serious criminal involvement/activity (Henggeler et al, 1993:286-287, 1997a:002). Further, Henggeler (1993:283) can speak of family preservation in these outcome studies because presumably there has been an absence or minimal amount of neglect or abuse perpetrated against the young person by their parents or primary caregivers. Indeed, it is possible to draw such a conclusion as the United States Child Protection system has been based on the same key principles as those in Victoria since the passing of the US Adoption and Safe Families Act (1997). This legislation similarly enshrined ‘the best interests and safety of the child’ as the primary imperative rather than family preservation (Delfabbro, 2003). Therefore one might reasonably conclude that if family preservation is being stated as an eminently desirable and achievable goal that the impact of any neglect or abuse has been far from severe.

This suggests to me that the adolescents who are engaged in serious and chronic offending in Henggeler’s MST outcome studies are in fact a different and distinct population with significantly different needs than those adolescents engaged in serious and chronic offending who have been placed in out-of-home care. Therefore, it is my contention that we cannot simply
import an intervention such as MST from working with adolescents who are serious offenders and who meet criteria for a diagnosis of severe conduct disorder residing at home; to working with the same group of adolescents who are classified as ‘high-risk’ and who reside in out-of-home care in residential units or specialised 1:1 home based placements. To do so is to seek to address ‘anti-social’ behaviour simplistically without an adequate acknowledgment of the constellation of issues present for an adolescent diagnosed with severe conduct disorder in out-of-home care. In particular, as Morton et al (1999:124) suggest, issues of attachment.

Therefore, I have believed for some time that the area of working with adolescents placed in out-of-home care diagnosed with severe conduct disorder is an extremely important and crucial area of practice requiring a more thorough investigation than has hitherto occurred. In stark contrast to the unfettered optimism displayed by the author and clinician Scott Henggeler in his 1996 publication titled ‘Treatment of Violent Juvenile Offenders: We Have the Knowledge’, I’ve had quite contrary experiences in working with adolescents diagnosed with severe conduct disorder in out-of-home care. I might swiftly add that my comparatively sober experiences have been when working with clients who have been exposed to an ‘ecological treatment model’ highly similar to that advocated by Henggeler (1996:137), namely MST. Indeed, Burke et al (2002:1283) state ‘Conduct Disorder has long been regarded as relatively intractable and resistant to treatment interventions. Findings from the past 10 years suggest no giant leaps in treatment’.

Over the past six years, I have worked with many high-risk adolescents in out-of-home care with severe emotional and behavioural disturbance – and severe conduct disorder is indeed found within this client group. Moreover, I have worked within the framework of the ‘best (evidence-based) practice’ models of the day as endorsed by the Department of Human Services (DHS) Child Protection, Juvenile Justice and Mental Health branches as well as Community Service...
Organisations. These models of intervention have included the multi-sectoral/ ‘wraparound’ services approach championed and jointly endorsed by the abovementioned service providers in the DHS (2000) document ‘The Working Together Strategy (WTS)’. The ‘wraparound’ approach has its theoretical basis in social learning theory, social-ecological theory and systems theory. It is defined by Burchard et al (2002:69) as ‘a definable planning process that results in a unique set of community services and natural supports that are individualized for a child and family to achieve a positive set of outcomes’. The idea is to ‘wrap’ an individualised blend of formal services and informal community and family supports around the child, young person and/or family in an unconditional, flexible manner and for as long as is needed. There is also a strong emphasis on a team-driven process with all members of the wraparound supports working together collaboratively and innovatively. Henggeler’s MST has also been advocated as a highly promising intervention for the past several years in the out-of-home care system in metropolitan Melbourne.

In addition, models of intervention regionally endorsed in Victoria and implemented by contracted CSOs have included an attachment/relationship based approach to providing case management and residential care to high-risk adolescents (Salvation Army Eastcare, 2002). Another approach has been a behavioural-based approach to providing case management and residential care to high-risk adolescents, also recently promoted with renewed vigour by the Youth Horizon’s Trust Program for young people with severe conduct disorder (Harris et al, 2002; Wesley Youth Services, 2004). Finally, various CSOs within metropolitan regions in Victoria have implemented one-to-one home based care also sometimes referred to as enhanced adolescent community placement (EACP) or therapeutic home based care (THBC). This model of intervention was also strongly endorsed in the review When Care is Not Enough (Morton et al, 1999:68-69). Cowie et al (2002:1) proudly proclaim ‘1:1 Home Based Care – It Works!’ in a
My own experience and anecdotal evidence from the experiences of colleagues working with adolescents placed in the out-of-home care system diagnosed with severe conduct disorder and classified as ‘high-risk’, is that mostly poor outcomes have been consistently observed. These outcomes include minimal hope for the future having been created in either the young person or people working with them. This is not to suggest that there have not been positive and edifying aspects to that young person’s time in out-of-home care but many key areas remain largely unchanged. Judy Cashmore, speaking at the second Practice Symposium of the Child and Family Welfare Association of Australia (CAFWAA), highlighted the type of problematic outcomes my colleagues and I have observed predominating in adolescents in out-of-home care diagnosed with severe conduct disorder. Cashmore (2003:7) describes ‘difficulty with trusting relationships; poor educational achievement; unemployment and dependence on income support; criminal justice involvement; homelessness, mobility; poor self-esteem and early/teenage parenting’.

This somewhat sobering assessment was echoed by the then Associate Professor of Social work Dorothy Scott (2003:1), University of Melbourne, during her opening address to the second Practice Symposium of CAFWAA: ‘We gather together in the knowledge that the child welfare systems in our country are failing. To move forward we need not just a shared vision. We need to be visionaries’.

Indeed, they are certainly failing the most disadvantaged found within the out-of-home care system – high-risk adolescents diagnosed with severe conduct disorder. This is why I have felt
compelled to undertake the investigation and research that will be presented to you in the following chapters.

1.5 Further Overview of the Thesis

In Chapter 2, I explore some of the basic ontological and epistemological issues and debates relevant to mental health. This will involve a discussion regarding the necessary differentiation between cause and correlate when discussing issues of mental illness/health. A comprehensive account of the history of conceptualisations about mental illness/health will also be provided. Foucault’s *The Archaeology of Knowledge* (1989a) will be substantially drawn upon to examine the historically variable and discontinuous conceptualisations of mental health. By extension, the contested nature of what becomes established knowledge will also be explored.

Following on from this analysis, I support the view that understandings gleaned from competing ontologies and epistemologies can be usefully considered in the examination and explanation of phenomena such as mental illness. In respect of mental illness, this view is also expressed by Gergen (2001) and Hacking (1999). In particular, that positivism and social constructionism can both offer insights into the nature of mental illness. The adoption of this philosophical position allows for an end to what is often referred to as the ‘science wars’ - the maintenance of a binary intellectual environment in which positivists or constructionists take turns at adopting an entrenched, dogmatic and symbiotic posture of critique. Gergen (2001:53) states that such a posture aims ‘to eradicate the evil or wrong-headedness of the other’s position’.

Chapter 3 will specifically examine conceptualisations of severe conduct disorder grounded in a positivist, empirical understanding as well as through the lens of critical theory that points to the
socially constructed dimensions of notions of mental illness. The emphasis here will be the
development and articulation of a ‘conceptual toolbox’ for understanding severe conduct disorder
rather than the establishment of rigid theoretical frameworks that disqualify other ‘lenses’ by
which understanding and insight may be gleaned. The main theoretical framework to be
investigated from a bio-psychological perspective will be that of attachment theory. Attachment
was first conceptualised as a human need by psychiatrist and psychoanalyst John Bowlby
(Holmes, 1993:1-10).

Attachment theory asserts that early and repeated experiences with the people who cared for us
set a foundation for our internal working models of relationships with self and others (Bowlby,
1969). In this way, our earliest experiences have a profound effect on how we approach
relationships, school, work and play (Colin, 1996:7-9). Numerous studies, literature sources and
reports have argued that a strong relationship exists between severe conduct disorder and
profound attachment difficulties (Moretti et al, 1994; Morton et al, 1999; Penzerro et al, 1995;
Sholevar, 1995).

Critical theory will then be utilised to examine the historical, sociological and political
dimensions of the major ‘constructs’ inherent in the thesis topic – mental illness/health and
criminality (particularly as they both relate to youth/adolescents). Pease et al (2003:2) explain
that the use of the term critical theory ‘does not designate a unified theoretical perspective. It is a
term that embraces a variety of different theoretical positions’.

Macey (2000:74) usefully describes critical theory as ‘a whole range of theories which take a
critical view of society and the human sciences or which seek to explain the emergence of their
objects of knowledge’. However, Kincheloe et al (2000) elucidate that it is possible to identify a
number of common basic assumptions among and between critical schools of thought. These commonalities include ‘that all thought is fundamentally mediated by power relations that are social and historically constituted; that facts can never be isolated from the domain of values or removed from some form of ideological inscription’ (Kincheloe et al, 2000 :291).

Pease et al (2003:2) also assert that the common intent of critical theory is to identify and explain sources of oppression in society such as hegemonic societal institutions and attendant dominant/dominating ideologies. They point out that such emancipatory education seeks to critically and practically address the impact on people’s lives of these institutions and ideologies (Pease et al, 2003:2). Martin (2003b) explains that there has been a long-standing association between critical theory and mental illness and deviance. This association, which most notably arose in the 1960s and 1970s, was fostered by many writers who offered a forceful critique of bio-medical definitions of mental illness, pathology and deviance (Foucault, 1989a, 1989b, 2002; Laing, 1961, 1965; Szasz, 1961, 1963).

In terms of examining the two major constructs of the thesis topic- mental health and criminality – Martin (2003b:155) asserts that critical theory is of central importance as it allows significant insight regarding the key questions ‘Who is deemed “mad” or “bad”, by whom and on what basis?’. Critical theory will therefore be utilised to explore notions of psychiatric diagnosis, criminality and anti-social behaviour in the context of adolescence/youth.

In Chapter 4, I will detail the research methodologies and methods chosen as well as the decision-making processes involved in their selection. Limitations of my research will also be acknowledged and examined. In particular, I will be arguing the validity and usefulness of intrastudy eclecticism in research that combines competing paradigms and perspectives within a
particular study (Becker, 1993; Feyerabend, 1975, 1978, 1987; Feyerabend et al, 1999; Geelan, 2002). Indeed, I chose to utilise both qualitative and quantitative methods in the research process, these obviously being derived from fundamentally different epistemological traditions. Another apparent source of philosophical tension is that given critical theory is one of the main theoretical frameworks referred to in my thesis and literature review, the later use of surveys by questionnaire and the presentation of the quantitative data they produce may appear to be problematic.

However, rather than become paralysed with the epistemological dimensions of methodologies and methods, Becker (1993) argues that such lofty concerns should mainly preoccupy those given to speculate on such matters within social science – specialised methodologists and philosophers within academia. Becker (1993) states that while research practitioners ‘in the field’ need to have a clear position in relation to their choice of methodologies and methods, such considerations should not be allowed to impede everyday research activity. Indeed, renowned social worker, academic and critical theorist Janis Fook (2000:2) states:

A rigid, or even loose, commitment to one type of perspective, be it positivist, qualitative or deconstructive, does not seem to provide the flexibility of thinking needed to work in changing circumstances. I have long ago given up the idea that debates between different paradigms are the way to yield better practice and research. For one thing, I would argue that all perspectives and methods require critical examination.

Having addressed philosophical and paradigmatic concerns as well as having detailed the nuts and bolts of my research work, Chapter 5 will describe the research findings yielded from my interviews and questionnaires. Research respondents were ten senior practitioners and managers
heavily involved in working with adolescents diagnosed with severe conduct disorder in out-of-home care. These research participants were of varying professional/disciplinary backgrounds and were sourced from across Child Protection, Mental Health, Juvenile Justice and Community Service sectors in metropolitan Melbourne. The information and reflections they provided will be presented employing thematic analysis.

Chapter 6 contains a discussion and analysis of my research findings. I found that my respondents provided many insightful and sometimes provocative reflections. Indeed, one respondent who is a senior practitioner and manager within Juvenile Justice (JJ) described adolescents diagnosed with severe conduct disorder in out-of-home care as ‘the ten percent’ of young people on statutory orders for whom the conventionally successful interventions such as MST do not appear to work. Another respondent, a senior practitioner and manager within Child Protection, stated that ‘nothing seems to work’ with adolescents diagnosed with severe conduct disorder in out-of-home care. This respondent also stated ‘some of them are very difficult to like when they’re spitting on you and threatening to thump you’.

Overall in Chapter 6, I will argue that existing interventions are generally ineffective in contributing to substantial and life-altering outcomes for young people diagnosed with severe conduct disorder in out-of-home care. This view was strongly reflected among my group of respondents who were senior practitioners and managers spanning the Child Protection, adolescent Mental Health and Juvenile Justice sectors.

Finally, Chapter 7 will contain conclusions and consequent recommendations that will address both research and practice gaps that I perceive in working with adolescents diagnosed with severe conduct disorder in out-of-home care. Overall, I will be asserting the need for a liberated
conceptualisation of working with this group of young people by adopting non-binary positions of understanding. By this I mean that phenomena such as mental illness/health and ‘anti-social’ behaviour be conceived of in ways that equally weight and pay attention to both biopsychological and societal dimensions.

Currently, when discussing issues such as delinquency or mental illness, there are unfortunately only two basic schools of thought that forever remain mutually hostile to each other. Proponents of a predisposition argument will invariably attribute organic-psychiatric factors only or dip their lid in a token manner towards ‘social’ factors (even then, this is largely only referring to inter-personal environments rather than societal or socially constructed factors). In a similarly exclusive fashion, advocates of an occasioning/contextual argument will attribute structural inequalities, discursive practices and other themes relating to powerlessness as pre-eminent and largely dismiss bio-psychological explanations. However, I believe that the issues relating to adolescents diagnosed with severe conduct disorder in out-of-home care in fact meet at the intersection of these two positions.

In practice then, this would mean that within mental health and criminal justice settings, health service professionals could and would conduct case presentations, reviews and assessments that mentioned and explored contributing factors on intra-personal, inter-personal and societal levels. Indeed, throughout this thesis, I will seek to demonstrate that adolescents diagnosed with severe conduct disorder in out-of-home care are in fact fundamentally and crucially alienated in respect of all three of these dimensions/levels – concurrently not selectively.
Furthermore, that none of the existing models of intervention are especially effective or helpful to the specific group of young people being discussed as they do not adequately account for or seek to address, all three dimensions in a holistic manner.
Chapter Two

Ontological and Epistemological Issues in Mental Health

- Where have we been and where are we going?

Truth is a river that is always splitting up into arms that reunite. Islanded between the arms, the inhabitants argue for a lifetime as to which is the main river.

- Palinurus (Cyril Connolly pseudonym)

2.1 Setting the Scene

The ontology and epistemology of mental illness/health has a rich and controversial history. It seems impossible to adequately examine specific mental illnesses or mental health issues, without prefacing such an examination with a consideration of the philosophical context in which they are conceptualised.

At the outset, it is important to highlight that philosophical debate surrounding mental illness is riddled with confusion between the epistemology of mental disorder and the ontology of mental disorder. Generally, the method of enquiry adopted in examining the nature of mental illness, such as biological or sociological/social constructionist, infers or implies an ontological position when all that has been established is perhaps a helpful epistemological standpoint. Indeed, Seidel (1998:v) states that ‘a particular method of enquiry does not determine the essence of what is being studied’. To date, neither biologically based nor sociological approaches have yielded single cause or pre-eminent explanations of mental illness/disorder.
Indeed, well known Australian psychiatrists Maurice Sainsbury and Leonard Lambeth (1988) agree that it is not possible to attribute mental illness to any single cause. Furthermore, they contend that the age-old debate of nature vs environment has not been decisively resolved in favour of one over the other but rather that there are ‘elements of truth in the stance of most movements’ (Sainsbury et al, 1988:16). They continue ‘We and our patients undoubtedly wish things were simple and easily explained, which could both tend to make us accept some simple and spurious dogma about causation and our patients to demand a single cause for their present emotional state’ (Sainsbury et al, 1988:121).

When considering ontology and mental illness, the familiar adage of chicken and egg - which comes first - may well be employed. For instance, particular neuro-chemical and heritable qualities have been correlated with particular mental illnesses and experiences such as trauma or abuse (Galvin et al, 1991; Maier et al, 1994; Perry et al, 1995; Post, 1992; Solomon et al, 2003). Yet it is equally true that a vast range of environmental and sociological correlates have been identified as well (Epstein et al, 2001a; Sawyer et al, 2000). For example, severe conduct disorder has been purported by some writers/clinicians to have its genesis in neuro-chemistry and neuro-anatomy (Ishikawa et al, 2003; Nigg et al, 2003; Perry, 1997) or heritable qualities such as temperament (Krueger et al, 1994; Lahey et al, 2003). In addition, there exists an equally vast array of literature that posit sociological correlates as central to the onset and maintenance of violent and ‘deviant’ behaviour such as severe conduct disorder (Anleu, 1999: 19-44; Howard et al, 1999: 33-35; McCaghy et al, 2000: 90-118; Muncie, 2004; Siegel, 2002: 78-105).

However, as Seidel (1998) asserts, it is vital not to confuse correlation with cause. In other words, if a particular neuro-chemical pattern corresponds to a particular mental illness, yet a set of
particular life experiences and social conditions do too, then which correlate may be deemed as ‘cause’ – did the neuro-chemical profile produce a certain set of behaviours and experiences or did the life experiences produce a particular neuro-chemical ‘mix’? It seems to me that it is unlikely that questions like these could ever be answered dogmatically. Indeed, Grob (1991:430) states ‘Perhaps the only constant is the process of change itself. The search for a definitive nosology, therefore, may simply be an expression of the perennial human yearning for omniscience - an attribute eagerly sought by many but never yet found’.

Therefore, I concur wholeheartedly with Seidel (1998), who argues that in all matters ontological and epistemological regarding the phenomena of mental health/illness, we must resist at every turn the temptation to be dogmatic or binary in our conceptualisations. Rather, we must in fact turn the ontological back into the epistemological, unmasking \textit{a priori} conceptualisations that are not capable of being clearly demonstrated as ontology but in fact, simply represent an epistemological position from which enquiry and examination may proceed.

\section*{2.2 Foucault and Historical Enquiry}

Indeed, the task of turning the ontological back into the epistemological was an approach strongly advocated and expanded upon, by critical philosopher and theorist Michel Foucault (Deacon, 2000; Foucault, 1989). Foucault’s \textit{Archaeology of Knowledge} (1989a: 36-37, 44-53) proposed archaeological research as a mode/method of historical and epistemological enquiry that examined neither meaning nor truth per se, but the historically contingent set of conditions or environment in which a particular truth or meaning arose. Foucault’s (1989a: 142-144) archaeology aimed to uncover/recover the historical \textit{a priori} or conditions of possibility and
existence within a particular period. Chambon (1999:54) describes this process of uncovering/recovering as ‘making the familiar visible’.

In other words, Foucault aims to critically identify and name the underlying - yet unstated - set of ontological presumptions that inform intellectual debate. Foucault described the habit of forming these underlying yet unstated presumptions as the positive unconscious of science – ‘that which makes scientific thought possible’ (in Jahoda, 1972:100). Therefore, this positive unconscious of science may be seen as ‘the grids of specification’ which define the space within which the sciences formulate their substantive work (Foucault, 1989a:46-47). This is the grid required for any sort of comment or debate to proceed regarding any given phenomena. Importantly, Foucault’s work does not take issue with the pre-existence of a given ontology or epistemology within debate, but rather the historical practice of not naming or clearly stating the existence of this pre-existing paradigm. Foucault regarded this lack of clear declaration as mischievous at best, since it would generally be practiced by those with power and would serve not only to rule in certain viewpoints as valid, but also serve to rule out certain viewpoints as invalid or irrelevant.

Foucault, therefore, not only critically sought to address dominant paradigms and discourses within a given historical period, but his genealogy of knowledge elucidated two other separate bodies of knowledge. These are referred to in Shawyer (1999:3) as ‘First, the dissenting opinions and theories that did not become established and widely recognised and, second, the local beliefs and understandings (think of what nurses know about medicine that does not achieve power and general recognition)’.
For instance, if a clinical neuro-psychologist is discussing a neuro-anatomical basis/cause for severe conduct disorder, s/he is not required to preface this dissertation with an acknowledgement of the underlying ontology or epistemology in operation - empiricism / logical positivism / neurology. Rather, this remains unstated and therefore not open to conjecture. Neither would she be required to preface the dissertation with any acknowledgment of alternative ontologies and epistemologies of mental illness – these are subtly yet powerfully ruled out and do not require any entertaining. Danaher et al (2000:17) explain the subtle and insidious nature of the operation of unstated yet presumed ontological and epistemological positions by referring to Certeau (1986:183):

Certeau explains why it is difficult for us to be aware of or question the grounds of our episteme by referring to cartoons where a character (say Felix the Cat or Wiley Coyote) is walking on thin air: as long as they don’t notice that there is nothing beneath them, they are fine -they keep going- however, as soon as they become aware that they aren’t on firm ground(s), they fall into the void.

By recasting traditional Enlightenment notions of the relationship between truth and knowledge, Foucault (1989a:55-59) challenged two of the most fundamental and unquestioned concepts of our time – the idea that truth could be identified in a disinterested way and, relatedly, that knowledge was something that was independent of power. Foucault (1989a:193) also challenged foundational views of history that typically start from the past and demonstrate the progressive evolution of a field of knowledge and its accomplishments over time. Danaher et al (2000:19) explain that this writing of history resembles the notion of paradigm shifts developed by American philosopher Thomas Kuhn:
This posits that scientific reason develops in a more or less linear progression, with each paradigm ‘discovering’ things that the previous, less developed paradigm couldn’t understand. In other words, Kuhn suggested that scientific shifts were like building blocks - you built on what was available (on those scientific truths that were already known), and added any new truths to the existing body of knowledge.

However, in contrast, Foucault (1989a:193) did not see a linear and progressive development from the Renaissance to the Modern age - just examples of sameness and difference, continuities and discontinuities. This challenges the view that current dominant ontologies and epistemologies of mental health are (simply) expressions of the progressive triumph of ‘true/truer’ accounts of the nature of mental health/illness over inferior, ‘less true/untrue’ accounts. In contrast, Foucault (1989a:143) argues that truth and knowledge, like everything else, have a history. Therefore, with the assistance of a Foucauldian lens, we may come to see that the truth and knowledge produced by dominant disciplines and discourses such as medicine and psychiatry or social science and sociology, are the result of power struggles in which they have triumphed over other disciplines and forms of knowledge. Indeed, Danaher et al (2000:27) state:

Nietzsche once suggested that where there is meaning, it is possible to trace the struggles, battles and violence that produced it. Part of the tactics of such struggles is to claim a universal and eternal truth for your discipline and knowledge…To do that, you have to demonstrate, or argue for, the connections between your discipline and its antecedents.

This means that from a Foucauldian perspective, knowledge is never ahistorical or neutral but always contested and the result of power struggles between differing discourses, within the episteme of a given historical period. Indeed, if we examine historical and current debates
regarding the ontology and epistemology of mental health/illness or severe conduct disorder, we can readily see that these debates are heavily influenced by the episteme operating at the time.

2.3 Epistemes and their Uses

Jahoda (1972:100) explains that by episteme Foucault means ‘the tacit assumptions underlying the effort to establish order among phenomena’. It is the product of certain organising principles that, as a result, determine how we make sense of things, what we can know and what we can say (Foucault, 1989a:211). An episteme is therefore ‘not in itself a form or body of knowledge, it is a structure defining the conditions that both make knowledge possible and restrict its scope’ (Macey, 2000:113). Foucault identified and assigned particular epistemes as corresponding to particular historical periods. For Foucault, there are three major epistemes which have operated over the last four hundred years – the Renaissance, the Classical and the Modern (in Danaher et al, 2000:19-20).

Up until the end of the sixteenth century, the episteme in operation is often termed the ‘Order of Divine Resemblances’ (Danaher et al, 2000:19). In this period, the central desire was to discover the God-ordained order and essence of everything (nature, people’s behaviour, buildings etc.) – the truth about/of God. The world was viewed ‘as a kind of book that God had written’ and to be interpreted in terms of a divine code which had to be deciphered (Danaher et al, 2000:19).

Indeed, Foucault termed the Renaissance as the age of resemblances because ‘the idea was that everything resembled (echoed or imitated) something else and that it was only through God’s code that all these resemblances could be fitted together, deciphered and made to make sense’ (in Danaher et al, 2000:19).
Therefore, the task of science and human endeavour was to establish similarity and to identify the qualities inherent in objects which make them alike. Although this episteme was still strongly imbued with the theology and spirituality of earlier centuries, it did support the notion of studying particular objects and then drawing conclusions about their essential qualities. To this extent, the Renaissance and its episteme of divine resemblances were the harbinger of future epistemes that would increasingly emphasise the classification and categorisation of particular objects and phenomena.

Indeed, the episteme of the Classical Age – seventeenth and eighteenth centuries – focused more on the truth about Nature and the order of things. Macey (2000:19) describes the episteme of this period in the following manner: ‘characterized or governed by a combination of mathesis (a general mathematical science of order), taxonomia (a more empirical form of classification) and genetic analysis’.

During this time, there was a growth and increasing prominence in scientific approaches and the world came to be understood in terms of natural order – ideas of order, measurement, identity and difference (Foucault, 1989a:175). It was therefore believed that understanding and knowledge would be increased through careful observation and identification. In this way, analysis and taxonomies were eminently possible and different objects or phenomena could be understood ‘through the use of tables of measurement…people began to understand and articulate things by pulling them out of their isolation, comparing one thing with another, and then arranging them in a table from the simplest to the most complex’ (Danaher et al, 2000:19-20).

From the end of the eighteenth century and beginning of the nineteenth century, the episteme of the Modern and its privileging of scientific rationality became powerfully entrenched via the Age
of Reason/Enlightenment movement and this episteme is still the dominant/dominating worldview today. This is despite the increasing influence of post-modern epistemology and thought during the twentieth and twenty-first centuries that fundamentally rejects the grand narratives of reason, progress and the Enlightenment (Jahoda, 1972:100; Macey, 2000:307). The central project within this episteme is to pursue truth which will emanate from Man (sic), with the order of things not being traced back to God or Nature, but to Man – ‘now man (sic) is responsible for knowledge’ (Danaher et al, 2000:20). Indeed, the hallmarks of this episteme are the establishment of a social order based on reason, the universality of rationality and progress, the infinite perfectability of humanity and the promise that humanity will be liberated by rational and scientific knowledge (Macey, 2000:111).

Foucault’s historical account of how the fundamental nature of knowledge, reality and ‘truth’ were re-defined and reconceptualised during certain periods in history according to the prevailing episteme of the day; makes us aware of the ‘shifting sands’ of ontology and epistemology. Indeed, I will now provide a brief historical overview of how these ‘shifting sands’ have effected definitions of mental health/illness over time.

2.4 Exploring Historical Conceptualisations of Mental Illness

2.4.1 Some Limitations

References to and ideas of, mental illness occur in both Eastern and Western civilisations from the earliest recorded times (Sainsbury et al, 1988:1). The following account of the development of these ideas is generally within a Western European context. This is not to venerate a Western perspective over other alternative accounts. Interestingly, considerably less if anything is written
about alternative historical accounts of how ideas about mental illness have developed, from a non-Western perspective. In particular, some indigenous and tribal cultures that record history largely through oral means may never have their unique perspectives on mental illness/health/well-being made widely known. However, I choose a mostly Western European context for historical examination as the nature and length of this thesis does not provide for an all-encompassing, truly global historical examination. Nonetheless, I wish to acknowledge such an absence as a limitation of the following discussion.

2.4.2 Prehistoric Period

The literature generally begins its account of ideas about mental illness in ancient times. Little appears to be known or written in terms of the Prehistoric period, however Mora (1985) explains that the concept of mental illness at that time was very mythical and supernatural. It was universally believed that mental illness was a supernatural phenomenon and that it represented a breakdown of the magical-religious system. The mentally ill were thought to have violated a taboo, neglected ritual obligations and/or become demon possessed. It was considered that people who simply couldn’t behave in ways that others expected were mentally ill. Treatment of those considered mentally ill was mostly carried out by shaman.

2.4.3 Ancient Times

During ancient times, a biological explanation of mental illness became the dominant paradigm, but the supernatural perspective still had many adherents (Gallagher, 2002). Later in this period, aetiologies emerged emphasising environmental factors. In approximately 700 BC, the physician-priest Alcmaeon argued that mental illness was caused by an illness of the brain (Martin, 1990).
Hippocrates (460-355 BC) also advocated a biological explanation of mental illness and his theory became the predominant one for this period of history (Martin, 1990). Hippocrates believed that mental illness was caused by an imbalance of the four bodily humours. Another proponent of a biological cause of mental illness in this period was Aristotle (384-322 BC), who believed that problems with the heart led to mental illness (Davison et al, 1997). Cicero (106-43 BC) propounded a biological perspective in that he believed that mental illness was caused by heritable personality types/temperaments (Mora, 1985). He focused particularly on anxiety-prone personalities and believed that ‘excessive perturbation might give rise to diseases of the soul’ (Mora, 1985:2035). Cicero maintained that the health of the soul depended on the proper harmony of the rational, irrational and lustful parts of the soul. Anetaeus (AD 30-90) appears to have been the first person to identify patterns of symptoms for specific illnesses (Martin, 1990).

Plato (429-347 BC) supported a supernatural cause of mental illness (Mora, 1985). He argued that there were four kinds of madness, each correlating to a form of spiritual possession (Martin, 1990). Two forms of possession were by good spirits – prophetic and poetic madness - and two by evil spirits – erotic and ritual madness. The biological explanation of mental illness was also rejected by Asclepides, who emphasised environmental factors (Martin, 1990).

2.4.4 Middle Ages

The Middle Ages saw a reversion back to the supernatural perspective as being the dominant paradigm for explaining mental illness, with the biological perspective diminished in its influence although still noteworthy for this period (Sainsbury et al, 1988). The environmental model of causation promoted earlier by Asclepides was of no significance at all in public debate throughout this period. The mentally ill were rarely seen as people who were sick and priests took
a principal role in the treatment of sufferers. In Arabic countries, many Muslims believed that the insane person was loved and particularly chosen by God to tell the truth.

Albert the Great (1193-1280) and Thomas Aquinas (1225-1274) stressed the unity of body and mind and the biological foundation of psychology (Mora, 1985). Their main theory of mental illness was the notion that the soul could not become sick, therefore, insanity was primarily a somatic disturbance. Interestingly, even ‘pathological’ character traits such as arrogance and impulsiveness were characterised as somatic elements. However, although this ‘body-mind’ theory appeared ostensibly to be advocating a biological position regarding the cause of mental illness, it remained in fact steeped in a supernatural understanding. This is because the somatic disturbances were in fact thought to be triggered by astrological influences on the psyche and/or by the evil power of demons.

Perhaps the only ‘pure’ biological explanation of mental illness with some influence in the Middle Ages was propounded by Constantinus Africanus (1020-1087) - the founder of the world’s first medical school in Salerno (Mora, 1985). Africanus attempted to advance the earlier theories of Hippocrates regarding mental illness and so furthered the view that mental illness was cause by imbalances in the body. Specifically, Africanus attributed an excess of bile to the onset of melancholia. A biological explanation of mental illness in this era was also promoted by the beginnings of notions of localized functions in the brain.

2.4.5 Renaissance Period

Moving into the Renaissance period, the supernatural explanation of mental illness acquired new levels of ascendance. The nexus of Church/State in Western Europe meant that alternative
paradigms were largely drowned out amid cries for the mentally ill to be tortured, punished and/or killed. The mentally ill were thought to be demon possessed, and in the case of numerous women, demon-possessed witches to be burnt at the stake (Davison et al, 1997). Two types of demon possession were distinguished – a person was unwillingly possessed by the devil as punishment for sinning or a person willingly entered into a pact with the devil (Rothman, 1970). The second group were defined as witches possessing supernatural powers, however the distinction between the two types of possession was often blurred and the ‘unwillingly’ possessed were often persecuted and killed along with the ‘willingly’ possessed.

In the seventeenth century the prominent Puritan minister in colonial Massachusetts, Cotton Maher (1663-1728), articulated the zeitgeist in his early writings on medicine and madness – ‘There is an unaccountable and inexpressible interest of Satan often times in the distemper of madness’ (quoted in Gamwell et al, 1995). Earlier, in the sixteenth century, the beginnings of a profound shift in treatment of the mentally ill was articulated by German-Dutch physician Johann Weyer (1515-1588) who called for more humane approaches to be implemented (Gamwell et al, 1995).

As in all periods of history, even while one particular paradigm of mental illness was dominant, there were, at the same time, competing explanations of the cause of mental illness. In 1602, Swiss physician Felix Platter (1536-1614) published the first medical textbook dealing with psychiatry and included classification of mental disease (Mora, 1985). Although Platter supported a theory of organic humoral causation, he did not rule out the devil as an aetiological factor. A more robust biological explanation of mental illness was advocated by German philosopher Gockel (1547-1628) who first used the term ‘psychology’ and emphasised the body-mind relationship. Gockel stated that bodily organs mediated between passions and body humours
Significantly, Richard Burton (1577-1640) resurrected Asclepides’ long discarded theory of causation, emphasising social/environmental factors. Burton combined these factors with psychological causes of mental illness and described key causal factors as being solitude, poverty, jealousy, fear, unrequited love and excessive religiosity (Gallagher, 2002).

The eighteenth century gradually ushered in many profound and lasting changes to the conceptualisation of mental illness and the treatment of people considered to be ‘mentally ill’. The dominant paradigm of mental illness in this century was biological, and supernatural explanations of mental illness were soon forcefully discarded (Gallagher, 2002). The eighteenth century, then, built upon the rise of modern science in the seventeenth century in its preference for scientific and rational ways of understanding the world. Unsurprisingly, in the early part of the century, shifts in thinking included a wholesale rejection of witchcraft as reflecting mental illness and the simultaneous adoption and development of many of the biological theories and ideas advanced during previous periods (Gamwell et al, 1995).

As the ‘demonisation’ of people considered mentally ill ceased, so too did the previously common practices of torturing and killing them. However, this cessation did not lead to more humane treatments straight away. Rather, the mentally ill were chained and incarcerated in jails (Gallagher, 2002). From the middle of the eighteenth century, the mentally ill became increasingly treated in hospitals/public asylums rather than being detained in jails. Again, this shift in treatment did not automatically bring humane treatment methods. Patients were sometimes characterised by staff as animals rather than rational beings and there was considerable conjecture as to whether treatment had any potential value or whether mental ailments were incurable (Mora, 1985). However, due to the combined increasing influence of the moral treatment movement and medical scientists from the mid-eighteenth century to mid-
nineteenth century, hospital treatment became increasingly humane and punitive approaches were seen to be anti-therapeutic (Sainsbury et al, 1988: 2-3).

