For Whose Benefit?

Social workers' understandings of children's behaviour

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To you, whose name amongst all of you is long gone

To you, because I do not forget you should be here

To you, who chose to go without saying goodbye

To you, because I did not see, and I did not hold your hand

To all of you but, above all, to you

Seeking forgiveness

It is no measure of health to be well adjusted to a profoundly sick society.

Krishnamurti

Acknowledgements

I am not allowed to name the people thanks to which this research has been completed: the social workers who generously donated their time and shared with honesty their experiences; the incredible selflessness of the adults with lived experience of the care and mental health systems, who trusted me without knowing me, and for which I am moved beyond measure; and, most of all, the children whose placements I supervised over the years and who taught me so much about living. They have become my lodestars. Meeting them has been my privilege.

If they cannot be named, I shall not name anybody else.

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And, in the end, to my wise friend, esto se empezó gracias a otros, pero solo se ha terminado gracias a ti, solo gracias a ti. I am rich thanks to you.

But most of all, I need to acknowledge my children, for every time the door to my working space was opened, seeking the mother who would acknowledge their existence, and they were greeted with that disease of 21st century parenting, the ‘later’ disorder. You sacrificed without even knowing what you sacrificed for. I had not realised that children grow quicker than thesis too. I fear, now that mamá is no longer ‘working’ at weekends, you have by now discovered your own amusements.

And finally, strangely and unexpectedly, myself. This thesis was completed under unanticipated painful personal circumstances. There were so many times that I wanted to let go, that I find myself, at the end, joining my daughter’s glee as she cries after accomplishing something, “I did it!".

I dread my patient colleagues at the Social Work and Social Justice Division learning about that, though.

Abstract

This study examines how social workers make sense of children's behaviour, how that understanding guides interventions, and their ethical or human rights perspective in this area of their practice. Research data was gathered through semi-structured interviews with 29 social workers. All data was analysed using reflexive thematic analysis.

The study is divided into an introduction and six chapters. The first chapter reviews what might be at stake from a self-identity perspective when making causal attributions about behaviour, as well as the social workers' professional context in understanding of children's behaviour. The second presents the methods used in the study.

Each of the three empirical chapters covers an aspect of the social workers' responses: 1) possible explanations for a child's behaviour and how they establish which one/s is the correct one for each child, 2) interventions to address children's behaviour, and 3) ethical and human rights considerations.

The final chapter concludes that the adult-led process of framing children's behaviours is not a neutral one. Adults themselves have a vested interest. Behaviours selected for intervention appear to be those disruptive for the adult/s around the child, with less consideration paid to the child's own experience. Further, some explanations allow adults to ignore their own potential responsibility for the child's behaviour.

Social workers showed moral distress at situations derived from the above; however, they rarely articulated this through an ethical/human rights perspective. The study suggests this could be due to another process of dislocation of responsibility, through emphasising organisational constraints and 'unseeing' ethical/human rights aspects of their practice. Whilst these processes may serve to sustain the social workers' own professional identity, it also preserves the sociopolitical circumstances that constrain their practice. The study proposes as a way forward the reappropriation of agency and responsibility, not from an individualising understanding, but from a political responsibility perspective.

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On terms

Before the reader goes any further, I would like to clarify the use of some terms within this dissertation.

All official psychiatric diagnoses as listed in DSM-5-TR (APA, 2022) or ICD-11 (WHO, 2019) appear in capital letters to distinguish them from informal expressions.

‘Child’/‘children’ is used to refer to any person below the age of 18.

‘Children in State care’ is favoured over the most common expressions of ‘children in care’ or ‘looked after children’. This is a moral choice which I owe to one of the study participants. Sharing an appalling case, they reflected how the situation did not resemble what those words (‘in care’) should mean. I couldn’t agree more. Therefore, I have chosen what I believe is a more accurately descriptive term.

Finally, this study takes a critical psychiatric perspective. That position does not imply a diminishing of very real struggles and suffering. It does imply, however, the discussion that there might be more productive ways of understanding and addressing that suffering. It does not imply either that the alternative must be ‘bad’ parenting/caring. That would only move the individualistic understanding from one person to another. It does imply, however, the discussion on our current conditions for parenting, and its possible failures, even when we undergo untold sacrifices to ensure the best for our children. Not being able to recognise those failures to ourselves and, most painfully of all, to our children, means failing them again. And yet, the wonder is not how parents fail, but how they manage not to do so under the current socioeconomic circumstances. Bowlby (1952:84) already said it over half a century ago, “a society that values its children, must cherish their parents”. Ours does not.

Introduction

When searching for a solution to a problem,
it is vital that the problem is carefully diagnosed.
It is only then that a solution can be considered.
If the diagnosis is wrong, no amount of solution will be effective. Mawlana Faraz Ibn Adam.

The world has been growing so much darker since I set out in writing this thesis. Is it not imperative, if we are to survive as human beings (all of us are already animals), that we learn to understand one another and ourselves with honest compassion? At the onset of any social work intervention there should be such ‘sense making’ activity (White, 1997; Gregory, 2023). The motivation for this study grew from my disquiet that, when it came to children in State care, this sense making was being interfered by adults’ and organisations’ interests and dynamics.

For approximately half a century two academic discussions of great importance for the understanding of children affected by abuse and neglect have run parallel to each other: critical psychiatry and childhood trauma. These two discussions intersected with each other at the beginning of the present century when the idea of developmental trauma disorder was proposed (van der Kolk, 2005). As a diagnostic category, developmental trauma was not incorporated into DSM-5; however, it has remained in the literature, representing, according to its supporters, a more accurate way to understand not only children, but also adults affected by traumatic experiences in their childhood.

In England, children's social care has been the object of another review (MacAlister, 2022). Subsequently, the government published a new Children's Social Care National Framework in December 2023 (DfE, 2023). The Framework's accompanying Dashboard (which will be the tool to guide data collection to monitor the Framework's progress) includes just two indicators to measure children's wellbeing: school attendance and school persistent absence/exclusion. This Framework provides a new guidance for practitioners on how to approach their work with children and families. Yet again it offers social work professionals a footprint for practice without a serious prior reflection on how we understand children.

Children in State care are a particularly vulnerable population. In 2023 there were 83,840 children in the care system in England (DfE, 2024). Experiences leading to removal from birth parents aside, the legal status of these children makes them particularly vulnerable because of two interconnected circumstances: 1) due to placement disruptions and staff changes, they are likely to lack a trusting adult present throughout their childhood who is committed to them and invested in advocating on their behalf; and 2) these disruptions are likely to contribute to experiences of lack of control over and understanding of their own life (Selwyn et al, 2018). In relation to mental health, young people leaving care are five times more likely to attempt suicide than their peers (HC, 2016). Besides, half of these children in the UK meet the criteria for a psychiatric disorder, compared with one in ten of the general population (ibid).

In England, there has been an ongoing concern regarding the wellbeing of children in State care (Narey and Owers, 2018; HC, 2016; Sen, 2018; Oakley et al, 2018, MacAlister, 2022), yet this has not led to any significant critical examination of their psychiatric diagnosing and treatment, despite the growing recognition of the extent to which children's early psychosocial experiences lie at the heart of their present difficulties (Crittenden, 2016; Oakley et al, 2018; Perry, 2002; Perry et al, 1995). Besides, over fifty mental health organisations expressed concerns that the diagnoses defined in the DSM-5 (APA, 2013) would mean "an increase in inappropriate treatment of vulnerable populations, including children...” (Ferguson, 2017: 44). Leading psychiatrists have built a body of evidence advocating for a diagnosis, of developmental trauma disorder (van der Kolk, 2005, D’Andrea et al, 2012), that would more accurately reflect children’s experiences, or for more tailored assessment and treatments, such as the neurosequential model (Perry, 2009), without reference to a psychiatric diagnosis. Adopting either proposal would lead to a reconsideration of existing diagnoses as well as psychiatrists’ current reliance on psychotropic drugs for treatment (Greenberg, 2013). There is, however, evidence that pharmaceutical companies benefit from the dominant position of the biomedical model and use illegal practices to expand the prescription of their psychotropic drugs to children in State care (see Rothman, 2010, for a list of pharmaceutical practices in relation to the promotion of risperidone). While in the USA excessive psychotropic medication prescribed to the looked after population has been a growing concern (Littrell, 2012; Osher and Brown, 2016), so far there has been limited research carried out on this topic in the UK.

It can be argued that the psychiatric diagnosing, and psychotropic drug prescription, of children in State care is a congruent development of neoliberalism, both sharing an individualistic perspective. And, as medicalisation has argued, the individualisation and decontextualisation of social problems dislocates responsibility from politicians, and other social actors (Conrad, 2007). Social workers are some of those other social actors. Social workers embody the corporate parental responsibility that falls on Local Authorities once a child is permanently removed from their parents’ care. All children in State care should have a social worker allocated as the professional overseeing their wellbeing. This social worker needs to reach their own understanding of what might be going on for a child to decide on the support needed. In understanding a child, social workers face some unique challenges (over and above those faced by birth parents). Social workers do not know children from birth, they do not undertake the child’s daily care, their access to many of the child’s experiences is largely through third party (sometimes, as in the case of past records, third party of third party) reports, they work with a multidisciplinary team (carers, teachers, health professionals, etc), and they are responsible for a group of children (their 'caseload') at any one point, with the time restrictions that derive from this.

This study, then, considers both the social workers' context of practice, as well as existing debates on the understanding of human behaviour and its potential medicalisation, examining how social workers understand the behaviour of children in the care system, how that understanding may guide their interventions, and their ethical and human rights considerations in this area of practice.

This research is less concerned with the scientific value of one causal explanation on behaviour over another, and more with the potential consequences – including 'unintentional' ones – on a person's identity of each possible explanation. In analysing the social workers' responses, the study is influenced by critical realism and critical theory. One of the premises of critical realism is that reality can never be directly or fully apprehended (Houston, 2023; White, 1997). Any representations of it can only be approximations, "from a particular perspective" (White, 1997: 742). Knowledge, therefore, cannot be "the reproduction of reality", but a "selective representation" of it (ibid). Stutchbury could not have provided a clearer explanation when she argues that critical realism "combines a realist ontology (there is something real to find out about) with a relativistic epistemology (different people will come to know different things in different ways)"[1] (2022: 113). According to critical realism, three levels can be differentiated within 'reality': "the empirical level consisting of experienced events; the actual level, comprising all events whether experienced or not; and, lastly, the causal level embracing the 'mechanisms' which generate events" (Houston, 2001: 850). This thesis studies the experienced

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[1] Perhaps not too dissimilar from the ancient parable of the elephant and the blind men.

reality of the participant social workers in making sense of children's behaviour, as well as the possible 'mechanisms' behind it, not necessarily part of participants' conscious experience.

If we consider knowledge as approximations to 'reality', historically and socially situated, drawn from a pool of cultural meanings coalesced around a range of social representations, the questions become what the mechanisms might be to construct and choose particular narratives, and how some versions get to take precedence over others. Critical realism takes an epistemic justice stance (Fricker, 2007). Since all narratives are but approximations to 'reality', all are equally valid (White, 1997). That does not mean, of course, that within one particular historically situated society, one narrative may not be more valued than another, or that one group's narratives are given consideration over the narratives propounded by other groups. Not all stories are equal from an individual or sociopolitical point of view. Narratives contribute to the construction of present and future experience. What becomes crucial is not a narrative's (relatively) relative approximation to 'reality', but its consequences on human experience. Not everything named exists physically (unicorns), or it might do so only from a very specific point of view (constellations), but a name creates a ripple of influences (Seeman, 1999). Narratives are real inasmuch as their consequences are real (Thomas and Thomas, 2018[1928]) and the questions to ask are, does it "advance the person's emotional wellbeing?" (White, 1997: 748) Does it advance *eudaimonia* (Nussbaum, 2001)?

Critical theory recognises knowledge is situated in relation to social and political power structures (Horkheimer, 2002; Freyenhagen, 2017). That is, power structures within a society do create situations of epistemic injustice. Of particular interest to this study, Foucault (2005) provides an account of those sociopolitical structures that support the precedence of the psychiatric discourse. Also relevant to this study is the asymmetry in adult-child relationships. The younger the child, the more likely it is that they will co-opt and incorporate to their own understanding the explanations about themselves provided by their parent/carers and/or professionals. Adults judge their own behaviour (which may or may not incorporate other people's views), and they may decide that it requires medical opinion[2]. In the case of children, however, it is their adult carer/s who judges the *child's* behaviour as requiring medical attention. There is, of course, a gradient in this situation, with the adults moving to more advisory roles as the child grows older, in a process idiosyncratic to each family[3].

The study considers three aspects in the relationship between behaviour and identity: within the self, or connecting one's own behaviour with their self-identity; interpersonal, or considering behaviour as re/action within relationships with others; and sociopolitical, or how our behaviour positions ourselves in relationship with the structures within which we live, as citizens or members of professional bodies. Considering all these three aspects allows to examine the person's agentic power in relation to the sociopolitical structures within which they are located. Any interpretation on behaviour carries some responsibility adjudication (how responsible is the person for what they did), which in turn implies an understanding of the extent of their agency towards that behaviour (in this case, capacity to change it). This is pertinent to social workers who, not only create narratives to make sense of children, but are expected to find ways to support them, whilst finding themselves in relation to political structures within frame their practice.

The thesis is structured into six chapters (and the present introduction). Chapter 1 considers the literature in relation to the construction of self-identity, as well as potential social and psychological mechanisms deployed to guide explanations on behaviour: medicalisation, attribution bias, and psychological defences. The second part of the chapter reviews the knowledge base and the frameworks for understanding children's behaviour employed within the social work profession, as well as the practice context within which this understanding takes

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[2] Sectioning being an exception to this situation.

[3] Legally, children are allowed to seek medical treatment without parental consent once they turn 16.

place.

Chapter 2 outlines the study's methods. Semi-structured interviews were conducted with 29 social workers, all of whom worked with children in the care system in different capacities. Seven adults with experience of both the care and mental health systems also participated in the study, sharing their own experiences and/or commenting on extracts from the social workers' interviews.

The next three chapters report on the study findings, focusing, respectively, on how social workers understand children's behaviour, what happens in practice to address this behaviour and what are the social workers' ethical and/or human rights perspectives on this.

Chapter 3 examines how social workers make sense of children's behaviour. Five potential and non-exclusionary causes behind a child's behaviour were identified by social workers: a psychiatric diagnosable condition; a form of communication; an adaptation to past experiences (in particular, trauma); a response to the child's relational environment; and/or as a result of socioeconomic conditions. Social workers recognised the child's behaviour could respond to a multi-layered causation, as well as the fact that similar behaviours might have different causes, reflecting on the difficulty, or impossibility, of disentangling what might be attributable to what and to what extent. Social workers emphasised the importance of getting to know the child and developing trust to aid with this disentanglement. Social workers also recognised that causal attributions could also be shaped by the observer's own interpretations, which entailed an element of subjectivity and was thus dependent on the specific adult. Discrepancies in understanding the child amongst professionals/carers were acknowledged.

Chapter 4 focuses on what happens in practice to address children's behaviour. Lack of professional continuity as well as time constraints hindered the establishment of a relationship with the child. In practice, the management, rather than the understanding, of behaviour appeared as the focal point, with support sought not based on the child's emotional wellbeing or even their particular behaviour, but on the adults' capacity to tolerate and/or manage that behaviour. In practice, social workers spoke of diagnoses less as causal explanations for behaviour and more as "beneficial", "useful" or "helpful", since they allowed access to the resources already identified as needed by professionals. A further bias towards the diagnosing of children could be appreciated whenever discrepancies within the adults around a child were discussed by social workers, with a prevalence of the psychiatric narrative whenever it was propounded as an explanation, regardless of the role of the adult supporting that narrative.

Chapter 5 considers the situations that caused moral distress to the social workers: the lack of children's involvement in decision-making; the potential long-term impact of a diagnosis on how children will come to understand themselves and their histories; and the uses of psychiatric diagnosis beyond its medical one (as access to increased finances or to psychotropic drugs to manage the child's behaviour, and to 'exonerate' adults and/or the children themselves from their responsibility regarding the behaviour). Yet, for the most part, social workers lacked an explicit and consistent professional discourse in relation to the ethics/human rights of their practice.

Chapter 6 provides the final discussion. The chapter examines: a) how the process of understanding and addressing children's behaviour may serve the adults' needs as much as, or above those of, the child's, in particular the adult's need to preserve their identity as a 'helper'; as well as b) how the limited explicit articulation of this acknowledged situation in ethical and/or human rights terms may respond to the social workers' own attempts at defending themselves from ethical stress and a potential spoiled identity.

In the end, whether it is through individualising understandings of behaviour, or through the obfuscation of professional ethical and human rights perspectives, the ultimate beneficiary, inasmuch as the *status quo* is allowed to continue, are the current sociopolitical structures that contribute to both the children's living conditions (prior to and during State care) and social workers' practice conditions. If a person's behaviour needs to be considered within their relational and sociocultural context, mediated by individual biology, so too social workers' practice needs to be considered within their practice context, albeit clearly mediated by practitioners' choices. A critique of the individualistic tendencies of medicalisation discourses should not coexist next to an understanding of ethics as an exclusively individualistic responsibility. Ethical practice, upholding the principles of human rights and social justice, does not depend exclusively on improved knowledge and training, but also on the understanding that ethical practice is a collective profession responsibility, whose accountability cannot fall solely on individual practitioners but must be a collective profession endeavour.

1. LITERATURE REVIEW

This study considers narratives from one professional group, social workers, on how they make sense of children's behaviour and how such understanding is reflected in their practice accounts. The chapter is divided in two parts. First, I examine the theoretical concepts used to analyse the social workers' accounts. Second, I provide a contextual background to children's social work practice.

The chapter considers the understanding of behaviour in relation to its role within identity formation, that is, it considers the exercise of finding explanations for behaviour in relation to making sense of who we are and who we would like to be. Then I examine a series of explanatory mechanisms that may operate when making sense of the behaviour of children in State care in particular: medicalisation (social level), attribution theory (interpersonal level), and psychological defences (intrapersonal level). These mechanisms are not meant to be exhaustive.

The second half of the chapter provides a context for children social work. I examine first the professional knowledge base from which social workers may draw explanations on children's behaviour. I then consider the responsibilities and expectations placed on social workers by human rights and professional ethical guidelines. The chapter finishes with an examination of the organisation and working conditions of children social work services within which those professional judgements and professional expectations and responsibilities take place.

Theoretical ideas

Identity

Here I consider the subjective and reflexive image felt by the person themselves, what Goffman (1984[1963]) named ego identity (see also Charon's (2007[1992]) concepts of self-concept, self-esteem and self-judgements). As a starting point, identity can be considered as "a set of integrated ideas about the self, the roles we play and the qualities that make us unique" (Scott, 2015: 2), conforming a boundary to differentiate us from others. Thus, identity is relational inasmuch as we define ourselves in relation or in contrast to others (Scott, 2015).

Over our lives we create self-narratives to make sense of ourselves, trying to preserve our sense of self (Bruner, 1991; McAdams, 1993). Explanations on behaviour can become incorporated to these narratives, either as self-generated, or as provided by others (as adults present children with what they believe is behind a child's behaviour). These explanations mediate between the statements 'I do/You do' and 'I am/You are'. That is, they constitute bridges between statements on behaviour (our own or that of others) and statements about identity (our own, or that of others). They can have enduring consequences inasmuch as they contribute to the creation and maintenance of a person's identity (Duveen, 2001). But the answer to the question 'Who am I?' not only produces identity statements, it also leads to statements on self-esteem (Stets and Burke, 2014). To that purpose it requires an answer that respects and reassures our worth as a human being and that addresses any possible cognitive dissonance between our aspirations and our deeds and social positions. A lot is at stake from a person's perspective, our psychological survival or flourishing.

Possible explanations on the causation of behaviour can be roughly organised around two axes: whether the behaviour is due to internal dispositions and/or external circumstances (internal/external), and the extent to which it can be managed, controlled or adjusted to (controlling/controllable) (Foster, 2007). At the same time, Burke's (1969[1945]) motivational grammar distinguishes five elements: the act, the scene, the agent/s, agency and purpose (the actors' motivations). In making sense of an agent's behaviour, we draw a line from their action/s to their possible motives, their constraints on choices (agency) and whether their circumstances (scene) had any impact upon the latter two. Markus and Nurius (1986) provide another connection between identity and motivation, considering the possible selves that a person relates to – whom I might become, whom I would like to become, whom I am afraid of becoming… The notion of possible selves and how to integrate them under a singular narrative of identity provides a way to understand different relationships between self-concept and behaviour, as well as introducing the possibility of self-distortion.

Identity, therefore, does not represent a static unity, but a process of becoming (Becker, 2018[1963]) mediated through social interaction, drawing from shared social representations, never finished, concerned both with self-perceptions, as well as the perceptions of others, with a performative enaction through our actions (Charon, 2007). Because of its performative nature and fluidity, it requires ongoing 'identity work'. This 'identity work' is not solitary work, it is part of a performance alongside others. Identity is relational also inasmuch as it is created and recreated through social encounters (Goffman, 1990[1959]). Thus, identity is both a process of formation and negotiation (Foster, 2007). This shared activity involves a series of elements. These social interactions require a shared language and symbols or social representations from which all participants can draw (Moscovici, 1988). These social interactions also create the space for social reflexivity. We do not only reflect on our self-identity, but also on how we might appear to/be judged by others, leading to the appearance of self-conscious emotions (see Cooley, 2009[1902]; Goffman, 1990[1959]; Tangney and Dearing, 2002; Tracy et al, 2007; see Gibson, 2019, for the application of self-conscious emotions to social workers' identity).

For Goffman, the person constructs their ego identity "out of the same materials from which others" (1984[1963]: 130) construct an external identity of the person. And part of the identity work involved in developing a self-identity relates to how the person feels they are viewed by others and how they would like to be viewed. So the subjective experience, the self- identity, is inextricably related to the person's external identities. People's identity work includes attempts to evade or exit undesirable identities and/or to remain in acceptable ones. Our self-narratives are influenced both by the external narratives directed at us by others, and by our attempts at controlling those external narratives, as well as our own. Identity is, therefore, the site of a relational and communicative negotiation (Scott, 2015).

The idea of identity as a process allows us to also introduce the concepts of trajectory and identity career. Strauss (1977[1969]) distinguishes two elements within an identity career: the objective – that of observable external events, and the subjective – that of the emotional experience that may lead to changes in self-image. The concept of careers implies an interplay and adjustment between agency and structural positioning (Becker, 1952). Goffman (1975[1961], 1984[1963]) developed the concept of moral career to describe those careers involving social negative judgements upon the person's actions. Such careers can leave a blemish, a stigma, with long-term effects on a person's image, thus spoiling their identity. Goffman discussed stigma as a particular product of social relations; however, stigma can also be self-perceived, it can be the product of self-judgements. In this way it relates to self-conscious emotions.

Moral careers imply the possibility of some level of deviance, hence the negative judgement. Again, this must be defined in social terms, defined as a deviance from social norms (Becker, 2018[1963]), which leads to notions of power (the power to set what is considered the 'norm', the social expectation on how one ought to behave), or in self-terms, deviance from the aspirational possible self. In social terms, in his study of the moral career of a mental patient, Goffman (1975[1961]) argued how compliance with institutional norms was interpreted positively, and the lack of it, as deterioration of the patient's condition, that is, further indication of disorder, rather than an agentic decision expressing disagreement and resistance.