In 1794, Vincenzo Chiarugi (1759-1820) published his ‘Medical Treatise’ on insanity and divided mental illness into melancholia, mania and amentia (Mora, 1985). Chiarugi also articulated the prevailing attitude towards the mentally ill when he stated that it was both a supreme moral duty and medical obligation to treat the mentally ill. French psychiatrist Phillipe Pinel (1745-1826) also made attempts to categorise symptoms of mental illness and described four types of insanity – melancholia (disturbance in intellectual functioning), mania (excessive nervous excitement, with or without delirium), dementia (disturbance in thought processes) and idiocy (obliteration of intellectual faculties and affects) (Mora, 1985). Benjamin Rush, considered by some as the father of American psychiatry, attributed mental illness to the blood vessels of the brain (Davison et al, 1997). Franz Gall (1758-1828), a Viennese brain physiologist, championed the rise of phrenology and claimed to have localised specific organs - 27 in the human brain - to which corresponded particular protuberances of the external cranial surface (Gallagher, 2002).

We can see then, that as more and more effort was devoted to establishing a biological cause of mental illness, an increasing variety of medical/psychiatric specialisations arose. Up to now, these specialisations can be seen to basically cluster around biological theories of temperamental predisposition, bodily humoral composition and balance, neurology and phrenology.

2.4.6 The Birth of Modernism

Throughout the eighteenth century then, the Enlightenment belief that progress would best be achieved through scientific study conferred increasing influence and authority to medicine as a
scientific practice (Epstein et al, 2001a:4-5). Following the birth of Modernism at the end of the eighteenth century/beginning of the nineteenth century, Western European societies developed an increasing understanding and array of professional and technical specialisations to more systematically advance the ideas of the earlier intellectual movement known as the Enlightenment. While the Enlightenment and birth of Modernism expressed themselves in a variety of ways according to national character and local conditions, it is certainly possible to point out the general trends and developments throughout the West at that time. Indeed, Epstein et al (2001a) explain that the impetus towards psychiatry, as a branch of medicine, devising specialist treatment for the mentally ill reached new heights by the end of the eighteenth century. At that time and heading into the nineteenth century, mental illness was finally authoritatively ‘captured’ by the medical profession (Epstein et al, 2001a:4).

For Foucault, this ‘capturing’ was aided and abetted by the specific socio-political conditions of the time. It is significant to note, that from the end of the eighteenth century and into the nineteenth century, the Industrial Revolution led to ever-increasing urbanisation and concentration of populations in and around cities that had previously been more widely dispersed (Epstein et al, 2001a:4). For Foucault (2002:136-137), this was the period in which ‘social medicine’ was born as the capitalist system required that medicine be increasingly brought into the collective, social sphere from the private. From a Foucauldian perspective, this shift was a strategic one as those with power in the formation of the modern State grappled increasingly with how to control, regulate and monitor mass populations (Foucault, 2002:134-156). Foucault argues that this desire for increasingly sophisticated methods of control and surveillance was reflected in the three stages of the formation of social medicine throughout Western Europe – state medicine, urban medicine and labor force medicine (Foucault, 2002:137).
Foucault (2002:137) states that ‘the body is a biopolitical reality and medicine is a biopolitical strategy’. Foucault (2002: 183) described how from the beginning of the nineteenth century, then, people’s physical and mental health became increasingly medicalised and that psychiatry gradually established itself as a medical specialisation – ‘previously it had been an aspect rather than a field of medicine’. Foucault (2002:179) argues that psychiatry also achieved its status as a discrete field of medicine via its entry and intervention in the field of law, especially between 1800 and 1835. In this period, Foucault (2002:179) states that the ‘psychiatrization’ of criminal danger and behaviour occurred, increasing the profile and ‘need’ of psychiatry and its specialised brand of medical intervention. In sum, Foucault (2002:184) states ‘Nineteenth-century psychiatry was a medical science as much for the societal body as for the individual soul’.

In the nineteenth century then, the medical model of mental illness and a biological ontology and epistemology of mental health consolidated itself. It was dominant right up until the end of the century when a psychological model of mental illness was articulated with more clarity than ever before with the beginnings of Freudian psychoanalysis (Martin, 1990). In the first half of the nineteenth century in Germany, psychiatry divided itself into two schools - the psychiker and the somatiker – i.e. between those propounding a mainly psychological cause of mental illness and those maintaining a more rigid biological/somatic disease model (Mora, 1985). However, biological accounts certainly held sway and Wilhelm Griesinger proposed that mental illnesses were brain diseases caused by abnormal quantitative variations in physiological states (Mora, 1985).

Later in the nineteenth century, the most influential theory of mental illness in history emerged from the nosological work of Emile Kraeplin (1855-1926). His classification system became the basis of the later American Diagnostic and Statistical Manual of Mental Disorders (DSM) and so
the conceptual structures established by Kraeplin persist, largely unchanged, to the present (Epstein et al, 2001a:5). Specifically, Kraeplin’s classification system for mental illnesses established a clear distinction between psychosis and neurosis (Mora, 1985). While psychosis was deemed to be fundamentally an organic, biological disease, neurosis came to be viewed as representing a more psychological illness. However, whilst the trend was increasingly for people with mental illness to receive treatment from particular doctors specialising in a branch of psychiatry (e.g. neurologists), scientific medical practice had not yet developed a specialisation for mental illness regarded as basically intra-psychic/psychological in nature. Therefore, the scene was set for the emergence of Freudian psychoanalysis at the turn of the century.

2.4.7 Twentieth Century

The twentieth century saw an unprecedented rate and variety of development in ontologies and epistemologies of mental illness. Not only this, but the pre-eminence of particular paradigms changed often, sometimes being significantly diminished in their standing and importance only to re-emerge more vigorously than ever at a later date. The contested nature of this knowledge development clearly reflected the historical patterns at play thus far.

In the twentieth century, up until the 1970s, the psychological model of mental illness was, overall, the most influential and dominant, however the biological model retained significance often overlapping with a biological approach to form a bio-psychological / body-mind perspective. This complementarity between the paradigms exists because both are operating from a science-practitioner model that is deeply rooted in the philosophical tradition of empiricism and positivism (Epstein et al, 2001a:5). Particularly during the 1960s and at different times subsequent to then, the sociological ontology and epistemology of mental illness has been of
some influence within mainstream mental health (Epstein et al, 2001a:5-6). While remaining fundamentally marginal compared with biological and psychological models, the more established paradigms in mental health and their powerful proponents have conceded some level of importance to sociological perspectives. This concession has given rise to what is now known as the biopsychosocial model of mental illness.

However, the social component can be quite tokenistic, often vaguely referring to inter-personal or ‘environmental’ factors without ever really adequately acknowledging the broader structural dimensions in society relating to mental illness that require lasting change. Driven by technological developments in genetics and neuroscience, the biological model of illness once again became dominant from the 1970s and remains so today, as we shall later examine.

Interestingly, at the turn of the twentieth century, the ontology and epistemology of mental illness held by Asclepides in 100 BC re-emerged and was further developed, emphasising environmental, social and cultural factors (Grobb, 1966). Historically, it is relatively easy to understand how this occurred, as the beginning of the twentieth century was a time of even more rapid industrial and technological change as well as urbanisation (Gallagher, 2002).

Also early in the twentieth century, Sigmund Freud (1856-1939) formerly established the school of psychoanalysis in Vienna. Building on the work of Joseph Breuer (1842-1925) regarding repressed traumatic material in the unconscious mind, Freud elucidated the linkage between psychological processes and mental illness (Davison et al, 1997). In this quasi-disease model of psychic determinism, notions of fixation and regression are believed to cause neurotic and psychotic symptoms (Steiner, 2004). Psychological forces are viewed as causing mental disturbance ‘within the unaware, unconscious mind, and conflicts at this level produce
disturbance in the aware self’ (Epstein et al, 2001a:5). Psychoanalysis, then, became established as a theory of personality development as well a means of treating mental disorders (Gallagher, 2002).

In 1908, Eugen Bleuler (1898-1927) coined the term schizophrenia and posited a biological cause for this particular mental illness (Shorter, 1997). Bleuler’s work was based on the earlier Kraepelinian medical model of classification of mental illnesses. Following the ascendancy of psychoanalysis and its fundamentally psychological conception of mental illness, the experimental science of psychology developed a range of perspectives that purported to explain mental illness – also from a psychological perspective (Epstein et al, 2001a:5). Perhaps the most influential of these has been behaviourism, which was mainly developed through the work of Pavlov and his work on conditioned responses as well as Skinner’s operant conditioning (Epstein et al, 2001a:5). Steiner (2004:33) describes behaviourism as a ‘black box, environmentalist, continuous trait model’. The essence of behaviourism is that people may form maladaptive behaviours and even develop mental illness based on environmental exposure to inappropriate behaviours and responses to situations (Reber, 1985: 86-87). People may then internalise these behavioural practices and they then become ‘learned’ behaviours that are repeated whenever certain stimuli are present. Therefore, treatment includes the replacement of maladaptive behaviours with appropriate/adaptive responses. This is achieved to a large extent by positive reinforcement of newly acquired adaptive behaviours whenever they are present and the corresponding negative reinforcement of the old, learned behaviours that are maladaptive and therefore maintain the person’s pathology.

A highly influential offshoot of behaviourism is cognitive behaviourism, developed by Beck (Reber, 1985:130). This approach retains the importance of learned behaviours yet places more of
an emphasis on the cognitive structures and thinking patterns that underpin such behaviours (Reber, 1985:86-87). As such, treatment is also focused on the adjustment and/or replacement of entrenched, ‘automatic’ ways of responding to stimuli, yet focuses on the replacement of maladaptive thinking patterns rather than maladaptive behaviours. It is thought that the acquiring of new, adaptive cognitive responses to familiar stimuli will correspondingly lead to the performance of new adaptive behaviours.

Another psychological theory of mental illness is derived from humanistic psychology, often referred to as the third force in psychology after psychoanalysis and behaviourism (Reber, 1985:330). Largely the creation of Albert Maslow, the emphasis here is that the development of mental illness or pathology is basically attributable to a lack of fulfilment of basic human needs and strivings, which are seen to be universal and common to all humankind. It is when these needs and strivings remain frustrated and unfulfilled for long periods of time that problems in a person’s psychological makeup may develop (Reber, 1985:330).

During the first half of the twentieth century, the mentally ill were predominantly treated within large hospital settings and were subjected to an authoritarian regime of patient management and a so-called authority-submission formula operated (Sainsbury et al, 1988:3). Within this framework, repressive controls such as locked doors, restraints, segregation of the sexes, heavy sedation, electro convulsive therapy (ECT), prolonged sleep and lobotomy were used (Sainsbury et al, 1988:3). Sainsbury et al (1988:3) explain that these treatments were often used punitively on patients as they were threatened with them ‘if they did anything to disturb the peace or the tidiness of the ward’. This encouraged patients to become maximally dependent and to lose their sense of initiative and responsibility – the end result was termed institutionalisation by D.V. Martin in 1955 (Sainsbury et al, 1988:3).
2.4.8 The 1960s and Anti-Psychiatry

The dominant ideological, moral, social and political settings then, could be considered as highly conducive to the emergence of the anti-psychiatry movement, most notably in the 1960’s – a time of much challenging of established/establishment ideology, morality and politics. The anti-psychiatry movement, the wider intellectual environment of the time and a number of ethnographic studies all played important roles in advancing a sociological ontology and epistemology of mental illness.

The key figures in the anti-psychiatry movement were Erving Goffman (sociologist, United States), Thomas Szasz (psychiatrist, United States) and R.D. Laing (psychiatrist, Britain). In the 1960s and 1970s, Goffman conducted a number of highly influential ethnographic studies involving ‘simulated’ patients. These important ethnographic studies (particularly those conducted by Goffman and Rosenhan) challenged psychiatry’s practice of diagnosis and notions of mental illness. The volunteers for the studies ‘expressed limited psychiatric symptomatology, but often successfully secured hospital admission’ (Epstein et al, 2001a:6). Following admission, the volunteers found that by virtue of their status as patients, ‘their subsequent relatively normal behaviour was often described as pathological by the observing staff’ (Epstein et al, 2001a:6).

Studies like these contributed to the further development of labelling theory and ideas about deviance amplification, as well as calling into question the notion of mental illness itself - i.e. was it merely a socially constructed phenomenon rather than a biological/organic reality.
These ethnographic studies therefore highlighted the ways in which social structures may ‘pre-
script’ particular social roles and the power of labelling operates ‘to circumscribe the
interpretation of behaviour’ (Epstein et al, 2001a:6).

Meanwhile, anti-psychiatry sentiments also emerged from within psychiatry itself. Szasz
(2001:115) coined the term pharmacracy to describe the dominance of the medical model of
mental illness and stated ‘The term “mental illness” is a semantic strategy for medicalising
economic, moral, personal, political and social problems’. Laing echoed these sentiments,
believing that notions of mental illness and deviance were (socially) constructed as a means of
practicing social control and regulating those who otherwise could/would not be regulated
(Epstein et al, 2001a:6). Hence, psychiatry itself was viewed as an actor in the perpetuation of
oppression, within the wider oppressive structure of capitalism. Epstein et al (2001a:6) state:
‘Such analyses provided armaments for challenges to the authority of the medical model in
understanding disease and mental illness’.

In the 1970s, other social movements also challenged the medical model of mental illness. The
feminist movement began to challenge dominant views of mental illness – ‘that women’s mental
distress refers to the effect of the material, social and political constraints of their lives under the
oppressive conditions of patriarchy’ (Epstein et al, 2001a:6).

The anti-psychiatry movement and the development of a range of new sociological theories
steeped in social constructionism importantly influenced the numerous reforms to the care and
treatment of the mentally ill over the following decades. These included the development of
therapeutic communities, de-institutionalisation and increase in community-based services.
However, the medical movement and its biological ontology and epistemology would ‘hit back
hard’ from the 1970s until the present, re-medicalising mental health and forcefully reclaiming the aetiological ground it had lost from both the psychological and sociological models of causation.

2.4.9 The Present Landscape

Biological theories have become dominant once again as developments in genetics and neuroscience have led to claims of identifying physical causes of mental health problems.

In 1989, United States President George Bush (Senior) declared the 1990s to be ‘the Decade of the Brain’ (Seidel, 1998:2). In 1992, the journal *Scientific American* contended that a powerful and exciting surge in biological research was going to increase our understanding about effective medical treatment of brain dysfunction (Seidel, 1998:2). This newly reinvigorated biological reductionism was spurred along by a number of technological advancements in medical research. These included the advancement of techniques such as positron emission tomography (PET), nuclear magnetic resonance imaging (NMR) and an increased capacity to identify DNA loci through genetic linkage analysis. Leahey (1997:110) clearly depicts the stealth of the re-emergent biological ontology and epistemology of mental disorder:

In this decade of the brain, we are learning how the brain’s machinery works, down to the biophysics of single cells. Struggling to oust magical, occult powers from matter,

Descartes set in motion the reduction of mental functions to mechanical processes that is only now coming to fruition.

Steiner (2004:33) describes the changes in the way we think about mental health and its causes over the last few decades as ‘monumental’ and embracing of the combination of a typologically
based disease model and a neuroscience driven reductionism. Indeed, changes to recent editions of the Diagnostic and Statistical Manual of Mental Disorders (DSM) have re-asserted the biological ontology, emphasising the ‘disease’ conceptualisation of mental problems (Albee, 2002). At the same time, these recent editions have de-emphasised psychological and social factors when compared with previous editions (Albee, 2002).

This ontological and epistemological environment has led to numerous studies aiming to confirm neuro-chemical, anatomical and genetic causes of mental disorder. Indeed, several studies have been undertaken to establish a bio-chemical basis for conduct disorder. These include the assertion that low levels of serum dopamine-hydroxylase (DBH) leads to the onset of an anti-social personality and the use of lithium treatment for young males causes them to display ‘anti-social’ behaviour (Galvin et al, 1991, 1995; Rifkin et al, 1997).

A great deal of the biological research into mental illness has been funded by large trans-national pharmaceutical companies, who clearly have a vested interest in advancing a biological explanation of mental illness (Seidel, 1998). In addition to funding numerous research studies, these companies have vast amounts of wealth to promote any findings that may boost sales. This promotional activity occurs via professional journals, the mass media and the sponsoring and/or organisation of various ‘conferences’ that serve to actively ‘court’ prescribing psychiatrists and paediatricians. The immense power and influence of these companies is perhaps difficult to estimate.

Pincus et al (1998) detail that in the United States between 1985 and 1994, the number of visits to psychiatrists in which psychotropic medication was prescribed almost doubled from the previous decade – from 7.77 million to 15.09 million. Also, the number of visits to psychiatrists in which
antidepressant drugs were prescribed increased from an average of 4.09 visits per week to 11.04 visits per week (Pincus et al, 1998). These trends were also noted in the same decade in terms of visits by children to psychiatrists and paediatricians. The number of these visits in which psychotropic medication was prescribed more than tripled (Pincus et al, 1998).

At times seemingly in concert with the pharmaceutical companies, the mass media also consistently support biological views of mental illness over other conceptualisations (Seidel, 1998). Indeed, many of the educational and advertising programs concerning mental health that appear in the media are sponsored by the pharmaceutical industry and clearly represent their interests. When referring to a person’s mental health issues, the electronic and print media will invariably refer to ‘mental illness’ with the overt implication that mental distress is essentially biological in origin (APS, 2003). Also, magazine and newspaper articles as well as news stories on television will usually report the latest pharmaceutical research into ‘mental illness’ in a tone that is dramatic, clear and highly persuasive (Breggin, 1991; Breggin et al 1994; Seidel, 1998). In this way, studies which often have equivocal and/or tentative results in primary sources, are reported as conclusive and authoritative (Breggin, 1991; Breggin et al 1994; Seidel, 1998).

In the United States, many health insurers insist that all patients must have a DSM-IV diagnosis to receive reimbursement (Albee, 2002). One health insurer, United Health Care, has previously tried to deny reimbursement to psychiatrists if they do not prescribe medications in the treatment of specific disorders (Norfleet, 2002). The American National Alliance for the Mentally Ill (NAMI) captures the tone of the health insurers when it refers to the existence of mental health problems as ‘no-fault’ biological brain disorders (Seidel, 1998). Unsurprisingly, the National Alliance for the Mentally Ill (NAMI) is sponsored by over a dozen of the largest pharmaceutical companies (Seidel, 1998).
Interestingly, pharmaceutical companies such as Eli Lilly & Co. deflect any criticism of their uncomplicated and uncompromising promotion of a biological model of mental disorder by describing such criticisms as anti-psychiatry, misleading, inaccurate and self-serving (Eli Lilly & Co., 1995; Seidel, 1998). The powerful nexus and mutually beneficial relationship between psychiatry and the pharmaceutical industry is perhaps well illustrated by Eli Lilly & Co’s statement that members of groups criticising the company ‘view psychiatry and psychiatric medicines as competition for their costly self-help programs’ (Eli Lilly & Co., 1995).

2.5 Lessons from History

In sum then, the dominant ontology and epistemology of mental illness at the moment is a biological one. However, when considering historical conceptualisations of mental illness, it can be seen that the dominant views have changed regularly. This suggests that issues of mental illness are indeed multi-faceted and comprise many varying complexities that contribute to a whole understanding. The diversity of ontological and epistemological positions regarding mental illness call into question notions of a definitive and/or singular perspective as being a useful or even relevant means of understanding mental health / illness. This is supported by the Foucauldian reading of history that is non-linear and not based on a scientific rationalist perspective that asserts the progressive triumph of superior ‘truths’ over the preceding inferior versions. Rather, conceptualisations of mental illness have been historical, contested and varied, with different perspectives gaining pre-eminence at different times.

Indeed, historically situated epistemes and a priori conceptualisations have always been highly influential in structuring the ongoing, possibly eternal, debate regarding the ontology and
epistemology of mental illness. As I have discussed, correlation (epistemology) has generally
been confused with cause (ontology) and this ‘confusion’ has arguably
not always been by accident! Rather, Foucault helps us to understand that the practice of
epistemology conferring ontology in mental health research and debate, has been part of a
repetitious set of processes that involve power, ‘truth games’ and the enacting of contested
knowledge – complete with winners and losers. Therefore, we can begin to clearly understand
that dominant ontologies and epistemologies of mental health/illness do not become so simply
because of their inherently greater ‘rightness’ and truthfulness over other perspectives. Rather,
pre-eminence is established because of a set of intricate social and political processes that are
deeply rooted in the existence and exercise of power.

However, I do not advocate a reactionary approach to such processes whereby dominant
ontologies and epistemologies are rejected on the basis of their dominant position and power per
se. This would be to (paradoxically) adopt an uncritical approach that does not recognise the
helpful knowledge and understandings that the dominant position may well have to contribute.
The corollary of this reactionary stance is to venerate one’s own alternative position as inherently
more ‘right(eous)’ and virtuous, often (ironically) regarding other perspectives as irrelevant or of
little importance. The reactionary response within philosophical and intellectual debate –
regardless of what is actually being debated – sets up binary environments in which particular
ways of understanding become subsumed by demands for philosophical correctness.

2.5.1 Critique as Symbiotic

Gergen (2001) describes this phenomenon as the limits of pure (puritanical) critique. He asserts
that pure critique is fundamentally symbiotic in nature. This is because its terms of engagement
are established from the preceding ontology to which it is responding. In this way, pure critique becomes driven by a critical negation of the preceding view. Assertion and advocacy are its focus. Gergen (2001:46) describes it thus – ‘If the assertion is that “armed intervention is necessary,” critique is limited to a linguistic domain in which the binary “war-not war” serves as the pivotal defining agent’. Hence, a critical negation of a preceding view reduces the number of relevant voices to about two. This structures a debate in such a way that any voice outside of the established binary becomes marginalised and/or made irrelevant. This intellectual environment fosters a successor discourse in which the totalising discourse is obliterated only to be replaced with another. This particular form of critique can ultimately only bring a ‘closure of conversation’ and is annihilationistic in its purpose (Gergen, 2001:46, 53).

Within mental health, ontological and epistemological debates tend to be characterised by this dogmatic approach. Generally, literature concerning mental illness will reflect the dominance of a bio-psychological position or that of a sociological/social constructionist position. For instance, Smith (2004:83) states:

…the psychiatry profession has polarised the debate about the nature of psychiatric illness by pursuing a medical model with vigour, creating a classification of psychiatric illness or disorder more precise than those of many physical disorders, yet lacking the most valid of all justifications, known causality.

Also, practising psychiatrist David Kaiser (1996) describes psychiatry as a particular branch of hegemony that has been relentless and uncompromising in its assertion that mental illness is fundamentally biological in origin. Kaiser (1996:2) goes on to state ‘although they admit a role
for environmental and social factors, these are usually relegated to a secondary status. Their unquestioning confidence in their biologic paradigms of mental illness is truly staggering’.

One recent example of literature written from a medical model perspective that venerates a bio-psychological explanation of mental illness is the executive summary of the report *Patterns and Precursors of Adolescent Antisocial Behaviour* from the Australian Temperament Project (2002). As the title suggests, this summary is clearly written from a bio-psychological perspective as it stresses the importance of early intervention for what they call dysfunctional families to prevent the development of individual characteristics in children that will predispose to adolescent delinquency (Australian Temperament Project, 2002). Socio-demographic factors are given only the briefest reference and certainly no significant importance is placed upon them.

However, those writing about mental illness from a sociological/social constructionist perspective are often drawn from left-leanin post-modernists such as Hil et al (2004) who frequently fail to apply the same standards of deconstruction to their own work as they do to their philosophical rivals. Within debate about mental health, these rivals are of course the empiricist, positivist scientists who claim superior medical rigour in drawing their conclusions. Rosenau (1992:176) asserts ‘post-modernists sometimes fail to examine their own assumptions or follow their own advice. They also fail to apply their well-honed critical capacities to their own intellectual production…Self-deconstruction is seldom on the post-modern agenda’.

A recent example of this form of critique is the journal article by Hil et al (2004) that analyses the conceptual, theoretical and methodological dimensions of the abovementioned executive summary of the Report from the Australian Temperament Project *Patterns and Precursors of Adolescent Antisocial Behaviour* (2002). The authors lament the failure of any social
constructionist account of adolescent anti-social behaviour and summarily dismiss the conceptual validity of the Report (Hil et al, 2004:27-28; 30). Indeed, characteristically, this critical response stridently challenges the epistemological assumptions in the Report, yet fails to apply any of the same rigour to itself. And so, the Mexican stand-off is maintained.

2.5.2 Ending the ‘Science Wars’

The binary intellectual environment in which debate about the ontology and epistemology of mental illness occurs is part of a broader phenomenon sometimes described as the ‘science wars’ (Gergen, 2001; Hacking, 1998, 1999). These ‘wars’ have occurred as natural/positivist science and social science, respectively, adopt ontological and epistemological positions in an entrenched, unyielding and uncomplicated manner. Gergen (2001:53) describes this approach as demonstrating the ‘tendencies toward totalitarianism within the critical exchange’. In terms of the ongoing debate about the nature of mental illness/health, therefore, a banal and predictable debate has eventuated where mental illness is defined as being essentially one or the other – biopsychological or socially constructed (Gergen, 2001; Hacking, 1998; 1999).

2.6 Concluding comments

Debates about the nature of mental health need to leave room for multiple voices and perspectives. Indeed, returning to one of the themes of this chapter, causes of mental illness have never been ‘proven’ and it is unlikely this will ever occur. Rather, correlates appear to have been established. These correlates are both bio-psychological in nature as well as sociological. A healthy environment for ongoing critical and rigorous debate is one in which the range of relevant
voices are not limited, but preserved. Indeed, regarding mental health, it is important to acknowledge a plurality of aetiologies and understandings that will likely all have something valuable to contribute in the understanding of mental health/illness. This is not to suggest that all perspectives will all be relevant, all of the time. It may be that particular ontologies and epistemologies are drawn upon for a particular purpose or at a particular point in time. The key is never to dismiss outright, any position *prima facie*. This is likely to lead to the adoption of a dogmatic position that will ultimately limit understanding rather than enhance it.

In devoting this chapter to the consideration of ontology and epistemology in mental health, I have sought to establish the conceptual space within which the rest of my thesis is situated. This is particularly so in the next chapter, where the conceptualisation of severe conduct disorder in adolescents takes place from two very different paradigms of mental illness. These paradigms will be bio-psychological and sociological. Within these broad paradigms, attachment theory and critical theory respectively are used to aid my conceptualisation of severe conduct disorder.

I will also outline in more detail, the philosophical and theoretical model in which I believe it is possible to hold in tension, normally ‘opposing’ aetiologies and epistemologies. Later in the thesis, it will also become apparent that the ontological and epistemological debates regarding the nature of mental illness are not merely academic or removed from the coalface. Rather, I believe these debates have important and serious implications for mental health practitioners, in that they help shape and define the context for direct practice.

This is due to the fact that the outcomes of aetiological and epistemological debates largely determine ‘treatment’ programs and therefore funding allocations. So, for adolescents diagnosed with severe conduct disorder in out-of-home care, the types of services they receive will be
significantly influenced by what people (‘experts’) believe causes or triggers their ‘mad’ and/or ‘bad’ behaviour. If we adopt a position that acknowledges a range of ontologies and epistemologies, we are likely to open up a more diverse and creative approach to the provision of services and interventions. This means that what initially may appear to be distracting or indulgent discussions about the nature of mental illness actually have real and lasting consequences. In the context of this thesis, these consequences are significant for practitioners and even more significant in respect of powerless and highly disadvantaged young people.
Chapter Three

Conceptualisations of Conduct Disorder

- The Abandonment of Rigidity

Is warfare - either subterranean or overt - the answer? Are we thrust again into postures of annihilation?

- Kenneth Gergen

3.1 Liberating Conceptual Space

Prior to utilising the specific conceptual tools by which severe conduct disorder in adolescents can be usefully understood, the broad conceptual space that is helpful to examine notions of mental illness will be re-visited. In doing so, the philosophical and theoretical terms of engagement that I have outlined in the previous chapter will be briefly expanded upon.

These terms of engagement are based on the central premise that the production, development and propagation of knowledge is in fact a contested process. As Foucault’s (1989a:49-53) Archaeology of Knowledge suggests, at any given point in Western European history, there exists more than one ‘knowledge’ for a given object of knowledge in the human sciences. The particular knowledge that prevails as dominant within a period, therefore, does so not on the basis of its inherent superiority, but its exercise of power in producing truth claims that override other accounts. This exercise of power is well supported when the contingent set of historical conditions necessary for a particular episteme to prevail, are present (Foucault, 1989a:44-53).

This account of the historicity of knowledge and truth alerts us to be cautious and perhaps even
sceptical of adopting unilateral or universal theoretical postures when examining particular phenomena.

A tendency to philosophical or paradigmatic correctness is also cautioned against by Gergen (2001), who describes the often symbiotic nature of critique in intellectual debate. This form of critique merely produces a successor discourse of winners and losers in which binary oppositions are maintained and ‘the intelligibility of the new alternative is established in terms of the opposition’s demise’ (Gergen, 2001:53). This intellectual environment has produced what is commonly referred to as the ‘science wars’ (Hacking, 1999:3-4). This is when natural science and social science in its social constructionist form, adopt entrenched, dogmatic and mutually hostile philosophical positions.

With particular reference to conceptualisations of mental illness, both Gergen (2001) and Hacking (1999) cogently argue for a conceptual and research space within which both bio-psychological and social constructionist perspectives might be permitted. Such a space will be occupied in this chapter and also later in the thesis. Indeed, the specific conceptual tools with which conceptualisations of conduct disorder will be examined are drawn from ‘competing’ paradigms, as mentioned in my introductory chapter. This approach reflects the complex and inter-woven set of dynamics extant in the case of adolescent conduct disorder. These dynamics are bio-psychological, familial, social/environmental and societal.

I deliberately use both the terms ‘social’ and ‘societal’ here as the term ‘social’ has many shades of meaning depending on the historical, philosophical, theoretical and disciplinary context in which it is being used. Indeed, Reber (1985:704) asserts that the term ‘social’ is a ‘splendidly broad adjective which can safely be used for any situation involving two or more conspecifics.
(members of a species)’. Fook (1993) and Martin (2003a) detail that the term ‘social’ can be deployed according to its more conservative meaning which is to describe a person’s social milieu or immediate social environment. Alternatively, a critical theorist and social worker would utilise the term ‘social’ to highlight an awareness of the broader political, ideological, economic and discursive forces that impact on individuals. This latter use of the term ‘social’ then, is clearly beyond the scope of its more traditional use and indeed its appearance in texts such as the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) and other bio-psychological literature. In this context then, I use ‘social’ to refer to a person’s immediate social environment that is essentially inter-personal and localised to their immediate social environment or network. My use of the term ‘societal’ then, refers to those abovementioned broader conditions and forces that impact on a person’s life.

However, while the conservative use of the term ‘social’ looks at the macro (only) to the extent that it is a reflection of the micro, progressive perspectives potentially minimise the immediate and intra-personal factors. In defence of critical theory, one might cite the mantra of radical feminism and later structural social work in the 1970s and 1980s – ‘the personal is political’ (Fook, 1993:15). However, while this phrase alerts us to the importance of analysing both micro and macro dimensions of human experience, it ultimately discounts the importance of intra-personal processes. In a sense, the phrase ‘the personal is political’ reflects an approach that looks at the micro to the extent that it is a reflection of the macro. While a person’s individual psychological and emotional state is linked to broader socio-political factors, it is inadequate to simply address these states with only a socio-political ‘lens’ - yet, it also requires this ‘lens’ to yield a proper understanding.
Indeed, I believe the disciplined eclecticism and dialectical approach to explaining phenomena as supported by Feyerabend (1974, 1988), Geelan (2002), Gergen (2001) and Hacking (1999), can best advance understanding. Given that a dialectical interaction between bio-psychological and social constructionist perspectives in conceptualising conduct disorder ensues, the following discussion of research in education by Geelan (2002:12) appears helpful:

One example of the power of a dialectical approach to understanding is to think about the contributions to education of the disciplines of psychology and sociology. It is of little value to decide that psychology’s emphasis on the cognition of an individual student is ‘wrong’, and that sociology’s focus on the social relations within the classroom is ‘right’, or vice versa. Neither is it particularly valuable to try to subsume both perspectives into a single one – richness and complexity that may be crucial to a productive framing of the problem would be lost. Instead, by first looking at a particular educational problem through the ‘lens’ (to use an almost clichéd metaphor) provided by psychology – the effects and influences and perspectives of the individual - and then looking at the same problem (although it cannot be exactly the same problem) through the ‘lens’ of sociology, a richer blend of description is available than through either discipline alone.

Geelan (2002:12) further explains that to think dialectically is to:

…metaphorically put on the ‘spectacles’ provided by one theoretical perspective, learn what can be learned of the situations, contexts and events which are of interest, then remove those spectacles and replace them with a different pair (in some ways, the more different the better), and see how the view changes - what is visible now that was hidden before, and vice versa?
Adolescents in out-of-home care presenting with severe conduct disorder are fundamentally and crucially alienated on intra-personal, inter-personal and societal levels. Given the complexity of these dynamics, it is essential that operating theoretical perspectives are those that are known to be particularly useful in elucidating upon particular dimensions. For instance, in relation to conduct disorder, a bio-psychological ‘lens’ is helpful in understanding bio-psychological processes at intra-personal and interpersonal levels, whereas a social constructionist ‘lens’ is helpful in elucidating upon societal factors in the person’s lived experience.

This approach seems to correlate with that put forward by Hacking (1999) regarding understanding mental illness. The main tenets of his argument and model for understanding mental illness are as follows. Firstly, he seeks to end simplistic arguments about whether or not a mental illness is ‘real’ or ‘socially constructed’. Indeed, Hacking (1999:108-109) contends that psychopathologies furnish ‘obvious candidates’ for phenomena that may in fact be both. In speaking of something as socially constructed, Hacking (1999:68,111) believes it is important to identify the ‘grade’ of social construction we wish to assert. In particular, clearly delineating whether we are asserting that X per se is socially constructed, or whether ideas about X are socially constructed.

Furthermore, Hacking (1999: 116) argues that social construction is not a ‘one-way street’ in which society constructs a mental disorder that either does not exist as described or would not exist at all unless it were described. Instead, Hacking (1999) proposes that there is a looping effect between a classification and the person/s classified. It is proposed that once a particular classification is made and becomes known to the (self-aware) people classified, this can cause changes in the way these individuals behave, ‘and loops back to force changes in the
classifications and knowledge about them’ (Hacking, 1999:105). Applying this to conceptualisations of mental illness, Hacking (1999) defines this process as classificatory looping that is of an interactive kind.