The self is thus at a crossroads between self-identity and external identities imposed or set up by others. The 'authorship of the self' becomes the site of "struggles for power and agency" (Scott, 2015: 143), whereby the person whose identity is at stake is not necessarily always the person with power to control the narrative (Lukes, 2021). Depending on structural conditions, but also power at the microlevel, the weight of identity as defined by others might be heavier than personal self-images (for instance, Said, 1995[1978]). This is the notion behind labelling theory (Becker, 2018[1963]; Scheff, 1999[1966]). The social representations used to coalesce into individual identities are the reflection of the dominant systems of knowledge at any one time in history. That is, not all representations are as likely to be chosen or as likely to be imposed on one person/group or another. These systems of knowledge are the site of power. These ideas led Foucault to talk of subjectivities (identities created by this power/knowledge) rather than identities (2020[1976], 1988[1965]). In his work, identity is understood less as an internal self-work, and more as an imposition by a disciplinary power that monitors and regulates its citizens through a subjectivity eventually adopted as own. This gaze includes systems to manage those who do not conform to normative subjectivities – the delinquents, mental health patients, feebleminded children… (Foucault, 2005). Eventually citizens willingly internalise these subjectivities, policing themselves. Within this framework, social work could be characterised as one of the 'control professions' (Rose, 2000; Briskman, 2013), bringing the deviant back to conformity, or at least minimising the disruption to the system. The formation of identity (and, by extension, the understanding of behaviour inasmuch as it contributes to identity) is thus both personal and political; it produces individuals as well as citizens.

It is in this latter sense that Rose (2019) referred to psychiatry as a political science; and Moncrieff (2010) has described psychiatric diagnoses as political devices. A psychiatric diagnosis reframes a person's characteristics, behaviours and/or emotional states as symptoms and attributes them to a physical accident in the person, removing responsibility for their behaviour away from them at the same time as it obscures the relationship with their sociopolitical context (Ferguson, 2017). A mental disorder label has consequences for how we see ourselves in relation to the social structures within which we live.

Psychiatric diagnosis can contribute to the maintenance of the sociopolitical *status quo* in two ways: it removes responsibility for the person's suffering from socioeconomic circumstances, and it diminishes the human capacity to address them. In a process that Fromm (2003[1961]) compared to the Old Testament concept of idolatry, psychiatric nosology, with its emphasis on biological accidents, takes away agentic power from the person and places it into a human-made item, product of the pharmaceutical industry, a pill[4], the idol of neoliberalism, "suggesting people into loving their servitude" (Huxley, 1949: para.4). Servitude because being exonerated of responsibility for our behaviour also means being deprived of the ability, the agency, to craft our lives (Gambrill, 2014; Timimi, 2002). However, this also has political consequences. By adopting a largely biological view of psychiatric illness, psychiatry has since the 1970s created a diagnostic system that individualises suffering but without making the individual responsible for it; therefore, it can be readily embraced by patients, with no resistance from them to be feared (Conrad, 2007). Constructing mental health problems as a brain defect, to the exclusion of socioeconomic contextual considerations, creates the illusion of an "apolitical vacuum" (Thomas et al, 2018; also, Illouz, 2008). This narrative of distress, equating it with a dysfunction within the individual, by virtue of its appearance in the DSM, becomes

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[4] The selling of the pill takes advantage of another characteristic of neoliberalism, consumerism. To sustain its existence, consumerism needs to create and maintain the feeling of dissatisfaction, that we are lacking something somehow, which is resolved by consuming, and then consuming some more (Moncrieff, 2008).

invested with scientific authority and becomes a tool "for use in the pursuit of broader political agendas" (Thomas et al, 2018: 2). Within this framework, the impact of social injustice on a person's emotional wellbeing can be treated as a mental health problem, remit of the health service, as opposed to a social problem, remit of the State. Thus, this narrative of distress exonerates the State from its responsibility to provide solutions to the contexts that produce that distress (Callaghan et al, 2017).

In examining how people come to choose their narratives, about both themselves and others, we need, therefore, to consider their position within social structures. According to critical theory, social structures can determine people's "thinking and behaviour, often unconsciously" (Paradis et al, 2020: 842; see also Bourdieu, 1984). Clegg has gone as far as stating that, "[o]rganisations exert power over their members by making them do things that they would not otherwise do and take on identities that they would not otherwise have assumed" (2006: 149), but this assertion leaves little role to human agency and, significantly from the point of view of a professional identity career, renders ethical behaviour non-existent. If overly deterministic explanations of human behaviour are to be avoided, as well as undue attribution of responsibility (or blame), an account that incorporates both human agency and the impact of social structure needs to be formulated. Both critical theory and critical realism support the view that "human action is at once constrained by social structures *and* capable of disrupting them" (Paradis et al, 2020: 844, emphasis original). For Bhaskar, "agents are always acting in a world of structural constraints and possibilities that they did not produce" (1998: x), but whose actions may serve to reproduce. Yet, people's actions are also influenced by innate psychological mechanisms (Houston, 2001), as well as their relational patterns (Crittenden, 2016), creating an 'open system' characterised by multi-causation in which we can only speak of possible tendencies (Houston, 2001), but in which human agency is capable of both authoring personal narratives of identity and transforming society (Scott, 2015; Bhaskar, 1998).

Mechanisms guiding explanations of behaviour

Medicalisation

Sociology first introduced the term medicalisation in the late 60s (Pitts, 1968). It was first used in an encyclopaedia entry on 'social control' by Pitts (Busfield, 2017). Pitts discussed how deviant behaviour could be controlled by being redefined as illness. Zola (1972), one of the pioneers of the sociology of medicalisation, reiterated some of these ideas in his article 'Medicine as an institution of social control'[5]. For Zola, religion and law were starting to be replaced by medicine as the major institution of social control. Not everything needed to be about controlling deviance though; in an increasingly secularised society, medicine also became a new source of support (Brinkmann, 2016; Busfield, 2011).

Medicalisation is understood as a process through which human problems come to be defined as illnesses and to be understood in medical terms. The concept suggests that a specific phenomenon is not inherently a medical problem but, rather, it needs to undergo a process of being framed as such (Conrad, 2007; Rosenberg and Golden, 1997). Medicalisation is less interested in whether these problems are 'medical' and more on the social consequences of defining them as medical (Conrad, 2007). In the following brief discussion, I focus on the medicalisation of emotional wellbeing and behaviour[6]. Within psychiatry, Foucault (2005) discussed the power of the psychiatric discourse. For him, this expansive process was a result of what he named disciplinary power, a sociopolitical form of control and standardisation of

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[5] Freidson (1988[1970]) expanded the field of medicalisation by pointing that it did not need to exclusively refer to deviance.

[6] Within the study of medicalisation in psychiatry, it is interesting to note Jutel's call (2009) for a sociology of diagnosis, related yet distinct from the sociology of medicalisation.

citizens, including their psychic lives. Through internalisation, these medical perspectives help to shape people’s subjectivities, outside of their own awareness.

The medical profession can act as an agent of social control since diagnoses set the boundaries of what is considered ‘normal’ and acceptable, “the role of medical norms is setting social norms” (Conrad, 2007: 149). In particular, psychiatric diagnoses are increasingly setting the boundaries of acceptable and dysfunctional mental and emotional life (Busfield, 2017). Horwitz and Wakefield (2007, 2012) have explored how psychiatry is transforming sadness and anxiety into pathologies. Lane (2007) has completed a similar examination in relation to shyness; whilst the diagnosis of Post-Traumatic Stress Disorder has been criticised by several authors (Summerfield, 2001; Young, 1995, Scott, 1990).

Conrad (2007) identified a shift in the forces driving medicalisation, with a diminishing role for the medical profession. Speaking from a US context, Conrad (ibid) named three ‘engines’ of medicalisation: biotechnology, consumers and managed care. Within biotechnology, drug approval rules mean that pharmaceutical companies need to demonstrate that their product targets a specific diagnosis. This has encouraged pharmaceutical companies to search for diagnoses which their products can be used to treat. Within psychiatry, the current nosology, based on symptoms lists for each diagnosis has been particularly favourable to this practice, increasing the role of pharmaceuticals in the expansion of diagnoses and the lowering of thresholds for existing ones (Conrad, 2007; Busfield, 2011, 2006). This expansion has affected children. In the UK, there was a 68% increase of psychotropic drug prescriptions for children between 2000 and 2002 (Wong et al, 2004). Beau-Lejdstrom et al (2016) identified a 34-fold prescription increase of ADHD drugs for children under 16 (4% of the children were under 6) between 1995 and 2008, with prescription rates stabilising between 2008 and 2013. However, the latest studies indicate that there is a continuous upwards trend. In a more recent study, although using data from a single NHS Scotland health board region, Ball et al (2023) found a

59% mental health prescription increase for children over 2 years of age between 2015 and 2021. In their latest annual report, the NHS Business Services Authority (2023) reported that central nervous system stimulants and ADHD drugs prescription had increased 12% in children. The significance of the pharmaceutical industry was foreseen by Foucault (2005), who described the capacity of disciplinary power to turn the management of anomaly into profit making activities.

Medicalisation has consequences for both the individual and their relational and sociopolitical context. Being diagnosed not only gives the individual "permission to be ill" (Jutel, 2009: 278), but it also legitimises the human trouble or complaint concerned (Parsons, 1951). Conrad (2007) referred to adult ADHD as the 'medicalisation of underperformance'. A diagnosis signals what a particular culture "is prepared to accept as normal and what it feels should be treated" (Jutel, 2009: 279). As such, it might bring psychological benefit to the person receiving it. This might come, however, at the expense of a 'narrative surrender', with the diagnosed individual co-opting the medical narrative, at the expense of their personal story (Jutel, 2009). At the same time, unnamed suffering, the suffering that does not receive a medical label, may become unrecognised suffering (Jutel, ibid).

Behaviours that are eventually framed as pathologies no longer fall under the individual's responsibility, they are not the person's choice, in what Conrad terms the "dislocation of responsibility" (2007: 152). Thus, medicalisation not only sets the boundaries of normality, but also of agency and responsibility (Busfield, 2011). And as the narrative moves from 'badness to sickness' (Conrad and Schneider, 1992), the social response in this 'humane' mode of social control (Zola, 1972) moves from punitive to therapeutic (Conrad, 2007). The term 'dislocation', however, it is not entirely accurate, since causation usually remains firmly set within the individual, it merely dislocates the responsibility from the person's will, from their agentic power. Thus, the problem receives an individualised medical intervention, rather than a collective or social one (Conrad, 2007). In this sense, the consequences of medicalisation are also sociopolitical.

Medicalisation also sets the boundary of what pertains to the individual and what to their relational and social context. Thus, the focus on the individual obscures the role of their sociopolitical context in their wellbeing (Conrad, 2007). Zola already referred to medical labels as '"depoliticizers" of an issue' (1972: 500). Medical diagnoses provide a 'natural' veneer of neutrality to moral and sociopolitical judgements (Jutel, 2009). Yet there is ample literature documenting the political and professional battles behind successive editions of the DSM, since its third edition (APA, 1980; Kutchins and Kirk, 1997; Davies, 2013; Greenberg, 2013; Whitaker and Cosgrove, 2015).

Framing human phenomena as medical problems is not only context-determined, but also context-determining (Rosenberg and Golden, 1997). Policies are made in relation to personal troubles rather than public issues (Mills, 1970[1959]). Responsibility is dislocated from the person's relational and sociopolitical context. Thus, the medicalisation of emotional wellbeing and behaviour becomes a political discourse inasmuch as it supports the management of citizens and the power *status quo* (Ferguson, 2017; Cohen, 2016). Within the DSM, for instance, there has been an increased preoccupation with occupational functioning (Davies, 2017). The functional impairment clause[7] was added in DSM-IV (APA, 1994) as a means to minimise false positives. Spitzer and Wakefield (1999) reviewed the clause ahead of DSM-IV-TR (APA, 2000) and concluded that it had achieved its goal only limitedly. However, the clause remained. Cohen (2016: 79) undertook a textual analysis of all editions of the DSM up to then and found how references to work had increased from 72 in DSM-III (APA, 1980) to 288 in DSM-5 (APA,

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[7] To be of clinical significance, the criteria for most diagnoses required that its symptoms had a negative impact on the person's social and/or academic/occupational activities.

2013) and from 91 to 257, regarding school[8]. Particularly significant is the increase between DSM-IV-TR (APA, 2000) and DSM-5, considering that both manuals are of similar length[9]. References to work and school were 204 and 170 respectively in 2000. Medicalisation can also shift the perspective from which we understand familial relationships. DSM-IV (APA, 1994) revised the diagnostic criteria for Reactive Attachment Disorder, presuming that the "disturbed behaviour" in the children (criterion A) was due to "pathogenic" care (criterion C). That is, rather than diagnosing as 'disordered' the adults who provided such "pathogenic" care[10], DSM labelled children's distress instead (Rapley et al, 2011). Acknowledging this latter set of consequences, Conrad (2007) called for sociopolitical studies to supplement the existing social constructivist perspectives on medicalisation.

Attribution theory

In a series of studies, psychologists Jones and Harris (1967; Jones, 1979) identified the tendency for an observer to see a subject's behaviour as based on their character (dispositional attribution), whilst the subject sees their own behaviour as determined by their circumstances (situational attribution). This unconscious cognitive attribution bias by the observer became known as the fundamental attribution error[11] (Ross, 1977) within attribution theory[12]. Attribution theory is particularly apt for this study since it interests itself with the "determinants and consequences of attributing causation for particular actions" (Jones & Davis, 1965: 220),

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[8] DSM-III had 494 pages and contained 228 diagnoses. DSM-5 had 947 pages and contained 541 diagnoses.

[9] DSM-IV-TR had 943 pages and contained 383 diagnoses. DSM-5 had 947 pages and contained 541 diagnoses.

[10] DSM-5 (APA, 2013) revised the criteria again and since then criterion C is described as the child having experienced "a pattern of extremes of insufficient care".

[11] The attribution bias, however, is not necessarily a cultural universal. In a comparative study between US and Indian youths, Miller (1984) found that the former, as they grew older, placed increased emphasis on general dispositions in explanations, whilst the latter referred more to contextual factors. That is, the DSM, with its emphasis on the individual as the locus of mental distress, was born in a culture with greater attribution bias in their social interactions and lack of attention towards context.

[12] Edward Jones, one of its initial proponents, referred to it as a "perspective, or a framework, rather than a theory" (1976: 300).

that is, with the observer’s processes of interpretation of why a subject behaves in a particular way. Attribution theory is used in a variety of fields (see, for instance, Martinko & Mackey, 2019); however, it has been not often applied to understand how the adults responsible for children in State care may make causal attributions to behaviour.

Research has identified several factors that make more likely for a person to make a fundamental attribution error. One of the explanations put forward to understand this bias is the fact that observers typically lack historical perspective on a subject (Jones & Nisbett, 1972). In addition, observers who are under pressure themselves find their cognitive resources to interpret the subject’s behaviour reduced, “enhancing the relative influence of less effortful automatic process” (Jones, 1993a: 660), leading to an increase in attribution bias. This has not only been studied in the general population (Gilbert, 1989) but also in relation to the parent-child relationship. Dix (1993) found how inexperienced, stressed or poorly supported parents generally found more difficulties with their children, resulting in negative images of their children’s character.

Most of the initial studies in attribution theory were laboratory experiments, where the role of the observer was a clear-cut passive one. However, attribution theory came to recognise that in real life situations the observer is also a subject within the same scenario and, therefore, the observer also has an active role in shaping, creating or constraining the situation in which their social perception is taking place. We are all “part of the stimulus environment to which others are reacting” (Jones, 1993b: 93). This allows us to understand attribution as a relational process, a “dyadic-level construct” (Dix, 1993: 635). Two aspects of this process are particularly important when considering professionals such as social workers’ role in making attributions about children’s behaviours. First, observers have a poor apprehension of their own influence, of the extent to which they are themselves constraining the situation and limiting the subject’s available responses (Gilbert & Jones: 1986). Second, observers’ attributions can become a self-fulfilling prophecy, since their own behaviours can elicit the expected behaviour from the subject and, therefore, confirmatory actions by the subject (Jones, 1993b). Studies have shown the influence of parents' beliefs and emotions in the outcomes for their children (Gottman et al, 1996; Murphey, 1992). This self-fulling aspect of the interaction can be present even before children are born (Dix, 1993). Dix (1993) quotes a study from Moss and Jones (1977) where the authors found that problematic interactions with children could be predicted from mothers' negative attitudes and attributions as assessed during pregnancy.

Psychological defences

Anxiety provoking settings, such as children social work, can lead to organisational defences (Whittaker, 2011) and/or defensive practice (Trevithick, 2011; Whittaker and Havard, 2016). Less studied is how social workers account for their decisions (Bull and Shaw, 1992; Shaw and Shaw, 1997a and 1997b). When defences are deployed to protect the self, an accompanying account must also be found to justify a particular decision or practice. These verbal strategies may also be unconscious; hence, I view them as part of the professionals' defences. The overlap between social work and psychoanalysis in terms of their emphasis on understanding human beings and the importance of relationships has been noted (Trevithick, 2011).

Freud described a tripartite personality structure. Ego, representing what can be achieved within social, pragmatic, and personal constraints, mediates between the passion-driven id and the idealistic and moralising super-ego (Freud, 2021[1923]). When the ego fails to keep the id satisfied and/or there is no correspondence between its actions and the super-ego's aspirations, anxiety appears (Freud, 2018[1937]). Freud distinguished three types of anxiety: reality, moral and neurotic anxiety. Whilst reality anxiety represents "rational responses to real threats" and neurotic anxiety derives from unsatisfied id's impulses, moral anxiety refers to the "feelings of guilt or shame that arise from the super-ego when personal, moral or societal codes are threatened or have been broken" (Trevithick, 2011: 394), that is, a "bad conscience" (Rycroft, 1995: 32). This latter type of anxiety is the one that is potentially relevant to this study, since it could help illuminate the understanding of what happens when social workers feel their moral and/or professional codes broken in their practice.

According to psychodynamic theory, defences are unconscious psychological mechanisms oriented to protect the person from feelings of anxiety (Trevithick, 2011). They have already been applied to study social work practice. For example, Rustin (2005) analysed Lord Laming's report (2003) on the death of Victoria Climbié in terms of professionals' defences against extreme mental pain. Rustin's analysis refers to the inherent nature of child protection work. However, besides the painful and anxiety provoking situations children's social workers should expect to encounter as part of their work, working conditions and/or policies and procedures can also become a source of anxiety when at odds with their professional ethos (Gibson, 2019 – see contextual background below).

Some authors have pointed to how defences may hinder the integration of information, distorting the perception of reality (Menzies, 1959; Trevithick, 2011). Rustin referred to it as a "systematic disconnection between things which logically belong together" (2005: 12). Hingley-Jones and Ruch (2016) referred to this moment as seeing and, simultaneously, not seeing. Since Freud's initial work further defences have been identified by a number of psychoanalysts, most significantly his own daughter, Freud (2018[1937]), but also Klein (1975). Cramer (2006) focused on three such defences – denial, projection and identification – which are the ones I consider here. Denial as a defence involves suppressing some upsetting experience or aspect of the external world. According to Cramer, pathological denial may occur "in adults who feel they have no capacity to affect reality" (2006: 50). The earliest form of denial is the non-perception of some aspect of reality, "to look and not to see" (2006: 51), what does not exist cannot hurt. Projection implies a process whereby disturbing aspects of the self are projected outwards, attributed to another (others are the 'bad' professionals (Taylor et al, 2008)). In an opposite direction, identification as a defence describes the process whereby a person identifies with another as a means to reduce anxiety or improve one's self-esteem (Cramer, 2006).

Defences have also been studied at structural level. It was Jacques in 1955 who first formulated the concept of social defences (Long, 2006), that is, is the organisation or system which works as a unity constructing over time individual and procedural practices to protect its members against unbearable emotions. The most famous study applying this theoretical framework is that of Menzies (1959). Menzies (ibid) carried out her research within the nursing service of a London hospital to determine the causes behind nurses' retention and training difficulties. She concluded that much of the organisation of the nursing system could be understood as a social defence against the anxiety provoking nature of the job. However, these social defences were not effective and were, in turn, creating a range of secondary anxieties, including job dissatisfaction. She found, amongst other practices, that turnover and transfers between teams could act as a defence, since they potentially created a psychological detachment between nurses and patients (and fellow team members).

Studies applying Menzies conceptual framework to social work settings coincide in defining managerial culture, akin to what Menzies defined as 'ritual tasks', as a form of social defence against anxiety (Hingley-Jones and Ruch, 2016; Lees et al, 2013; Whittaker, 2011; Valentine, 1994). They agree in pointing out how prescriptive procedures, whilst reducing professional discretion and judgement, serve to defend against uncertainty and the fear and anxiety at having to make 'judgements of Solomon' (Taylor et al, 2008). Beckett et al (2007) identified this anxiety as stemming from the fantasy that the 'right' decision can be reached with good enough assessment and expertise. Fear of public criticism and persecution by the press is also named in the literature (Lees et al, 2013; Taylor et al, 2008). Upward delegation ('I need to talk to my manager') (Whittaker, 2011) has also been identified as a defence in research on professional practice.

Regardless of the conscious or unconscious motives or purposes of any procedures and other organisational practices, professional practice requires accountability. In this sense, the justification of any decision or decision-making process is an important step within any moral (professional) career. Justifying a decision is not only about providing evidence of how a conclusion was reached but reassuring others and/or oneself that such decision-making process took place within the profession's ethical and/or personal moral parameters, that the decision reflects a 'good' professional. In this sense, these justifications can be considered as part of the psychological defences available to professionals, in this case, social workers. Accounts theory provides an instrument to analyse how social workers justify their decisions.

The roots of accounts theory lie in the works of Goffman (1990[1959]) on people's daily presentations strategies to preserve their self-identity in front of others, and in Garfinkel's analysis (1956) of status degradation scenarios. Accounts theory was developed in detail by Scott and Lyman (1968[13]; Lyman and Scott, 1989). According to them, an account is a narrative intended to bridge "the gap between action and intention" (1968: 46). Accounts theory is interested in the narratives used to protect the self from perceived deviance (Orbuch, 1997), in the case of this study, deviance from professional ethos. In this regard, it is related to perspectives emphasising the importance of language to create reality (Berger and Luckmann, 1966), as well as earlier sociological studies on the 'vocabularies' or 'grammar' of motives (Burke, 1969[1945])), and can be located within the wider perspective on how we use narratives to construct our private and public identities (McAdams, 1993). Accounts theory mirrors

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[13] There are some comments within this paper that reflect more the moral prejudices of the time rather than social science. My use of this paper does in no way imply agreement with or minimisation of such comments.

attribution error in the sense that both relate to causal explanations, the former in relation to one's own behaviour, the latter in relation to that of another. An excuse is a particular type of account whereby the actor acknowledges the action as wrong, "but denies full responsibility" (Scott and Lyman, 1968: 47). Explanations can thus become psychological "survival kits" (Bull and Shaw, 1992: 643). Social workers, for example, could argue that they are "a civil servant with a legal obligation to uphold the civil law" (Banks, 2016: 57) even when they do not agree with a case outcome. The danger here is that this account closely resembles Eichmann' defence of following orders (Arendt, 2006[1963]; Balfour et al, 2020). Underneath any account giving, or requesting, there is a process of identity negotiation (Scott and Lyman, 1968), of attempting to sustain a moral career in front of others.

The different processes discussed above are neither exclusive nor exhaustive. However, there are potential synergic effects if the above mechanisms appear simultaneously. Thus, for instance, when medicalisation facilitates the displacement of explanations on behaviour from the person's will to the person's biology, it offers a ready-made narrative that may facilitate a dispositional attribution to behaviour (yet without blaming the person). In turn, this non-blaming dispositional attribution provides a kind of 'black box' explanation[14] for busy social workers who might then no longer feel the need to look for more complex combinations of potential causal factors. This 'black box' explanation can also provide a neat justification for intervention preserving the self-concept of a conscientious and dedicated professional. To the social workers and their practice context I turn next.

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[14] In science, a black box is a system that can be considered regarding its inputs/stimulus and outputs/responses, without reference to its internal functioning. A computer, for those of us without IT knowledge, is a black box. In science studies, Latour used the concept to describe the social process by which "scientific (…) work is made invisible by its own success" (1999: 304).

Children’s social work practice. Contextual background

Social workers’ knowledge base

As representatives of corporate parenting, children’s social workers do have the parental responsibilities of making sense of the child’s behaviour, deciding when it is appropriate to seek medical advice. So what is the profession’s knowledge base that social workers can use to support their understanding of children’s behaviour?