However, as stated earlier, Hacking (1999) also wishes to leave conceptual and research space for natural science/positivist approaches to understanding mental illness. This is achieved by also explaining the looping effect that can occur between changes in our mind/thinking and our physiological/physical condition. Hacking (1999) describes this type of looping effect as bio-looping that is of an indifferent kind. It is indifferent in that bio-looping can continue to occur with or without / independent of, (socially constructed) classificatory looping. In simple terms, if a person was not particularly aware of the classification that had been applied to them, the looping effect between their mental state and physiological/physical state would continue regardless.

Hacking (1999:110) contends that with particular examples of mental illness, both types of looping can be in operation and in fact mutually reinforce each other. So, here we have a conceptual position that holds that mental illness can be both an indifferent and interactive kind. This makes room for bio-psychological and socially constructed conceptualisations of mental illness, respectively. This is described as a predisposing/occasioning model of mental illness where the predisposing cause may be bio-psychological - indifferent, while the occasioning cause may be social - interactive (Hacking, 1999:119).

This model of mental illness and its capacity to look through different ‘lenses’ at different times to see different things, is of great benefit in exploring adolescent conduct disorder. This is because I believe adolescent conduct disorder crucially consists of distinct bio-psychological as
well as socially constructed dimensions. To use Hacking’s terms, both bio-looping and classificatory looping, respectively. In order to explain issues related to bio-looping, attachment theory is employed to assist in understanding the particular bio-psychological processes that appear to be at work in conduct disorder. Critical theory and non-positivist sociological approaches follow and explore the socially constructed dimensions of adolescent conduct disorder. These constructs include notions of adolescence, criminality/delinquency and mental illness.

In exploring both bio-psychological and socially constructed dimensions, my intention is to resist adopting mutually exclusive, dualistic philosophical positions that rigidly claim a causal rather than correlational relationship to mental illness. Howe et al (1999a:34) elucidate this approach well – ‘there is an increasingly strong belief that, instead of seeing nature and nurture, genes and environment, biology and culture as mutually exclusive influences on development, there is a complex, subtle interplay between the two’. The abandonment of aetiological rigidity is also supported by Plomin (1994) who argues that the emphasis in discussions about the biological and environmental dimensions of mental illness needs to be on their interaction. This emphasis on interaction is similar to Hacking’s discussion of looping - ‘with influences running both ways’ (Plomin, 1994:34).

3.2 Attachment Theory

3.2.1 Setting the Parameters

In examining the bio-looping dynamic of conduct disorder, I will describe how attachment theory accounts for its development in terms of both neurological and psychological processes as well as
how these two areas of process interact or ‘loop’ to reinforce each other. In doing so, I will not be
asserting the primacy of one process over the other.

Before exploring attachment theory in some detail, I wish to outline some parameters for this
discussion. Attachment theory has a long history, with the first writings appearing in the late
1930s and early 1940s, produced by its founder child psychiatrist John Bowlby (1938, 1939,
1940, 1944, 1945-46). While Bowlby continued to write about attachment theory into the late
1980s, a number of post-Bowlbians from the United States, Britain and Germany expanded upon
his writings and published extensively from the 1960s – 1980s and beyond (Ainsworth, 1967,
late 1980s until the present, many theorists, researchers and practitioners have published work
that assists in ‘contemporising’ attachment theory further, as well as increasing its application to
age groups beyond infancy and early childhood to later childhood, adolescence and adulthood
et al, 1999a, 1999b; Hughes, 1999, 2004; Marrone, 1998). In addition, there has been significant
feminist critique of attachment theory as well as critique from a cross-cultural perspective
(Badinter, 1981; Benjamin, 1988; Berry, 1992; Chodorow, 1978; Chodorow et al, 1982;

Attachment theory has also been expanded upon by the relatively new and emerging field of
interpersonal-neurobiology (Solomon et al, 2003). As the term implies, this area of study is not
biologically reductionist, for it seeks to explore the inter-relationship between life experiences
and the maturation of the brain and mind in influencing mental health and mental illness (Siegel
et al, 2003). This expansion of attachment theory into neurological science gained increased
momentum in the 1990s during what some have already described as ‘the Decade of the Brain’ (Seidel, 1998:2). During that decade and since, there have been many progressive advances in new technologies allowing for detailed examination of neural anatomy and circuitry in terms of its interaction with life experiences. These include positron emission tomography (PET), nuclear magnetic resonance imaging (NMR) and an increased capacity to identify DNA loci through genetic linkage analysis.

Hence, the field of attachment theory is indeed vast. Given the constraints of this thesis, I will mostly explore attachment theory to the extent that it is required to relate to the issue and people at hand – interventions with adolescents in out-of-home care diagnosed with severe conduct disorder. This means that my account of attachment theory and its varying critiques will not be exhaustive however I wish to acknowledge this directly. In addition, I have already addressed the potentially contentious issue of using attachment theory and critical theory within the same thesis from a philosophical, epistemological and ontological perspective (see Chapter 2 and also the beginning of this chapter). Firstly, I will examine attachment theory in terms of its psychological processes, before exploring its neurological workings.

3.2.2 Attachment – Psychological and Emotional Processes

Calvert et al (2001:28) assert that ‘Attachment in its broadest sense is consistently found to be the most significant factor in assessing long-term outcomes for children’. Indeed, the founder of attachment theory, John Bowlby, contended that attachment theory in psychiatry represented the equivalent of the study of immunology in medicine (Bowlby, 1969, 1973, 1980). In other words, that the attachment dynamics of any individual crucially impact on their very sense of integrity and security, as well as fundamentally shaping their vulnerability or otherwise to a wide range of
psychological, emotional and social difficulties (Holmes, 1993a:178). Bowlby published exhaustively regarding attachment theory, from the late 1930s until the late 1980s. However, the foundational texts for attachment theory are his ‘Attachment and Loss’ trilogy – Attachment (1969), Separation (1973) and Loss (1980). Attachment theory was itself influenced by several theoretical traditions including evolution theory, ethology, the object-relations tradition in psychoanalysis, cognitive science and systems theory (Guy, 2005; Howe et al, 1999a).

Bowlby (1969, 1973, 1980) asserted that in the process of evolution, humankind had developed a predisposition and drive to form attachments. Bowlby (1980:40) states:

Attachment behaviour has become a characteristic of many species during the course of their evolution because it contributes to the individual’s survival by keeping him [sic] in touch with his caregiver(s), thereby reducing the risk of his coming to harm, for example from cold, hunger or drowning and, in man’s environment of evolutionary adaptedness, especially from predators.

Bowlby advanced that this in-built drive toward forming and maintaining attachments is universal and initially expressed between children towards their primary caregivers and then continued throughout the lifespan to a range of individuals. This means that attachment theory applies to individuals throughout their life cycle and its application is not merely confined to the life stage of childhood – attachment behaviour characterises human beings from the cradle to the grave.

Bowlby (1969:371) defined attachment as being strongly disposed to seek proximity to and contact with, a specific figure/s and to do so in certain situations such as being frightened, tired or
ill. The establishment of attachment leads to the formation of enduring and strong affectional bonds to particular others. Attachment occurs within dyadic relationships and in this way is a two-person psychology; i.e. ‘attachment’ occurs within one two-person relationship ‘at a time’ (Bowlby, 1980:39). This means that it is possible for individuals to have different types of attachments with different people, depending on the particular relational context. For example, a child may have one type of attachment with their mother and yet another with their father (Bowlby, 1969:304-306). Bowlby was also keen to draw a distinction between attachment and attachment behaviour. Bowlby (1969:371) asserted that attachment is an innate propensity and state whereas attachment behaviour refers to any of the various forms of behaviour that a person commonly engages in to attain and/or maintain a desired proximity to some other differentiated or preferred individual. Bowlby also contended that the attachment behavioural system takes precedence over feeding and exploration. There is also an important distinction to be drawn between affiliative and attachment behaviour (Colin, 1996:169). Attachment behaviour is not in a constant state of activation but rather is activated only by certain conditions such as hunger, fatigue, illness, distress, strangeness, fear or unavailability or unresponsiveness of an attachment figure (Bowlby, 1980:40). Therefore, attachment behaviour is activated under certain conditions and when proximity to, contact with and availability of, the attachment figure is established, it is deactivated.

For instance, Colin (1996:169) provides an illustration from observable interactions between a human infant and a parental figure:

We cannot just count smiles or approaches or minutes of physical contact to determine whether an attachment bond exists. We must look at the behaviours in context and attend to the meaning of and motivation for the behaviours. Does the infant use the father as a
secure base, monitoring and maintaining proximity to him when they are away from home? When frightened, does the infant cry for the father or rush to him? Does contact with the father soothe the infant? Does the baby protest when the father leaves the house? These behaviours would indicate attachment.

While attachment theory relates to the entire lifespan, Bowlby (1969:204-205) propounded that the first three years of life were the most crucial in terms of humans forming and developing positive attachments. Hughes (1997:3) describes this initial period of life as the context for the psychological birth of each person, making a clear distinction from the earlier physical birth. The early attachment experiences of people are therefore viewed as being crucial to ‘the nature and quality of our physical, affective, behavioural and cognitive development’ (Hughes, 1997:3). Stern (1985) also asserts that it is during the first three years of life that a person’s sense of self is initially and vitally formed, proposing four stages of development of the self during this time. These stages are the development of the emergent self from 0-2 months, the core self from 2-6 months, the subjective self from 7-15 months and the verbal self from 18-36 months. Attachment theory holds, therefore, that the earlier in the lifespan unhealthy attachment patterns are developed, the less likely they are to be subject to later updating and revision (Bretherton, 1987; Marrone, 1998; Schank, 1982). For instance, when healthy attachment pathways and processes are disrupted in infancy and early childhood, a person is least able to process this experience due to the age-related lack of cognitive development. Fairchild-Kienlen (2001:5) details numerous studies that reflect important continuities between early childhood attachment experiences and attachment patterns evident later in a person’s life.

Bowlby (1969:244-249) explains that an infant seeks to form attachments through attachment behaviour that is a combination of signalling behaviour and approach behaviour. Signalling
behaviour is intended to bring the attachment figure to the child and includes crying, smiling, babbling or vocalising, laughter and raising arms. Approach behaviour is intended to bring the child to the attachment figure and includes seeking, following, crawling, nipple grasping and sucking. However, the establishment or otherwise of healthy attachment and bonding occurs within an attachment behavioural system that ‘comprises a reciprocal set of behaviours shown by care-seeker and care-giver in which they are aware of and seek each other out whenever the care-seeker is in danger due to physical separation, illness or tiredness’ (Holmes, 1993a:218). In this way, the desired attachment figure needs to respond in a prompt, appropriate, emotionally attuned, consistent and predictable manner, to the child’s signalling and approach behaviour if a healthy attachment is to be formed. It is also imperative, of course, that the child is able to receive these responses by the caregiver. This capacity to receive caregiver responses may be significantly restricted or impeded when an infant or young child is suffering from physical ailments and/or unrelieved pain is present.

Bowlby (1969) initially identified different types of possible attachment and that they could be classified as secure or insecure. However, it was Ainsworth who subsequently developed a standardised assessment procedure, known as the strange situation, and methodology of classification of attachment behaviour. Three distinct and organised attachment patterns were identified and articulated as secure (‘B’), insecure-avoidant (‘A’) and insecure-ambivalent (‘C’) (Ainsworth et al, 1969; Ainsworth, 1978). Later still, Main et al (1986) identified a fourth attachment pattern known as insecure-disorganised (‘D’). These four attachment classifications have been related to infancy, childhood and adolescence. Later, Main and Goldwyn (1984-1994) developed an adult attachment interview (AAI) and attachment classifications for adulthood that directly correspond to the four classifications at earlier stages. These are secure-autonomous (‘B’), insecure-dismissing (‘A’), insecure preoccupied/entangled (‘C’) and insecure-unresolved
Attachment theory recognises that a range of factors influence the attachment pattern or style a person will adopt, but it is thought that the caregiving responses a person receives from their early environment are the most influential (Bowlby, 1969, 1973, 1980; Colin, 1996; Holmes, 1993a; Howe et al, 1999a).

Bowlby (1969:70-80) believed that caregiving responses from an attachment figure were analogous to ‘instructions’ to the care-seeker about how best and most reliably they might achieve their set-goal – attachment to the care-giver. This is because, in keeping with evolutionary principles, the attachment behavioural system is one that is goal-corrected, capable of adapting itself according to the success or otherwise in achieving its goal. Colin (1996:8-9) defines a goal-corrected behavioural system as ‘a set of discrete behaviours that function in some centrally organized way to help the individual achieve some goal’. For the securely attached child, little adaptation to their attachment behavioural system is required. This is because they are able to ‘approach carers directly and positively, knowing that their distress and upset will be recognised and responded to unconditionally with comfort and understanding’ (Howe et al, 1999a:27).

However, when faced with a lack of consistent responsiveness from an attachment figure, attachment theory holds that the child will ‘correct’ or adapt their attachment behavioural system to redress the situation. Attachment is a biologically-driven, instinctual need, and therefore a lack of consistent responsiveness from a care-giver leads to feelings of insecurity and anxiety in the care-seeker (Howe et al, 1999a:26-27). In order to cope with and manage this anxiety, the child must develop a defensive strategy that compensates for the rebuff by their care-giver as well as restoring the maximum amount of proximity, felt security and attachment to them. Let us consider the formation of the first organised yet insecure attachment pattern - insecure-avoidant
(‘A’) - as one form of defensive strategy (Holmes, 1993a:79). When an attachment figure is consistently unresponsive and sometimes rejecting, interfering and/or controlling, attachment behaviour appears to annoy or agitate them. Therefore, attachment behaviour will cause a strong verbal rebuke or forceful attempt to control or deny the child’s need for care. In other words, ‘conventional’ attachment behaviour does not achieve its goal of proximity to and felt security with, the attachment figure. Therefore, the defensive strategy of choice is to minimise or deny attachment behaviour and affect - strong feelings are defensively excluded and emotional self-containment is established (Howe et al, 1999a:27). Holmes (1993a:79) states that in this scenario, the child is able to remain in reasonable proximity to the attachment figure ‘whose rejection, like the person’s own neediness, is removed from consciousness…by defensive exclusion’. People with an insecure-avoidant attachment pattern, therefore, over-regulate their emotions.

The second organised yet insecure attachment pattern is insecure-ambivalent (‘C’). The caregiving style in which this attachment pattern arises is one that is inconsistently responsive. Attachment figures are insensitive and unreliable and children have to ‘maximise their attachment behaviour in order to break through the parent’s emotional neglect, unavailability and lack of responsivity’ (Howe et al, 1999a:28). This means attachment behaviour is often highly demonstrative, demanding, angry, threatening and loud. The care-seeker is preoccupied with the availability of the care-giver. They believe that attention-seeking behaviours are required to gain the attention of the care-giver because they are not worthy of automatic interest (Fairchild-Kienlen, 2001:6-7). Furthermore, ‘this continual dependency of self on external others retards the development of affective self-regulation capabilities and thus leaves the individual peculiarly vulnerable to stress and emotional lability’ (Lopez, 1995:400). People with an insecure-ambivalent attachment pattern, therefore, under-regulate their emotions.
The third type of insecure attachment pattern is not organised and is insecure-disorganised (‘D’). This attachment pattern forms within very disturbed caregiving relationships, where the attachment figure is the actual cause of the initial distress (Howe et al, 1999a:29). This may be due to the attachment figure being neglectful, abusive, mentally ill, drug or alcohol dependent and/or highly traumatised. This means the caregiving style is likely to be very chaotic and often frightening, the attachment figure not responding to any of the three organised attachment behavioural systems (secure, avoidant and ambivalent) (Main et al, 1986). For a child, an organised defensive strategy to the caregiver’s inconsistency and unavailability is not possible since they are faced with a chaotic and unpredictable caregiving style that may be, in turn, responsive-rejecting-abusive-disinterested-over-involved and unreachable. In this situation, it means that whatever behavioural strategy a child would use, it would not foster proximity or care towards them. Remaining distressed at these unmet needs, attachment behaviour becomes increasingly incoherent and disoriented, with a confused mix of withdrawal, avoidance, angry approaches, controlling behaviour and inertia (Teti, 1999).

It is important to note that although the insecure yet organised attachment patterns – avoidant and ambivalent – achieve some proximity and felt security with caregivers, feelings of anxiety and insecurity in relation to the attachment figure remains (Howe et al, 1999a:27). This ongoing state of anxiety and insecurity remains in a more severe and distressing manner with the insecure-disorganised pattern, since attachment needs are not even partially met.

Bowlby (1969:80-83; 1973: 241-243; 1980: 229-244) contended that caregiving responses act as a crucial feedback loop from which the infant and young child build up an internalised, representational map or model of self, others and the world around them. In attachment theory, this model is most commonly referred to as an internal working model. Bowlby believed that the
propensity to form such models was again, intrinsic and biologically driven according to the
demands of Darwinian evolution (1969:80-83). Bowlby held that higher animals required a map
or model of the world if they were to predict, control and manipulate their environment, thus
rising above a basic stimulus and response relationship with their environment (Holmes,
1993a:221; Howe et al, 1999a:21). Fundamentally, our internal working model generates and
carries a mental representation of the self, other people and the relationship between self and
others (Fairchild-Kienlen, 2001:4). Internal working models are therefore made up of an
organismal model that tells us about ourselves in relation to the world, as well as an
environmental model that tells us about the world itself (Holmes, 1993a:221). Therefore, internal
working models contain ‘expectations and beliefs about one’s own and other people’s behaviour;
the lovability, worthiness and acceptability of the self; and the emotional availability and interest
of others, and their ability to provide protection’ (Howe et al, 1999a:22).

Hence, when a child receives caregiving responses that are prompt, emotionally attuned, reliable
and consistent, a secure attachment style (‘B’) is likely to be established (Fairchild-Kienlen,
2001:6). It is important to note that it is not enough for the caregiver to be merely physically
present; the child must believe that they are mentally and emotionally available to them. In secure
attachment, the child develops an internal working model of others as responsive, loving, reliable
and capable and of a self that is good, worthy of love, care and attention. Also, the world will be
internally represented as safe, relatively predictable and as presenting many desirable
opportunities for exploration, creativity and play. Howe et al (1999a:27) state ‘A sense of trust in
others and recognition of the value of cooperation behaviour soon develop’. In an environment
where the primary caregiving is consistently unresponsive and/or rejecting, the organised yet
insecure attachment style likely to develop is avoidant (‘A’) (Howe et al, 1999a:45). In an
environment where the primary caregiving is inconsistent – at times distant and at other times
intrusive - the organised yet insecure attachment style likely to develop is ambivalent (‘C’) (Howe et al, 1999a:45). These two insecure attachment styles will lead to the development of an internal working model of others as insensitive, unavailable, unreliable, inconsistent and/or incompetent and of a self that is ineffective, unworthy of love, care and attention and lacking intrinsic value. In addition, the view of the world that is internalised is one of it being ‘a dangerous place in which other people are to be treated with great caution’ (Holmes, 1993a:79).

When a child receives primary caregiving that is helpless, dangerous (abusive), emotionally unreachable (e.g. psychosis, depression or heavy drug or alcohol abuse) and fails to protect, a disorganised attachment style is likely to be established (‘D’) (Howe et al, 1999a:29, 45). In this situation, the attachment figure is viewed simultaneously as a potential source of fear and distress as well as the potential source for diffusing/deactivating attachment-related anxiety and fear. The internal working model is of a self that is unloved and/or bad and other people are essentially unavailable, threatening, frightened or frightening (Bartholomew et al, 1991:226-244). The world is internalised as highly unpredictable and a hyper-vigilance is maintained in order to defend against ever impending attacks and profound threats to self. At times when the individual is not immediately caught up in fear and distress, there may be an underpinning ‘organised’ insecure attachment style of avoidant or ambivalent (Howe et al, 1999a:122, 213-214).

It is important to note that attachment theory does not hold that parents and primary caregivers who occasionally communicate with their children in ways that may be regarded as unsupportive or lacking in sensitive responsiveness will foster insecure attachment styles. Indeed, Marrone (1998:94) states ‘It is assumed that the constant repetition of these communications, rather than occasional expression, is what may contribute in a substantial way to insecurity’. It is therefore pathogenic caregiving communications that promote insecure attachments in children, not
imperfect ones. Some of the specific caregiving communications and behaviours that would likely lead to insecure attachments if chronically and persistently displayed are: invalidation of the child’s request for comfort; disconfirmation of the child’s perceptions of family events; guilt-inducing communications; invalidation of the child’s subjective experience; threats; unproductive criticisms; shame-inducing communications; intrusiveness and mind-reading; double-binding; paradoxical comments; unfavourable comparisons; counter-stimulating comments; constant blaming; communications undermining the child’s best intentions; denial of child’s entitlement to have opinions; self-referring comments in response to children’s subjective accounts; dismissive or hard-hearted responses and over-reactive responses (Marrone, 1998:94-101). Additional behaviours and communications by attachment figures that will likely lead to insecure attachments are: inability to respect the child’s sense of initiative; rejection; neglect; inability to play with the child; pushing excessively for achievement; role reversal; role delegation and inconsistency (Marrone, 1998:94-101).

The caregiving environment that is usually the most damaging to a person’s attachments and overall mental health is one in which their early years are marked by exposure to moderate-severe parental mental illness; parental drug or alcohol addiction; domestic violence; exposure to adults’ promiscuous sexual behaviour; unnecessary separation and abandonment; neglect and/or physical, emotional or sexual abuse (Fahlberg, 1998; Holmes, 1993a; Hughes, 1997; Marrone, 1998). Marrone (1998:106) details that repeated and ongoing exposure to a caregiving environment such as this engenders a cumulative trauma by virtue of exposure to a traumatogenic parent.

However, it is certainly not the case that attachment theory proposes that the die is cast if attachments are not healthily developed during the first several years of life. Indeed, Bowlby
(1988) contended that insecure attachments may be revised and updated in the light of later positive relational experiences, for instance in a partner relationship or with a therapist. It is also possible for children and adolescents to update and disconfirm previous negative or even abusive attachment experiences by being placed with non-biological caregivers who provide close, consistent, responsive and attuned care (Howe et al, 1999a; Hughes, 1997). Colin (1996:5) describes the inherent capacity for unhealthy attachment experiences to be updated:

What about human attachment behaviours? Are they stable, automatic, and rigid, like fixed action patterns? …the forces of evolution permit and even reward variability (within limits) in instinctive behaviour. Humans have adapted to a wide range of physical and social environments, so it is likely that attachment and caregiving behaviour systems include great (but not infinite) flexibility. The way an individual organises and expresses his or her attachment behaviour certainly reflects some learning.

However, Bretherton (1987) asserts that the internal working models of individuals with insecure attachment patterns are particularly difficult to update or revise, as compared with individuals with a secure attachment pattern. Borrowing from the work of Schank (1982), Bretherton argues that mental structures are organised hierarchically from low-level event-scripts to basic assumptions. For instance, low-level event scripts ‘such as When I hurt myself my mother comes to comfort me through intermediate generalisations like My mother is usually there when I need her to basic assumptions My mother is a loving person. I am lovable and loved’ (Holmes, 1993a:120). Bretherton (1987) postulates that in individuals with insecure attachment patterns who have negative core assumptions, communication between the different levels of the hierarchy is distorted and restricted. This means negative internal working models are not readily or easily updated in light of experience. For example, a basic assumption of ‘I am hateful’ may
remain impervious to contrary evidence provided by a loving partner relationship or the care of a therapist (Holmes, 1993a:120-122). Hoffman (1999) also notes that the degree of difficulty in updating and repairing insecure attachments is influenced by the age at which the rupture in attachment occurred; the degree of attachment established prior to any rupture; length of time during which the trust-attachment cycle was broken; constitutional and temperamental factors and the nature of the overall environment during the period of attachment ‘break’.

3.2.3 Attachment – Neurobiological Processes

As mentioned earlier in this chapter, the last decade has seen rapid advancements in the field of neurobiology. This is particularly due to technological developments in positron emission tomography (PET) and nuclear magnetic resonance imaging (NMR) or magnetic resonance imaging (MRI). These technologies allow much more detailed studies of brain anatomy, circuitry and endocrinology. While these scientific advances are finding a range of applications within society, our concern is its application to theories of attachment, psychic vulnerability and violence/conduct-disordered behaviour. The application of neurobiology to human behaviour has been defined as the specialisation of affective neuroscience or interpersonal neurobiology (INB) (Schore, 2003; Solomon et al, 2003). INB essentially aims to explore how a person’s interpersonal/relationship experiences, especially early in life, impact the development of the neural pathways involved in attachment and self-regulation. INB is therefore concerned with the interactions between brain and mind, mind and brain. In terms of Ian Hacking’s bio-looping covered earlier in the chapter, the following neurobiological exploration of attachment can be seen as the biological dimension that interacts/ ‘loops’ with the psychological dimension of attachment covered in the previous section.
Siegel (2003:17-18) describes the human brain as extremely social in that although genes program the maturation of the brain, life and relational experiences have a critical level of influence in shaping the structure of the brain. Filley et al (2001) assert the critical interface between brain, mind and behaviour by arguing that in order to understand human behaviour, the organ that produces that behaviour cannot be overlooked. This has been found to be especially significant when considering attachment - disordered and violent, anti-social behaviours (Filley et al, 2001; Ishikawa et al, 2003; Perry, 1997).

Brain development and maturation appears to begin in utero and extend until early adulthood, although the human brain grows faster than at any other stage of the life cycle during the first two years of life (Ishikawa et al, 2003:280-281; Schore, 2003:112-113). However it is during the early years, especially from birth to age three, that the growth and development of the right hemisphere of the brain is predominant. This is highly significant since it is the right brain that is strongly associated with attachment, emotional regulation and some forms of decision making (Ishikawa et al, 2003:280-281). The earliest years of life are therefore viewed as critical in terms of attachment experiences and brain development.

The right hemisphere of the brain contains the prefrontal and orbitofrontal cortex. The development of the prefrontal cortex, especially during the first three years of life, is foundational to the development of a sound emotional base (Schore, 1994:18-19). This is because the prefrontal cortex acts in the capacity of an executive control function for the entire right hemisphere of the brain. The prefrontal cortex is associated with information-processing skills such as working memory, manipulation and encoding of information, maintenance of information in the presence of distracting stimuli and emotion processing (Ishikawa et al, 2003:280).
The orbitofrontal cortex, also in the right hemisphere of the brain, matures completely postnatally and is in a critical period of growth in the first year of life and dominant for the first three (Schore, 2003:112-115). The orbitofrontal cortex acts in the highest level of control of behaviour, especially in relation to emotion and attachment (Garavan et al, 1999; Price et al, 1996; Schore, 2003). It regulates autonomic reactivity, social and self-awareness and regulation of affect. A part of the (ventromedial) prefrontal cortex also ‘overlaps’/directly interacts with a part of the orbitofrontal cortex. This area is implicated in risk-related and emotion-based decision making.

Brain and attachment researchers believe that the development of healthy brain structure, anatomy, function, synaptic networks and neurons are to a significant extent, experience dependent (Lott, 1998). More particularly, attachment experience dependent. This understanding has been reached by neurobiological attachment researchers documenting the endocrinological correlates to secure and insecure attachment. This documentation has been made possible through advances in a range of brain imaging technologies. For instance, these technologies have been utilised in studies that photograph sequences in neurological activity during interactions between primary caregivers and infants. Also, neuroendocrinological states in various comparison samples of young children have been documented to further illustrate the correlation between attachment experience and brain development. Siegel et al (2003:xv) describe the prefrontal cortex as being ‘experientially sculpted’, and Greenough et al (1992) were the first neurobiological attachment researchers to use the term ‘experience dependent synaptogenesis’. Perry (1997) contends that the primary caretaking relationships of infancy and childhood determine core neurobiological organisation for the human individual.

Lott (1998:2) explains that attuned interactions between an infant and primary caregiver are essential to synaptic development – ‘By tuning in to every subtle shift in the infant’s states, the
caregiver accentuates positive states of excitement, joy and pleasure, and minimises distress...the infant feels felt’. In this way, the primary caregivers serve ‘as an affect regulator, an auxiliary cortex for the infant’s still underdeveloped brain’ (Lott, 1998:2). Indeed, when a caregiver regulates their own affect, they are also regulating the release of neurohormones in the infant’s brain. Schore (2003) contends that the facial and emotional expressions of the primary caregiver/s play a key role in determining the emotional development of an infant, with the face - especially the eyes - being the most potent stimulus in an infant’s environment. It has been observed that interactive mutual gazing between a primary caregiver and an infant helpfully trigger high levels of endogenous opiates in the child’s growing brain (Schore, 2003).

For example, an infant who experiences positive heightened arousal (e.g. excitement) from environmental stimuli will experience a corresponding release of dopamine. If a primary caregiver is attuned to the infant’s excitement and makes eye contact with them on this basis, the eye contact with the infant will cause a further release of dopamine which in turn will increase eye contact (Hoffman, 1999:2). In this way, a positive and nurturing caregiving response to a child’s behaviour can directly impact and activate desired neurological activity and development. This in turn increases the child’s capacity and desire to display appropriate attachment seeking behaviour, which in turn increases the likelihood of positive caregiving responses, which further promotes desired neurological activity and so on. Renowned neurodevelopmental researcher Bruce Perry (1997:126) states ‘There is no more specific “biological” determinant than a relationship’.

In sum then, when a person is exposed to positive attachment experiences during infancy and childhood, this means there will most likely be a healthy course of brain development charted. This is because neurobiological research has illustrated a clear, mutually reinforcing, ‘looping’
effect between psychological-emotional states and neurological-endocrinological states. In the early years of life, the need for this looping effect to be highly positive is crucial to the formation and development of the right hemisphere of the brain. Given that this side of the brain is concerned with attachment, social and self awareness and the capacity for emotional and behavioural regulation, its healthy development is crucial to emotional and social functioning. Where the right hemisphere of the brain and its prefrontal and orbitofrontal cortex areas are unable to follow a normal course of maturation, a variety of chronic, severe and relatively intractable psychological, emotional and behavioural problems are likely to develop (Howe et al, 1999a; Lott, 1998; Perry, 1997; Schore, 2003; Solomon et al, 2003).

Schore (1997) explains that chronic states of caregiver misattunement, neglect and abuse are likely to maintain high levels of cortisol in the brain, a stress hormone that has been shown to destroy brain synapses. This is because when cortisol levels are maintained at consistently high levels, ‘there is an overpruning of synapses in the right orbitofrontal cortex, leaving individuals with impaired ability to modulate and regulate emotion in response to stress’ (Lott, 1998:2). In contrast, when a caregiver is attuned to the child’s need for settling when stressed, elevated cortisol levels and stress hormones in the infant’s brain are not sustained but are reduced by the caregiver’s attuned and attachment-promoting response – ‘As a result, the frontal cortex develops a greater concentration of glucocorticoid receptors that can modulate stress responses’ (Lott, 1998:3). A number of studies, including some based on the classic strange-situation test developed by attachment researchers, have correlated significant cortisol rises with impaired and markedly insecure attachment (Lott, 1998; Main, 1996).

Siegel (2003) states that excessive and prolonged stress hormone secretion is neurotoxic and causes a number of direct brain insults. These include a reduction in overall brain size as well as
‘impairments in the development of the corpus callosum, the bands of neural tissue allowing for the transfer of information between the two halves of the brain’ (Siegel, 2003:16-17). In addition, excessive stress hormone secretion can cause damage to the brain stem and limbic structures, significantly inhibiting soothing functions. Also, Siegel (2003:17) reports that excessive stress hormone secretion may cause the hippocampus to be shrunken, impairing the operation of explicit memory and the development of a sense of self in the world. It can be understood then, that the brain of a young child is not merely affected by interactions with their caregiver, ‘its growth literally requires brain-brain interactions’ (Schore, 1996:62). This means that a caregiver needs to be able to effectively regulate their own affect/emotional state via a healthy right brain capacity, in order that their caregiving style can directly lead to healthy right brain development in the child. This is the ‘right-brain to right-brain affective experiences that are the stuff of secure attachment’ (Fosha, 2003:225).

So far, I have explained how poor attachment experiences substantially hinder the development of the right brain, with its prefrontal and orbitofrontal cortical areas being crucially linked to social and self-awareness, affect regulation, emotion processing and impulse control. Perry (1997) also details that poor attachment experiences during the early years of life specifically compromise the brainstem, midbrain and limbic structures. We can picture the brain perhaps most usefully as an inverted pyramid. At the bottom of the pyramid we have the lower and more primitive portions of the brain, the brainstem and midbrain, which are highly reactive and reflexive to stimuli. These areas regulate physical and physiological states such as blood pressure, heart rate, body temperature, sleep, appetite/satiety, arousal and motor regulation. Moving further up our ‘inverted pyramid’, the limbic and cortical areas sit above the brainstem and midbrain. These areas are directly associated with emotional reactivity, sexual behaviour, attachment, affiliation, concrete and abstract thought.
Perry (1997:130) describes the development of these respective areas: ‘During infancy and childhood, sequential development of the brain necessitates that the lower more primitive portions of the brain develop first and, over time, the output of these areas is shaped, modulated, and modified in more mature fashion as the higher brain areas develop’. If an infant and young child are exposed to ongoing poor attachment experiences that are also traumatic in nature, the lower portions of the brain are likely to become overdeveloped, while the limbic and cortical areas will be underdeveloped. These events will then predispose the child to developing more impulsive, reactive and dysregulated behaviour, particularly violent and anti-social behaviour (Ishikawa et al, 2003; Perry, 1997; Schore, 1996; 2003). With an over-utilised and overdeveloped brain stem and midbrain, children become adolescents who possess qualities such as hyper-vigilance, hyper-arousal, hypersensitivity, high levels of reactivity, a bias towards perceiving threat and hostility and a persistent stress-response state. As previously mentioned, neurobiological studies also report underdevelopment and impairments in the prefrontal and orbitofrontal cortex as a central mechanism in the behavioural expression of poor attachment, lack of empathy and violence (Best et al, 2002; Schore, 2003; Volavka, 1999).

Perry (1997:138) summarises and describes the effects of poorly attached children with an overdeveloped lower brain and underdeveloped higher brain as the malignant combination:

This is characterised by an overdevelopment of brain stem and midbrain neurophysiology and functions (e.g. anxiety, impulsivity, poor affect regulation, motor hyperactivity) and an underdevelopment of limbic and cortical neurophysiology and functions (e.g. empathy, problem-solving skills). This experience-based imbalance predisposes to a host of neuro-psychiatric problems – and violent behaviour.