Manuals on social work practice with children in State care give limited attention to the sense making activity in this area. Textbooks provide information on these children’s mental health (Sen, 2018), a description of roles and responsibilities in this area (Cocker and Allain, 2008[15]), or some limited critical reflection, for instance, focusing on a more natural diet to try to address ADHD symptoms (Rogowski, 2013).

In terms of official statements, the Professional Capabilities Framework, currently held by the British Association of Social Workers, serves as a generic guidance framework for the expected competencies of social workers through nine different levels of experience, from point of entry to training up to strategic social worker (BASW, 2023). The expectations set by this Framework on the knowledge of social workers after their first two years in practice are that they would be able to apply “a working knowledge of human growth and development” as well as “recognise the short- and long-term impact of psychological, socioeconomic, environmental and physiological factors on people’s lives, taking into account age and development” (BASW, 2018: 7-8). Social workers are also expected to understand and use systemic approaches when

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[15] This textbook states incorrectly that DSM-5 (APA, 2013) provides a multi-axial assessment – a feature from the DSM-III (APA, 1980) up to the DSM-IV-TR (APA, 2000).

working “with the person or family in their environment, social context and relationships”. They should also “acknowledge the centrality of relationships” and attachment as a “key concept” (ibid: 8). The Government has also produced qualifying and post-qualifying statements on the knowledge and skills expected of children and family social workers. The expectations in relation to child development are the same for both statements. A child and family social worker should be able to “[t]ake account of typical age-related physical, cognitive, social, emotional and behavioural development over time, accepting that normative developmental tasks are different for each child depending on the interactions for that child between health, environmental and genetic factors”, and they should also be able to “[e]xplore the extent to which behavioural and emotional development may also be a result of communication difficulties, ill health or disability” (DfE, 2018a/2018b: 4).

Although the statements contained in both documents appear similar, they have different authors, a professional organisation and the government respectively. In the early 2010s social work education became a focus of attention of the then Conservative government, with two different ministers commissioning two separate independent reviews into social work education in the same year, one covering all social work education (Croisdale-Appleby, 2014) and the second focusing on children and families social work (Narey, 2014). Narey’s review was commissioned by the then Education secretary, Michael Gove, who had, in a speech to the NSPCC in 2013, criticised social work training stating that it involved “idealistic students being told that the individuals with whom they will work have been disempowered by society”, and being “encouraged to see these individuals as victims of social injustice whose fate is overwhelmingly decreed by the economic forces and inherent inequalities which scar our society” (Gove, 2013: unpaginated). Narey’s review did acknowledge the negative impact on parenting of social disadvantage and poverty, only to add, without any reference that “[t]here may be a partial correlation between disadvantage and poor parenting but there is not a causal link" (2014: 11).

The review was criticised by respected social work academics (Jones, 2015). Singh considered the government had "a preference for a psychological discourse of dysfunctional families" along with a "contempt with structural explanations for child abuse and neglect" (BASW, nd). Tunstill criticised the privatisation and political interference in social work knowledge production, that reduced "the likelihood of social workers being able, willing, or allowed to take a socially critical position" (2019: 73) in their practice. Taylor (2015) noted how curricula prescription could erode professional judgement and confidence. Political interference has not been limited to knowledge production and education, political attempts to influence or exert control over the profession had already been noted (Gibelman, 1999). In England, more recently, the government had to backtrack on its plan to directly control the profession's regulatory body (McNicoll, 2016). The profession's concern regarding the reduction of professional discretion in decision-making and increased emphasis on following procedural guidance can be added to these criticisms (Parton, 2008). There is also an emphasis on the constraints imposed on professional discretion by current managerialism (Kirkpatrick, 2006; Rogowski, 2011; Pascoe et al, 2023).

Social work frameworks for understanding children's behaviour

Social work as a profession does draw from the above factors (psychological, socioeconomic, environmental and physiological) named within the Professional Capabilities Framework to understand the persons social workers engage with. I next consider these frameworks – psychological (attachment and trauma), socioeconomic context, and biological (neuroscience and psychiatric nosology) in turn.

Psychological frameworks: Attachment and trauma

Within social work there has been a historical focus on attachment theory, and more recently on trauma. The relationship between social work and attachment can be traced to the theory's origins. Psychiatrist Bowlby's ideas were influenced by his postgraduate training with two social workers at the London Child Guidance Clinic (Bretherton, 1992). Bowlby's early work also included collaboration with social worker James Robertson (Bowlby and Robertson, 1952). Together they successfully campaigned to allow parents to accompany children to hospital. Attachment theory has become an important guide for professional practice within children and family social work (Beckett, 2006). This is unsurprising since the theory eventually provided a framework to understand children who have been abused (White et al, 2020). Social work has relied on it for a long time (Argles, 1980; Howe, 2005), including the training of foster carers (Harlow, 2021). Wilkins (2017), in his study of twenty-four child protection social workers, found that these professionals felt the theory and research on disorganised attachment supported them both in understanding the child and in decision-making in relation to intervention. However, both the theory and its application in social work practice have been criticised by social work academics (Garrett, 2023a, 2023b; White et al, 2020). Social workers themselves have been criticised in court for their use of attachment theory, leading Shemmings (2018) to recommend the use of the term 'relationship', rather than attachment, and for social workers to acknowledge that they are not trained in classifying attachment behaviour.

In relation to trauma, there is now a body of evidence linking adverse experiences in childhood and adult mental health (Janssen et al, 2004; Kessler et al, 2010; Read et al, 2014; Shonkoff et al, 2012)[16]. These adverse experiences range from maltreatment (abuse, neglect), interpersonal

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[16] Negative experiences in childhood are also linked to adult poor physical health (Bellis et al, 2019).

loss (death, separation), family dysfunction (substance abuse, criminality) to socioeconomic deprivation. In relation to children who have suffered abuse and/or neglect, there is a body of research examining their behaviour/s as adaptative survival responses to their abusive/neglectful environment (Crittenden, 2016; McCrory & Viding, 2015; Kinderman et al, 2013; McCrory et al, 2012).

During recent years social work has recognised the relatively high prevalence of trauma[17] amongst the population with which professionals engage (Marlowe and Adamson, 2011). Joseph and Murphy (2014) advocated a greater focus on trauma in both social work training and practice, arguing there was "a shortage of social workers knowledgeable and skilled in working with trauma" (ibid: 1106) and proposing trauma as a unifying concept within social work. Within the profession, a body of literature has developed documenting and evaluating different programs that incorporate training in trauma as part of social work education, although these are not necessarily with a focus on children (Lotty et al, 2024; Goodwin and Tiderington, 2022; Wilkin and Hillock, 2014; Strand et al, 2014; Marlowe and Adamson, 2011; Breckenridge and James, 2010). Parallel to this research and evaluation, there is a second body of literature discussing the need to develop practice that reflects awareness of trauma and its effects on people (Levenson, 2017; Bent-Goodley, 2019; Mersky et al, 2019). Research publications also evidence the effort to incorporate trauma perspectives into the delivery of social work services (for example, in relation to extra-familial harm: Firmin et al, 2024; or as part of organising family time for children in State care: Collings et al, 2022). These last two pieces of research also stress the importance of relational social work in developing a sense of safety and trust in people affected by trauma. Firmin et al (2024) distinguish between people

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[17] There is at time ambiguity in the literature as to whether 'adverse experiences' and 'trauma' refer to the same phenomena. Some studies seem to use the terms interchangeably (Goddard, 2021; Zarse et al, 2019). The Center for Disease Control and Prevention makes a distinction between the terms, stating that adverse childhood experiences are "potentially traumatic events" (CDC, 2024: no page). Other authors distinguish between adverse childhood experiences and traumatic toxic stress (Oral et al, 2016) or trauma (van der Kolk, 2015).

being ‘known-to-services’ and being ‘known-by-professionals’.

The concept of ‘trauma’ and its incorporation into social work practice it is not without criticism. Against Joseph and Murphy (2014), Bath (2017) argues that trauma does not encompass all the phenomena social work deals with, and it does not serve the needs of all service receivers. Criticisms cluster around two main issues: the term’s polysemy – the coexistence of different possible meanings – and its closeness to the medical model. Research on trauma within social work practice and education highlights and, in some cases, explicitly acknowledges, the differing meanings behind the use of the term ‘trauma’ (Beddoe et al, 2019; Bath, 2017; Marlowe and Adamson, 2011), including identifying all adversities as trauma inducing events (Bath, 2017). Chatterjee and Park (2024) conducted a discourse analysis on 30 social work articles on trauma published between 2010-2020. Their conclusions highlighted the term’s polysemy, as well as a gap between the intent (depathologisation) and the functions of trauma discourse within social work. They identified how discourses on trauma can run counter to professional discourses on social justice through the individualisation of the phenomenon on the “‘broken’ traumatised other” (ibid: 2000), moving away from a more structural analysis on the situations that give rise to traumatic experiences. Marlowe and Adamson (2011) made similar reflections on how trauma labelling may feel an imposition for service receivers and hinder areas of social work practice such as recovery and resilience. As early as 1999 Davis (1999) had already criticised the psychiatrisation and depoliticisation of trauma through the PTSD diagnosis, advocating for a critical perspective within social work. In their research amongst social work students and educators in New Zealand, Beddoe et al found educators sceptical towards what was perceived as the new ‘buzzword’, which could detract attention from “structural explanations and approaches” (2019: 1577). More recently, Ross et al (2023) conducted research amongst Canadian social workers and found a dissonance between a dominant medical model against a social justice-based practice, with social workers reporting feeling constrained by working within the medical model. The social workers in this study emphasised the influence of structural factors contributing to the experience of trauma.

Environmental framework: Socioeconomic context

Behaviour can be understood in relation not only to the immediate relational context, as examined above in relation to attachment and trauma, but also the wider socioeconomic one. The positive correlation between poverty and inequality and mental health difficulties has been established by research (Bell, 1990; Callaghan et al, 2017; Friedli, 2009; McGibbon, 2012; Shaw & Taplin, 2007; Wilkinson & Pickett, 2019, 2010). Friedli, in her report for the WHO, stated that "levels of mental distress among communities need to be understood less in terms of individual pathology and more as a response to relative deprivation and social injustice" (2009: iii). This correlation between poverty and mental health is also felt through the life course, with studies showing a clear association between childhood deprivation and adult health problems (Graham & Power, 2004; Poulton et al, 2002). This recognition has led some authors to talk of the psychiatrisation of poverty (Friedli, 2009; Mills, 2015). Thyer (2006: 63) points to a "disordered environment" rather than a "disorder *in an individual*" (author's emphasis). In the UK, prevalence studies of mental disorders amongst children and adolescents show a correlation between children's mental disorders and household income (Meltzer et al, 2000; Green et al, 2005; Sadler et al, 2018). In its report on the mental health of children and young people in England, Public Health England includes socioeconomic disadvantage and homelessness as risk factors for mental health (2016). However, when listing aspects that build resilience within the community these two factors are not addressed. Consequently, the "actions to manage" different diagnoses centre around the individual child/young person, parenting programs and, to a lesser extent, the school. No action to tackle disadvantage in the wider socioeconomic context is mentioned. Yet, Costello et al (2010) found that the introduction of family income supplements correlated with lower psychopathology rates compared to a control group within the same geographical area.

Within social work, Feldman states that poverty “is central to the core mission of social work” (2019: 1076), supporting a relational perspective on poverty that can be traced back to Sahlins (2017[1972]), who discussed poverty as a relation between people. Poverty has attracted renewed interest in social work in the UK (Cummins, 2018; Backwith, 2015; Parrott, 2014). This literature has paid particular attention to the impact of deprived socioeconomic conditions on parenting, and its implications for social work practice (Bywaters et al, 2022; Featherstone et al, 2019; Morris et al, 2018). At the same time there have been small scale studies examining social workers’ views on poverty and parenting. For example, Innes-Turnill (2023), interviewing four children’s social workers, found their explanations focused on mothers’ inadequacies, missing the structural influences of poverty, which concurred with other research findings (Morris et al, 2018; Gilligan, 2007). Hingley-Jones and Ruch (2016) identified the tension in simultaneously accounting for individual and structural factors as explanations of people’s situations. Similarly, Jones (2023), in her interviews with six children’s social workers, found them aware of the tension and conflict between individualising policy and organisational discourses and families’ disadvantageous socioeconomic positions, showing that concerns about social workers’ individualistic explanations of poverty (Sheedy, 2013) do not apply to all professionals. Jones also found that the awareness of this tension was having an emotional impact on the social workers, leading to disillusionment, “leading some to reconsider their roles” (2023: 165).