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Attachment theorists and researchers writing in the area of neurobiology also hold that poor attachment experiences can be ‘undone’ or disconfirmed, as do their colleagues writing from a more explicitly ‘psychological’ basis (i.e. without any emphasis on neurobiology). The views of the latter grouping of attachment theorists in this regard have been included towards the end of the previous section. Attachment neurobiologists such as Allan Schore (2003:146) believe that poor attachment and attendant impaired brain development is not irreparable and may be updated by exposure to a positive and significant attachment figure:

Most emotionally neglected or traumatized children do not turn into violent criminals or sociopaths. Usually, if these children have had some positive relationships – for example with a grandparent or cherished teacher – they will manage to function, even prosper. However, those not so lucky will most likely suffer a sense of emptiness and loneliness, because they are unable to connect with others. Others connect, but only through relationships that are destructive or disturbed.

In this way, it can be said that there is both continuity and plasticity with regard to neurobiological organisation (Fosha, 2003:222-223). This plasticity is believed to be present after critical periods of brain development have passed, meaning that a significant positive relational experience with a caregiver, therapist and/or partner can be effective in functionally reversing the effects of prior traumatic attachment experiences. Indeed, neurobiological attachment research exists that documents ‘…the suppleness of the psyche and its attuned responsiveness to current conditions, especially those favouring self-righting tendencies’ (Fosha, 2003:223). This means that significant, positive attachment experiences and/or specialised attachment therapy, may
promote new neural connections in a person’s right hemisphere and better coordination between the right and left hemispheres of the brain (Lott, 1998:5). Fosha (2003:223) states:

There is evidence that just one relationship with a caregiver (and that caregiver does not have to be the principal caregiver) who is capable of autobiographical reflection, in other words, a caregiver who possesses a high reflective self function, can enhance the resilience of an individual. Through just one relationship with an understanding other, trauma can be transformed and its effects neutralised or counteracted.

In summary then, poor attachment resulting from significant relational trauma can lead to severe and chronic neurobiological, psychological, emotional and behavioural difficulties. However, both ‘schools’ of attachment theorists – psychological and neurobiological – believe that these difficulties are capable of being repaired and overcome with specialised and focused interventions. In this scenario, the ‘bio-looping’ that occurs between brain and mind/biology and psychology, can be manipulated and utilised for healing and recovery though previously this looping effect had consolidated and entrenched damage and dysfunction.

3.2.4 Attachment Theory - Critique

Prior to making more specific connections between attachment theory and adolescents in out-of-home care diagnosed with severe conduct disorder, I wish to briefly address some of the critique directed towards attachment theory from a critical theory perspective. As previously mentioned, the critique of attachment theory from a critical theory perspective has been essentially based in both feminist and anti-racist analyses. I will mostly restrict my reflections to those regarding the feminist critique since it is far more extensive and widely published than the anti-racist analysis.
Also, the confines of this thesis prevent a significant discussion of the anti-racist and any other critiques, as well.

In respect of ethnocentrism and cross-cultural issues, it should be noted that while attachment theory proposes universal application, it acknowledges that due to the vast number of human cultures on earth, culture-specific aspects of attachment will exist (Colin, 1996:145-166). In particular, the distribution of attachment patterns or sub-patterning will vary according to the culture’s values regarding child rearing – e.g. one variable relates to the timing and degree to which autonomy and independence are encouraged in childhood. Also, attachment theory must be thoughtfully applied to Australian Aboriginal communities since a network-based approach to child rearing is valued rather than the more dyad and triad based approaches now common to Anglo-Celtic practices (See Yeo, 2003).

The feminist critique proffers several key points of concern although it fundamentally argues that the underlying logic of attachment theory is based upon essentialist, biologically determinist and gendered assumptions (Hays, 1998:783). Attachment theory, then, is viewed as inherently oppressive towards women because of its historical association with notions of maternal deprivation (Chodorow, 1978; Chodorow et al, 1982; Hays, 1998). Feminists have been concerned that attachment theory advocates that mothers and mothering are the most important determinants of the emotional and psychological well-being of children. This mother-child exclusivity is therefore seen as placing an unnecessary and unjust emotional burden on women in terms of care-giving for children. Hays (1998:783) contends that this maternalism reflects a cultural ideology of women as passive, nurturing caretakers who are defined by this role, forgoing any broader sense of self. I believe that the feminist critique in this particular instance is partially flawed and based on somewhat of an over-simplification of attachment theory. First, an
over-simplification of John Bowlby’s main arguments and second, those of contemporary attachment theory which has evolved some considerable way from the 1940s – 1960s and the early writings of Bowlby.

I believe Bowlby’s theory of monotropy has been misrepresented as holding that a child’s principal attachment figure must be the mother and can in fact only be the mother. Bowlby’s (1969) monotropy asserted that in the earliest years of life, a child would naturally establish a principal attachment figure from within a broader hierarchy or context of subsidiary attachment figures but that this did not necessarily mean to the mother. Bowlby (1969:305) describes this position clearly:

> It is evident that whom a child selects as his principal attachment-figure, and to how many other attachment figures he [sic] becomes attached, turn in large part on who cares for him and on the composition of the household in which he is living. As a matter of empirical fact there can be no doubt that in virtually every culture the people in question are most likely to be his natural mother, father, older siblings, and perhaps grandparents, and that is from these figures that a child is most likely to select both his principal attachment-figure and his subsidiary figures.

The essential point that Bowlby (1969) makes is that in his view, the principal attachment-figure for a child is generally a mother because for a variety of reasons, they tend to be the primary caregiver, not because this is biologically ‘natural’ or even preferable. Indeed, Bowlby cites case studies from Scotland and Uganda to illustrate (1969:305-306). In these studies, some children were observed to be securely attached to mother and father but to prefer the father; some children demonstrated no attachment to their mother but instead to their father and older half-sister, and
some children’s principal attachment figures were their grandmothers. Furthermore, Bowlby (1969:314) rejects the assertion that a principal attachment figure is likely to be a mother on the basis of her capacity to breastfeed – ‘no evidence has ever been produced that supports the traditional theory that the crucial reinforcer of attachment behaviour is food and that a reason a child becomes attached to a particular figure is because she feeds him [sic]’. Rather, Bowlby holds that the most crucial reinforcer of attachment behaviour is the way those involved in the infant’s life respond to its social advances or attachment-seeking behaviour.

When Bowlby’s position that mothers need not be a child’s principal attachment figure is considered, it also assists in understanding his motivation in advocating strongly against any significant separation of children from mothers, especially in the first three years of life. Writing as he did, in the historical and socio-political context of Western Europe following World War Two, it was simply the case that the vast majority of primary caregivers for children were women.

Therefore, Bowlby’s protestations regarding children’s separation from mothers is not because they are mothers, it is because they represent the most likely primary caregiver and hence principal attachment figure, to a child. Hence, Bowlby’s concerns were in relation to a child being separated from its principal attachment figure, not its mother per se, and that separation from this figure is likely to be more unsettling than other attachment figures.

Due to Bowlby’s alleged desire to pin women down in their homes, as contended by Mead (1962), his work in calling for the professionalisation of child care, adequate and decent resourcing of child-care facilities and greater valuation by society of motherhood is also often overlooked. Significantly of course, it is these very same concerns that some feminists have felt
particularly strong about and have also advocated and actively campaigned for (Holmes, 1993a:41, 48). Indeed, Bowlby’s advocacy regarding the need for good day-care facilities to be available for women needing or wanting to engage in paid work as well as state provision of wages for work in the private sphere, reflect some of the political activities of feminists (Holmes, 1993a:41).

However, I do not wish to write as an unqualified apologist for Bowlby, since it is certainly true that he failed to adequately assert the need for fathers in particular, to be more involved and central in caregiving activity. As discussed earlier, since Bowlby held no fundamental belief that women had to be a child’s principal attachment figure, his lack of comment regarding the absent father-patriarchal society seems at least partly attributable to the socio-historical context in which he was raised and later formed most of his ideas (Holmes, 1993a). This context was Western Europe from the early-mid twentieth century and as part of the upper-middle class in London. To some degree, it is possible that Bowlby did not speak out about a greater role/involvement for fathers in parenting and/or as principal attachment figures as he was unable to imagine or conceive of fundamentally different family patterns (Holmes, 1993a:202). However, the simple truth of the matter is that Bowlby’s writings were insufficient in their calls for more robust paternal involvement in parenting and this has in fact been addressed quite thoroughly by contemporary attachment theorists and literature. This is another area sometimes overlooked, possibly allowing for a critique of attachment theory to be less complicated and easier to mount.

The essential position of contemporary attachment theorists and indeed practitioners, is that attachment theory needs to speak very clearly about parenting as opposed to mothering and that ‘mother’ and ‘father’ are indeed interchangeable terms when considering principal/ primary attachment figures (Colin, 1996; Holmes, 1993a; Howe, 1999a; Leupnitz, 1988). The historical
research bias in attachment theory towards researching mother-child interactions is also being addressed, with research identifying that fathers are as capable of providing responsive attunement as mothers (Brazelton et al, 1991).

3.2.5 Attachment, Severe Conduct Disorder and Out-of-Home Care

In the earlier sections that discuss attachment theory from a psychological and neurobiological basis, it is posited that very poor and damaged attachment has serious consequences for emotional, psychological and neurobiological well-being. This is an important point, for it is not the contention of attachment theory that mildly insecure attachment patterns will lead to those difficulties reflected in the diagnosis of severe conduct disorder. Mildly insecure attachment patterns ‘do not equate with psychopathology’ (Howe et al, 1999a:61). Only if the attachment process becomes ruptured or damaged will significant to severe developmental and mental health difficulties potentially arise. Indeed, as has been discussed, poor attachment will be associated with violent and anti-social behaviour included in severe conduct disorder when caregiving experiences have been significantly or severely inadequate – to the extent that it was traumatic and ‘life-changing’ for the person concerned.

The following discussion of secure attachment provides further detail as to its importance, since all the qualities associated with a secure attachment can be seen as crucial to healthy human functioning. Where severely insecure and damaged attachment exists, all the highly necessary qualities resulting from secure attachment are mostly missing and actually substituted with their direct opposite (e.g. capacity for empathy ‘substituted’ with lack of empathy). Howe et al (1999a:60) state ‘the behaviours and skills sponsored by secure attachments act as a
psychological benchmark against which the psychosocial characteristics associated with insecure attachments can be measured’.

Secure attachment is essential in learning basic trust and reciprocity, which serves as a template for all emotional relationships. During infancy through to early childhood, a child’s secure attachment to a caregiver can be evidenced by the child approaching them especially in periods of distress, showing no fear of them, being highly receptive to being cared for by them and displaying anxiety if separated from them (Reber, 1985:65). Early secure attachment, then, provides a protective safe haven in times of distress or danger as well as an exploratory secure base from which to play, explore and develop. Following early childhood, a secure attachment style can be evidenced by a number of socio-emotional competencies including – accurate awareness of one’s own emotional state; ability to read others emotions; empathic involvement in others emotions; knowledge of the impact of one’s own behaviour on others; healthy displays of trust, intimacy and affection; ability to self-regulate negative emotions and impulses; prosocial coping skills; assumption of other’s emotional availability; good self-esteem; age-appropriate levels of autonomy; social effectiveness and competence; formation of enduring friendships; greater concentration at play; more positive affect; resilience in the face of adversity; skills in conflict resolution and lower fearfulness (Crittenden, 1995; Howe, 1990; Saarni, 1990).

In addition, securely attached children and adolescents will have developed an appropriate amount of compassion and conscience and have relatively few behavioural problems at home and/or school. They also have a substantially reduced likelihood of referral to a mental health clinic, including later in life as adults. Finally, secure attachment in children and adolescents can be evidenced by a positive and hopeful belief system about self, family and society and they’ll be able to promote secure attachment in their own children when they become adults.
When one considers the abovementioned hallmarks of secure attachment being absent and substituted with their direct ‘opposite’ in cases of severe attachment difficulties, the link between these difficulties and the development of severe conduct disorder seem pivotal. The American Psychiatric Association (1994:95-96), in its Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), includes the following in its descriptive features concerning conduct disorder:

Individuals with Conduct Disorder may have little empathy and little concern for the feelings, wishes, and well-being of others. Especially in ambiguous situations, aggressive individuals with this disorder frequently misperceive the intentions of others as more hostile and threatening than is the case and respond with aggression that they then feel is reasonable and justified. They may be callous and lack appropriate feelings of guilt or remorse. It can be difficult to evaluate whether displayed remorse is genuine because some of these individuals learn that expressing guilt may reduce or prevent punishment. …Poor frustration tolerance, irritability, temper outbursts, and recklessness are frequent associated features.

It is these features which comprise ‘A repetitive and persistent pattern of behaviour in which the basic rights of others or major age-appropriate societal norms or rules are violated’ (American Psychiatric Association, 1994:98). Specific behaviours include persistent and repetitive aggression to people and/or animals, destruction of property, deceitfulness and/or theft and serious violations of rules. When these individual features and patterns of behaviour are well in excess of the minimum level required to meet the criteria for a diagnosis, or considerable harm to others is indicated, the specifier ‘severe’ is made to the diagnosis of conduct disorder (American

These young people who engage in chronic and persistent anti-social and criminal behaviour are also those placed in out-of-home care due to highly dysfunctional family backgrounds and histories of severe abuse, neglect and trauma (Department of Human Services, 1998; Fonagy 2001; Howe et al, 1999b; Hughes, 1997; Jobes, 2004; Jonson-Reid et al, 2000; Levy et al, 1999; Maier, 1987; Moretti et al, 1994; Morton et al, 1999). Penzerro et al (1995:363) discuss these young people in the following manner:

Attachment theory suggests that these are young people who have internalised a view of the world as a hostile, rejecting place and their antisocial acting-out behaviours are evidence of alienation from others. These behaviours also have the effect of alienating others and reinforcing the worldview. As the youth drift from placement to placement, a pattern of drift through relationships becomes entrenched as a way of life.

From the perspective of attachment theory – both psychological and neurobiological – the development of severe conduct disorder can be seen to have its basis in relational trauma, abuse and neglect and corresponding neurological damage in infancy and early childhood (Schore, 2003:137). Werry (2005a:25) states ‘The harsh truth is that severe conduct disorder begins in the first few years of life and continues throughout it’. The Evergreen Attachment Treatment and Training Institute (2005:1) states:
Disrupted and anxious attachment not only leads to emotional and social problems, but also results in biochemical consequences in the developing brain. Compared to securely attached children, attachment disordered children are significantly more likely to be aggressive, disruptive and antisocial. Teenage boys, for example, who have experienced attachment difficulties early in life, are three times more likely to commit violent crimes. Disruption of attachment during the crucial first three years can lead to what has been called ‘affectionless psychopathy’, the inability to form meaningful emotional relationships, coupled with chronic anger, poor impulse control, and a lack of remorse.

3.3 Critical Theory

3.3.1 Examination of the Constructs and Discourse relating to Adolescents presenting with Severe Conduct Disorder

Notions of adolescence, criminality/delinquency and mental illness, are now explored from the perspective of critical theory and critical social work. These constructs inter-relate and mutually reinforce each other when considered in the context of adolescents in out-of-home care diagnosed with severe conduct disorder.

Firstly, let me re-state the parameters of my use of the term ‘critical theory’. As discussed in Chapter 1, critical theory is not a neatly defined or unified theoretical perspective. Rather, it is comprised of different theoretical positions. Indeed, there is considerable ongoing debate as to which theories might rightly fit within a critical perspective and/or which is the correct version of critical theory (Ife, 1997; Pease et al, 2003). In addition, differing intellectual positions exist regarding whether or not critical theory should draw upon both modernist and post-modernist
critical perspectives (Allan, 2003a; Pease et al, 2003). Instead of looking to define critical theory in a specific manner, I wish to subscribe to Macy’s (2000: 74) use of the term as referring ‘to a whole range of theories which take a critical view of society’ and attempt to explain the emergence of the objects of knowledge in the human sciences.

In particular, the social constructionist perspective within critical theory will be focused upon to explore notions of adolescence, criminality/delinquency and mental illness. Having earlier explained my belief in adopting different conceptual lenses to identify different aspects of the same phenomena, a social constructionist perspective assists in suspending a positivist paradigm of enquiry. Indeed, Martin (2003b) explains that critical theory and its social constructionist analysis of objects of knowledge in the human sciences have a strong association and tradition. This association is most notable from the 1960s. Of course, the human sciences that fall within the ambit of this chapter would include psychiatry, psychology and criminology. Their objects of knowledge under consideration include those referred to earlier - adolescence, criminality/delinquency and mental illness.

Social constructionism rejects the positivist and empiricist claims of being able to establish that which is intrinsically ‘real’ and instead seeks to identify how particular phenomena become defined and acquire their meaning through particular traditions of social relationships (Gergen, 2002:7-11; Thio, 2004:4-5). Gergen (2002:11) is helpful here in his quotation of American philosopher Nelson Goodman (1978) ‘If I ask about the world, you can offer to tell me how it is under one or more frames of reference; but if I insist that you tell me how it is apart from all frames, what can you say?’ As an anti-foundationalist, Foucault subscribes to a socially constructed view of (social) reality and knowledge (Bessant et al, 2002:62). For Foucault (1989a:46), Goodman’s frames of reference are described as the ‘grids of specification’. These
are the systems according to which different kinds of mental illness, criminal behaviour and developmental stages are divided, contrasted, related, regrouped, classified and derived.

Indeed, having extensively discussed and illustrated Foucault’s archaeology of knowledge in Chapter 2, his central ideas around issues of knowledge, truth and power are now expanded upon. In particular, Foucauldian theories about discourse and discursive practices will be the theoretical context in which dominant discourses about adolescence, criminality/delinquency and mental illness are identified, explored and examined. In this way, the manner in which ideas about adolescence, criminality/delinquency and mental illness are socially constructed are elucidated. In Hacking’s (1999:111) terms, the grade of social construction that will be explored is therefore ideas about X as being socially constructed, rather than X being socially constructed per se.

Now, to revisit some earlier themes. In Foucauldian terms, systems of discourse emerge in the context of the particular episteme that (pre) dominates within a particular historical period. Dominant discourse emerges within the ontological and epistemological conditions laid down by the prevailing episteme. These (pre) conditions are subsequently rarely uttered, named, visible or made conscious yet continue to set the underlying terms of intellectual engagement. Within the Foucauldian tradition, Macey (2000:100) defines discourse in the following manner: ‘In the contemporary human sciences, the term is widely, and often very loosely, used to describe any organized body or corpus of statements and utterances governed by rules and conventions of which the user is largely unconscious’.

Foucault contends that discourse produces discursive formations or orders of discourse, by which and through which, epistemes may speak themselves (Danaher et al, 2000:21-22; Foucault,
Discursive formations produce objects of knowledge, further organising ideas and concepts (Foucault, 1989a:34-36, 201). For instance, during the nineteenth century, the Modern episteme and its privileging of scientific rationality created the historical conditions necessary for medical discourse to thrive and achieve clear ascendancy (Foucault, 2002). One implication of this ascendancy was the discursive formations around psychopathology and the ‘claiming’ of mental illness as an object of knowledge for study within a medical model.

To continue the illustration, medical discourse has assisted in establishing disciplines such as psychiatry and its subject-position, psychiatrists (Foucault, 2002:183-184). Disciplines such as psychiatry then disseminate their ongoing commentary through institutions such as professional colleges/associations, hospitals and universities. This commentary becomes recorded in books and other literature. This body of literature depends on, and is organised around, ‘names’. For instance, some of the names around which psychiatry might be studied at an Australian university include Emile Kraeplin, Sigmund Freud, Anna Freud, John Bowlby, Donald Winnicott and Sidney Bloch. The commentaries and theories produced by ‘names’ that hold a privileged place within a discipline ‘carry what the French sociologist Pierre Bourdieu calls cultural capital’ (Danaher et al, 2000:22). This means that within a given discipline, claims to truth or knowledge often depend on who is claiming it and whether their expertness carries the requisite amount of (cultural) capital. Foucault (1989a:55) states:

…who is speaking? Who, among the totality of speaking individuals, is accorded the right to use this sort of language? Who is qualified to do so? Who derives from it his own special quality, his prestige, and from whom, in return, does he receive if not the assurance, at least the presumption that what he says is true?
We can see then, that knowledge and power are inextricably linked and intertwined (Foucault, 2002). This inter-relationship between knowledge and power hints at Foucault’s complex understanding of power. Foucault’s thesis regarding power is that it is not a material structure or object that can simply be dismantled, seized or transferred but is held and used by individuals and groups (Foucault, 1979). Danaher et al (2000:xiv) explain:

…power for Foucault…is both a complex flow and a set of relations between different groups and areas of society which changes with circumstances and time…it is not solely negative (working to repress or control people): it is highly productive…it produces what we are and what we can do; and it produces how we see ourselves and the world (xiv).

Foucault writes that knowledge and power have an interweaving effect in that social relations of power produce knowledge discourse and this knowledge discourse then serves to reaffirm and re-establish the power of those producing knowledge discourse (Foucault, 2002). However, while power is productive or positive it can also be negative in the sense of fostering social regulation and control as well as marginalising particular groups of people. The nature of dominant discourses regarding adolescence, as well as criminality and mental illness as they relate to adolescents, are examples of dominant/dominating discourses that marginalise adolescents in out-of-home care presenting with severe conduct disorder. In establishing the nature of contemporary dominant discourse in the West regarding these three phenomena, the ways in which these discourses negatively impact on adolescents in out-of-home care diagnosed with severe conduct disorder becomes apparent. In particular, these young people may experience inferiorisation and internalised oppression.
3.4 Constructs and Discourse regarding Adolescence, Youth Crime and Mental Illness – An Abridged Historical Survey

It is important to state that within the parameters of this thesis, it is not possible to provide an exhaustive or even (necessarily) comprehensive description of the development of dominant discourses around adolescence as well as crime and mental illness as they relate to young people. The following account, then, is concerned with the historical and dominant discourses regarding these three constructs within a Western context only. Also, I wish to acknowledge that although dimensions such as class, gender and race/ethnicity have been present in the formation of these dominant discourses, space does not permit a thorough account of these dimensions. However, a relatively succinct description and overview follows to allow some important points to be raised.

There has been a significant inter-relationship between dominant discourses regarding adolescence, (youth) criminality and (youth) mental illness. The development of discourses in these areas have frequently overlapped and mutually reinforced each other. As a result, they are discussed not sequentially or compartmentally, but in an integrated manner that reflects the nature of their emergence and perpetuation.

Historically in the West, the term adolescence has featured most prominently to describe young people from around 193 BC until the Middle Ages and then from the beginning of the twentieth century (Graham, 2004:25-26). During other periods in history, discourse regarding young people has centred on the use of the terms youth, teenager or delinquent (Bessant et al, 1998; Graham, 2004). Of course, throughout much of history these terms have been used inter-changeably. While different terminology has been used at different times, I believe there have been nonetheless clear and important continuities and relations between the terms employed and so I will not be speaking only of ‘adolescence’ per se. Indeed, Bessant et al (1998:12) assert that
adolescence is a sub-category of youth, and Wyn et al (1997:52) describe adolescence as ‘the cornerstone of the developmental model of youth’. It is then, difficult and problematic to draw rigid lines of demarcation between the different terms used to describe young people. There is in fact more commonality between the substance of these terms than difference.

3.4.1 Ancient Times

The term ‘adolescence’ is believed to have first been used around 193 BC in ancient Rome and is derived from the Latin ‘adolescere’ which means to ‘grow up’ (Graham, 2004:25). The Latin term for adulthood is adultus, which means ‘to have grown up’. From the outset then, the term and discourse of adolescence has been imbued with deficit – an absence of adulthood or deficit of the adult state. Wyn et al (1997:11) argue that the concept of adolescence or youth is and always has been a relational one ‘because it exists and has meaning largely in relation to the concept of adulthood’. Interestingly, in Classical times, adolescence was used in terms of young people who had not achieved full social rights as adults (Graham, 2004: 25). At that time, this meant that adolescence did not end until somewhere between the ages of 35-42 years old.

3.4.2 Middle Ages

Approaching the Middle Ages, the term adolescent declined in use and was largely replaced by the term ‘youth’ in English speaking countries. Graham (2004:24) states that this is at least partly attributable to the notable decline in the use of Latin and words derived from Latin. During the Middle Ages, concepts of youth varied widely, as did the stages associated with its passage (Bessant et al, 1998:4-5). In France for example, youth was seen to be a long phase extending between childhood and old age. It was believed to be that period of life associated with ‘vitality
and productivity’ (Bessant et al, 1998:5). The designation of life stages such as youth also occurred according to social status rather than chronological age and so someone we might think of as a middle-aged adult might still be described as a child.

3.4.3 Renaissance Period

During the Middle Ages, Renaissance and Early Modern periods in England, an influential view of youth was propounded by the Christian Church. Youth were characterised as ‘brutish and devilish’ and ‘their tendency to sin, to a lack of control over sexual passions, and to indulgence in bodily pleasures grew’ (Ben-Amos, 1994:25-27). At the same time, the astrological belief system also engaged in discourse that rendered youth as being particularly vulnerable to emotionality, the impulse towards love and persistent disconsolation in times of lost or unrequited love (Graham, 2004:27). So, historically, while adolescence and youth had not yet been defined according to chronological and biological frameworks that dominate today, a pathologising discourse had been largely established. Mostly, adolescence and youth had been conceptualised in deficit terms and as being vulnerable to particularly strong bouts of emotionality, impulsiveness and immorality.

Foundations for the modern idea of youth continued to be laid in the eighteenth century throughout much of the Western world as Romantic notions of youth became popularised (Bessant et al, 1998:5). In Germany, Bessant et al (1998:5) explain that there was a whole genre of novels devoted to ‘youthful search, struggle and resolution’. This notion of youth depicted young people as potential heroes, subject to their negotiation of turbulent passions. Goethe, influenced by Rousseau’s philosophy of human development, typified the zeitgeist in regard to youth in his novel Sorrows of Young Werther (Graham, 2004:28). The novel describes the
‘neurotic debility of a young man, eventually driven to suicide by grief over his lost love’
(Graham, 2004:28). The Romantic discourse around notions of youth began to consolidate the
‘natural’ instability of young people and the inherent nature of youth being one of ‘sturm und
drang’ or ‘storm and stress’.

3.4.4 Birth of Modernism

Following the Industrial Revolution, the way in which youth was constructed and discussed was
crucially affected by the political, social, economic and cultural changes that established the
Modern world. In pre-industrial times, an apprenticeship and service system existed whereby
youth – roughly viewed as occurring between the ages of 8 until the mid twenties - would
commonly go to live and work in an ‘employer’s’ household, making their first moves of
independence from their family at age 7 or 8 (Bessant et al, 1998:4-6). The collapse of this
‘apprenticeship’ and service system was gradual and was perhaps a pre-condition for the
emergence of those versions of adolescence and youth most familiar to us today.

Status-conscious, middle-class families were the first to discontinue the practice of sending their
children away for apprenticeship and service, initially keeping their children at home (Bessant et
al, 1998:6-7). As the nineteenth century progressed, the middle classes were successful in
establishing a comprehensive secondary school education system readily accessible to children
from its own class. (Over time, girls were encouraged to attend secondary school although
initially this encouragement was for boys only). The education system therefore established a
long and clearly demarcated state of dependence for youth that did not exist in previous
generations. Significantly, Gillis (1974:102) asserts that this system of education effectively
created a new stage of life that more clearly corresponds to what we now call ‘adolescence’.
Indeed, Bessant et al (1998:14) state ‘the institution central to the establishment of adolescence was the secondary school’.

The history of working class youth ran parallel to these developments although working class youth eventually became incorporated into the secondary education system as well (Bessant et al, 1998:7-14). As production moved from the cottage to the factory, whole working class families were initially employed (Perrot, 1997). However, from the mid eighteenth century to the end of the nineteenth century, increased mechanisation and technological advances meant that the unskilled labour of young people became increasingly redundant (Musgrove, 1964). The increasing levels of youth unemployment that these developments created perhaps led to the first concerns about social disorder resulting from potentially idle, disaffected and delinquent young people. Indeed, Magarey (1978) contends that this point in history arguably marked the invention of notions of juvenile delinquency. As such, this is one of those very notable points in history where there was a clear moment of conjunction between the development of adolescent/youth discourse and that of youth criminality/delinquency.

Of course, the context for this conjunction had been well and truly established given that adolescent and youth discourse had already been couched in terms of instability, impulsiveness and particular vulnerability to deviancy.

In addition to technological advancement in the workplace, the other key historical condition that contributed to the progressive exclusion of youth from the workplace was the Rousseauesque sentimental and romantic view of youth (Graham, 2004:28). Children and young people were characterised as innocent, virtuous and particularly vulnerable to the cruelties and harshness of society. In England, this led to the passing of legislation known as the Factory Acts, which were
passed in 1833 (Bessant et al, 1998:9). This legislation placed tighter restrictions on the participation of children and youth in the workplace as well as declaring that factory owners should provide some level of schooling for their ‘juvenile employees’ (Muncie, 1983:32). Here we see the genesis of the dominant discourse of adolescence today whereby young people are characterised as simultaneously deviant and vulnerable, offender and victim. This discourse naturally invites high levels of ongoing monitoring, supervision, intervention and further marginalising and/or pathologising discourse (Wyn et al, 1997:89).

Although applied mostly to working class youth, the discourse around youth criminality/juvenile delinquency began to be cemented in Europe and Australia during the nineteenth century (Magarey, 1978; Muncie, 2004). Due to the combination of technological advancement and sentimentalisation of youth, a growing number of young people were neither at work or school. And, for those young people able to find work, good wages and increased leisure time provided levels of independence of some concern to ‘adults’. All of this meant that an increasing number of young people maintained quite a public presence in the streets and were highly visible. Whether or not these young people were committing crimes or not, and some certainly were, ‘moral panics’ about juvenile delinquency grew. In England, this led to new legislation being passed from 1829 that enabled police to ‘clear the streets’ of young people. Bessant et al (1998:11) state that this ‘reform produced a huge increase in the rate of imprisonment of young people, and in public perceptions of the criminality of young people’. Due to the eventual numbers of young people requiring imprisonment under the new laws, separate prisons for young people began to be established. In Australia, this occurred from the 1830s (Bessant et al, 1998:11).
The establishment of these separate prisons for young people meant that the discourse of the juvenile delinquent could now develop as never before as a ready and available supply of youth were available for scientific observation and study. This in turn provides for expert knowledge to be generated and disseminated, which in turn reinforces the object of juvenile delinquency/youth criminality within the broader discourse of youth/adolescence itself. By the end of the nineteenth century, secondary education was made universal and compulsory. This was in part a strategy of the middle class to address the criminality and delinquency of young people and working class youth were incorporated into the secondary system.

It is important to note here, however, that criminality was not thought of as only residing in working class youth. Rather, at the end of the nineteenth century, ‘most young people were considered to be potentially delinquent’ (Gillis, 1974:172). Heading into the twentieth century then, the constructs of youth, delinquency and criminality had clearly begun to merge. An inherent psychopathology in young people had also been stated or implied in the dominant discourses regarding adolescence and youth from around 193 BC until the end of the nineteenth century. In the twentieth century, this becomes more pronounced as psychologists and psychiatrists wield substantial power in their production of an ‘adolescent’ discourse that clearly emanates from historical conceptions of adolescence and youth; but which asserts the inherent and universal instability of young people with renewed and unparalleled vigour.

3.4.5 The Twentieth Century

By the beginning of the twentieth century, established age segregation and the later age of school leaving (particularly for middle class young people) meant that the years from 13-18 were being conceptualised by writers and educators as a discrete stage of life. ‘Adolescence’ became the
prevalent term to describe young people again and it was seen as beginning with the onset of puberty and ending with school leaving (Graham, 2004:31).

In 1905, psychologist Granville Stanley Hall published the two-volume work *Adolescence: Its Psychology and its Relations to Physiology, Anthropology, Sociology, Sex, Crime, Religion and Education*. This work has been the most influential in cementing notions of young people as inherently pathological, deviant and disturbed and its legacy is easily recognised today. Hall’s conceptualisation of adolescence drew heavily on Darwin’s theories of human evolution. Hall argued that human development occurred in stages that corresponded to the stages in the evolution of humankind (Muncie, 2004:68-70). In this way, particular age-stages represented a recapitulation to a corresponding evolutionary period. Given the discursive historical backdrop, it is perhaps unsurprising to find that adolescence was imbued with the most negative and pathologising attributes in this evolutionary recapitulation. Briefly, Hall equated childhood with animal-like primitivism, adolescence with savagery and civilisation with adulthood. Adolescents were characterised as ‘half animal, half human, and the struggle between these impulses directly caused a period of emotional storm and stress: adolescence’ (Muncie, 2004:69). Hall associated notions of barbarity with adolescence and asserted that increased criminality was a natural outcome of this age stage. Hall states that ‘adolescence is pre-eminently the criminal age…criminals are like overgrown children’ (Hall, 1905:325, 338).

Hall’s social Darwinism was gradually disregarded in the first half of the twentieth century, but his conceptualisation of adolescence persisted and was essentially retained in subsequent Freudian and psychoanalytic theories of human development (Bessant et al, 1998: 23). Bessant et al (1998:21) argue that Hall’s other crucial legacy was the positioning of adolescence as an object of scientific study. This was a result of his assertion of a materialist theory of the soul or psyche,
meaning that psychology became biology and biology is a matter for scientific analysis and observation. The reductionist approach to conceptualising adolescence in bio-psychological terms means that social, cultural and historical dimensions are largely unaccounted for. Now, delinquency appeared a clear and present danger as never before, since it could be ‘viewed as an attribute of “natural” social and psychological growth and could only indirectly be related to social and economic conditions’ (Muncie, 2004:69). Indeed, Springhall (1986:27) explains that the life stage of adolescence was now perceived as the cause of delinquent behaviour. Again, the discourse of adolescence, youth criminality and pathology/deviance are intertwined.

From the 1920s and 1930s, Sigmund Freud and his theoretical descendants continued in the tradition of characterising adolescence as being particularly tumultuous (Graham, 2004:29-30). Freud postulated that the flood of sexuality that occurred in adolescence brought with it especially turbulent intra-psychic conflicts. Influential American psychoanalyst Peter Blos described adolescence as a period of disarray and inherently regressive. Anna Freud held the view that a ‘normal’ adolescence was marked by disturbance and that ‘the upholding of a steady equilibrium during the adolescent process is in itself abnormal’ (in Graham, 2004:29). Donald Winnicott, the renowned British psychoanalyst, discussed adolescence in illness terms and contended that the cure for adolescence was the passage of time and the gradual maturation process.

From the 1940s to the 1960s, classical sociologists from the structural functionalist perspective also made significant contributions to the dominant discourse around adolescence. Sociologists such as Talcott Parsons and Robert Merton propounded the view that society was a system that seeks to promote its own internal social order or equilibrium while protecting itself from disorder (Merton, 1957, 1967; Parsons, 1963, 1964). Within this framework, individuals who failed to be
socialised properly would become deviants, requiring ongoing surveillance and remedial socialisation. Given the nature of dominant discourse relating to adolescence prior to this period, adolescents were readily seen as likely sources of deviancy within the structural functionalist framework. Bessant et al (2002:170) note: ‘In effect, to be an adolescent in the terms set up by this sociological story is already to be deviant’. In the 1960s, psychoanalyst Erik Erikson articulated his theory of life span psychological development (Peterson, 1989:45). Erikson asserted that each stage of life had a distinctive crisis or turning point and that although these stages were universal across all societies, they were socially experienced and culturally specific. In relation to adolescence, he did not describe it as especially troubled, but his use of the term ‘identity crisis’ for that period of life suggested particular difficulties for young people existed. Certainly, as Bessant et al (1998:27-28) contend, his ambiguous descriptions and use of crisis-based language meant that his account of adolescence still maintained a clear place within the dominant discourse of adolescence. Therefore, while challenging some of the central tenets of human and adolescent development proposed before him, he kept ‘the faith with the founding principles of Hall and Freud’ (Bessant et al, 1998:28).

Throughout the twentieth century, there were alternative discourses of adolescence that challenged dominant views (Graham, 2004; Muncie, 2004; Muuss, 1988; Peterson, 1989; Wyn et al, 1997). From the 1920s – beginning with the pioneering work of Margaret Mead - a number of anthropological studies have challenged the idea of adolescence as being bio-psychological, universal and riddled with turmoil (Graham, 2004; Peterson,1989). Using cross-cultural comparisons, these studies have contended that adolescence can be seen as ceremonial rather than developmental, and culturally specific rather than biologically driven. Adolescence was also claimed to be relatively untroubled in some communities.
Within psychology, significant challenges to ‘storm and stress’ renderings of adolescence began with Daniel and Judith Offer in the late 1960s (cited in Bessant et al, 1998:26-27). These challenges are based on studies of what researchers such as Offer describe as ‘non-patient’ or ‘normal’ adolescent populations. These studies have suggested that while young people face significant challenges, they are generally able to negotiate them competently and without drama. With the increasing importance and influence of sociology after 1945, adolescence also began to progressively be located within a social context (Bessant et al 1998:25-31).

Theorists such as Bandura and Sullivan, while retaining age stages in development, argue that development is a continuous process and non-universal. In particular, development is argued to be more about progressing through changing social relationships within a specific social context, rather than negotiating intra-psychic conflict (Muuss, 1988:123). Also, theorists such as Bronfenbrenner and Garbarino have further promoted the view of adolescence as a social creation through a social-ecological systems model (Bessant et al, 1998:29). This model, most notable from the 1970s through to the 1980s, emphasises the development of young people as being inter-dependent of the network of social systems that make up an individual’s ecology.

More recently, sociologists such as Bessant, Watts and Sercombe have also challenged dominant discourses of adolescence by emphasising the social context of young people and the continuities of experience that exist throughout the lifespan of individuals (Bessant et al, 1998; 2002). Some historians also argue that society creates the kind of adolescence it needs according to the given historical period. For example, during times of war adolescents have been portrayed by psychologists as more grown-up, mature and adult-like as compared with periods of high unemployment such as the Depression when they have been characterised as more child-like (Graham, 2004:41-42).
However, despite challenges to the dominant discourse of adolescence throughout the twentieth century, ‘the idea that “the adolescent” is naturally irresponsible, emotionally unstable, rebellious, difficult and almost certainly deviant…is now widely held to be the truth by most adults’ (Bessant et al, 2002:169). This view is also relentlessly endorsed by media representations of adolescents and young people (Bessant et al, 2002; Graham, 2004; Muncie, 2004; Sercombe, 1999; White et al, 2004; Wyn et al, 1997). The representation of young people and dominant discourses of adolescence in the media are encapsulated by Graham (2004:10) - ‘Men may be from Mars and women from Venus, but teenagers arrive direct from Hades’.

3.5 Continuities of Discourse Concerning Adolescence, Youth Crime and Mental Illness

Overall then, the dominant discourse surrounding adolescents suggests clear and ‘natural’ continuities to anti-social behaviour, criminality, psychopathology, psychiatric distress and deviancy (Bessant et al, 2002; Fuller, 1998; Graham, 2004; Muncie 2004). The continuities between adolescence and psychiatric distress are indeed readily established since dominant discourses of adolescence and mental illness are both clearly situated within the Modern episteme and its veneration of scientific rationality. In particular, the dominant discourses of adolescence and mental illness are constructed around a bio-psychological essentialism that reflects the hegemony of the medical model and the medicalisation of public discourse (Kaiser, 1996).

The dominance of the medical model in conceptualising mental illness has been discussed extensively in Chapter 2 and will not be repeated here. Critiques of psychiatry’s claim to scientific neutrality have been challenged far and wide. Some of these critiques have concentrated on its literary article of faith, the Diagnostic and Statistical Manual of Mental
Disorders or DSM-IV (Caplan, 1995; Kutchins et al, 1997; Stoppard, 2000). However, a central theme that occurs in the critiques of the medical model and its discourse of mental illness is its embracing of the polarised categories or binary oppositions that characterise the wider discourse of the Modern episteme (Bainbridge, 1999; Banton et al, 1985; Morley, 2003; Parker, 1997). Within these polar opposites, a hierarchy is established that privileges one category over the other. Within the context of adolescents and their association with criminality and mental illness, the binary oppositions that marginalise them include adult/child-adolescent, normal/deviant and healthy/ill.

Given that adolescence is conceptualised as belonging to that stage of life that is dominated by bio-psychological forces that create emotional and psychological instability, we can see that it is a short step indeed to defining adolescence and adolescents as being mentally ill. Indeed, also as inherently anti-social or criminal and this has been discussed earlier in some measure. The inherent bias towards pathologising young people is not only present in the media, but also among health professionals who work with young people (Epstein et al, 2001b; Graham, 2004:30). For instance, in an English television documentary in 2002, an American psychoanalyst being interviewed stated that if he heard of a young person who had negotiated their adolescence without significant turmoil, he would assume that a serious mental illness was likely to be present (Graham, 2004:29). Also, a study published in the 1980’s detailed how American mental health professionals viewed even a normal, mentally healthy adolescence as being characterised by a range of clinical problems, that are not actually present for most young people (Graham, 2004:30).

From the perspective of critical theory, this represents a particular form of ageism. However, as previously mentioned, discourses of adolescence have also represented particular discriminatory
and marginalising practices in terms of class, gender and race/ethnicity (Muncie, 2004; White et al, 2004). For instance, the discourse of adolescence has often been centred on males and masculine images and paid little attention to teasing out gender dynamics and the distinct social experiences of young men and young women (Hudson, 1984:47; Muncie, 2004:42). Also, the origins of the concept of adolescence as a discrete age stage can be viewed as inherently middle-class, since it gained momentum during the establishment of secondary education that was initially only provided for middle-class young men (Bessant et al, 1998:6-8). In addition, young people from working class and minority ethnic and racial groups are significantly over-represented within the Juvenile Justice system. This means that discourses around adolescent criminality become associated with young people from particular class and ethnic groupings (White et al, 2004). Much more can be said in relation to the class, gender and race/ethnicity dynamics that underpin discourse regarding adolescence, (youth) criminality and (youth) mental illness. However, as mentioned earlier in this chapter, the confines of this thesis do not permit a comprehensive exploration of such themes but the acknowledgment of them is important.

In sum then, it can be seen that even ‘normal’ or ‘mainstream’ adolescents are subject to a pathologising discourse that invalidates, disempowers and oppresses them as a group of people. If such discourse and the practices it gives rise to are keenly felt and experienced by normal or mainstream adolescents, the impact on adolescents in out-of-home care diagnosed with severe conduct disorder is likely to be even more profound. This is because the full import of the entire potential stigma associated with being an adolescent is fully bestowed on these particular young people. In short, their age-related instability and impulsivity is confirmed as being fully realised as ‘adolescents’, as well as their anti-social behaviour, criminality and mental illness being fully confirmed by mental health diagnosis. (According to their class, gender, race/ethnicity and sexuality, this strong sense of marginalisation may be further exacerbated). The impact of
dominant discourse is also compounded by the fact that these young people are already experiencing high levels of intra-personal, inter-personal and societal alienation due to the impact of profound attachment and relationship difficulties discussed earlier in this chapter. From the perspective of critical theory and critical social work, the impact of dominant discourse on these young people is likely to produce significant levels of inferiorisation and internalised oppression.

3.6 Lasting Effects of Negative Discourse

Given that Foucault (1978) propounded that the ‘self’ is a product of discourse and that through discourses subjectivity is formed, the sense of self developed by adolescents in out-of-home care presenting with severe conduct disorder is likely to be profoundly negative and disempowered. Pease (2003:192) contends that social work practice informed by critical theory ‘must address the processes by which oppression and domination become internalised in the psyches of individuals’. Dr. Michael Lerner (1986:xii), a philosopher, social theorist and clinical psychologist, argues that ‘the “self” that needs help is intrinsically social’. However, I do not wish to adopt a binary or mutually exclusive concept of the ‘self’, but to assert that the ‘self’ that requires assistance is at once ‘individual’ and ‘social’. I believe that the ‘psychic alienation’ Bartky (1975:56) describes as resulting from oppression is socially derived yet nonetheless individually experienced, embodied and felt. Mullaly (2002:122) highlights this, stating ‘it is impossible to construct a general theory of oppression, in general, and internalised oppression, in particular’. However, I do wish to explore those dynamics associated with the psychology of oppression that emanates from ‘real’ structural oppression and oppression wrought by dominant discourse. Mullaly (2002:124) defines the first internalised effect of oppression, inferiorisation, in the following manner:
…not only an acceptance of a second-class or inferior citizenship status in society by a member of an oppressed group, but a belief that he or she and all members of that group are inferior to the dominant group. It is a belief that their oppression is deserved, unique, unchangeable or temporary and that their problems in living are due to their personal shortcomings.

Mullaly (1997; 2002) contends that inferiorisation almost inevitably progresses one step further to internalised oppression. Internalised oppression may be defined as encompassing not only beliefs of inferiority, but also behaviour (often self-destructive) that tends to ‘confirm’ those beliefs to oppressed persons themselves as well as to members of the dominant group. This involves the oppressed ‘acting out’ the negative things that are said about them. Adam (1978:59) described this manifestation of internalised oppression as the commission of guilt expiation rituals. This is when ‘oppressed persons are typically riddled with internalised self-hatred and guilt and engage in circular, self-destructive rituals, which serve to punish them, and ultimately reinforce the portrait they have of themselves as devalued persons’ (Moreau, 1990:59).

In consequence then, the combined effects of dominant discourse, inferiorisation and internalised oppression are to ontologise alienated and oppressed persons as fundamentally flawed, and by extension, without hope. It might be suggested that structural oppression robs people of actual opportunity for change and betterment of life circumstances, while dominant/dominating discourse robs people of the perception or hope that things could positively change. This is because ‘things are as they are’ and that there is something of a natural order of things, complete with winners and losers, that is unalterable. Moreau (1990:60) suggests that in response to such a die being cast, oppressed persons:
…systematically set themselves up to be devalued and put down by others in a variety of ways. Such moves provide an illusory feeling of temporary release and freedom from the tyranny of the oppressor because the inferiorised individuals are the ones who order personally their own punishment.

Mullaly (1997:152) describes this response of complicit self-destruction as a rational coping mechanism ‘employed in everyday life to lessen the suffering of oppression’ though it is irrational in that it functions to sustain domination.

It is, as Freire (1970) describes, that the oppressor has got in the head of the oppressed. The oppressed are imbued with defeatism, fatalism, self-deprecation, self-blame, self-hatred, alienation and powerlessness. When considering adolescents in out-of-home care presenting with severe conduct disorder, the profoundly negative discourse that attends being an adolescent, a ‘juvenile delinquent’, mentally ill and a ‘wardie’/ward of the state is almost too overwhelming to contemplate. Indeed, I have personally listened to many such young people display profound levels of inferiorisation with statements such as ‘Oh well, what can you expect, I’m just a f****d up Wardie…nothing is going to change’. Indeed, Victorian State Advocate for Children in Care, Toby O’Connor, noted the particular shame children and young people in care describe in his address to the National Protective Behaviours Conference in Melbourne, October 2005 (O’Connor, 2005). His presentation, entitled ‘Kidsp eak’, reported on comments made by children and young people in care to researchers seeking their input to assist in shaping future policy.

It is also the case that adolescents in out-of-home care presenting with severe conduct disorder demonstrate the strongest patterns of acting out behaviour that cause the highest levels of
placement disruption and breakdown within the out-of-home care system (Delfabbro, 2003; Delfabbro et al 2001; Penzerro et al, 1995). Internalised oppression is repeatedly revealed by specific alienating behaviours such as lying, stealing, sexual inappropriateness, physical violence, threats of violence to harm, retaliate and kill, as well as substance abuse. Naturally, this alienates these young people from others while reinforcing their worldview that they are ultimately unable to change or alter their life-course or trajectory.

Exceptionally clear patterns of alienation exist for adolescents in out-of-home care presenting with severe conduct disorder. Their experience of attachments/relationships as well as discursive location as adolescents, criminals and mentally ill mean that they have a deeply internalised sense of inferiority, unworthiness, defeatism and fatalism. In terms of attachment theory and critical social work theory respectively, their internalised working model of themselves, others and the world, and internalised oppression, eliminate hope and any sense of positive agency in the world. They are then vulnerable to enacting circular patterns of self-sabotage which perpetuate their alienation from themselves, others and society. In the following chapter, Chapter 4, I will discuss in detail the paradigm, methodologies and methods chosen for my research into interventions for adolescents in out-of-home care diagnosed with severe conduct disorder.
Chapter 4

Research Paradigms, Methodologies and Methods

- Embracing Pragmatism and Flexibility

Theory is a dangerous, greedy animal, and we need to be alert to keep it in its cage.

- Howard S. Becker

4.1 Rationale for Selection of Research Topic – ‘Interventions with Adolescents in Out-of-Home Care Diagnosed with Severe Conduct Disorder’

My rationale for selecting this research topic emanated from my work in the field as well as my awareness of existing literature and research. In the Foreword and Chapter 1, I have detailed much of the rationale for choosing to do a study on interventions with adolescents in out-of-home-care diagnosed with severe conduct disorder. During these two sections, I provided ‘snapshots’ from my working life with this client group and communicated my passionate concern for these young people.

Further, in Chapters 1 and 3, I discussed the extreme difficulty that practitioners from the Welfare, Juvenile Justice and Mental Health sectors experience in working with this group of young people. Also, the great difficulty that these young people experience in working with the adults provided by the State to assist them. I also described how adolescents diagnosed with severe conduct disorder are possibly the most difficult adolescent population to work with, even
more so if they are also found within the out-of-home care system. This is due in large part, to the complex and at times seemingly intractable constellation of difficulties that involve severe attachment disruption, significantly impaired brain development, experience of repeated abuse and trauma related to these experiences.

These profound difficulties are further exacerbated by the negative discourses that attend this group of young people, further robbing them of a sense of hope as well as those working with them. So, the need to conduct research regarding the nature of interventions implemented with this group of young people was and is clear. There remains no current view that existing interventions are achieving significant qualitative or life-altering outcomes. Kazdin (2002:79), providing a meta-analysis of the effectiveness of psycho-social treatments for conduct disorder, states ‘We cannot yet say that one intervention can ameliorate CD and overcome the poor long-term prognosis’. Morton et al (1999) also note the tendency for overseas research and literature to cluster or isolate around particular problem behaviours such as anti-social behaviour and violence. This approach fails to address the issue of formulating interventions to work with these behaviours when they occur in young people existing at the extreme end of out-of-home care.

This particular research and practice gap is further highlighted by Kazdin (2002:79) who notes that of the several interventions tentatively supported for working with conduct disorder, ‘there is a strong emphasis on the family; four of the five treatments explicitly focus on parents and family interaction in some way’. For adolescents diagnosed with conduct disorder in out-of-home care, family members are usually unable to participate in treatment approaches due to their own very troubled, abused and/or abusive background (Department of Human Services, 1998; Fonagy,
2001; Howe et al, 1999b; Hughes, 1997; Jobes, 2004; Jonson-Reid et al, 2000; Levy et al, 1999; Maier, 1987; Moretti et al, 1994; Morton et al, 1999). Indeed, where there has been extensive and repeated abusive behaviour by family members towards the young people concerned, their involvement may not even be considered desirable or helpful.

My research also assists in addressing gaps related to the study of young people within out-of-home care who live in residential care. Although my research was not about residential care per se, it examines the issues and needs of the client group most likely to require and utilise residential care placements (Barber et al 2002:34; Bath, 1998:23; Delfabbro et al, 2001:789).

Cashmore and colleagues conducted an audit of Australian out-of-home care research for the ten-year period 1995-2004. In it they found out of a total of 94 identified research projects, only three were conducted regarding residential programs and their likely client group (Cashmore et al, 2004:9, 24). The importance of my research and how it relates to gaps in the field is further highlighted by the audit which found there was a comparative lack of research culture and activity in the Australian out-of-home care context. Moreover, what research is conducted is often heavily influenced by ideas generated from overseas studies. Cashmore et al (2004:29) state:

Researchers, practitioners, and policy makers in Australia can learn much from international research, and from the different perspectives it brings, but differences in the culture and the child Welfare systems also mean that the findings are not automatically transferable from one jurisdiction to the other. We cannot rely on overseas research but
need to develop a strong research base that reflects and speaks to the Australian service system.

So, based on my experience of working in the field and reviewing available literature, a clear research gap became increasingly evident. I perceived a clear need to begin the process, modestly, of conducting research that could progress the understanding of the field and society generally regarding useful conceptions and interventions that address the needs of possibly the most alienated, disadvantaged and stigmatised young people in our community. These young people are indeed those that occupy most of the residential placements within out-of-home care – adolescents diagnosed with severe conduct disorder. Kazdin (2002:80) urges ‘further progress in understanding the nature of CD is likely to have very important implications for improving treatment outcome’ and that the bases of therapeutic change in working with these young people requires further investigation and clarification.

4.2 The Research Study – Overview and Sampling Employed

Having developed and refined my research topic, based on my working life thus far and knowledge of existing research and literature, one of the next major decisions in designing my study was to determine the type and number of respondents to be included. Initially, at the earliest stages of formulating a proposal, I had intended to select four types of respondents. These were ten senior practitioners and decision-makers and ten young people from the relevant client population, a significant family member associated with each young person and the case manager of each young person.
This added up to a total of 40 respondents, with an intention to administer a questionnaire and interview with each one. Looking back, this was an overly ambitious plan, particularly given the confines of a master’s by research degree thesis - ambitious not only in the number of respondents, but also the type. Certainly, the ethical considerations and complexities of interviewing the potentially quite vulnerable young people and their family members would require some resolving. In the context of these issues and discussions with my primary and secondary supervisors, I eventually settled on a much smaller number of respondents.

Indeed, I eventually concluded that I would consciously choose to conduct exploratory research rather than research of a more comprehensive and wide ranging nature. As mentioned elsewhere in this chapter, I view the research I have completed as the first stage of a two stage process. Sarantakos (1993:7) posits that exploratory research can indeed be ‘undertaken in order to provide a basis for further research’ and that the use of ‘expert consultation as sources of data is commonly employed’. My final decision was to have ten respondents who were all senior practitioners and/or decision makers from the sectors related to the client population which is the focus of my research – Welfare, Juvenile Justice, Child Protection and Mental Health. I employed non-probability sampling which is often used in exploratory and qualitative research and does not claim representativeness (Sarantakos, 1993:126, 137). In particular, the type of non-probability sample I used was purposive sampling. Purposive sampling involves purposely choosing subjects/respondents, often those considered ‘expert’ in their field.

In terms of my chosen group of ten respondents, I thought it was important to include people from the variety of sectors involved in working with the client group concerned.
This is because each sector tends to have views based on its own areas of speciality and particular experiences, as well as tending to include health care professionals from particular disciplines. As a result, I included four respondents from the Welfare sector, two from Juvenile Justice, two from Mental Health and two from Child Protection. In addition, I sought to select respondents with different disciplinary backgrounds. This was achieved to a reasonable degree with six respondents being social workers, two clinical psychologists, one an occupational therapist and one a psychiatric nurse. All of these senior practitioners were in positions as key decision makers in their various sectors and were located throughout metropolitan Melbourne. More information regarding these respondents will be provided in the next chapter in the context of presenting my findings.

In terms of sourcing the respondents, I had a significant advantage in that I have worked in the field for some time and have to some degree, specialised with the client group that is the focus of my study. Furthermore, I have worked in both Welfare and Mental Health sectors in Victoria and South Australia and closely alongside staff from the Child Protection and Juvenile Justice sectors, in both states. This meant I had a vast existing network of contacts from which to draw my respondents. Taking into consideration the sourcing of respondents from various sectors and different disciplines, I proceeded to phone nine potential respondents and enquire as to their availability and willingness to participate in my research. At the time of my initial phone call, all nine respondents agreed to participate in my research and we made appointments to meet for this purpose. A tenth respondent was arranged at the time of meeting one of my other respondents, who provided me with their contact details and undertook to recommend me and my study to them.
Five of my ten respondents agreed to participate in the research subject to my e-mailing them the formal written invitation to participate in the research that I’d prepared, as well as wanting to sight the ethical conditions, guidelines and overall framework that my research was adhering to. The other five respondents agreed to participate without any such qualification, being content to view and sign these documents at the beginning of our scheduled meeting rather than receiving them in advance.

4.3 Some Initial Comments on Limitations of the Study

From the perspective of critical theory and critical research, this would be viewed as a weakness and significant limitation of my study since it is ‘top-down’ and expert driven. In this way, a critical researcher would contend that the crucial goal of the emancipation of disempowered and disenfranchised persons is compromised because only the ‘voices’ of those with power and claims to ‘expertness’ are recorded and heard (Fook, 1993; Kincheloe et al, 2000; Smith et al, 1986; Sutherland, 1986). Given my use of critical theory in helping to conceptualise my research topic in Chapters 2 and 3, these issues were not lost on me. However, for the philosophical, political and practical reasons previously covered in Chapters 1-3 and that will be further addressed later in this chapter, I determined to proceed with the abovementioned respondents.

Also, I believe it is important to place the abovementioned limitation or weakness from a critical perspective in the broader context of my study. My exploratory study is aimed at attracting the attention of persons drawn from the same level of influence and power as the respondents. It is hoped, and I believe without any undue optimism, that this study will provide momentum for a follow-up study that is focused on the young people being discussed as respondents as well as their family members.
I myself am well placed to conduct such a study in my current employment as a project consultant to organisations working in the area of interest, extensive working history with the young people concerned, as well as future plans to complete work-based and/or doctoral research that builds on this study.

4.4 Ethical Considerations

In accordance with RMIT University higher degree by research standards, I was required to complete and submit an ethics application for approval of research involving participants. In addition to of course supplying details regarding the research topic and planned methodology, the key aspect of this application is to provide an estimate of potential risk to research participants. Given the type of respondents I finally settled upon, I submitted an ethics application that estimated the risk level for participants to be Category NR (no risk above the everyday) / Risk level 1. The other two risk categories were Category MR (minimal risk) / Risk level 2 and Category AR (at risk) / Risk level 3. In successfully arguing for a risk category of NR for my study, I considered the following factors in terms of the ethics framework and criteria set down by the then current University Faculty of the Constructed Environment (Faculty of the Constructed Environment Research Committee, 1998).

To begin with, the personal and professional backgrounds of participants assisted in rendering risk of harm to them as Risk level 1. The participants were senior health care professionals with high levels of socio-economic and political empowerment as well as being beneficiaries of significant tertiary/higher education. As such, participants were clearly not drawn from disadvantaged, disenfranchised or vulnerable groups such as minors, the disabled, prisoners, the elderly or those who are mentally or physically ill. Therefore, their level of overall vulnerability
could be seen to be negligible. Indeed, it may be strongly contended that at the time, the participants had even greater levels of personal and professional power than myself (I conducted all the interviews and administered all the questionnaires utilised in the study).

Furthermore, risk was highly minimised due to the fact that the participants were not public figures, officials, office bearers or group representatives involved in public discourse. In addition, it can be clearly seen that none of the participants could’ve been considered in any way as being in a ‘dependent’ relationship with me. One potential area of vulnerability for research participants was their expression of views that could be deemed critical of the organisation they worked for or received funding from. However, I believe this potential vulnerability was negated/minimised by the fact that all data gathered was recorded and will be presented, maintaining the utmost confidentiality and in such a way as to preserve and protect the identity of participants.

In addition to the demographics of the participants ensuring no risk above the everyday, the actual research processes and methods themselves assisted in relation to risk. Firstly, the research processes followed ensured the ‘voluntariness’ of participants was easy to identify and establish and that their consent was able to be given freely and without impediment. This was facilitated in part by the personal and professional backgrounds of participants as mentioned above, but also by adhering to the two steps detailed as necessary in obtaining informed consent in the then current ethical research guidelines drawn up by the university faculty of the constructed environment (Faculty of the Constructed Environment Research Committee, 1998). These two steps were to firstly provide a plain language statement about the research and secondly to provide a formal consent form for researcher and participant completion. The plain language statement must be written at the recipient’s level of comprehension and include adequate
information about the purpose, methods and demands of the study. I provided this information in the form of a research invitation letter that was sent to each participant following my initial phone call (see Appendix 1). The letter also included contact details for myself, the research supervisor and the university human research ethics committee.

Then, at the time of meeting the participants and prior to commencing with any of the interview or questionnaire items, I provided the then current ‘Prescribed Consent Form For Persons Participating In Research Projects Involving Interviews, Questionnaires, Focus Groups or Disclosure of Personal Information’ (see Appendix 2). This form helpfully includes standards and conditions relating to the freedom to withdraw from the project at any time and to withdraw any unprocessed data, the assurance of anonymity and confidentiality of information provided and the assurance that the security of the data obtained would be maintained at all times including following the study. Confidentiality and security of data have been and will be maintained in several ways.

The research participants will only ever be referred to both within this thesis and in any future publications in a generalist manner with no references to their name, job title or office location. For instance, a participant would be referred to as respondent A, a senior practitioner from the Child and Adolescent Mental Health sector working in metropolitan Melbourne with a nursing background. In addition, only I have had access to the contact details of participants and data collected. The original copies of these have been kept in the locked filing cabinets of both my home office and work office. It is important to note that the master list of participants has been stored securely away from the thesis and the questionnaires and interview transcripts. The master list has been stored in a separate locked filing cabinet at my home office which requires a
different key for access to the other filing cabinet which will store the main project information and data. A copy of the master list has also been stored in a separate locked cabinet to the one housing the main project information and data, in my places of work. In respect of work, it is only myself who has access to the abovementioned filing cabinets. In this way, I alone have been responsible for the security of confidential information relating to the study. Indeed, I conducted the research with no-one assisting me.

Secondly, the research methods / techniques chosen also assisted in relating to potential risk. This is because I simply sought information regarding interventions used in working with the client population under consideration and therefore information provided by participants was unlikely to be of a prejudicial or incriminating nature. In any case, as previously mentioned, I recorded data in such a manner as to prevent identification of participants and to preclude identification at a later date. Moreover, the research methods employed were not intrusive or invasive but were a quite typical questionnaire format and a relatively unstructured, open interview which provided participants with high levels of determination regarding the comments they chose to offer. Therefore, the research methods were unlikely to cause discomfort or in any way be of a ‘therapeutic’ nature. In summary then, the research was very unlikely to expose any participants to physical, psychological, social or political risk.

4.5 Paradigmatic Tensions in the Research Design

It is certainly the case that designing my study and choosing accompanying methodologies and methods has been at various times a source of consternation, vexation, aggravation, paralysis, worry and intellectual stimulation. The main source of these different emotional and mental states has been extant underlying philosophical and paradigmatic tensions in the approach to my thesis.
and research. These tensions perhaps began with my choice to analyse and conceptualise my research topic – interventions with adolescents diagnosed with severe conduct disorder in out-of-home-care - from the standpoints of two apparently competing conceptual perspectives.

Returning briefly to the contents of the previous chapter, I chose to conceptualise my research topic from the positivist-based view of Attachment theory, then in turn, from the non-positivist standpoint of critical theory. In doing so, I found the philosophical sophistication and pragmatism of Hacking (1999) and Gergen (2001) especially helpful and indeed liberating. Their positions are discussed at some length in Chapter 3; however essentially, they assert the possibility and desirability of a conceptual and research space within which competing theoretical perspectives might be permitted. Namely, those from opposing ontologies and epistemologies – perhaps broadly definable as positivist and non-positivist.

Of course, my choice at that point to select competing theoretical perspectives as my two main conceptual tools directly raised issues as to the choice of my research methodologies and methods. This is because the ‘science wars’ that have played out in the realm of the philosophy of science (between natural science and social science), have in fact mirrored the ‘paradigm wars’ in the field of social research (fundamentally between positivist and non-positivist approaches) (Becker, 1993; Creswell et al, 2003; Gage, 1989; Geelan, 2002; Greene et al, 2003; Guba et al, 1994; Hacking, 1999; Niglas, 2004; Paulston, 1990; Patton, 1997; Tashakkori et al, 2003).

Indeed, whilst Gergen (2001) criticised the science wars as an inherently annihilistic pursuit with no real winners, Geelan (2001:1) states that the paradigm wars have ‘often generated more heat than light’. Before proceeding further into this discussion, let me define my use of the term ‘paradigm’.
The meaning and use of the term paradigm varies considerably within social research, sociology and social science and there is no complete agreement about its usage and meaning (Sarantakos, 1993:31). However, my working definition will be that adopted by most sociologists – ‘a set of propositions that explain how the world is perceived; it contains a world view’ and is directly related to the major philosophical and theoretical ‘schools’ within science and social science (Sarantakos, 1993:30-31). Similarly, Guba et al (1994:105) defines paradigm as ‘the basic belief system or world view that guides the investigator, not only in choices of method but in ontologically and epistemologically fundamental ways’.

Within the field of social research, Guba et al (1994:109) articulate that four major research paradigms may be seen to exist – positivist, postpositivist, critical and constructivist/interpretive. There are of course significant variations within each of these paradigms, perhaps more notably within the broadly defined critical and interpretive paradigms (Guba et al, 1994; Sarantakos, 1993). For instance, the critical paradigm includes post-modern, feminist and Marxist approaches and the interpretive paradigm can be said to include the perspectives of symbolic interactionism, ethnography and phenomenology. However, there is enough underlying commonality among various approaches to enable grouping together such that four main paradigms may be spoken of (Guba et al, 1994; Sarantakos, 1993). These four main theoretical/conceptual paradigms can be further distilled at the level of methodology in terms of a quantitative (positivist and postpositivist) and qualitative (critical and interpretive) paradigm (Patton, 1997). The basis of the phrase and activity of the ‘paradigm wars’, is the belief in and valuing of, the pursuit of orthodoxy and the ‘correct’ epistemological path to the truth/s by which ultimate reality may be known (Becker, 1993; Geelan, 2002). Geelan (2002:7) characterises this as the ‘drive toward the homogenisation of research into a single dominant paradigm’.
Historically, this has led to social scientists and researchers conducting a prolonged, intractable and mutually hostile debate about paradigmatic and methodological soundness and the incommensurability of combining positivist – quantitative approaches with non-positivist – qualitative ones (Creswell et al, 2003; Gage, 1989; Greene et al, 2003; Niglas, 2004; Patton, 1997; Tashakkori et al, 2003). For researchers, especially post-graduate research students, this is quite a troublesome philosophical and paradigmatic fracas to walk into – ‘But some researchers – most especially graduate students – are especially vulnerable to the questioning doubts that paralyse thought and will and work. For them the evil is serious’ (Becker, 1993:3).

As previously mentioned, having chosen attachment theory (positivist) and critical theory (non-positivist) as my conceptual tools and ‘lenses’ by which to analyse my research topic, I needed to address that tension in terms of the ‘science wars’ issue. However, this philosophical/paradigmatic tension also ‘dropped down’ into the choosing of my research paradigms and methodologies. If I was to engage in the ‘paradigm wars’ debate as historically conducted, there possibly would be no resolution. This is because I would have had to choose, in a binary and binding sense, between methodologies congruent with a positivist/postpositivist position (reflecting my earlier use of attachment theory) or those more congruent with a critical approach (reflecting my earlier use of critical theory). Becker (1993:219) points out that in terms of the traditional research paradigm debate - characterised by entrenched binary oppositions and symbiotic critique - there can be no settling of the debate:

Epistemological issues, for all their arguing, are never settled, and I think it fruitless to try and settle them, at least in the way the typical debate looks to. If we haven’t settled them definitively in two thousand years, more or less, we probably aren’t ever going to settle them.
4.6 The Post-Paradigmatic Position and Combined Methods

Guba et al (1994:116) state that any move toward a resolution of the ‘paradigm wars’ necessarily involves ‘the emergence of a metaparadigm that renders the older, accommodated paradigms not less true, but simply irrelevant’. So, just as I found in reading about the ‘science wars’, there is a good deal of writing within the field of social research that is as philosophically pragmatic and sophisticated as that of Hacking (1999) and Gergen (2001).

However, I am in agreement with Fook (2000:2) in that I do not advocate an ‘anything goes’ approach to research activity or as described by Geelan (2002:8), a degeneration into ‘bland relativism’. I do not believe that pragmatism is a euphemism for laziness or sloppiness. Indeed, as I have found, it can take more intellectual and emotional energy to mount decent arguments for the combining of ostensibly incompatible perspectives, than it might arguing for more conventional, theoretically homogeneous pieces of work and thinking. Becker (1993:220), paraphrasing ethnomethodologist Harold Garfinkel, states that paradigmatic and epistemological debate should indeed be ‘a topic rather than an aggravation’. This echoes the thoughts of Geelan (2002) who advocates disciplined (intra-study) eclecticism within social research. This approach of disciplined eclecticism excludes no epistemologies or paradigms on the grounds of orthodoxy and to that extent can be viewed as a pluralistic/anarchistic approach. However, Geelan (2002) also asserts the need for paradigmatic positions to be explicitly stated. In this way, the philosophical and paradigmatic issues within my thesis and research are not ones I wish to dismiss or be fatalistic about, but rather I want them to be an earnest topic. Guba et al (1994:116) posit ‘Paradigm issues are crucial; no inquirer, we maintain, ought to go about the business of inquiry without being clear about just what paradigm informs and guides his or her approach’.

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However, as Becker (1993) cautions, these issues should not be allowed to progress to an aggravation whereby research activity is unnecessarily paralysed. Patton (1997) contends that the practical researcher cannot resolve paradigmatic tensions in the ultimate sense since consensus will never be reached regarding the ultimate nature of reality and the attendant concerns of what is ‘real’, what is knowable and how it is knowable. Rather, Patton (1997:296) states ‘Pragmatism can overcome seemingly logical contradictions. I believe that the flexible, responsive evaluator can shift back and forth between paradigms within a single evaluation setting’.