Biological framework: Neuroscience and psychiatric nosology

There is also a growing body of research on how adverse experiences impact on brain development and human genetics. Research in epigenetics and neuroscience supports the idea that early traumatic experiences have observable consequences in a child's brain, the effect depending on the timing and nature of the experience (Andersen et al, 2008; Ciccheti, 2015; Puetz et al, 2020; Schore, 2016[1994]; Shonkoff et al, 2012; Teicher et al, 2003; McCrory et al, 2012; McCrory et al, 2011; McCrory et al, 2010; Perry and Szalavitz, 2006; Perry, 2009, 2002). Other studies have reported brain structural and functional differences in people affected by maltreatment (De Brito et al, 2013; Gerin et al, 2019; McCrory et al, 2011; McCrory et al, 2011; McCrory et al, 2012; McCrory et al, 2013; Teicher et al, 2014; Teicher et al, 2012; Teicher et al, 2003). These studies focus on: the prefrontal cortex – required in executive functioning; the amygdala – known as the brain's "alarm system"; the hypothalamus-pituitary-adrenal (HPA) axis – one of the key systems in the regulation of stress responses; and the hippocampus – the centre of memory and learning. Problems in these areas correspond with behaviours such as reactivity, difficulties in self-regulation, in learning, etc. Studies also show that adverse experiences can affect key genetic processes. Meany and Szyf (2005) have studied how early adversity affects methylation not only in rats, but also in humans (Suderman et al, 2012). Methylation is a biological process that chemically coats segments of DNA. Over time, excessive methylation silences genes (Moore et al, 2013). Radtke et al (2011) found methylation in adolescents was affected in relation to the HPA axis their mothers had experienced domestic violence during pregnancy[18].

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[18] Studies with rats found that those suffering maternal neglect had a change in the gene expression of two of the biochemical systems which enable mammals to feel calm: GABAa and benzodiazepine receptors (Caldji et al, 2000).

Some social work authors support the incorporation of these recent developments in neuroscience into social work knowledge (Lefmann and Combs-Orme, 2013; Egan et al, 2011). There is a body of literature integrating neuroscience into social work practice (Black and Conway, 2018; Matto et al, 2014; Farmer, 2009), and social work education (Mason et al, 2020; Egan et al, 2011). This incorporation of neuroscience within social work's body of knowledge has not taken place without criticism. At the same time as sociology started to critically appraise the social influence of the ascendancy of neuroscience beyond its own field (Rose and Abi-Rached, 2013), voices within social work have also advocated for a critical application of neuroscience without losing social work's focus on social justice (Gibson, 2021). Within social work and early childhood policies, neuroscientific studies have been problematised, highlighting how the uncertainties of research in this area can be obscured when their results are translated into policy and practices (Wastell & White, 2017; Bruer, 1999)[19].

Behaviour can also be understood as a dysfunction caused by a genetic and/or biological accident, as suggested by our current psychiatric nosology (WHO, 2019; APA, 2022[20]). In opposition to the adaptations and survival strategies propounded by attachment and learning theories, psychiatry's proposed frame is that of mental dysfunctioning (see the 'mental disorder'[21] definition in DSM-5-TR (APA, 2022: 15)), that sets the boundaries of the human behaviour, emotion and cognition to be considered 'normal' (Horwitz and Wakefield, 2007).

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[19] For a critical view on animal models of childhood abuse, see Teicher et al, 2006. For an overview of brain imaging used in neuroscience, see Nelson & Bloom,1997. For a detailed and critical analysis of positron emission tomography (PET), see Dumit, 2004.

[20] There are currently two psychiatric diagnostic manuals: the *International Statistical Classification of Diseases and Related Health Problems (*ICD), produced by the World Health Organisation, and the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), produced by the American Psychiatric Association. Most of the literature critical of the current psychiatric nosology focuses on the DSM. Both manuals, however, largely follow the same principle of symptom lists with limited reference to aetiology. Services in the UK generally follow the ICD manual.

[21] A definition of "mental disorder" appeared for the first time in DSM-III (APA, 1980). DSM-5 (APA, 2013) offered a revised definition (Cooper, 2018; Stein et al, 2010). Wakefield's (1992a, 1992b, 1999a, 1999b) take on the subject is, so far, the most commented one, including an issue in the *Journal of Abnormal Psychology* dedicated to it (Busfield, 2011; Cosmides & Tooby, 1999; Fulford, 1999; Kirmayer & Young, 1999; Klein, 1999; Lilienfeld & Marino, 1999; Richters & Hinshaw, 1999; Sadler, 1999).

Social workers have, however, been advised against using the DSM-5 (Frances and Jones, 2014; Robbins, 2014). Frances, the man behind DSM-IV (APA, 1994), alerted social workers on the process of editing the DSM-5 describing it as "secretive", "scientifically unfounded", "inadequately tested", lowering diagnostic thresholds, and exacerbating "the existing medicalization of normal behaviour" (Frances and Jones, 2014: 11). Robbins echoes much of Frances and Jones' criticisms, adding how "biological reductionism may well divert our attention from the very real social, economic, and cultural factors that lead to human distress" (2014: 204).

Morley (2003) reported that most of the literature indicated an uncritical embrace of biomedical psychiatry by social workers, echoing Lacasse and Gomory's (2003) findings in the US context. More recent social work manuals seem to continue with this trend (Ow and Cheong Poon, 2020; Bland et al, 2021), but not all (Coppock and Dunn, 2010). Golightley and Goemans' textbook in its 7th edition, advocates for "professional cynicism" towards psychiatric diagnoses and considers it "unfortunate" (2020: 50) that there was no formal response to the DSM-5 (APA, 2013) from organisations representing social work. And, even if it might be in a minority position, a critical stance towards biomedical psychiatry is also present amongst frontline mental health social workers in England (Manchester, 2015). Some social work scholars can be counted amongst the most prolific critics of psychiatric nosology (Wakefield, 2013; Kirk and Kutchins, 1992). Probst interviewed US social workers on their use of diagnostic and person-in-the-environment perspectives and found that professionals did not experience "a conflict between the two perspectives, but made use of both in a reciprocal, mutually interacting, and holistic manner as a both/and rather than either/or" (2013: 188-189). He reports that most practitioners found the therapeutic relationship "to be more essential to their practice that either perspective" (ibid: 189). Some interviewees, however, admitted using diagnoses against their professional opinion because this was the only way to secure support services. Hitchens and

Becker (2014) found ambivalence towards the DSM-5 amongst the twenty social workers they interviewed in the US, including a troubled feeling at being required to diagnose in order to obtain third-party reimbursement. Also in the US, Lyter and Lyter (2016) surveyed 319 social work educators and found cautious acceptance towards the manual, although only a few were aware of the controversies surrounding its publication[22].

Beyond these general warnings to social workers in relation to current psychiatric nosology, in relation to children in State care, there is a general consensus in the literature that the early interpersonal trauma experienced by most of these children "leads to complex constellations of symptoms and pervasive impact on development" which the DSM inadequately accounts for (DeJong, 2010: 589). This has led Music (2011) to refer to this population as "misunderstood and misdiagnosed". The diagnosis of Developmental Trauma Disorder was proposed for inclusion in DSM-5 (APA, 2013), as a way to more accurately capture the sequelae of symptoms presented by these children (D'Andrea et al, 2012). However, Glaser (2000) warns there is no such thing as a "post-maltreatment syndrome". Music, amongst others, proposes a move "beyond narrow diagnostic labelling" towards a recognition of the different developmental trajectories likely to arise from early abuse and/or neglect (2011: 3). Perry (1995, 2002) has studied the brain's neurobiological and neurophysiological adaptations to early trauma and created a model of assessment and treatment, the neurosequential model, based on each person's developmental trajectory (Perry and Szalavitz, 2006).

These three broad frameworks of understanding are not exclusive. They do differ, however, in two important aspects. First, the different explanations imply different remedial intervention.

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[22] In the US, unlike in the UK, social workers can themselves make a diagnosis using the DSM, which could explain why their perceptions of the manual have been researched. It also makes the absence of social work involvement in the preparation of DSM-5 more significant.

Second, they afford differing levels of agentic power to the person. Whilst attachment or trauma theories understand behaviour as survival strategies, psychiatric nosology guides professionals to understand children as a product of dysfunctional biology that is out of the children's control. However, the less capacity to choose a behaviour or another, not only means less responsibility, but also less agentic power to change that behaviour (Larkins, 2019). In addition, when it comes to childhood psychiatric diagnoses, the functional impairment clause – termed the clinical significance criterion – raises questions as to what the expected social functioning of children is (Isobel, 2024), creating the possibility of diagnoses being sought for behaviours that adults struggle with, in family and/or school settings (ibid). The diagnostic criteria for ADHD, for example, includes "clear evidence that the symptoms interfere with, or reduce the quality of, social, academic, or occupational functioning" (APA, 2022: 70). Thus, these frameworks of understanding do not stand in a vacuum, they form part of a wider network of interrelated social representations, which include normative notions of parenting and of social work practice, as well as expectations of how children should feel and behave. I turn next to the policy instruments that delineate that 'good' social work practice.

Professional guidelines on ethics and human rights

Social workers are expected to adhere to ethical principles when exercising their professional judgement and applying knowledge to practice. Professional codes stipulate what service receivers and the general public can expect from social workers, incorporating an element of accountability and internal regulation to the exercise of the profession (Banks, 2004; Ife et al, 2022). The International Federation of Social Workers (IFSW) (2018) has produced a Statement of Ethical Principles. In England social workers must abide by the professional standards set by their regulator, Social Work England (SWE) (2019). These standards incorporate the promotion of ethical practice (standard 6) and state that social workers will work within ethical frameworks (standard 3.1). However, SWE does not provide any such framework, other than pointing to the Federation's (2018) or the British Association of Social Workers (BASW) Code of Ethics (2021) (SWE, 2020).

All these documents have in common an individualist discourse, where ethical behaviour is equated with the ethical decision-making of single social workers, with no role for the service receiver, the social worker's employer, or the structures within which practice takes place (Ife et al, 2022; Banks, 2016). However, the Local Authorities' position as social workers' employers can create conflicting situations for the practitioners when the interests of the organisation do not correspond to those of the service receivers (Ife et al, 2022). For instance, it might be in the Authority's financial interest to choose the cheapest placement provider for a child in State care; however, that placement might not be the most appropriate for the child. BASW's Code of ethics stipulates that "[s]ocial workers have a duty to bring to the attention of their employers, policy makers, politicians and the general public situations where (…) policies and practice are oppressive, unfair, harmful or illegal" (2021: 8). Those could be their own employer's policies. This situation could create a psychological burden for social workers, all of whom we could expect to be invested in ensuring they have a 'moral career' (Goffman, (1984[1963]) as ethical practitioners. Balfour et al (2020) show how organisational procedures can redefine practice away from professional ethics, something to which social workers have not been immune (Ioakimidis and Wyllie, 2023).

However, any discussion of the application of ethical principles requires us to consider the existence of autonomous moral agents able, even if only in a limited way, to carry out such application. If practitioners were so constrained by the structures within which they practice that had an absolute lack of agency, there would be no point in discussing ethical practice (Gray, 1995). The acknowledgement of the limitations that social structures impose on human action, and even thought, has, therefore, to be carefully and critically balanced with the acknowledgement of the existence of human agency (however much they have), if we are to avoid the reification of the said structures and recognise space for human self-awareness. In a way the earlier discussion on the agentic implications of explanations of behaviour, parallels this discussion in relation to professional agency. In their analysis of Spanish social workers' discourses in relation to their practice, Orgaz Alonso et al (2023) identified a significant proportion of 'conformist' discourse with a high level of identification between the worker and the administration[23]. In England, Gibson (2019) has researched on the experience of self-conscious emotions, in particular shame and pride, as part of social work practice. In his study, Gibson showed how those social workers who identified with their Local Authority employer were able to minimise feelings of shame and guilt (in relation to professional values). This identification served to minimise their psychological discomfort by reducing the cognitive dissonance between professional rhetoric and actual practice. Gibson documented how the Local Authority where he carried out his ethnographic research directed practices to elicit shame and/or pride in their social workers according to the extent to which they fulfilled their bureaucratic responsibilities. He also documented social workers who resisted this identification; however, this resistance was accompanied by emotional struggles. Fenton (2016) carried out a study amongst experienced criminal justice social workers in Scotland and found that 'organisational professionalism' was becoming the profession's practice framework. This included a reliance on agency procedures, increasing managers' role and "the redundancy of a working theoretical and ethical knowledge base" (ibid: 199).