Indeed, Patton (1997:295) asserts that while philosophical issues in research will remain, ‘The connection between philosophical paradigms and methods has been broken’. Indeed, many social researchers now believe we exist in a ‘post-paradigmatic’ environment in which it is no longer a case of either/or but either/and when it comes to research paradigms, methodologies and methods (Creswell et al, 2003; Datta, 1994; Gage, 1989; Greene et al, 2003; Niglas, 2004; Patton, 1997; Tashakkori et al, 2003). This movement or approach is also referred to as the ‘pragmatist paradigm’, disciplined intra-study eclecticism, utilisation-focused and meta-paradigmatic (Denzin et al, 1994; Geelan, 2002; Niglas, 2004; Patton, 1997). Niglas (2004) asserts this ‘post-paradigm’ view as a third methodological movement that upholds a mixed or combined methods research approach and is a separate methodological orientation to historical research frameworks. Niglas (2004:21) contends that the use of the term ‘combined’ methods research is ‘an umbrella term for all research approaches where qualitative and quantitative aspects have been combined in one way or another’.

Geelan (2002:12) states ‘When combining research approaches which have different epistemological bases, the approach is dialectical rather than synthetic: synthesis would remove
the very richness that the dialectical interaction of incommensurable perspectives is intended to foster’. Indeed, this dialectical interaction between incommensurable perspectives echoes the thoughts of Geelan (2002) in his description of alternating between different conceptual/theoretical ‘lenses’ when viewing and analysing the same phenomenon. Becker (1993:219) also reflects this approach:

Because, though everything can be questioned, we needn’t question it all at once. We can stand on some shaky epistemological ground Over Here for as long as it takes to get an idea about what can be seen from this vantage point. Then we can move Over There, to the place we had been treating as problematic while we took Over Here for granted and, taking Over There for granted, make Over Here problematic for a while. It’s John Dewey’s point: Reality is what we choose not to question at the moment. (There’s also Lily Tomlin’s point, as it comes out of the mouth of Trudy the Bag Lady, no mean philosopher herself: After all, what is reality anyway? Nothin’ but a collective hunch…)

It is this pragmatic approach that allowed me then, to thoughtfully and thoroughly address the issue of how using competing conceptual perspectives (attachment theory and critical theory) to explore my research topic in the literature review section would impact on my choice of methodologies and methods. The post-paradigmatic position allows for the use of combined methods that reflect positivist and non-positivist origins, respectively. Accordingly, I eventually decided to start out by formulating three research hypotheses and using them to directly inform the structure and content of subsequent questionnaires and interviews. This decision was certainly a reflection of my philosophical and paradigmatic pragmatism and belief in the capacity and even
desirability of shifting between ‘competing’ epistemologies to yield maximum and multi-faceted understanding. Feyerabend (1988) asserts that when standards for research practice are contravened by the use of persuasion and rule-breaking, causing ‘heretical’ research to proceed, that knowledge has its greatest chance of advancing. Patton (1997:297) echoes the sentiments of Feyerabend stating, ‘The debate over which paradigm was the right path to truth, has been replaced, at the level of methods, by a paradigm of choices’.

4.7 Political Tensions and Considerations

My decision to utilise hypotheses, questionnaires, a literature review and interviews as my research tools and methods was not only informed by the abovementioned beliefs. An absolutely central consideration for me was consideration of the audience I most hope to impact in presenting my research findings. Given my research topic – adolescents diagnosed with severe conduct disorder in out-of-home care – my target audience will consist of the service providers and sectors who service this client group. This means representatives from the Child Protection, Mental Health and Juvenile Justice branches of the Department of Human Services (DHS) as well as Community Service Organisations. The various branches of the DHS listed above, when conducting their own research, routinely utilise positivist epistemology, methodology and methods as the basis for acquiring and presenting information (Department of Human Services, 1998; 2000; 2001).
In addition, reports that are commissioned by State and Federal government departments that are highly influential on the decisions taken by departmental branches are also highly positivist and quantitative in nature (Morton et al, 1999; Sawyer et al, 2000).

Furthermore, influential journal articles and books that are written calling for the adoption of quantified and ‘evidence-based’ approaches for working with young people are also steeped in positivist ontology, epistemology, methodology and methods (Fonagy et al, 2002; Henggeler, 1993, 1997, 1998; Kazdin, 2002; Nathan et al, 2002). Publications such as these carry significant weight in determining which approaches to working with young people become ‘de rigueur’ and often lead to conferences at which the ideas and research advanced in them are further promoted to key decision makers (Werry, 2005b). It is rare indeed for any of these publications and reports to include any qualitative data that could be said to be drawn from an interpretive or critical research paradigm. The view advanced by Guba et al (1994:116) continues to hold true: ‘Postpositivists (and indeed many residual positivists) tend to control publication outlets, funding sources, promotion and tenure mechanisms, dissertation committees, and other sources of power and influence’. The postivist perspective continues to represent the ‘in’ group and ‘the strongest voice in professional decision making’ (Guba et al, 1994:116).

Post-modernists, feminists and other theorists who might be loosely grouped together under a critical theory ‘umbrella’ have long railed against the scientific rationalist, phallologocentric, expert driven, elitist and ‘malestream’ nature of positivist based research (Kincheloe et al, 2000; Reinharz, 1992; Smith et al, 1986; Sutherland et al, 1986; Tong, 1989). I share some of the philosophical and political concerns of this group of theorists and writers.
Nevertheless, I do not believe it is in the interests of the young people for whom I am trying to advocate, for my research to be sidelined, marginalised and/or dismissed because of it being viewed as eccentric and/or fundamentally ‘unpalatable’ to an audience of decision makers. Therefore, my choice to formulate three research hypotheses and utilise questionnaires was indeed a strategic decision and motivated by political pragmatism in addition to more philosophical considerations. Fook (2002:157), herself a critical theorist, researcher and social worker, appears to subscribe to this politically pragmatic view and asserts a ‘methods for situations’ approach to the selection of research methods – ‘many different research methods may be needed to engage with many different situations’.

Fook (2000:1-2) also states ‘The parameters of practice are often totally unlike the dictates of theory. …A rigid, or even loose, commitment to one type of perspective, be it positivist, qualitative or deconstructive, does not seem to provide the flexibility of thinking needed to work in changing circumstances’. This political pragmatism, combined with earlier philosophical pragmatism, is a feature of the post-paradigmatic position in social research, is ‘utilisation-focused’ and politically savvy (Patton, 1997:290-291). The aim is for my research findings to be ‘heard’ so that the needs of the client group under consideration can be foregrounded. Hence, my approach has been to gather information from key decision makers among the intended professional and governmental audience, at times utilising positivist based methods, as the first stage of a two stage research process. In short, that my initial research will inform further studies by providing some overall clarity around current interventions and service outcomes for adolescents in out-of-home care diagnosed with severe conduct disorder.
While in my research conducted as part of this thesis, information has been gleaned from ‘top-down’ or ‘expert’-driven sources, this has been done in the broader context of promoting further research in this topic area from the ‘bottom-up’ perspective of the young people under discussion. In my current role as a project consultant within the industry and specialising in the area of the client group under consideration, I will be well placed to promote and/or personally undertake this research in the future. I believe that pre-existing and related industry concerns combined with the interest my research findings will generate, will provide an important impetus for the second stage of the overall exploration and investigation of adolescents in out-of-home care diagnosed with severe conduct disorder.

4.8 Methodological Issues

Having largely addressed the philosophical, paradigmatic and political dimensions to my research, I will discuss in detail issues of methodology and methods. Firstly, I will need to define my use of the term ‘methodology’. Sarantakos (1993) details that the relative confusion that attends the definition of research paradigms is also reflected in the defining of what constitutes methodology. Essentially, three definitions exist. The first regards methodology as identical to the research model employed by a researcher in a given project. In this context, every research project has a distinct methodology (Lather, 1992:87). However, Sarantakos (1993:32) asserts that this definition of methodology is in fact ‘a research model rather than a methodology’. A second definition of methodology holds that every branch of a theory or theoretical orientation has several methodologies.
For instance, this would include notions of feminist methodologies, Marxist methodologies, post-modern methodologies and existential methodologies. However, the working definition of methodology that I agree with and will adopt is one in which two basic categories of methodology are spoken of – quantitative and qualitative (Alston et al, 1998; Gomm, 2004; Niglas, 2004; Sarantakos, 1993).

Guba et al (1994) elucidate that the methodology chosen and implemented is directly related to and emanates from, previously adopted ontological and epistemological positions. According to this definition, methodology offers research principles related closely to a positivist or non-positivist paradigm. These principles then provide guidelines regarding particular research practices and methods. Quantitative methodology reflects a positivist position regarding ontology and epistemology, being based on the idea that there is an ‘objective’ reality that can be known by utilising a deductive approach (Alston et al, 1998). The deductive approach involves beginning with theory and then testing these ideas empirically. Research hypotheses are formulated prior to the collection and analysis of data and are subsequently confirmed or falsified. As the name suggests, quantitative methodology is focused on ‘quantitativism’ – emphasising the quantification of research data. Gomm (2004:7) explains that quantitative methodology involves asking people questions and recording the results in such a way as to produce numerical data.

In contrast, qualitative methodology utilises an inductive approach whereby research is begun with few or no pre-conceived ideas, and theories are developed from patterns observed in the data collected (Alston et al, 1998). Hypotheses may be developed following the collection and analysis of data, ‘moving from specific observations or interactions to general ideas and theories’ (Alston et al, 1998:9). In essence then, qualitative methodology reflects a non-positivist position regarding ontology and epistemology.
It rejects the notion of an ‘objective’ reality which exists independently of people’s experiences and perceptions and is measurable. Gomm (2004:7) explains that qualitative methodology involves asking people questions to produce the kind of data that will be handled as words. Hence, qualitative data includes ‘detailed descriptions of situations, events, people, interactions and observed behaviours; direct quotations from people about their experiences, attitudes, beliefs and thoughts…’ (Patton, 1997:273).

Earlier in this chapter, I discussed the historical philosophical, paradigmatic and methodological tensions or ‘wars’ within social research, characterised by the adoption of entrenched, mutually hostile intellectual positions. I have also explained that many theorists and researchers now regard these tensions and hostilities as resolved via a contemporary pragmatism. I have also discussed the post-paradigmatic emergence of a ‘third’ methodological paradigm described as a combined methods approach in which both quantitative and qualitative methodologies are combined within the one study – intra-study eclecticism. Alston et al (1998) also comment that researchers now commonly combine quantitative and qualitative methodologies. Indeed, De Vaus (1995) contends that instead of viewing deductive and inductive approaches as diametrically opposed, they can be seen as simply different phases of developing knowledge within a broader cyclical process – one of theory building and theory testing.

Alston et al (1998) explain that a researcher may use both quantitative and qualitative approaches to explore different aspects of the same issue. This approach to research, including the philosophical and political considerations discussed throughout this chapter, led me to combine quantitative and qualitative methodology and methods within my research study.
These will be covered in more detail later in this chapter. However, briefly, quantitative methodology and corresponding methods used were research hypotheses and questionnaires; while qualitative methodology and corresponding methods used were a literature review and interviews.

4.9 Triangulation – Increasing Validity, Reliability, Credibility and Utility

The combined use of quantitative and qualitative methodology and methods within the one study is referred to as inter-method triangulation (Denzin, 1989; Gomm, 2004; Guba et al, 1994; Patton, 1997; Sarantakos, 1993). Here, one source of data is compared with another source from a different methodological origin. Sarantakos (1993:155-156) asserts that inter-method triangulation has other distinct advantages in terms of an overall approach to research. In particular, inter-method triangulation overcomes the deficiencies of single method studies, obtains a variety of information on the same issue and uses the strengths of each method to overcome the deficiencies of the other. Guba et al (1994:106-107) posit that studies presenting quantitative data only are problematic in that data is stripped of context and the meaning of it is less clear than if triangulated against qualitative data sourced within the same study. Inter-method triangulation can also achieve a higher degree of reliability (Patton, 1997).

During the research process then, quantitative data was balanced with qualitative depth. My use of inter-method triangulation is demonstrated in that quantitative information and qualitative information can be ‘cross-checked’ against each other. For instance, research hypotheses and questionnaire data can be cross-checked against the literature review and interview data.
In this way, inter-method triangulation can be utilised to establish consistencies in information gathered, as well as the veracity of this information.

Due to the nature of the multiple research methods I chose for my study, intra-method triangulation is also possible when reviewing and analysing the data collected. Denzin (1989) elucidates that intra-method triangulation occurs when one source of data is compared with another source of data of the same methodological origin. For instance, in my study, I am able to compare research hypotheses with the findings of my questionnaire (quantitative methodological origin), alongside a comparing of my literature review with the findings of my interviews (qualitative methodological origin). Intra-method triangulation is observed to offer similar overall benefits to the research study as inter-method triangulation, such as enhanced reliability (Patton, 1997; Sarantakos, 1993). Gomm (2004:188; 269) uses the term triangulation interchangeably with the term ‘validation’. This is because the practice of comparing one source of data against an alternative source within the same study can increase the validity of overall research findings (Gomm, 2004; Patton, 1997). Reinharz (1992:192) also states that triangulation ‘increases the likelihood of obtaining credibility and research utility’.

Of course, it is important to acknowledge that any form of triangulation does not, of itself, ‘guarantee’ increased validity, reliability, credibility and utility regarding data collection. Indeed, Sarantakos (1993) contends that the validity and reliability of all (individual) research methods employed must be rigorously considered. In other words, the mere activity of triangulating/comparing data between two different methods within the same study is not going to assist with the robustness of the findings if one or both of the methods employed has fundamental flaws.
The first quantitative method I chose to use was the formulation of hypotheses. The hypotheses I formulated are quantitative in nature as they were written ‘as a step towards research’ rather than as emerging out of the research, which would be a qualitative approach to formulating hypotheses (Sarantakos, 1993:119). I generated these hypotheses according to the general bases upon which they are formulated - intuition, commonly held beliefs and anecdotal evidence from the field, existing theories in relevant literature and the research findings from studies related to my research topic (Selltiz et al, 1976). Rather than being prescriptive, I chose to form hypotheses as a guide only and to offer some direction and a clear framework within which my research might be conducted. This use of hypotheses is described by Sarantakos (1993:123) as ‘to constantly remind the researchers of their topic, their aim, and their limits, and help in this way to rationalise the research process by concentrating on the important aspects of the research topic by avoiding peripheral and less significant issues’.

The working hypotheses I initially developed and then confirmed as my research hypotheses were:

1) Adolescents in out-of-home care diagnosed with severe conduct disorder have poor treatment outcomes.

3) Adolescents in out-of-home care diagnosed with severe conduct disorder are a particularly difficult client group to work with because of issues of attachment.

4) The diagnosis of severe conduct disorder negatively impacts upon the work professionals undertake with adolescents in out-of-home care diagnosed with conduct disorder.

These hypotheses adhere to important criteria for hypothesis construction such as being clear, specific, precise and not containing statements that are contradictory (Bailey, 1982).
The second quantitative method I chose was questionnaires. First, I will provide an overview of some of the processes involved. Initially, I searched for any relevant questionnaires already developed by other investigators; however this did not yield any useful examples. Consequently, I developed a new questionnaire adhering to accepted standards for questionnaire construction (see Appendix 3). After constructing a first draft, I undertook a self-critique and found that issues such as relevance, symmetry, clarity and simplicity had been adequately addressed. I then subjected the questionnaire to external scrutiny by placing it before four senior practitioners in the field with whom I had previous contact (these practitioners were not later used as respondents). Their review did not suggest any amendments. I then conducted a pilot of the questionnaire with another senior practitioner and former social work academic. His impression of the questionnaire was that it was very sound and that the questions were highly relevant to the topic and written in such a way as to ‘hook’ respondents into answering in a considered way due to the attitude of positivity and collegiality conveyed in the questions. He also found the questionnaire to be clear and easy to complete. This feedback was similar to that of the abovementioned four practitioners who had previously reviewed the questionnaire. Due to the consistency and strength of the positive feedback I had received, revision was not required and the questionnaire was ready for use.

As mentioned earlier in the chapter, a plain language statement in the form of an invitation to participate in the research was provided to participants in advance of my meeting with them. I believe doing this is ethical in terms of people being clear about what will be required of them and the sponsors of the research being made explicit. In addition, this research invitation or cover letter helps to ‘neutralise any doubt or mistrust respondents might have about the study, as well as to motivate them to participate in the study and answer the questions…’ (Sarantakos, 1993:160).
In my research invitation/cover letter I informed participants that the questionnaire would take up to ten minutes to complete. The manner in which the questionnaire is presented and introduced is highly influential in determining the availability and willingness of respondents in completing the questionnaire (Bailey, 1982).

In the case of all ten questionnaires, I administered them myself immediately following the completion of the interview. All ten were completed within the ten minute timeframe.

The questionnaire consisted of nine questions/items and essentially contained three sets of three questions within it. These questions corresponded directly to my three research hypotheses. Questions 1-3 corresponded to hypothesis 1, questions 4-6 corresponded to hypothesis 2 and questions 7-9 corresponded to hypothesis 3. My six interview questions were also formulated in a way which directly corresponded to my hypotheses. This assists in the capacity to triangulate questionnaire findings with the hypotheses and interview findings. It also provided the questionnaire with a logical order and good transition and flow. In designing the questionnaire, I used six primary and three secondary questions.

Sarantakos (1993:162) describes primary questions as eliciting information directly related to the research topic and secondary questions as those that are ‘not directly related to the research topic, but are helpful for checking consistency of opinions or reliability of the instrument used’. In this way, the use of primary questions followed by secondary questions enhances methodological soundness. Questions 1-2 were primary questions followed by a secondary question at question 3, to check the consistency and reliability of respondents answers. In the same way, primary questions were used for questions 4-5 and 7-8, with secondary questions at questions 6 and 9.
The questions were pre-coded and presented in a fixed-alternative format in which respondents had a choice between four possible answers for each question. This question format, in contrast to open-ended questions, is easier to administer, answer, quantify and evaluate. Also, Sarantakos (1993:165) states it ‘helps to produce fully completed questionnaires and to avoid irrelevant answers’.

Gomm (2004) explains that the validity and reliability of a questionnaire is increased when issues of co-operation, social desirability and acquiescence biases are not present. Co-operation bias occurs when a person doesn’t know the right answer to the question but gives an answer regardless, while social desirability bias occurs when an inaccurate answer is provided in order to make a favourable impression. Finally, acquiescence bias occurs when the respondent is unwilling to give what they believe to be the right answer, but provide another answer that they believe is what the researcher is looking for. Due to the personal and professional backgrounds of my participants and their extensive knowledge of the research topic, I believe it is highly unlikely that any of the abovementioned biases were present in the final results. This is strengthened by the fact that all participants could be said to occupy positions of greater power and privilege than the writer, at the time of administering the questionnaire.

The response format of the questionnaire was to include unidimensional response sets. This assists greatly in providing clarity and simplicity to the questionnaire since the set of response categories for each question contain only one construct, in only one dimension (Sarantakos, 1993:166). This means, for example, that in question four, respondents had to choose between items of not important, moderately important, important and extremely important rather than not important, moderately important, influential and extremely influential. Clarity and simplicity in the questionnaire were also enhanced by the use of both verbal and numerical scales for the
response items in each question. Also, ingratiating or acquiescent responses were further addressed by mixing up positive and negative response items throughout the questionnaire (Bartu, 1996; Nguyen et al, 1983). For example, while the number four always represented the most ‘positive’ answer, response items were written from left to right from four to one and at other times, one to four. The numerical scale included in response items is useful for data reduction, analysis and coding of responses for presentation purposes (Sarantakos, 1993). Certainly, collation of my data from the questionnaires was made easier by using this approach.

During the abovementioned stage of external scrutiny and pre-testing of my questionnaire, the five senior practitioners involved all attested to the a priori and content validity of it, their intuitive estimate of the content validity being high. Also, based on their knowledge of the research topic and client population involved, the questionnaire was viewed as highly appropriate for examining interventions with the client group concerned and as clearly reflecting relevancy, cohesiveness and balance. Construct validity is evident when the dimensions included in a questionnaire are conceivably primary targets for the topic being examined (Nguyen et al, 1983; Sarantakos, 1993). The questionnaire included the following dimensions of evaluating interventions: success of interventions; quality of outcomes from interventions; comparative value of interventions; importance and relevance of accepted key approaches and understandings in intervening; preconceptions in use of interventions; willingness to provide interventions and expectations regarding outcomes from interventions. In this way, and including critical feedback during the external scrutiny and pre-testing stage, construct validity and intrinsic validity can be seen to be present.
4.9.2 Tensions in the Use of Quantitative Methods

It can be argued that a tension exists in terms of utilising research hypotheses and questionnaires when critical theory is one of the theoretical frameworks contained within my thesis. In the main, I have addressed the attendant philosophical and paradigmatic issues earlier in this chapter and elsewhere in the thesis. However, in particular, it may be posited that relatively open-ended research questions are more congruent in terms of a critical approach since critical research rejects a scientific rationalist approach to research and any pursuit and establishment of empirical ‘facts’ (Fook, 1993; Kincheloe et al, 2000; Smith et al, 1986; Sutherland, 1986; Tong, 1989).

However, as mentioned above, I did not wish the research hypotheses to define the reality to be explored in a simplistic, prescriptive and dictatorial manner. Rather, the hypotheses were formed as merely beginning points from which to explore pertinent issues. Indeed, I believe that my thesis and research study is characterised by a considered philosophical and paradigmatic pragmatism, disciplined eclecticism and commitment to inter-method triangulation. It is this pragmatism, eclecticism and triangulation which I believe assists in the prevention of making overly simplistic observations and conclusions, which is sometimes the criticism of positivist based, quantitative research made by critical theorists and researchers.

4.9.3 Qualitative Research Methods – Literature Review and Interviews

The literature review undertaken was a complex process for a number of reasons, principally because I have chosen to analyse and review literature from competing theoretical perspectives in order to gain further understanding of the research topic. As mentioned elsewhere throughout the thesis, I have chosen to utilise the theoretical ‘lenses’ of attachment theory and critical theory in
respect of my topic ‘Interventions with adolescents in out-of-home care diagnosed with severe conduct disorder’. Within the area of attachment theory, I reviewed both neurobiological and psychological discussions of attachment issues as they relate to the client population under review. It was interesting to note that there is a real scarcity of literature focused specifically on adolescents in out-of-home care diagnosed with severe conduct disorder. Also, I did not become aware of any specific research in this area. Reviewing literature from within the field of critical theory is also challenging in that it encompasses a broad array of anti-foundationalist approaches (Pease et al, 2003). However, I chose to focus on a post-modern critical approach which examined the discourse associated with the essential constructs associated with my research topic – adolescence, mental illness and delinquency/crime – and their points of intersection. Martin (2003b) explains that there is a natural and historical association between constructs such as these and critical theory. In addition to numerous journal articles and books written from these theoretical perspectives, I also reviewed many reports and discussion papers authored and/or sponsored by governmental departments at the State and Federal level. Also included was literature from internet sites, conference papers and proceedings and documents produced by peak bodies in the field. Finally, policy and program documents from non-government Welfare agencies providing services to the researched client population were also included.

The second qualitative method I chose was interviews. There are several interview types and potentially, an interview may be quantitative in nature if it is highly structured, standardised and uniformly administered with the interviewer acting in a ‘scientific’ and neutral manner towards the respondent (Fontana et al, 1994; Gomm, 2004; Sarantakos, 1993). However, the interviews I chose to conduct were qualitative for many reasons. The interviews were semi-structured in nature, unstandardised and contained open questions only with no response categories.
The interviews were also single interviews and primacy was afforded to the respondent throughout the interview as they were given room to form and shape their answers to questions without any pressure or re-direction from myself as interviewer. In this way, the interviews possessed an inherent flexibility whereby I followed the course of the respondents answers with only occasional non-directive probing of a verbal and non-verbal nature. Indeed, respondents were allowed to raise their own issues, there was little in the way of control measures and I related to the respondents in a natural manner according to my own personal characteristics.

The interview schedule I wrote for all the ten interviews contained a total of six questions (see Appendix 4). As previously mentioned, these six questions corresponded directly to my three research hypotheses. Questions 1-2 correspond to the first hypothesis, questions 3-4 correspond to hypothesis two and questions 5-6 correspond to hypothesis three. Each participant was interviewed for around 40-45 minutes which allowed a significant allocation of time in which to answer each of the six questions although the interviews could not be said to be in-depth/depth interviews. I arranged to meet with the participants via initial phone contact and made an appointment time that was convenient to them. I had a 100 per cent response rate for people agreeing to participate as respondents and I believe this was at least partly due to my purposeful design of the interview schedule and questionnaire which was able to be completed within an approximate one hour timeframe.

I also chose to record respondents comments by extensive note taking rather than tape recording answers. Although this may be contended as a potential weakness in terms of the accuracy of data recording, all ten respondents commented that they were made far more comfortable and at ease by my decision.
Indeed, I deliberately chose this method of recording answers because I believed it may increase the candour and openness of respondents and this was confirmed by their feedback. To further facilitate their comfort, I arranged to interview in a setting of their choosing. All respondents chose to be interviewed at their places of employment and interviews occurred in rooms that were quiet and free of distractions. As will be seen in the following chapter, the method of data analysis used for my extensive interview notes was thematic analysis. This involved reviewing my handwritten interview notes, identifying themes and then coding them in order to collate them.

4.9.4 Terminology used in Questionnaire and Interview Schedule

I wish to make a brief comment concerning the terminology or wording used in the questionnaire and interview schedule. Although the title of my thesis and research topic is ‘Interventions with Adolescents in Out-of-Home Care diagnosed with Severe Conduct Disorder’, I have not included the specifier ‘severe’ in my questionnaire and interview schedule. Rather, I have simply referred to ‘adolescents in out-of-home care diagnosed with conduct disorder’ or ‘adolescents diagnosed with conduct disorder in out-of-home care’. I did this in order to increase the simplicity and readability of the questions and reduce any tendency towards ‘wordiness’. However it is generally accepted that adolescents who reside in out-of-home care who have been diagnosed with conduct disorder will have a severe presentation of it, regardless of whether this is explicitly specified (Department of Human Services, 1998; Fonagy 2001; Howe et al, 1999b; Hughes, 1997; Jobes, 2004; Jonson-Reid et al, 2000; Levy et al, 1999; Maier, 1987; Moretti et al, 1994; Morton et al, 1999). Certainly this would have been known to my research participants, all of whom currently work with this group of young people and have extensive experience in doing so.
For instance, one interviewee who is a senior practitioner and manager within Juvenile Justice (JJ) described adolescents diagnosed with conduct disorder in out-of-home care as ‘the 10 per cent’ of young people for whom conventionally successful interventions do not appear to work. Another interviewee, a senior practitioner and manager within Child Protection, stated that ‘nothing seems to work’ with adolescents diagnosed with conduct disorder in out-of-home care.

Therefore, I do not believe that the absence of the specifier ‘severe’ in relation to the use of the term conduct disorder in my interview schedule or questionnaire represents any problem or issue effecting the relevance or applicability of the results to my stated research title and topic. The next chapter, Chapter 5, details the findings of my research.
Chapter 5

Research Findings

5.1 Interview Findings - Presentation

First, I will present the findings from my semi-structured, unstandardised interviews. As mentioned in the previous chapter, the interview schedule contained six questions. These six questions can be divided up into three groups of two. Each group of two corresponds to one of my three research hypotheses.

The key emergent themes from responses are detailed below each question in descending order of frequency and are bolded. There is also a short summary statement at the end of each question’s findings.

5.1.1 Hypothesis 1) Adolescents in out-of-home care diagnosed with severe conduct disorder have poor treatment outcomes.

Question 1: What have been your experiences in working with adolescents in out-of-home care diagnosed with conduct disorder?

Key Quote: ‘Well, that these young people are at the point of no return’. Senior manager and practitioner, Juvenile Justice - social worker.
The most frequently occurring theme that emerged in the ten interviews was the issue of attachment. Six out of ten respondents commented that the key difficulty in working with these young people was their attachment difficulties and that as such, approaches working from the basis of attachment theory are vital if any progress is to be made. Respondents reflected on the sheer difficulty of forming attachments with the young people concerned and commented that even if some form of positive relationship or attachment is formed, it tends to ‘break down’ very quickly. Peer relationships were cited as being often the most influential relationships in the young people’s lives but this was seen as often to their detriment as they tended to be with other young people also engaged in chronic anti-social behaviour. It was very difficult then, for staff to build up trust and make connections with these young people and so a lot of ‘stickability’ is required. It was contended that the specific and inter-woven combination of poor attachments and anti-social behaviours render this group of young people the most difficult to work with in out-of-home care.

The second most prevalent theme that emerged was that of profound complexity. Four out of ten respondents commented at some length about this issue. It was thought that the complexity of these young people had increased significantly over time. It was reported that these young people tend to have the greatest number of service providers involved, both across and within service sectors. For instance, it would be customary for Child Protection, Welfare, Juvenile Justice, Mental Health and Drug and Alcohol sectors be simultaneously involved. Respondents spoke of the confusion and chaos that often ensues as well as the substantial amount of time that systems work consumes. At times, this makes balancing the needs of the client and the requirements of the service system very difficult. It was commented that the chaos in the client’s life is often mirrored or paralleled in the service system working with that client.
The following three themes were each reflected upon by three respondents out of ten. Firstly, the **behavioural management** of these young people was described as very difficult. Important elements here are the high levels of impulsivity in clients as well as it being difficult to communicate with them in terms of their significant cognitive and educational deficits. The **severe trauma and abuse background** of these young people was also noted, including parents who had ‘often pulled up stumps’. This background was cited as being crucial to understanding the underlying nature and meaning of their anti-social behaviours. **High-risk taking behaviours** were also noted as significant, the young people being described as ‘playing on the edge’ and ‘being on that knife edge’. Sometimes, the strong focus on containing these behaviours means that the issues underlying them fail to be adequately addressed.

Overall, respondents to question 1 reported that due to the abovementioned key themes, these young people were generally consigned to the ‘too hard basket’ and that services and individual workers were reluctant to work with them.

**Question 2: How do these experiences compare with those working with adolescents in out-of-home care generally?**

Key Quote: ‘Most of psychiatry and psychology miss the point on conduct disorder…as well as the Child Protection and residential care systems. They work better with other populations’. Senior manager and practitioner, Welfare - clinical psychologist.

The most frequently occurring theme emerging from answers to this question was that adolescents in out-of-home care diagnosed with conduct disorder are a **far more difficult and ‘extreme’ population to work with** than adolescents in out-of-home care generally.
This point was directly raised and made by six out of ten respondents. One contributing factor here is the sheer amount and complexity of systems work involved where Child Protection, Welfare, Juvenile Justice, Mental Health and Drug and Alcohol services would usually all be involved. Each discipline and service system tends to have philosophies unique to their perspective, confidentiality issues can be complicated with so many ‘players’ involved and clarity around roles and responsibilities often becomes blurred. As one respondent stated ‘The service system mirrors the complexity and chaos of the client’. Another element that contributes to work with adolescents diagnosed with conduct disorder in out-of-home care being far more difficult than with the general adolescent out-of-home care population is violence. It was commented that adolescents in the general out-of-home care population had a much greater range of problem-solving skills. In contrast, adolescents with conduct disorder posed a much greater threat of violence and risk to staff as they do not possess many alternative problem-solving skills.

Four out of ten respondents highlighted the issue of attachment as an important distinguishing feature between adolescents diagnosed with conduct disorder and those not, within out-of-home care. It was commented that the former population have, comparatively, much greater levels of attachment disruption and are far more likely to lack empathy, being ‘more of a means to an end type people’. Adolescents in out-of-home care not diagnosed with conduct disorder are seen as having a far greater capacity to form secure attachments over time. Also, the influence of adult relationships can be equally or more influential than those with peers. One respondent described adolescents in the general out-of-home care population as the ’98 per cent’ with which staff can form connections, but forming such connection with adolescents diagnosed with conduct disorder was often not possible, leaving staff and young people ‘very vulnerable’.
Three out of ten respondents spoke of the negative prejudices that adolescents diagnosed with conduct disorder are subjected to, compared with adolescents in the general out-of-home care population. The origin of this prejudice is viewed as the particular diagnostic label of conduct disorder, that it is ‘…one of the particular diagnoses that seems to influence the whole attitude of staff’ working with these young people. It was commented that adolescents in the general out-of-home care population were more likely to be offered therapeutic services and a wider array of creative service options. It was noted that given the developmental stage of adolescence and its emphasis on identity formation, that young people with conduct disorder exposed to negative prejudices have a greater propensity to internalise the negative attitudes from staff.

Finally, three out of ten respondents reported much less optimism and motivation to work with adolescents diagnosed with conduct disorder than those adolescents in the general out-of-home care population. It was commented that the latter group usually received more sympathetic responses from staff and agencies as they were viewed as more engaging and engageable and more likely to respond positively to interventions. It was commented that ‘you don’t get much back’ working with adolescents diagnosed with conduct disorder, only an occasional ‘spark’ of hope or positive feedback.

Overall, respondents to question 2 reported that their experiences of working with adolescents diagnosed with conduct disorder in out-of-home care were far more problematic than those had working with adolescents in out-of-home care generally.
5.1.2 Hypothesis 2) Adolescents in out-of-home-care diagnosed with severe conduct disorder are a particularly difficult client group to work with because of issues of attachment.

Question 3: What models of intervention, if any, have you found useful in working with adolescents in out-of-home care diagnosed with conduct disorder?

Key Quote: ‘Overall, you need an eclectic approach. You can’t just use one model…because you’re working with complexity, you need flexibility. So, it’s complex responses to complex clients. An eclectic approach may appear inconsistent at times… that’s if you don’t keep the larger therapeutic picture in mind’. Senior manager and practitioner, Welfare - social worker.

Two main themes occurred as frequently as each other in responses to this question. Seven out of ten respondents cited two models of intervention as being of equal importance - a collaborative systems approach and attachment-based approach. The two models were spoken of as highly inter-related and inter-dependent. Essentially, an attachment model was viewed as ‘…the basis of it all’. The collaborative systems approach was seen as crucial to providing the overall necessary level of structure, containment and predictability in the client’s environment. It was believed that attachment-based work could only be effectively undertaken within such an environment and that the promotion of secure attachments is defeated if the service system around the client ‘…mirrors the chaos in the client’s life’.

A collaborative systems approach was described as containing the following various components. The central component was to develop comprehensive behaviour management plans
that allowed for pre-planned, consistent, specific and ‘methodical’ responses to various issues, particularly crises. Indeed, crises were seen as likely to be commonplace in working with adolescents in out-of-home care diagnosed with conduct disorder.

Also, these plans allow for consistency in the strategic use of rewards and consequences in seeking to effect behavioural change. It was highlighted that these behaviour management plans needed to be developed collaboratively between all service systems, professionals and family members and/or carers – as well as with the client themselves. One respondent referred to this containing approach as similar to the theory regarding the management of adult clients diagnosed with an anti-social personality disorder – that ‘…the system needs to be bigger than the client’.

The same respondent commented that it was a ‘mistake’ to attempt to meet the needs of an adolescent in out-of-home care diagnosed with conduct disorder with a lack of structure or consistency of approach across different settings.

An attachment-based approach was emphasised as ideally underpinning all service interventions. This approach was seen as ‘vital’ since the issues of adolescents in out-of-home care diagnosed with conduct disorder were viewed as beginning with severe attachment difficulties from birth–early childhood. An attachment approach was seen as helpful in building up a relationship history of clients, allowing for greater understanding of what underlies the client’s behaviours – both for the professionals involved and potentially, the client themselves. It was commented that the provision of stable and secure adult relationships to a client within the service system was crucial, otherwise destructive and traumatising relationship patterns for the client would be re-enacted, replicating and maintaining harmful attachment dynamics.

Respondents also reflected it was important to have staff and carers who themselves had a secure attachment type and so were in turn able to generate secure relationships with the young people they worked with, demonstrating persistence and being able to ‘survive the (client) behaviours’.
Finally, three out of ten respondents mentioned cognitive-behavioural approaches as being a useful model of intervention.

This approach was perceived to potentially offer many benefits such as awareness of thinking patterns and triggers leading to violent acts, enhanced problem-solving and social skills, anger management skills and development of empathy. One respondent lamented that adolescents in out-of-home care diagnosed with conduct disorder often did not receive cognitive-behavioural input because they were ‘…not worked with from the point of view of being capable of changing’.

Overall, respondents to question 3 most commonly endorsed collaborative systems and attachment-based approaches as models of intervention for working with adolescents diagnosed with conduct disorder in out-of-home care. The cognitive-behavioural approach was the other model of intervention to register multiple and significant endorsements.

*Question 4: What are the particular difficulties experienced working with this client group?*

Key Quote: ‘They burn people out. The lack of ability to contain their behaviour wears people out quickly. …Nothing seems to work’. Senior practitioner and manager, Child Protection - social worker.

The most frequently cited difficulty in working with this client client group was attachment disruption. This was highlighted by eight out of ten respondents. It was commented that it was often only possible to form a ‘superficial’ relationship with these young people and this was viewed as highly problematic since a more ‘therapeutic’ relationship is needed to achieve change.
and positive client outcomes. It was remarked that, working with young people, such a relationship needs to be in place before any of the broader issues can be addressed.

One respondent stated eloquently: ‘These young people don’t heal through quality moments, but long-term consistent relationships. …the ones that do best have stable empathic adults available to them over time’. Also, it was commented that adolescents diagnosed with conduct disorder in out-of-home care usually have biological family that has little if any involvement in their life and if so, that involvement is likely to be unhealthy and/or abusive. It was remarked that this makes it very difficult to address the trauma of lost and/or abusive relationships with attachment figures, which in turn renders the achievement of clients adopting new, healthier attachment patterns in the future even more difficult.

Five out of ten respondents commented that a particular difficulty in working with this client group was the high levels of risk-taking behaviour they engaged in. Respondents reflected that this behaviour meant that significant risk issues were always present, both to the young person themselves and staff working with them – especially risk of physical harm. One respondent commented that ‘…these young people are the ones that services can least survive yet need the most intervention’. It was reflected that services typically spent most of their time, money and resources in attempting to contain these behaviours in a reactive, crisis management mode. This focus was seen to be necessary but ultimately detrimental to providing more therapeutic input, time and resources. One respondent reported: ‘Healing gains are lost due to their unstable environment’.

A prevalent theme related to the abovementioned attachment difficulties was the frequent resentment and/or despair in staff experienced when working with adolescents diagnosed with conduct disorder in out-of-home care. Four out of ten respondents highlighted this issue. One
respondent stated: ‘Some of them are very difficult to like, especially when they’re spitting on you and threatening to thump you’.

Respondents also reported that it was often very difficult to observe any positive changes or differences in the client group too. It was reflected that staff often had low expectations when working with these young people and so their subsequent reported difficulties in working with these young people reflected the dynamics of a ‘self-fulfilling prophecy’. Also, due to low levels of formal training among caregivers in particular, there was little capacity to de-personalise behaviours via a broader conceptual understanding of the clients behaviours. Perhaps worst of all, the high levels of burn-out and staff rejection serves to re-traumatise clients. Finally, one respondent remarked ‘Many people write them off and those that like them tend to be isolated and burn out quickly anyway’.

Overall, the three main difficulties particular to working with adolescents diagnosed with conduct disorder in out-of-home care were reported to be attachment disruption, high-levels of risk-taking behaviour and resentment and/or despair in staff.

5.1.3 Hypothesis 3) A diagnosis of severe conduct disorder for adolescents in out-of-home care negatively impacts upon the way in which professionals work with them.

*Question 5: Within the out-of-home care system, in what ways might the diagnostic label of conduct disorder influence a professionals’ work with an adolescent?*

Key Quote: ‘People generally don’t want to work with them...they feel there’s nothing you can do. Most people think they’re not grateful and all they do is throw it back in your
Eight out of ten respondents commented at some length that the diagnostic label of severe conduct disorder would have a **negative influence** on professionals’ work with adolescents in out-of-home care. One respondent remarked that professionals would think ‘Instantly, here’s trouble’ and expect the worst. Respondents described that due to the extreme difficulties experienced by both staff and adolescents in working together, the diagnostic label of conduct disorder carries particularly negative connotations and lowered expectations of intervention outcomes. One respondent described the diagnostic label as ‘A burden put on the young person without hope’, as well as weighing down the hopes of family members and professionals involved. Indeed, respondents reported that staff struggle to ‘get past’ the diagnosis. One respondent described it as analogous to reducing a patient in hospital being treated for kidney disease to a kidney, rather than viewing them as a whole person who is being treated for a kidney problem. Respondents felt then, that adolescents in out-of-home care diagnosed with severe conduct disorder were often reduced from ‘a person to a diagnosis’. In this way, the diagnosis potentially ‘depersonalises’ the young person. It was noted that this focus on the diagnosis often causes people to forget about the young person’s actual experiences of trauma and abuse, focusing only on their challenging behaviours. This was described as ‘…not remembering the whole of the young person’s life and past, present and future experiences’.

Also, once given, one respondent noted that the diagnosis of conduct disorder tended not to be revisited which meant the young person concerned could continue to be ‘stigmatised’ or experience prejudice, even when positive changes in behaviour occur and progress is made. Respondents also noted the negative influence of the diagnostic label of conduct disorder on
professionals’ work with an adolescent in terms of it making staff feel anxious, frightened and/or panicked, especially in relation to their physical safety. One respondent remarked that this anxiety sometimes led to staff looking for ways to exclude the young person from their service.

Four out of ten respondents identified that the diagnostic label of severe conduct disorder would have a positive influence on professionals’ work with adolescents in out-of-home care. One respondent encapsulated this theme with the following: ‘The label can be a benefit because you know what you’re dealing with and you don’t take their behaviours personally’. So, the capacity to be able to depersonalise the client’s behaviour was seen to be enhanced by providing a diagnostic framework in which to conceptualise it. Also, the diagnosis was regarded as having a positive influence because it provided a level of containment for professionals involved. In addition, it was believed that sometimes the diagnostic label increased access to specialised services for the young people concerned.

Finally, three out of ten respondents felt that the diagnostic label of severe conduct disorder would have quite a variable influence on professionals’ work with adolescents in out-of-home care. This variability was attributed to the service the professional worked for, the nature of their role in the young person’s life and their level of experience and/or exposure to working with the client group.

Overall, the majority of respondents felt that the diagnostic label of severe conduct disorder would have a negative influence on a professionals’ work with adolescents in out-of-home care. Other notable responses were that the label would have a positive influence and a variable influence.
Question 6: In what ways might a diagnostic classification of conduct disorder influence an agency’s provision of services to an adolescent in out-of-home care?

Key Quote: ‘Agencies tend to work well with internalising behaviours, not so well with externalising behaviours’. Senior manager and practitioner, Mental Health – occupational therapist.

Seven out of ten respondents commented that a diagnostic classification of conduct disorder would have a negative influence on an agency’s provision of services to an adolescent in out-of-home care. One respondent described a likely ‘knee-jerk’ reaction of ‘We’re not taking them’. This statement encapsulated the overall feeling of respondents that these young people are usually pigeon-holed as too difficult to work with. Respondents spoke of the practice by agencies to move to exclude these young people from their service, following an apparent sudden ‘review’ of client numbers and/or redefining of agency criteria for service provision. This practice of ‘looking for points of exclusion’ is not only informed by the pessimism about working with this client group, but also a range of additional agency factors related to working with them. Respondents spoke of the increased financial costs of staff turnover from burnout and insurance and workcover claims from stress and physical assaults by clients towards staff. Also, respondents spoke of the overall high organisational stress levels that attend working with this client group. This included an increased sense of external scrutiny from government departments and the local community as well as the resource-intensive nature of the work and the impact this has on other areas of the agency’s activities.
It was also noted that when agencies did admit these young people to their service, the quality of service provision would often be diminished due to the total impact of the abovementioned stresses, staff resentment towards the client group and the sometimes limited capacity of agencies to adequately support staff due to overall resource and funding issues.

One respondent expressed the view that the often negative attitude of agencies towards these young people simply reflected the wider societal view of the young people which was mostly rejecting and resentful.

Four out of ten respondents felt that a diagnostic classification of conduct disorder would have a neutral influence on an agency’s provision of services to an adolescent in out-of-home care. These respondents felt that there were many agencies and services who received much of their funding to work with this client group and in the case of those agencies, the presence of the abovementioned diagnosis would be regarded as ‘expected’ in their work, having a neutral effect. Indeed, respondents described that some agencies would regard the client group as part of their specific ‘mission’ or charter.

Overall, respondents reported that a diagnostic classification of conduct disorder would have a negative influence on an agency’s provision of services to an adolescent in out-of-home care. The other significant theme was that it would have a neutral influence.

5.2 Questionnaire Findings – Presentation

Below are the findings yielded from my questionnaire. As mentioned in the previous chapter, the questionnaire contained nine questions. These nine questions can be divided up into three groups of three. Each group of three corresponds to one of my three research hypotheses. Questions 1-3
correspond to hypothesis 1, questions 4-6 correspond to hypothesis 2 and questions 7-9 correspond to hypothesis 3.

Each question contained both verbal and numerical scales. The verbal scale information is referred to in the summary statements following each question. The numerical scores are detailed in tables placed directly underneath these summary statements. At the conclusion of this chapter, Table 10 contains the questionnaire data obtained for all questions.

### 5.2.1 Hypothesis 1) Adolescents in out-of-home care diagnosed with severe conduct disorder have poor treatment outcomes.

*Question 1: How successful are interventions working with adolescents diagnosed with conduct disorder in out-of-home care?*

When asked to consider the level of success achieved for interventions working with adolescents diagnosed with conduct disorder in out-of-home care, nine out of ten respondents selected a score of ‘2’, describing it as only moderately successful. One out of ten respondents selected a score of ‘1’, indicating the level of success as not successful at all. These findings are presented in Table 1.

*Table 1: Questionnaire data obtained for Question 1*

<table>
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<tr>
<th>Respdt.</th>
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<td>2</td>
<td>19</td>
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</tbody>
</table>

N.B. – Coding is as follows for selected score
When asked to consider the quality of service outcomes for adolescents diagnosed with conduct disorder in out-of-home care, nine out of ten respondents selected a score of ‘2’, describing it as poor. One out of ten respondents selected a score of ‘3’, indicating the quality of service outcomes as adequate. These findings are presented in Table 2.

Table 2: Questionnaire data obtained for Question 2

<table>
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<th>R3</th>
<th>R4</th>
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<td>2</td>
<td>3</td>
<td>21</td>
</tr>
</tbody>
</table>

N.B. – Coding is as follows for selected score

1 = Very poor, 2 = Poor, 3 = Adequate, 4 = Excellent

When asked to compare their work with adolescents diagnosed with conduct disorder in out-of-home care with those adolescents in the general out-of-home care population, six out of ten respondents selected a score of ‘2’, indicating that it was more difficult to work with the former client group.
Three out of ten respondents selected a score of ‘1’, indicating that it was far more difficult working with adolescents diagnosed with conduct disorder in out-of-home care than with those adolescents in the general out-of-home care population. One out of ten respondents selected a score of ‘3’, indicating that it was easier to work with the former client group. These findings are presented in Table 3.

Table 3: Questionnaire Data Obtained for Question 3

<table>
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<tr>
<th>Respdt.</th>
<th>R1</th>
<th>R2</th>
<th>R3</th>
<th>R4</th>
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<th>R6</th>
<th>R7</th>
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<td>18</td>
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</tbody>
</table>

N.B. – Coding is as follows for selected score

1 = Far more difficult,  2 = More difficult,  3 = Easier,  4 = Much easier

5.2.2 Hypothesis 2) Adolescents in out-of-home-care diagnosed with severe conduct disorder are a particularly difficult client group to work with because of issues of attachment.

Question 4: How would you rate the importance of the issue of attachment in working with adolescents diagnosed with conduct disorder in out-of-home care?

When asked to rate the importance of the issue of attachment in working with adolescents diagnosed with conduct disorder in out-of-home care, eight out of ten respondents selected a score of ‘4’, rating it as extremely important. Two out of ten respondents selected a score of ‘3’,
rating the issue of attachment in working with adolescents diagnosed with conduct disorder in out-of-home care as **important**. These findings are presented in Table 4.

**Table 4: Questionnaire data obtained for Question 4**

<table>
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<tr>
<th>Respdt.</th>
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<th>R3</th>
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<th>R7</th>
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<th>R9</th>
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<td>38</td>
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</tbody>
</table>

N.B. – Coding is as follows for selected score

1 = Not important, 2 = Moderately important, 3 = Important, 4 = Extremely important

**Question 5: How often would the use of attachment theory inform your practice working with adolescents diagnosed with conduct disorder in out-of-home care?**

When asked to consider how often the use of attachment theory would inform their practice working with adolescents diagnosed with conduct disorder in out-of-home care, six out of ten respondents selected a score of ‘3’, indicating that it would be used **often**. Three out of ten respondents selected a score of ‘4’, indicating that their use of attachment theory would inform their practice working with adolescents diagnosed with conduct disorder in out-of-home care **very often**. One out of ten respondents selected a score of ‘2’, indicating their use of attachment theory in informing their practice with the abovementioned client group as **not often**. These findings are presented in Table 5.
Table 5: Questionnaire data obtained for Question 5

<table>
<thead>
<tr>
<th>Respdt.</th>
<th>R1</th>
<th>R2</th>
<th>R3</th>
<th>R4</th>
<th>R5</th>
<th>R6</th>
<th>R7</th>
<th>R8</th>
<th>R9</th>
<th>R10</th>
<th>Total / 40</th>
</tr>
</thead>
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<td>4</td>
<td>4</td>
<td>2</td>
<td>32</td>
<td></td>
</tr>
</tbody>
</table>

N.B. – Coding is as follows for selected score

1 = Never, 2 = Not often, 3 = Often, 4 = Very often

Question 6: To what extent does the nature of the relationship between workers and adolescents diagnosed with conduct disorder in out-of-home care, influence service outcomes?

When asked to consider the extent to which the relationship between workers and adolescents diagnosed with conduct disorder in out-of-home care influenced service outcomes, six out of ten respondents selected a score of ‘4’, indicating it to be highly influential. Four out of ten respondents selected a score of ‘3’, indicating that the extent to which the relationship between workers and the abovementioned client group influenced service outcomes as being influential. These findings are presented in Table 6.

Table 6: Questionnaire data obtained for Question 6

<table>
<thead>
<tr>
<th>Respdt.</th>
<th>R1</th>
<th>R2</th>
<th>R3</th>
<th>R4</th>
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<th>R6</th>
<th>R7</th>
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<td>3</td>
<td>36</td>
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</tr>
</tbody>
</table>

N.B. – Coding is as follows for selected score

1 = Not influential, 2 = Moderately influential, 3 = Influential, 4 = Highly influential

171
5.2.3 Hypothesis 3) A diagnosis of severe conduct disorder for adolescents in out-of-home care negatively impacts upon the way in which professionals work with them.

Question 7: To what extent would a professionals’ knowledge of a diagnosis of conduct disorder influence their work with an adolescent in out-of-home care?

When asked to consider the extent to which a professionals’ knowledge of a diagnosis of conduct disorder would influence their work with an adolescent in out-of-home care, five out of ten respondents selected a score of ‘3’, indicating that it would be influential. Similarly, two out of ten respondents selected a score of ‘4’, indicating that the extent of the influence would be highly influential.

Two out of ten respondents selected a score of ‘2’, indicating that the extent to which a professionals’ knowledge of a diagnosis of conduct disorder would influence their work with an adolescent in out-of-home care would be moderately influential. Finally, one out of ten respondents selected a score of ‘1’, indicating that a professionals’ knowledge of a diagnosis of conduct disorder would be not influential in their work with an adolescent in out-of-home care. These findings are presented in Table 7.

Table 7: Questionnaire data obtained for Question 7

<table>
<thead>
<tr>
<th>Respdt.</th>
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<th>R3</th>
<th>R4</th>
<th>R5</th>
<th>R6</th>
<th>R7</th>
<th>R8</th>
<th>R9</th>
<th>R10</th>
<th>Total / 40</th>
</tr>
</thead>
</table>

172
Question 8: How would you rate the impact of a diagnosis of conduct disorder for an adolescent in out-of-home care, in their receiving of agency services?

When asked to rate the impact of a diagnosis of conduct disorder for an adolescent in out-of-home care in their receiving of agency services, seven out of ten respondents selected a score of ‘2’, indicating that the impact of the diagnosis would be a negative impact. Three out of ten respondents selected a score of ‘3’, indicating that the impact of the diagnosis would be a positive impact. These findings are presented in Table 8.

Table 8: Questionnaire data obtained for Question 8

<table>
<thead>
<tr>
<th>Respdt.</th>
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<th>R5</th>
<th>R6</th>
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<td>23</td>
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</tbody>
</table>

N.B. – Coding is as follows for selected score

1 = Not influential, 2 = Moderately influential, 3 = Influential, 4 = Highly influential

Question 9: How might the diagnosis of conduct disorder for an adolescent in out-of-home care impact upon service provider expectations regarding outcomes?

When asked to consider how the diagnosis of conduct disorder for an adolescent in out-of-home care might impact upon service provider expectations regarding outcomes, eight out of ten
respondents selected a score of ‘2’, indicating that the impact would be a negative impact. One out of ten respondents selected a score of ‘1’, indicating that the impact would be a very negative impact. Finally, one out of ten respondents selected a score of ‘3’, indicating that the impact would be a positive impact. These findings are presented in Table 9.

Table 9: Questionnaire data obtained for Question 9

<table>
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<tr>
<th>Respdt.</th>
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<th>R3</th>
<th>R4</th>
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N.B. – Coding is as follows for selected score

1 = Very negative impact,  2 = Negative impact,  3 = Positive impact,  4 = Very positive impact

Overall Questionnaire Data Obtained

Question 1 yielded a total score of 19 out of a possible total of 40. This score indicated that most of the respondents rated the success of interventions working with adolescents diagnosed with conduct disorder in out-of-home care as only moderately successful.

Question 2 yielded a total score of 21 out of a possible total of 40. This score indicated that most of the respondents rated the quality of service outcomes for adolescents diagnosed with conduct disorder in out-of-home care as poor.

Question 3 yielded a total score of 18 out of a possible total of 40. This score indicated that most of the respondents rated working with adolescents diagnosed with conduct disorder in out-of-
home care as considerably more difficult than working with those adolescents in the general out-of-home care population.

Question 4 yielded a total score of 38 out of a possible total of 40. This score indicated that most of the respondents rated the importance of the issue of attachment in working with adolescents diagnosed with conduct disorder in out-of-home care as extremely important.

Question 5 yielded a total score of 32 out of a possible total of 40. This score indicated that the use of attachment theory would often inform the practice of most respondents when working with adolescents diagnosed with conduct disorder in out-of-home care.

Question 6 yielded a total score of 36 out of a possible total of 40. This score indicated that most respondents rated the nature of the relationship between workers and adolescents diagnosed with conduct disorder in out-of-home care as highly influential regarding service outcomes.

Question 7 yielded a total score of 28 out of a possible total of 40. This score indicated that most respondents rated a professionals' knowledge of a diagnosis of conduct disorder to be influential in their work with an adolescent in out-of-home care.

Question 8 yielded a total score of 23 out of a possible total of 40. This score indicated that most respondents rated the impact of a diagnosis of conduct disorder for an adolescent in out-of-home care as having a negative impact on their receiving of agency services.
Question 9 yielded a total score of 20 out of a possible total of 40. This score indicated that most respondents rated the impact of a diagnosis of conduct disorder for an adolescent in out-of-home care upon service provider expectations regarding outcomes as negative.

These overall findings are presented in Table 10.

*Table 10: Overall questionnaire data obtained*

<table>
<thead>
<tr>
<th>Quest.</th>
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Overall, my three research hypotheses appear to be supported by the findings detailed in this chapter. In the next chapter, Chapter 6, I will discuss the findings at some length including expanding upon their relationship to my research hypotheses as well as considering them in the context of my literature review.
Chapter 6

Discussion of Research Findings

6.1 Format

Having presented my research findings in the previous chapter in a way that corresponded to my research hypotheses, I will discuss the nature of these findings in a similar format here. Briefly, I will present a research hypothesis and then beneath it I will discuss the findings from those questions in the interview schedule and questionnaire that correspond to that hypothesis. This allows for a triangulation of results obtained from research methods of different methodological origin. For instance, under hypothesis 1, the findings from questions 1-2 in the interview schedule and questions 1-3 in the questionnaire will be discussed. Finally, the discussion of findings under each hypothesis will be situated within the findings of the literature review.

6.1.1 Hypothesis 1) Adolescents in out-of-home care diagnosed with severe conduct disorder have poor treatment outcomes.

The first question in the interview schedule asked respondents to offer their general reflections about working with adolescents in out-of-home care diagnosed with severe conduct disorder. The overall feedback from respondents was that this client population was experienced as especially difficult to work with in comparison to working with other groups of adolescents who may be in receipt of Welfare, Juvenile Justice, Child Protection, Mental Health and/or Drug and Alcohol
services. Indeed, one respondent articulated the overall thoughts of the respondents, stating that adolescents in out-of-home care diagnosed with severe conduct disorder are ‘the hardest young people in the system’. Respondents provided several key points as to why positive and encouraging intervention outcomes with this population were rarely experienced. These included the severity of attachment disruption; the profound complexity of simultaneously addressing multiple issues across multiple service providers and systems; great difficulty in managing client’s behaviours and communicating with them; the severity of trauma and abuse backgrounds and high-risk taking behaviours.

The second question in the interview schedule asked for respondents to build upon their responses to the first question, comparing the experiences of working with the client population under review with those working with adolescents in out-of-home care generally. The responses to these questions clearly indicated that working with adolescents in out-of-home care diagnosed with severe conduct disorder was more difficult than working with adolescents in out-of-home care generally. In addition to the sheer complexity of systems work involved and difficulties resulting from significant levels of client violence, respondents also noted the greater level of attachment disruption. Respondents also spoke of the negative prejudices held by staff towards adolescents in out-of-home care diagnosed with severe conduct disorder and the diminished levels of optimism and motivation in working with them. Indeed, adolescents within the general out-of-home care population were described by one respondent as the ’98 per cent’ with whom it was possible to achieve meaningful connections so as to bring about significant change. In contrast, adolescents in out-of-home care diagnosed with severe conduct disorder were described by another respondent as the ’10 per cent’ for whom the existing and conventional interventions ‘don’t seem to work’.
Overall then, the findings from responses to the first two questions of the interview schedule appear to support my first hypothesis that adolescents in out-of-home care diagnosed with severe conduct disorder have poor treatment outcomes. However, when the findings from the first three questions of my questionnaire (that also correspond to hypothesis 1) are triangulated against/alongside the interview findings above, support for hypothesis 1 appears to be further strengthened. Question one of the questionnaire asked respondents to rate the success of interventions working with adolescents in out-of-home care diagnosed with severe conduct disorder. Nine out of the ten respondents selected the second ‘lowest’ score from the four item response set provided. This was a score of ‘2’, indicating that the rate of success could be said to be only ‘moderately successful’. The only lower score possible here was a ‘1’, indicating that interventions were ‘not successful at all’. This was selected by the other respondent. Perhaps the selection of a score of ‘1’ only occurred once since it implies that virtually no aspect of service intervention is of any use, rather than there being a significantly held belief that ‘moderate’ intervention outcomes are actually achieved.

This interpretation would appear to be supported when considering the responses to question two of the questionnaire, which asked respondents to describe the quality of service outcomes for adolescents in out-of-home care diagnosed with severe conduct disorder. Here, nine out of the ten respondents selected the second ‘lowest’ score of ‘2’, from the four item response set provided. Selecting this score indicated that the quality of service outcomes was believed to be ‘poor’. Significantly, responses to question three of the questionnaire again highlighted the sheer difficulty of working with adolescents in out-of-home care diagnosed with severe conduct disorder. When asked to compare their work with these adolescents and those within the general out-of-home care population, nine out of the ten respondents chose the second lowest or lowest score from the four item response set provided. This meant that respondents indicated that
working with the client population under review was ‘more difficult – far more difficult’ than working with adolescents in the general out-of-home care population.

The responses from question three of the questionnaire are directly supported by respondents answers to question two of the interview schedule. This is because both questions asked respondents to compare their experiences with adolescents in out-of-home care diagnosed with severe conduct disorder with those working with adolescents in the general out-of-home care population. Furthermore, responses to both questions indicated that working with the former group of young people was substantially more difficult than working with the latter group. Indeed, the questions generated much reflection by respondents regarding the quite pessimistic context within which working with adolescents in out-of-home care diagnosed with severe conduct disorder occurs. The findings from question two of the interview schedule and question three of the questionnaire then, appear to suggest that treatment or service outcomes with adolescents in out-of-home care diagnosed with severe conduct disorder are indeed poor.

Having reviewed and triangulated the findings from those questions in the interview schedule and questionnaire which correspond to hypothesis 1, further clarity as to the nature of support for my hypothesis is provided by placing these findings alongside those of my literature review (mostly contained earlier in the thesis yet briefly revisited here). As noted elsewhere in this thesis, working with adolescents diagnosed with conduct disorder and/or severe conduct disorder has been considered an extremely difficult task for many years now, with treatment outcomes in the Welfare, Mental Health and Juvenile Justice literature being reported as generally poor (Day, 1994; Hemphill, 1996; Leventhal et al, 2000; Penzerro et al, 1995; Shamsie et al, 1994). In his extensive review of psychosocial treatments for conduct disorder, Kazdin (2002:79) states
‘We cannot yet say that one intervention can ameliorate CD and overcome the poor long-term prognosis’.

Kazdin (2002:72-73) elucidates that even with well regarded treatment approaches such as multi-systemic therapy (MST), there are significant problems associated with their findings in terms of the real impact of treatment and the magnitude of therapeutic change – ‘Promising treatments have achieved change, but is the change enough to make a difference in the lives of youths who are treated? Also, what proportion of youth improves with treatment and improves in ways that materially affect their functioning… There are no clear answers to these important questions’. Indeed, Kazdin (2002:73) contends that any change effected in a client’s life needs to be clinically significant:

Clinical significance refers to the practical value or importance of the effect of an intervention, that is, whether it makes any ‘real’ difference to the patients or to others with whom they interact. Clinical significance is important because it is quite possible for treatment effects to be statistically significant, but not to have impact on most or any of the cases in a way that improves their functioning or adjustment in daily life.

In other words, while there are treatments that may achieve a reduction in the degree of conduct disorder ‘symptoms’, there appear to be no treatments or interventions that actually achieve a qualitative and life-altering shift in the lives of young people with conduct disorder, severe or otherwise. Not only this, but frequently reviewed ‘evidence-based’ approaches tend to cluster around isolated behaviours such as serious and chronic offending, rather than around a constellation of symptoms (Kazdin, 2002; Morton et al, 1999). This issue is particularly pertinent to adolescents diagnosed with severe conduct disorder in out-of-home care, since their anti-social
and/or offending behaviours likely present within a much wider and more complex backdrop of severe attachment, trauma and abuse issues (Goddard, 1992; Rosen, 1999).

Furthermore, of the current array of suggested ‘evidence-based’ approaches, many have a strong emphasis on interventions with family members, particularly parents. The difficulty here is that adolescents diagnosed with severe conduct disorder in out-of-home care usually come from backgrounds where their parents have been highly abusive towards them and/or have a range of life stresses which render their participation in ongoing individual, group, marital, family and/or parental therapy simply untenable (Jonson-Reid et al, 2000; Kazdin, 2002; Lask et al, 1981; Moretti et al, 1994, 1997; Sawyer et al, 2000). These life stresses tend to include domestic violence, childhood history of abuse, drug and alcohol misuse, mental health concerns, involvement with the criminal justice system, low income, unemployment, low levels of formal education and/or poor and inadequate housing. Indeed, these difficulties and their high impact on the capacity of commencing and/or remaining in therapeutic programs aimed at redressing their children’s behaviours are reflected in the high attrition rates of these families discontinuing treatment (Chamberlain, 2003; Kazdin, 2002). Overall then, the literature concerning intervention and treatment outcomes for adolescents diagnosed with conduct disorder indicates that outcomes are poor and any ‘positive’ results tend to be of statistical significance rather than clinical or life-impacting significance.

In sum then, my hypothesis that adolescents in out-of-home care diagnosed with severe conduct disorder have poor treatment outcomes appears to be supported by my abovementioned research findings as well as the literature review undertaken related to this client group.
6.1.2 Hypothesis 2) Adolescents in out-of-home-care diagnosed with severe conduct disorder are a particularly difficult client group to work with because of issues of attachment.

In question three from the interview schedule, respondents were asked to comment on the models of intervention they had found useful in working with adolescents in out-of-home care diagnosed with conduct disorder. Overall, the strong theme that emerged was that attachment-based and collaborative systems approaches were considered to be the most useful models of intervention working with this client group. Although both models of intervention were equally endorsed in terms of frequency, an attachment-based approach was viewed as needing to underpin all service interventions and the collaborative systems approach was seen as important in providing the context in which an attachment-based approach could be applied. This was because the promotion and establishment of secure and consistent relationships between young people and staff was considered to be extremely difficult if/when chaos in the service system around the young person prevailed. The clear feedback from respondents was that optimum intervention with adolescents in out-of-home care diagnosed with conduct disorder requires that an attachment-based approach be established as the basis upon which all/any interventions are planned.

In question four of the interview schedule, respondents were asked to reflect on the particular difficulties working with adolescents in out-of-home care diagnosed with conduct disorder. The strongest and most prevalent theme was that the particular difficulty of greatest importance was that of attachment disruption. Respondents spoke of the establishment of a secure and therapeutic attachment relationship with these young people as being the precondition for achieving significant change in their lives. However, the great difficulties and barriers that exist in forming
such relationships between these young people and staff mean that therapeutic relationships are rarely formed and that the working relationship tends to remain on a more ‘superficial’ level. Significantly, a secondary theme that emerged in responses to this question was the resentment and/or despair staff often felt towards adolescents in out-of-home care diagnosed with conduct disorder. This is an important theme to note here as I believe it relates directly to the theme of attachment disruption above. This is because it highlighted the importance of having staff who possess the personal and professional qualities necessary to form secure, therapeutic attachment relationships with these young people, if/when these young people begin to seek such connection.

In sum then, the findings from the third and fourth questions of my interview schedule appear to support my second research hypothesis that adolescents in out-of-home-care diagnosed with severe conduct disorder are a particularly difficult client group to work with because of issues of attachment. This appeared indicated as attachment disruption was reported as representing the greatest difficulty in working with these young people and that an attachment-based approach was endorsed as the model of intervention pivotal and most crucial to achieving client change. When triangulating the findings from the interview questions with those from the questionnaire, support for hypothesis 2 appears further bolstered.

In question four from the questionnaire, respondents were asked to rate the importance of the issue of attachment in working with adolescents in out-of-home care diagnosed with conduct disorder. Here, eight out of the ten respondents selected the ‘highest’ score of ‘4’ from the four item response set provided. This score indicated that attachment was considered to be an ‘extremely important’ issue in working with these young people. The remaining two respondents selected the second ‘highest’ score of ‘3’, indicating the issue of attachment to be ‘important’.
Significantly, no respondents chose the scores of either ‘2’ or ‘1’, indicating the issue of attachment to be only ‘moderately important’ or ‘not important’, respectively.

In question five of the questionnaire, respondents were asked to advise how often the use of attachment theory would inform their practice in working with adolescents in out-of-home-care diagnosed with severe conduct disorder. Six out of the ten respondents selected the second ‘highest’ score of ‘3’, indicating that attachment theory would ‘often’ inform such practice. Three out of the ten respondents selected the ‘highest’ score of ‘4’, indicating that attachment theory would ‘very often’ inform their practice in working with adolescents in out-of-home-care diagnosed with severe conduct disorder. The remaining respondent selected the second ‘lowest’ score of ‘2’, indicating that attachment theory would ‘not often’ inform her/his practice with these young people.

Given the incongruence of this response with the rest of the responses to this question and responses to other questions, it would be interesting to explore the reasons for such a response. This is especially so since the same respondent selected the second highest score of ‘3’ at the previous question, rating the issue of attachment as ‘important’ in working with adolescents in out-of-home care diagnosed with conduct disorder. Perhaps the explanation for this respondent indicating that the issue of attachment is ‘important’ and subsequently indicating at the next question that attachment theory does ‘not often’ inform her/his practice, is a lack of confidence and/or understanding in linking this theory directly to practice. Alternatively, the specific work context of the respondent may offer an explanation as to the apparently contradictory feedback regarding the importance of attachment and attachment theory.
At the time the research was conducted, the respondent was employed as a senior practitioner and manager at a custodial facility for adolescents in Melbourne. It may be the case that the use of attachment theory in this practice context is regarded as too difficult due to the custodial nature of the setting and its relatively inflexible, highly structured and regimented nature. I am not sure about the capacity and extent to which attachment theory is able to inform practice with adolescents diagnosed with severe conduct disorder serving a custodial sentence, who normally reside in out-of-home care, but I believe it could be a worthwhile research topic in itself.

Question six of the questionnaire asked respondents to rate the extent to which the nature of the relationship between workers and adolescents diagnosed with conduct disorder in out-of-home care, influenced service outcomes. Six out of the ten respondents selected the ‘highest’ score of ‘4’, indicating that the nature of this relationship was ‘highly influential’ to service outcomes. The remaining four respondents selected the second ‘highest’ score of ‘3’, indicating that the nature of this relationship was ‘influential’ to service outcomes. It was significant that no respondents even selected a score of ‘2’, which indicated that the nature of the relationship between workers and adolescents diagnosed with conduct disorder in out-of-home care, was only ‘moderately influential’ regarding service outcomes.