In relation to human rights, the principles under the global definition of social work state that "advocating and upholding human rights (…) is the motivation and justification for social work

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[23] The number of participants allowed the researchers to establish correlations between the social workers' discourses and their employment status.

(IFSW, 2014). In the UK, BASW has produce a practice guide on human rights (Harms-Smith et al, 2019) covering different practice areas, including children and families, but not mental health. In relation to children, in 1991 the UK ratified the United Nations Convention on the Rights of the Child (UNCRC) (UNICEF, 1989), meaning that government and public bodies must consider the UNCRC when creating new policies for children. The UNCRC identifies the requirement for primary consideration to be given to the child's best interests in all actions concerning them (article 3) and the child's right to express their views in all matters affecting them and have those views given due weight (article 12). The Children and Social Work Act 2017 named seven principles on corporate parenting, which included references to the child's best interests, consideration of their "views, wishes and feelings", and the need for stability in children's lives (section 1(1)). Children's best interests and their participation in decision making are, therefore, statutory guiding principles for social work practice.

The UN Committee on the Rights of the Child has, however, criticised the implementation of the UNCRC in the UK. The Committee noted in its latest report that the principle of the best interests of the child was "not systematically applied in all matters affecting children" (2023: pt 21) and their views were "not systematically taken into account in decisions affecting them" (2023: pt 23). In its earlier fifth report, the Committee had already pointed out that "many children feel that they are not listened to by their social workers, reviewing officers, paid carers, judges (…) in matters affecting them" (2016: 30(d)). The Committee recommended the UK "to ensure that children are heard in decisions affecting them in alternative care placement" (2023: pt 38(g)). The imprecision with which these principles are formulated in policy can lead to multiple and contradictory interpretations when it comes to implementation, with the presence of polysemy – coexistence of different possible meaning – but also polyphasia – the presence within the same individual of different representations, even contradictory ones, to choose from depending on the situation (Moscovici, 2008).

In practice, being able to determine what the child’s best interests are and the extent of their participation in decision-making is complex. There could be, for instance, a potential conflict between short and long-term interests (Thomas and Winter, 2025). How to determine what the child’s ‘best’ interests are is another question (ibid). When a social worker has to choose between a child staying in a less-than-ideal placement or moving the child to a new one, with no guarantee of subsequent success but guaranteed disruption, where in practical terms lies the child’s best interests? The UNCRC concedes “primary” consideration to the child’s best interests, rather than “paramount”, acknowledging that there may be other interests at play, and that these may need to take precedence in certain circumstances (Sutherland, 2016). However, the existence of other interests, raises the question of possible conflicts of interest. Recommendations such as the one from the UN Committee that “all children in alternative care: (i) have access to independent, well-resourced, child-friendly advocacy services” (2023: 38(b)), seem to imply that children’s social workers cannot, or are not, independent advocates for the children allocated to them. What is unclear is from what the social workers, or any advocate, should be independent.

Ife et al (2022) highlight the oppressive dangers of deciding on somebody’s best interests without involving them. The child’s right to participation, also included in official social work discourse, is intimately related to best interests’ considerations. However, research suggests that adults’ experience, rather than the child’s, may take precedence. Goodman concedes that teachers may initiate a referral based on the burden they experience rather than on the level of symptoms presented by the young person (1999: 798). Bonfield et al, in their study of help-seeking behaviour by foster carers in relation to their foster children, hypothesised that “those having difficulty coping and experiencing burden may be more likely to seek help from specialist services” (2010: 1346). Both studies (conducted in England, with a sample of 452 teachers and 113 carers respectively) support the view that the adult’s interest can take precedence in deciding whether to refer to specialist services.

The International Federation, in articles 4 (self-determination) and 5 (participation) of its Statement of Ethical Principles, states that professionals “respect and promote people’s rights to make their own choices and decisions” and promote “their full involvement and participation in all aspects of decisions and actions that affect their lives” (2018). As people, it can be considered that children are included in these principles. The UNCRC (UNICEF, 1989), in article 12, establishes the child’s right “to express [their] views freely in all matters affecting [them]”, with their views “being given due weight” according to the child’s “age and maturity”. Parallel to this language of rights, the sociology of childhood has started to view children as social agents in their own right, not projects in the making (James and Prout, 1997).

Participation in decision-making, however, may have additional meanings for children in State care, the majority of whom come from backgrounds of abuse and neglect by adults who should have cared for them. Participation may serve to restore some sense of power and control over their own lives. Children in State care consistently report a lack of control over and understanding of their own life (Children’s Commissioner, 2019b; House of Commons Education Committee, 2016; Wigley et al, 2011; Munro, 2001). Selwyn et al found that 15% of 11–18-year-olds and 19% of 8–10-year-olds did not feel included in decision making (2018: 30). In relation to understanding the reasons for being removed, 31% of 4–7-year-olds and 11% of 8–10-year-olds felt these reasons had not been explained to them, and 22% and 25% respectively felt that this had been done only partially (ibid: 36). Yet, research with these children shows that they value involvement in decision making and that this positively correlates with their emotional wellbeing (Cashmore, 2002; McLeod, 2007; Leeson, 2007; Munro, 2001). However, research on social work practice in this area reports a disparity of outcomes. Shemmings (2000) found polarised views amongst 42 child protection social workers around the age of decision-making for children, although nearly all of them agreed children should attend child protection conferences. Toros (2021), in a systematic review on children's participation from child welfare workers' perspective, found they worried about the potential harm and burden when including children in difficult conversations. Research has also found differences on the part of professionals in the use of the term participation (Toros, 2021), as well as related concepts such as competence (Moran-Ellis and Tisdall, 2019).

In this respect, research has found that, for meaningful participation to take place, children should not be treated as mere witnesses (i.e. in meetings) but their voices must carry influence (Davey, 2010; McCafferty and Mercado García, 2024). In Bouman et al's (2018) model of participation, before hearing and involving them, children need to be informed. McLeod (2007) also points out that participation should start with taking part in setting the agenda, rather than participating in the conversation chosen by adults. However, the point most consistently reiterated in the literature is the need for a trusting relationship to enable meaningful participation (Munro, 2001; McCafferty and Mercado García, 2024; Bell, 2002). Leeson (2007) concludes that the discussion should shift from whether children are able to participate to whether adults are able to support children's participation. The opposite danger, however, could be to align our understanding of childhood too closely, and uncritically, to the neoliberal ideal of a fully independent and fully responsible individual. Backe-Hansen (2023) emphasises the need to conceptualise participation as an interdependent and relational process, and Mayall (2000) points out how children view themselves, not as autonomous, but within a relational web.

Social workers' practice context

Much of the interpretive work carried out by social workers of children's behaviour, as well as the understanding of their own role (professional identity career) takes place within the organisations that employ them, mainly Local Authorities (LAs). LAs can be understood as social organisations, structures within which particular activities take place, patterned by their own rules (statutes, policies and procedures in this case) with a predetermined objective (Scott, 2015). As institutions, social organisations serve a function within their wider sociopolitical system. LAs, therefore, participate in the power configurations of the system within which they find themselves. At the same time, they are the object of differing social representations as to what they do and/or should do (Gibson, 2019). Organisations also have their own identity, which can serve as a form of control inasmuch as employee behaviours are rewarded or censured according to their degree of conformity with the organisation's identity (Gibson, 2019; Alvesson and Willmott, 2002; Whetten and McKey, 2002; Ashforth and Mael, 1989). Social workers, therefore, try to make sense of children's behaviour whilst they are themselves situated within structures that seek to restrict and direct their own behaviour. However, LAs are not the only source of professional identity for social workers. Practitioners can also draw social representations of what the profession is meant to do and how from the formal rhetoric of social work organisations.

BASW runs a yearly survey of social workers' experience of their working conditions. In the latest one, completed by 1,114 social workers, the adequacy of staffing levels (46.9%), access to resources (46.1%) and workload demand (43.6%) were identified as the three biggest challenges in the workplace (BASW, 2024). 50.2% of respondents felt unable to manage their workload, with 53.2% working for between 1 and 10 additional hours per week and 16.3% for over 10 additional hours per week[24] (BASW, 2023). The Department for Education (2024) reports an upward trend in children's social workers turnover since 2017 (when data collection started), standing at 15.9% in 2023, after its peak on the previous year (17.1%). Studies of the emotional wellbeing and retention of social workers coincide on the significance of

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[24] 67.16% reported not getting paid for any of those additional hours (BASW, 2024).

organisational characteristics, over individual ones, and report on the impact of organisational structures on job satisfaction and staff retention (Ferguson et al, 2020; Coffey et al, 2004). Antonopoulou et al (2017), after surveying children's social workers in five LAs found that a sense of control over their work and a feeling of adequate support were behind the lower stress levels in two of the five LAs. McFadden et al, in a systematic review of 65 articles considering resilience and burnout amongst child protection social workers concluded that "defensive organisational culture with poor social supports and unmanageable caseloads" related to the intention to leave the profession (2015: 1558). In England, the expected working life of a social worker is 7.7 years (Curtis et al, 2010).

According to research mentioned in the previous section, enabling the participation of children requires a trusting relationship (Munro, 2001; McCafferty and Mercado García, 2024; Bell, 2002). Decision-making concerning the best interests of a particular child requires knowledge of the child and their experiences. However, neither of these two conditions are facilitated by current working conditions and structural organisation of social workers. To start with, a children's social worker has limited time for each child allocated to them. In a 35-hour working week, with a caseload of 15 children, a social worker has 2 hours and 20 minutes per child per week (assuming no toilet breaks). This includes visits (at least every 6 weeks, or 4 times a year in a long-term placement), meetings (biannual reviews[25], and a Personal Educational Plan every term), case planning, recording and travelling. In September 2018 the average caseload of a children social worker was 17.8, ranging from 12.0 to 26.8 (DfE, 2019). The latest figures released by the DfE (2025) report an average caseload of 15.4, down from 16 the previous year.

In addition to time constraints, there are frequent changes of worker due to staff turnover or case transfer to a different team. Whilst each LA varies in their organisation, a typical one

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[25] Reviews are chaired by an Independent Reviewing Officer (IRO), usually with a social work background, whose responsibility is to monitor how the LA is fulfilling its statutory duties towards the child.

would include Children in Need (support with no safeguarding concerns), Child Protection (safeguarding investigation and/or court proceedings), Children in Care (those already in the care system), Post-16 and Post-18 teams (for 16+ and 18+ young people in the care system, with a focus on preparation for/support with independent living). This means a child could potentially have five social workers by simply moving between teams as their legal situation or chronological age changes[26]. These moves are compounded by workforce turnover as staff change jobs. The Stability Index (Children's Commissioner, 2019a) gathers information regarding children in State care stability since 2017. According to the data submitted by 140 LAs, three in five children experienced at least one change of social worker in 2017/18, while just over one in four experienced two or more changes. Over a two-year period, more than half (55%) experienced two or more changes of worker, while one in three (32%) experienced three or more changes.

The figures, however, do not say anything about how changes are managed, whether there was time or thought given for transitioning or simply saying goodbye. In their survey of 2,263 children in State care from 16 different LAs, Selwyn et al found that 15% of them did not know the identity of their social worker; this included 23% of those four to seven years old (2018: 18). In some cases, it is the new social worker who informs carers and children that there has been a change. This lack of farewell inevitably erodes the next relationship, "what's the point of opening up to them?" (Children's Commissioner, 2019b: 8), since the child has learnt that it can end at any point without warning. Discussing changes of social worker, children described feeling lack of control, not knowing "what is going to happen", as well as a sense of

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[26] In recent years some LAs have started to realise the consequences of their teams' divisions and have merged some of them. This was one of the recommendations of The Care Inquiry (2013: 18). The Inquiry also made several recommendations to support the long-term relationships between children and young people and the people who cared for them, even when either of them had moved on – job or placement.

worthlessness, not being “valued” (ibid: 9).