The findings from the questions contained in the interview schedule and questionnaire that correspond to hypothesis 2 appear to support the hypothesis. Specifically, that adolescents in out-of-home-care diagnosed with severe conduct disorder are a particularly difficult client group to work with because of issues of attachment. Within these findings, respondents highlighted attachment disruption as the key difficulty in working with these young people; they tended to rate the issue of attachment as extremely important in working with them and considered that the use of attachment theory would often inform their practice. The other prominent highlights within
the findings were that an attachment-based approach is the key model of intervention for working with this client group and that the nature of the relationship between workers and adolescents diagnosed with conduct disorder in out-of-home care, is highly influential regarding service outcomes.

Again, the findings from my literature review appear to correspond to those from my interviews and questionnaires, adding further overall weight to my hypothesis. Rosen (1999:659), in discussing the nature of young people found within residential care in Australia, also describes the nature of the young people that are the focus of this thesis:

The children are tough, aggressive, confrontational. Many, the victims of violence and abuse, are angry, depressed, alienated, impulse ridden, anxious, distrusting, ever vigilant. Taken from their families, and some abandoned by families, they learn to distrust others. They have no sense of belonging, yet they cannot sufficiently trust others to form close attachments. They carry the diagnostic label of Conduct Disorder…

Moretti et al (1994:360) also make clear links between the development of severe conduct disorder and disrupted attachment, stating ‘that conduct disorder typically develops in the context of an impoverished and often abusive primary socialization experience. It is precisely this type of experience that has been identified as a precursor of insecure attachment’. It is primary socialisation experiences such as these that make up the infancies and/or childhoods of the vast majority of adolescents diagnosed with severe conduct disorder in out-of-home care (Department of Human Services, 1998; Fonagy, 2001; Howe et al, 1999b; Hughes, 1997; Jobes, 2004; Jonson-Reid et al, 2000; Levy et al, 1999; Maier, 1987; Moretti et al, 1994; Morton et al, 1999).
These experiences leave children and young people without basic emotional, psychological and social capacities such as emotional regulation, impulse control, feelings of empathy, ability to trust and prosocial coping skills (Crittenden, 1995; Howe, 1990; Saarni, 1990). In addition, these same children and young people will likely have sustained relatively stable neurobiological damage in the form of an overdeveloped lower brain and underdeveloped higher brain (Perry, 1997). These neurobiological deficits further entrench and perpetuate the difficulties like those described above, making it ‘functionally’ difficult to incorporate new, positive attachment experiences that may potentially assist in repairing both mind and brain from the effects of severe attachment disruption.

My literature review has indicated that the issue of attachment disruption – from both a ‘psychological’ and neurobiological perspective – can be seen to lead to profound ‘gaps’ and deficits in basic neurobiological, emotional, psychological and social functioning. Moreover, the findings from my literature review and those derived from my respondents, indicate that this significant attachment disruption and its attendant difficulties, can be crucially correlated with the development of severe conduct disorder.

Overall then, my hypothesis that adolescents in out-of-home-care diagnosed with severe conduct disorder are a particularly difficult client group to work with because of issues of attachment appears to be well supported.
6.1.3 Hypothesis 3) A diagnosis of severe conduct disorder for adolescents in out-of-home care negatively impacts upon the way in which professionals work with them.

In question five of the interview schedule, respondents were asked to reflect on the ways in which the diagnostic label of conduct disorder might influence a professionals’ work with an adolescent. Eight out of the ten respondents commented that the nature of this influence would be a ‘negative’ one. This was related to the experiences that staff generally have with this client group, which as discussed earlier in this chapter, are that this is an extremely difficult client group to work with. Hence, it was reported that when staff hear that a young person has been classified or ‘labeled’ with a diagnosis of conduct disorder, it tends to readily trigger feelings and thoughts related to a lack of hope and optimism as well as for some, fear and anxiety. Respondents reflected that these thoughts and feelings were difficult to overcome and meant that professionals find it hard to move beyond the diagnostic label and more particularly, its connotations. Some respondents also reflected that the presence of a diagnostic label of conduct disorder could also be a negative influence on the adolescent themselves, if/when they became aware of it.

Significantly, this view that the diagnostic label of conduct disorder would have a negative influence on a professional’s work with an adolescent in out-of-home care was tempered with two other views expressed to a lesser yet not insignificant degree. Four out of the ten respondents expressed the view that the label may be a ‘positive influence’, in that it provided a sense of clarity, containment and context in which to conceptualise behaviours that were otherwise easy to ‘personalise’. In addition, some respondents felt that the diagnostic label of conduct disorder may be a positive influence in terms of gaining access to specialised services. Also, three out of the
ten respondents felt that the diagnostic label of conduct disorder would have a ‘variable influence’ on a professional’s work with an adolescent in out-of-home care.

The findings from question six in the interview schedule echoed those from the previous question. Here, respondents were asked to reflect on the ways in which a diagnostic classification of conduct disorder might influence an agency’s provision of services to an adolescent in out-of-home care. The strongest theme here was that this diagnostic classification would have a ‘negative influence’ on the work undertaken with the young person concerned, this time from an agency perspective. Seven out of the ten respondents emphasised this, reflecting on the common practice of finding a rationale to exclude the young person from a service. Also, the diagnostic classification of conduct disorder tended to provoke anxiety in agencies regarding the potential for critical incidents between adolescents and staff as well as the overall resource intensive nature of working with this client group. However, four out of the ten respondents reflected that a diagnostic classification of conduct disorder also had the potential to have a ‘neutral influence’ on the work undertaken with the young person concerned, from an agency perspective. This was regarded as potentially occurring as some agencies have a focus in working with adolescents diagnosed with severe conduct disorder in out-of-home care. In that case, respondents felt that the diagnostic classification of conduct disorder would be highly familiar to agencies and so they may be relatively untroubled or unconcerned by it.

The findings from questions five and six of the interview schedule generally seem to support the hypothesis that a diagnosis of severe conduct disorder for adolescents in out-of-home care negatively impacts upon the way in which professionals work with them. The findings from questions 7-9 in the questionnaire appear to bolster this support. In question seven, respondents were asked to rate the extent to which a professionals’ knowledge of a diagnosis of conduct
disorder would influence their work with an adolescent in out-of-home care. Seven out of the ten respondents selected the two ‘highest’ scores (‘3’ and ‘4’) from the four item response set provided, indicating that a professionals’ knowledge of a diagnosis of conduct disorder would be ‘influential’ or ‘highly influential’ in their work with an adolescent in out-of-home care.

At question eight, seven out of the ten respondents selected the second ‘lowest’ score of ‘2’. This indicated that the impact of a diagnosis of conduct disorder for an adolescent in their receiving of agency services would be a ‘negative’ one. In the case of three respondents however, the impact of a diagnosis of conduct disorder for an adolescent in their receiving of agency services was thought to be of a ‘positive’ nature. In question nine, respondents were asked to rate the impact of a diagnosis of conduct disorder for an adolescent in out-of-home care, upon service provider expectations regarding outcomes. Eight out of the ten respondents believed it would have a ‘negative impact’ on expectations regarding outcomes while one other respondent believed it would have a ‘very negative impact’. The other respondent for this question believed it would have a ‘positive impact’.

Overall then, the findings from those questions in the interview schedule and questionnaire that correspond to hypothesis three appear to support the hypothesis that a diagnosis of severe conduct disorder for adolescents in out-of-home care negatively impacts upon the way in which professionals work with them. This negative impact was consistently and most prevalently indicated throughout the findings in this section. The predominant theme that a particular diagnostic classification can negatively influence the attitudes of health professionals towards clients with mental health concerns, and subsequently the quality of services offered to them, has been explored in studies of consumer experiences as well as staff attitudes (Epstein et al, 2001b; Graham, 2004).
Mental health workers have identified that different diagnostic labels carry differing levels of stigma, with diagnoses associated with anti-social behaviour being one of the most negatively effected (Epstein et al, 2001b). In addition, consumers of mental health services have reported their experiences of service provision as being significantly linked to their diagnostic classification. Epstein et al (2001b: 17) state:

Consumers have spoken about how the label given to their distress has a great bearing on the ways in which they are treated within services. Some people have noticed that a change in diagnosis (swapping of labels) has resulted in a noticeable alteration of attitude on the part of their treating professional and other workers.

Indeed, the impact of dominant discourses associated with mental health difficulties on both professionals and clients in receipt of their services, was explored in Chapter 3.

However, I believe there was a notable and significant amount of feedback in my research findings that a diagnosis of severe conduct disorder for adolescents in out-of-home care could have a positive or ‘neutral’ impact upon the way in which professionals work with them. It is interesting to note that when respondents reflected on the mostly negative impact of a diagnosis of severe conduct disorder for adolescents in out-of-home care upon the way in which professionals work with them, the discussion highlighted the negative connotations of this diagnosis rather than the ‘label’ per se. This may assist in explaining the less frequent yet still significant findings that the diagnostic classification of conduct disorder can have a positive, neutral and/or variable impact on the way in which professionals work with adolescents in out-of-home care.
It may be argued that this distinction is arbitrary; however I believe it is potentially relevant to the long-standing debates and discussion concerning the validity and desirability of maintaining a system of mental health / psychiatric diagnoses. The nature and origins of such debates have been covered elsewhere in this thesis, particularly in Chapters 2 and 3. However, to briefly revisit, these debates and discussions have been characterised by symbiotic critique and the adoption of mutually hostile, entrenched and binary philosophical positions (Geelan, 2002; Gergen, 2001; Hacking 1999). Consequently, positivists have argued strongly for the retention of a system of mental health diagnoses while social constructionists have mostly argued for the dismantling of such a system. This comprises some of the intellectual and conceptual terrain of the ‘science wars’, as applied to the field of psychiatry and mental health.

In terms of interpreting my findings in relation to hypothesis 3 then, I believe there is a distinction to be made between the negative impact of a diagnostic classification of severe conduct disorder per se vs the negative impact of the connotations or discourse associated with this classification. By advocating this position, I believe freedom from the narrowly constructed historical debates can be found, arguing neither for the abolition of the system of psychiatric diagnoses nor the dismissal of understandings to be gleaned from a critical, social constructionist perspective.

This approach seems to correlate with the approach to understanding mental illness put forward by Hacking (1999) and discussed in more detail in Chapter 3. Revisiting his argument briefly, he seeks to end simplistic arguments about whether or not a mental illness is ‘real’ or ‘socially constructed’. He contends that psychopathologies furnish ‘obvious candidates’ for phenomena that may in fact be both (Hacking, 1999:108-109). In speaking of something as socially
constructed, Hacking believes it is important to identify the ‘grade’ of social construction we wish to assert (1999: 68,111). In particular, clearly delineating whether we are asserting that X per se is socially constructed, or whether ideas about X are socially constructed. Also, Hacking argues that social construction is not a ‘one-way street’ in which society constructs a mental disorder that either does not exist as described or would not exist at all unless it were described (1999: 116).

Similarly, I believe that severe conduct disorder can be considered a ‘real’ and discrete mental health condition and not ‘purely’ an act of social construction. However, I also believe that there is a discourse that attends this diagnosis that is socially constructed and is informed by the overall pathologising manner in which adolescence, adolescents, criminality and mental illness are discussed and understood in Western society, its media and healthcare professions. In this sense, I am applying Hacking’s (1999) concept of grades of social construction in that I believe ‘X’ or conduct disorder is not socially constructed but that ideas about ‘X’ or conduct disorder certainly are. Again, in Hacking’s (1999) terms, I am adopting the position that both bio-looping and classificatory looping effects are present in discussing mental health conditions, as discussed in Chapter 3.

In the findings related to hypothesis 3, respondents did not offer concentrated argument or reflection upon the negative or unhelpful nature of a diagnosis or diagnostic system per se. Rather, the connotations and expectations surrounding this diagnosis and the young people in receipt of it, were highlighted as being problematic and as having a negative impact upon the way in which professionals worked. These connotations and expectations are profoundly reinforced by wider conceptualisations of adolescence, adolescents, criminality, mental illness and their inter-relationship. These conceptualisations, as well as an absence of intervention models and
treatments that actually seem to make a life-changing impact, generate significant pessimism in working with adolescents diagnosed with severe conduct disorder in out-of-home care.

Indeed, I believe if notions of adolescence, adolescents, criminality, mental illness and their inter-relationship were not inherently negative, a great deal of hope and optimism might be generated in the health and Welfare professionals working with adolescents diagnosed with severe conduct disorder in out-of-home care. This could occur if adolescence and adolescents were not regarded as inherently, immutably and uniquely unstable but subject to psychological, emotional and social changes like all of us are throughout the lifespan. Also, if mental health conditions such as severe conduct disorder and persistent criminal behaviour in adolescents were not regarded as basically intractable but capable of being profoundly altered and shifted. In this context, the diagnosis of severe conduct disorder could still be made and the abovementioned benefits of a classificatory system of diagnosis raised by respondents could be retained. In this way, the mere existence of this diagnosis would not need to have its current mostly negative impact on professionals working with adolescents in out-of-home care, since the discourse that attends it would no longer be so fatalistic and defeatist.

6.1.4 Overall Findings from Interviews and Questionnaires

In sum then, my hypothesis that adolescents in out-of-home care diagnosed with severe conduct disorder have poor treatment outcomes appears to be supported by my abovementioned research findings as well as the literature review undertaken related to this client group.

My hypothesis that adolescents in out-of-home-care diagnosed with severe conduct disorder are a particularly difficult client group to work with because of issues of attachment appears to be
supported by my abovementioned research findings as well as the literature review undertaken related to this client group.

My hypothesis that a diagnosis of severe conduct disorder for adolescents in out-of-home care negatively impacts upon the way in which professionals work with them appears to be supported by my research findings as well as the literature review undertaken related to this client group and this issue.

6.2 Further Comments Regarding Strengths and Limitations of my Research

Throughout Chapter 4, strengths, limitations and tensions present in my research were discussed. However, I wish to make further comment following the presentation and discussion of my findings. While I believe that all three of my research hypotheses appear to be supported by the findings from my interviews, questionnaires and literature review, the nature of the context and methods utilised to conduct my research mean that no claims to statistical ‘representativeness’ can be made. Indeed, as outlined in Chapter 4, the nature of my sampling was purposive and its scope intended to represent a ‘key informants’ and exploratory approach as the first stage of a two-stage research process. In addition, the context of my research being part of a master’s by research degree thesis meant that an increased number of research participants would have presented difficulties regarding the length of my final piece of work as well as the time required to complete it.

Also, I’m not aware of research conducted previously and specifically around interventions with adolescents diagnosed with severe conduct disorder in out-of-home care. There is much research that is related yet it is not the same. For instance, research exists regarding adolescents diagnosed
with severe conduct disorder but the young people involved have usually not been placed in out-of-home care and therefore do not possess the particular constellation of difficulties that have been examined in my thesis. Moreover, research into interventions with adolescents diagnosed with severe conduct disorder that has been conducted is mostly from the United States and to a lesser extent, Canada and New Zealand. In Australia, research into out-of-home care has tended to focus almost exclusively on foster care - a placement option that is normally not appropriate or relevant for adolescents diagnosed with severe conduct disorder, as discussed in Chapter 1. The placement option they are most likely to be found in, residential care, is the least researched placement type in Australia (Cashmore et al., 2004).

This means that there is a limited capacity indeed to compare my research with like research. This perhaps adds a degree of difficulty in assessing its overall merit, usefulness and/or potential for application. However, my work has addressed a long-standing research gap and to that extent, I believe it makes a valuable contribution to the field, particularly within the Australian context. As my findings appear to indicate, there is a level of resignation and at times despair in working with adolescents diagnosed with severe conduct disorder in out-of-home care. As such, I believe social workers and all other interested parties welcome attempts such as mine to improve understanding and knowledge in this crucial area of practice.
Chapter 7

Conclusions and Recommendations

7.1 Conclusions

From the findings of my study as well as literature review, it appears that working with adolescents diagnosed with severe conduct disorder in out-of-home care is an extremely difficult, complicated and somewhat vexed area of practice. Currently, poor outcomes for young people and service providers are yielded from existing interventions with this client group (Ainsworth, 2003; Davis et al, 2000; Morton et al, 1999; Thomas, 2003). These findings are highly consistent with my own experiences as a social worker working in this area of practice, as well as accumulated anecdotal evidence from the field. Furthermore, interventions with similar client groups overseas such as adolescents diagnosed with moderate-severe conduct disorder residing at home, do not appear to be readily transferable to the out-of-home care context in Australia (Cashmore et al, 2004; Maluccio et al, 2000).

This is because the young people in out-of-home care diagnosed with severe conduct disorder will normally have a more complex and deeply entrenched constellation of difficulties requiring attention than those young people for whom it is still possible and appropriate to live at home (Morton et al, 1999). Indeed, treatment approaches often cited as instructive such as multi-systemic therapy and therapeutic foster care are directed at young people at the more preventative end of the service continuum (Chamberlain, 2003; Cunningham et al, 1999; Henggeler et al, 1997b; Kazdin, 2002). Also, they are quite contingent on the ability, capacity and willingness of biological family members to participate in quite rigorous and sustained treatment programs
(Henggeler et al., 1996, 1998, 2002a; Kazdin, 2002). In Australia, there has also been an almost complete absence of research into models of residential care, the placement type most adolescents in out-of-home care diagnosed with severe conduct disorder are likely to require (Barber et al., 2002; Bath, 1998; Cashmore et al., 2004; Delfabbro et al., 2001; Thomas, 2003). This has further contributed to the lack of hope, optimism, creativity, understanding and knowledge regarding interventions with adolescents diagnosed with severe conduct disorder in out-of-home care.

However, I believe the findings from my study and literature review contain understandings that are useful in suggesting ways in which new intervention models and research might be developed. Having interviewed and surveyed ten senior managers and practitioners from across key service sectors and from varying disciplinary backgrounds, their reflections indicate that attachment theory has a crucial role in informing such developments. Research respondents consistently highlighted the centrality of profound attachment difficulties in understanding adolescents diagnosed with severe conduct disorder in out-of-home care. This was also supported by the findings from my literature review (Fosha, 2003; Hughes, 1997, 2004; Perry, 1997; Schore, 2003; Werry, 2005a). Again, these findings are highly consistent with my own experiences as a practitioner as well as accumulated anecdotal evidence from the field.

Apart from at the level of conceptualisation, respondents and indeed most of the literature itself, seems relatively unclear about how understandings from attachment theory might be applied in an ‘everyday’, conversational and practical manner when working with adolescents. Given the abovementioned conclusions, it would seem that there is a significant need to develop new models of intervention that address the needs of adolescents diagnosed with severe conduct disorder in out-of-home care. New models of intervention need to be developed in ways that
allow the profound attachment disruptions of these adolescents to be practically addressed.

However, as I have argued throughout my thesis, I believe that mental health difficulties are most usefully addressed utilising bio-psychological and critical approaches. This overall approach represents moving away from conceptualisations of mental illness steeped in the ‘science wars’, which posit mutually hostile and exclusive explanations based on either a positivist or social constructionist ontology and epistemology (Gergen, 2001; Hacking, 1999).

I believe a critical approach is particularly helpful when considering the findings from my study which highlighted that a diagnosis of severe conduct disorder for adolescents in out-of-home care negatively impacts upon the way in which professionals work with them. This overall finding was tempered by significant albeit less frequent reflections that the diagnostic classification of severe conduct disorder can have a neutral or indeed positive impact upon the way in which professionals work with clients. From these overall findings, some may argue that the system of diagnostic classification needs to be dismantled due to the negative impact it has upon the attitudes and efforts of professionals towards their clients. However, I believe these findings can be better understood within Hacking’s (1999) framework for understanding mental health difficulties. This framework holds that it is important to identify the ‘grade’ of social construction to be asserted. Specifically, delineating whether we are asserting that X per se is socially constructed, or whether ideas about X are socially constructed.

Within this framework, I hold the view that adolescent conduct disorder can be considered as being ‘real’, yet there are many ideas related to it that are socially constructed. I believe it is these ideas that are the source of the negative impact this classification has on the way in which professionals work with these young people, rather than the classification itself. Hence, I believe that the findings from my study relating to the impact of diagnostic classifications does not
suggest that diagnostic classifications themselves need to be abolished, but rather the dominant discourses that attend such classifications.

By applying understandings from critical theory (Fawcett et al, 2005; Foucault, 1978, 1979, 1989a, 1989b, 2002; Martin, 2003b; Pease, 2003), the impact of dominant discourse upon the way in which individuals perceive themselves as well as how others perceive them, can be understood. Specifically, the ‘self’ and subjectivity can be seen to be crucially shaped by discourse and as such the ‘individual’ self is conceptualised as being intrinsically ‘social’ (Foucault, 1978; Lerner, 1986). Critical theory and social work practice can address the processes by which dominant discourse can lead to an internalisation of inferiorisation and oppression (Pease, 2003; Mullaly, 2002). As discussed in Chapter 3, adolescents diagnosed with severe conduct disorder in out-of-home care demonstrate high levels of internalised inferiorisation and oppression due to their discursive location as simultaneously adolescents, mentally ill, and criminal. In addition, health professionals working with these young people can be significantly influenced by the dominant discourse surrounding them, contributing to the lowering of optimism, expectations, regard and quality of service provision (Epstein et al, 2001a, 2001b; Graham, 2004).

In sum then, drawing on both attachment theory and critical theory, I believe that adolescents diagnosed with severe conduct disorder in out-of-home care are profoundly alienated from themselves, others and the society in which they live. Having experienced serious attachment disruption, these young people have internalised a view of themselves as unworthy, unlovable, bad, evil and/or undeserving while their view of others is that they are fundamentally uncaring, unreliable, inconsistent, intrusive, dangerous and/or disinterested. Also, they are likely to have experienced impaired neurological development due to the effects of prolonged relational trauma.
These young people are also subject to a dominant discourse that informs them that they have received the ‘lot’ in life that they deserve and perpetuate due to their inherent inferiority compared with others, meaning that the possibility of an alternative life is remote indeed. Further still, this dominant discourse negatively impacts upon the professionals who seek to assist them such that their attitude and quality of service provision is diminished.

Brendtro et al (2002:10-11; 15-17) describe such young people as ‘unclaimed’ and as living in ‘climates of futility’ where negative environments and expectations can produce failure and futility in young people as well as the adults who share their lives. I believe that this description readily applies to adolescents diagnosed with severe conduct disorder in out-of-home care as well as many of those who work with them.

### 7.2 Recommendations

In order to adequately and appropriately address the needs of adolescents diagnosed with severe conduct disorder in out-of-home care, I believe an overall approach that tackles the damaging effects of seriously disrupted attachment and dominant discourse is required. This approach would address issues of alienation at the intra-personal, inter-personal and societal levels, ‘undoing’ the harmful effects of what Hacking (1999) refers to as bio-looping of an indifferent kind, and classificatory looping of an interactive kind. As such, this approach could lead to new and creative practice models that would afford conceptual and research space to both positivist and social constructionist ‘lenses’ of understanding.

In moving towards the development of such a model, I believe it is necessary to first conduct further research regarding interventions with adolescents in out-of-home care.
diagnosed with severe conduct disorder. As mentioned previously, I would regard my own research as the necessary first stage of a two-stage research process. The second stage needs to include respondents that are the young people discussed in this thesis, as well as someone from their family. The findings from their perspectives can then be compared with those from the more ‘expert’, professional views expressed by the respondents in my study and in the existing body of literature related to this client group. In addition, this second stage study could pay significantly more attention to the dimensions of class, race/ethnicity and gender and how these dimensions particularly affect the experiences and issues of adolescents diagnosed with severe conduct disorder in out-of-home care. A second stage study of this nature would greatly assist in addressing some of the more significant limitations of my study, particularly from the perspective of critical theory and research.

When both stages of research have been conducted, a possible model of intervention able to be developed could be a residential program that does not merely reflect the current care and accommodation paradigm, but embodies the shift to a therapeutic paradigm. Such a shift has been strongly advocated within the Australia context but has yet to occur (Ainsworth, 2001, 2003; Bath, 1998, 2005; Cashmore et al, 2004). The need for a paradigm shift of this nature is well encapsulated by Ainsworth (2003:28):

> It is time to build a new generation of powerful tertiary level community services to address the needs of ‘at risk’ youth to go alongside less intensive foster care, residential programs and refuge services that provide care but not ‘care and treatment.’ It’s time to make a difference in the lives of these vulnerable young Australians. In fact, it’s way past time and we are running late.
Within such a therapeutic residential program, I believe young people’s attachment issues need to be addressed at multiple levels or stages including referral, assessment, case conceptualisation and direct contact with young people, especially by those staff employed as residential staff. At this level, purposeful yet non-threatening conversations could be held that look to raise awareness of the attachment and relationship issues underlying various choices, communication strategies and behaviours by both young people and staff.

Within such a program, I also believe that the negative impact of dominant discourse regarding the constructs that relate to adolescents in out-of-home care diagnosed with severe conduct disorder, would need to be addressed. This could be undertaken in various ways and formats both with the young people themselves and the staff working with them. With the young people themselves, critical counselling practices such as consciousness-raising, critical questioning, deconstruction and reconstruction could be employed in order to address the alienation resulting from an oppressive discursive location within dominant discourse (Allan, 2003b). In this way, I believe young people can address their inferiorisation and internalised oppression as well as that alienation resulting from severe attachment disruption. In terms of staff, supervisory and training settings could foster and instruct in a culture of critical reflection as well the abovementioned counselling practices being adapted for purposeful use in individual and group supervision sessions.

Employing this innovative and inter-epistemological model of intervention, I believe adolescents in out-of-home care diagnosed with severe conduct disorder could achieve a sense of re-connection to themselves, others and to society. At that point, I believe lasting positive changes are possible and new life trajectories truly achievable…including for young people like Billy.
In Chapter 1 I discussed a young person whom I gave the name of ‘Billy’, in order to preserve his anonymity. Following the incident described in Chapter 1, I worked with Billy as his case manager for approximately twelve months. During that time, Billy did not develop any feelings of empathy regarding his anti-social and violent behaviours and his life continued to follow a destructive path with frequent offending and contact with the Juvenile Justice system. Subsequent to being his case manager I have had no contact with him. However, as a result of continuing to work in the field, I have become aware from time to time of his circumstances. In essence, his behaviours and life trajectory remain unaltered and he is now somewhat of a notable fixture in the adult male prison population.

Without doubt, Billy’s story continues to be a troubling and unsettling one. It is for men and women like Billy that I believe there must be a continued searching for new understandings and practices that can offer truly life changing outcomes. The life of Billy and others like him are too precious to be squandered.
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Research Invitation

Project Title: “Interventions with Adolescents in Out-of-Home Care Diagnosed with Severe Conduct Disorder”

Dear [Name],

My name is Lothar Wahl and I am a social worker currently completing my Master of Social Work degree by Research Thesis. I am studying within the School of Social Science and Planning, which is part of the Portfolio of Design and Social Context at RMIT University.

About the Project:

The aim of the research is to examine the different services and interventions used by welfare, mental health and juvenile justice agencies to assist adolescents aged 12-17 years old who are residing in out-of-home care and meet the criteria for a diagnosis of severe conduct disorder.

The research aims to identify and critique existing interventions in this area and begin to explore new ways of working with these young people that would improve client outcomes.

About Participating in the Project:

I am writing to you to seek your participation in completing an interview and brief questionnaire with me. Including a brief explanation of both the interview and questionnaire process, I would anticipate that the overall time commitment would total 1 hour of your time.

The interview questions are based around the theme of working with adolescents in out-of-home-care who have been diagnosed with severe conduct disorder. In particular, the questions will ask you to reflect on your experiences and perceptions of working with these young people, including reflections around particular interventions. I would anticipate that this interview could be completed within a 40 minute time-frame.
Following the interview, I would also be grateful if you could complete a brief questionnaire which contains nine questions that would relate to the interview themes and issues mentioned above. I would anticipate that the questionnaire would require up to 10 minutes to complete.

If you decide to participate in the research, I will provide a clear Consent Form and Confidentiality Agreement as per the RMIT University protocols and standards regarding research involving participants.

These protocols and standards include the following conditions:

- Should you choose to participate, you will be free to withdraw from the project at any time and to withdraw any unprocessed data.

- Anonymity and the confidentiality of information provided is assured.

- The security of the data obtained is assured following completion of the study.

I also wish to state that there is a likelihood that the research will be published. In this event, a report and/or copy of what is published will be provided to you.

I would also be pleased to make myself available to provide presentations, seminars and/or training to your team relating to the research topic.

**Project Contact Details:**

Lothar Wahl

phone : 0407 527 710

e-mail : lothar.wahl@rmit.edu.au

Senior Supervisor for Research

Dr Jenny Martin

phone : 9925-3131 / 0438 424 799

e-mail : jenny.martin@rmit.edu.au

Any further enquiries or complaints about your participation in this project may be directed to the Secretary, RMIT Human Research Ethics Committee, University Secretariat, RMIT, GPO Box 2476V, Melbourne, 3001. The phone number is (03) 9925-1745.
Thank-you for taking the time to consider my request and I look forward to hearing from you.

Yours sincerely,

Lothar Wahl
Social Worker
B.S.W., M.S.W. Candidate (RMIT University)
RMIT HUMAN RESEARCH ETHICS COMMITTEE

Prescribed Consent Form For Persons Participating In Research Projects Involving Interviews, Questionnaires, Focus Groups or Disclosure of Personal Information

PORTFOLIO OF
SCHOOL/CENTRE OF

Name of participant: _____________________________________________
Project Title: __________________________________________________

Name(s) of investigators: (1) _______________________________________
(2) _______________________________________
Phone: ____________________________________ Phone: ________________

1. I have received a statement explaining the interview/questionnaire involved in this project.
2. I consent to participate in the above project, the particulars of which - including details of the interviews or questionnaires - have been explained to me.
3. I authorise the investigator or his or her assistant to interview me or administer a questionnaire.
4. I give my permission to be audio taped ☐ Yes ☐ No
5. I give my permission for my name or identity to be used ☐ Yes ☐ No
6. I acknowledge that:
   (a) Having read the Plain Language Statement, I agree to the general purpose, methods and demands of the study.
   (b) I have been informed that I am free to withdraw from the project at any time and to withdraw any unprocessed data previously supplied.
   (c) The project is for the purpose of research and/or teaching. It may not be of direct benefit to me.
   (d) The privacy of the information I provide will be safeguarded. However should information of a private nature need to be disclosed for moral, clinical or legal reasons, I will be given an opportunity to negotiate the terms of this disclosure.
   (e) The security of the research data is assured during and after completion of the study. The data collected during the study may be published, and a report of the project outcomes will be provided to _____________(researcher to specify). Any information which may be used to identify me will not be used unless I have given my permission (see point 5).

Participant’s Consent

Name: __________________________________________________________ Date: __________________________
(Participant)

Name: __________________________________________________________ Date: __________________________
(Witness to signature)

Where participant is under 18 years of age:

I consent to the participation of _____________________________ in the above project.

Signature: (1) ______________ (2) ______________ Date: __________________________
(Signatures of parents or guardians)

Name: __________________________________________________________ Date: __________________________
(Witness to signature)

Participants should be given a photocopy of this consent form after it has been signed.

Any complaints about your participation in this project may be directed to the Secretary, RMIT Human Research Ethics Committee, University Secretariat, RMIT, GPO Box 2476V, Melbourne, 3001. The telephone number is (03) 9925 1745. Details of the complaints procedure are available from www.rmit.edu.au/council/hrec
**Questionnaire**

Please circle your selected answers.

(1) **How successful are interventions in working with adolescents diagnosed with conduct disorder in out-of-home care?**

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<th>3</th>
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<th>1</th>
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<tbody>
<tr>
<td>Highly successful</td>
<td>Successful</td>
<td>Moderately successful</td>
<td>Not successful at all</td>
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(2) **How would you describe the quality of service outcomes for adolescents diagnosed with conduct disorder in out-of-home care?**

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<tr>
<td>Very poor</td>
<td>Poor</td>
<td>Adequate</td>
<td>Excellent</td>
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(3) **How would you compare your work with adolescents diagnosed with conduct disorder in out-of-home care with those adolescents in the *general* out-of-home care population?**

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<tbody>
<tr>
<td>Much easier</td>
<td>Easier</td>
<td>More difficult</td>
<td>Far More difficult</td>
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(4) **How would you rate the importance of the issue of attachment in working with adolescents diagnosed with conduct disorder in out-of-home care?**

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<tr>
<td>Not important</td>
<td>Moderately important</td>
<td>Important</td>
<td>Extremely important</td>
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</table>

(5) **How often would the use of attachment theory inform your practice working with adolescents diagnosed with conduct disorder in out-of-home care?**
(6) To what extent does the nature of the relationship between workers and adolescents diagnosed with conduct disorder in out-of-home care, influence service outcomes?

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<tr>
<td>Never</td>
<td>Not often</td>
<td>Often</td>
<td>Very often</td>
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<th>4</th>
<th>3</th>
<th>2</th>
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<tbody>
<tr>
<td>Highly influential</td>
<td>Influential</td>
<td>Moderately influential</td>
<td>Not influential</td>
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(7) To what extent would a professionals’ knowledge of a diagnosis of conduct disorder influence their work with an adolescent in out-of-home care?

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<tbody>
<tr>
<td>Highly influential</td>
<td>Influential</td>
<td>Moderately influential</td>
<td>Not influential</td>
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</table>

(8) How would you rate the impact of a diagnosis of conduct disorder for an adolescent in out-of-home care, in their receiving of agency services?

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<tbody>
<tr>
<td>Very negative impact</td>
<td>Negative impact</td>
<td>Positive impact</td>
<td>Very positive impact</td>
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</table>

(9) How might the diagnosis of conduct disorder for an adolescent in out-of-home care impact upon service provider expectations regarding outcomes?

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<tr>
<td>Very negative impact</td>
<td>Negative impact</td>
<td>Positive impact</td>
<td>Very positive impact</td>
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</table>
Thank you very much again for your time.

Sincerely,

Lothar Wahl.
Interview Questions

(1) What have been your experiences in working with adolescents in out-of-home care diagnosed with conduct disorder?

(2) How do these experiences compare with those working with adolescents in out-of-home care generally?

(3) What models of intervention, if any, have you found useful in working with adolescents in out-of-home care diagnosed with conduct disorder?

(4) What are the particular difficulties experienced working with this client group?

(5) Within the out-of-home care system, in what ways might the diagnostic label of conduct disorder influence a professionals’ work with an adolescent?

(6) In what ways might a diagnostic classification of conduct disorder influence an agency’s provision of services to an adolescent in out-of-home care?