Changes are not limited to social workers. Placement instability increases with the number of years children remain in State care. Over a two-year period, 20% of children had experienced two or more placement moves. Over a four-year period 58% of children had experienced at least one placement move (Children’s Commissioner, 2019a). Placement moves can be accompanied by a school move. Over a two-year period 14% children experienced all these changes and a third experienced two of them (Children’s Commissioner, 2019a).

What the figures cannot describe is how each placement/school move means a disruption in friendships, routines, opportunities to pursue hobbies, in the little details that make each family life and that so many of us take for granted. And to all these little details a child needs to get used anew each time they change placement, each time they are told they have a ‘new home’. A scenario builds up where children lack a trusting adult present throughout their childhood who is committed to them and invested in advocating on their behalf (Osher and Brown, 2016). The Committee on the Rights of the Child expressed its concern about the frequent changes of social workers for children in State care, considering that it “negatively affects all aspects of their life” (2016, 52c), reiterating its concerns in its latest report (2023). Looking at corporate parenting, Bullock et al concluded “it still seems sad that a care system allegedly based on good relationships is wont to obstruct their formation or, where they exist, to squander them unnecessarily” (2006: 1357).

Conclusion

This examination of the context of social work practice is important because, as long as people’s narratives are interrelated, we need to be mindful that, “in seeking a better story for one person, things are not made worse for another, more vulnerable individual" (White, 1997: 751). And social workers have a professional responsibility towards that 'more vulnerable individual'.

In addition to the profession's knowledge base (sociological, psychological and physiological theories), in this chapter I have examined some of the potential mechanisms guiding social workers causal attributions to children's behaviour. This examination does not intend to be exhaustive, but it does intend to show that causal explanations on children's behaviour – the narratives weaved to understand why they do what they do, that are recorded as official accounts of the 'truth' on children's files – are not necessarily or entirely consciously chosen. Some of the mechanisms considered are sociological in nature (medicalisation), others refer to psychological biases (attribution error) or defences. Thus, the understanding of a human being is not only relational, but also affected by multilayered influences, of both structural and individual origin. At the same time, not all consequences stemming from a narrative are necessarily intentional; therefore, it is also necessary to separate the narrators from the narratives and acknowledge that the concealment of social ills by using certain narratives is not necessarily a purposeful intention of those who have chosen that narrative (Freyenhagen, 2019).

Considering the mechanisms leading to the choice of one or more narratives over others should include a consideration of the historical and political context of the social work profession, as well as of the extent to which those choices are the product of a reflexive exercise by its professionals. This is important because epistemic reflexivity incorporates agentic power. Further, I would argue that the ultimate purpose of this reflexivity should be to move towards greater social justice (Bhaskar, 1991; Horkheimer, 2002; Freyenhagen, 2017). Scientific knowledge should not be separated from political action (Horkheimer, 2002). Science is a political approximation to 'reality' inasmuch as greater awareness (concientisation in Freire's terms (2017[1970])) of oppressive structures leads to their meaningful change (Houston, 2001), even when the price is for society and oneself to become uncomfortable, becoming aware of one’s (the researcher’s) own biases and partial perspective (Freyenhagen, 2017). These considerations should be an imperative for the social work profession since its global definition states that it “promotes social change” and “the empowerment and liberation of people” and that it “engages people and structures”; with its commentary notes adding that “advocating and upholding human rights and social justice is the motivation and justification for social work” (IFSW, 2014). In addition, the BASW Code of Ethics includes the obligation to challenge unjust policies and practices, adding that “[s]ocial workers are expected to bring to the attention of their employers, policy makers, politicians and the general public situations where resources are inadequate, and/or where distribution of resources, policies and practice are oppressive, discriminatory or otherwise unfair, harmful or illegal” (2021: 7).

2. RESEARCH METHODS

I'm glad that someone's looking into it. Pippa[27]

This chapter outlines the methodological decisions undertaken throughout this qualitative research as well as offering the rationale behind those decisions. The chapter considers first the research questions, followed by a description of the methods of participant recruitment, data collection and analysis employed in the study. The chapter concludes with an examination of the research's ethical considerations as well as its methodological limitations.

Research questions

As argued in the previous chapter, understanding another person's behaviour is a complex process with multiple potential layers to consider. This process is further complicated when the interpreter is part of those circumstances that may be influencing the person's behaviour, that is, when the interpreter is both observer and potential cause. When the interpreter is an adult and the behaviour to interpret belongs to a child, there is an additional layer of power to consider, since children may rely on the adult/s to offer that interpretation, to support them in making sense of their own behaviour, the more so the younger the child. Finally, when that child is in State care there are further layers of complexity. The child themselves will have

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[27] Pseudonyms are used for all names. Unless otherwise stated, pseudonyms refer to participant social workers.

experienced some extreme events early on in their lives, and these experiences will have had an impact on the child's emotional wellbeing. At the same time, when children are in State care, the adults around the child who are making sense of the child's behaviour will have been part of the child's life only for a limited time. And, instead of one or two parents, the child will encounter a multiplicity of professionals and carers.

These considerations are important because one of the possible explanations for a child's behaviour is having a psychiatric disorder. As noted in the previous chapter, the current psychiatric nosology is based on a biomedical model and has been the subject of ongoing criticism (Whitaker and Cosgrove, 2015; Kinderman, 2014; Johnstone, 2000). This model supports particular political and economic interests. Reifying emotional struggles as biological accidents relieves the State from its responsibility in creating the most optimal socioeconomic conditions for child rearing. At the same time, supported by this psychiatric system, the pharmaceutical industry has become one of the most profitable industries worldwide (Mikulic, 2024; Ledley et al, 2020). This industry has also been the subject of criticism (Spielmans and Parry, 2010; Abraham, 2008: Busfield, 2006; Smith, 2005). Relevant to this study, the pharmaceutical industry has been criticised for targeting children in State care in the marketing of their pharmaceutical products, as a population of 'easy' consumers (Brill, undated; Littrell, 2012; Malisow, 2011a, 2011b; Osher & Brown, 2016).

The latter situation should require social workers responsible for the wellbeing of children in State care, to scrutinise their practice and decision-making in relation to the emotional wellbeing of these children. From the moment that competing interests intervene in the understanding of children's behaviour, making sense of children behaviour becomes the scenario of ethical and human rights dilemmas.

Considering the above, this study seeks to address the following sets of research questions:

1. (a) Which approach/es do social workers adopt to understand children's behaviour?

   (b) To what extent does psychiatric diagnosis inform or form part of their approach(es)?

   (c) How does this compare with the experiences of care experienced adults?

2. (a) How do those approaches translate into social work interventions to support the recovery of children affected by abuse and/or neglect?

   (b) How are those interventions experienced by care experienced adults?

3. What are the ethical and human rights considerations that social workers engage with in this area of practice?

Methods

This thesis reports on the views and experiences of social workers with experience of working with children in State care. A small number of adults with childhood experience of the care and mental health systems (hereafter adults with relevant lived experience)[28] also participated in the study. The section starts with a discussion on sampling and recruitment of both participant groups. It then describes the data collection methods employed with each group. The section concludes with a discussion on data analysis, for which reflexive thematic analysis (Braun and Clarke, 2022) was used.

The data generated by adults with relevant lived experience is not examined as part of this thesis due to space constraints. Their recruitment, data collection and analysis are included here, however, because it informed reflections on the analysis of social workers' interviews and the

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[28] These are not necessarily two distinct groups, since there is overlap between them.

ultimate reported findings.

Participants

The research recruited two different participant groups: adults with childhood experience of the care and mental health systems and social workers with experience of working with children in State care. The initial plan was to recruit the adults with relevant lived experience first and, in a second phase, the social workers. Due to recruitment difficulties, eventually both phases overlapped, and I continued to actively seek to recruit adults with relevant lived experience when I had already started to interview social workers. Participants were recruited using purposive sampling (Bryman, 2016), through my own professional networks, contacting relevant organisations, social media ads and snowball sampling. In this section I discuss the recruitment of each participant group in turn. Recruitment difficulties were ongoing and recruitment criteria for both participant groups underwent a series of changes, all of them directed at increasing the pool of potential participants. All changes were discussed with and approved by the University of Essex's Department of Sociology's Ethics Officer. Eventually, the decision was made to include a payment for participant social workers, which seemed to help with their recruitment. I finish this section with considerations around this recruitment practice.

Both participant groups were recruited exclusively within England since each country in the UK has its own children and families' statutory framework as well as regulatory body in relation to social workers. In this way both groups' experiences and practices were located within the same historical policy context.

Including in the same study adults with childhood experience of the care and mental health systems and social workers was an epistemological decision. If we want to build a bridge between the private lives of children in State care and the public system of care that social workers represent, it is not enough to separately explain their perspectives in different research projects. Children in State care and social workers' perspectives interact daily amidst the reality of care placements. These perspectives also need to be examined in interaction in research as in reality. Children in State care and social workers cohabit the same practice space. Research should allow them to share the same epistemological space so we can better appreciate the magic of their understanding and the tragedy of their contraposition (Bourdieu, 1999). It is, therefore, with great sadness and regret, due to time and other constraining circumstances, that this study only reports on the findings from the social workers' group. Recruitment, data collection and analysis procedures for the adults with relevant lived experience are, nonetheless, reported here, since they took place as part of this research and because their collaboration supported the analysis of the social workers' interviews. I would not have understood the latter in the same way without the conversations (orally or via email) that I held with these adults. I plan to report on their contribution in the near future.

All participants will receive a copy of the final version of this thesis. Social workers have received copies of final drafts of the three finding chapters[29].

Adults with lived experience of the care and mental health systems in childhood

The initial recruitment criteria for this participant group were adults born in the UK who were between 18 and 30 years of age and had a minimum of two years' experience of foster care, and who had received a psychiatric diagnosis whilst in foster care.

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[29] All participants except two social workers who expressed their desire to not receive any further information from the research.

I decided to recruit adults instead of children for epistemological reasons. Due to the lack of research in England on the experiences of children in State care on their psychiatric diagnosis and treatment, I consider it important to start to explore the subject with reflexivity and life-course perspective, as I wanted to explore the potential lifelong impact of how we understand these children. Children would not be able to have gained any perspective on any psychiatric diagnosis and/or the mental health support received, or to reflect on whether it had had any role in shaping the beginning of their adult lives. That said, this was not an easy choice. Children are notoriously a voiceless group in the public sphere (Alldred, 2000), although over the last decade the views of children in the care system have been increasingly sought (see, for instance, Selwyn et al, 2018; The Care Inquiry, 2013; Voice for the Child in Care, 1998). My hope is that, once we have learnt more on the study's subject from the perspective of adults with lived experience of the care system, we will be able to move on to asking children in State care directly about their views, enabling us to compare how their views and experiences on the subject may change over their life. I did hope, however, that the inclusion of adults, rather than children, moved the research away from a "childhood fixed" narrative (Plummer, 2001: 193) by allowing me to consider the different trajectories through which the initial impact of a psychiatric diagnosis and/or mental health services unfolded through subsequent life up to the time of the interview.

The decision to include only adults born in the UK was intended to exclude unaccompanied asylum-seeking children. This is certainly a group that requires attention, now possibly more than ever. However, I thought that their experiences of trauma would have distinct features, and cultural differences in interpreting behaviour would have to be given prominence. This criterion remained throughout the recruitment phase.

The original age limit was set for two reasons. Firstly, it was intended to ensure that the adult's experience of their care system coincided with the same legislative framework as the social worker's practice, since the State's approach to the care of children changed significantly after the Children Act 1989 came in force. Secondly, it sought to mitigate potential problems with recall. The decision, however, unwittingly reinforced an existing grievance within the 'care leaver' community: the fact that most research and policy refers to young adults who have just ceased to be in State care, and very little is considered about the experiences of older adults who spent part of their childhood in State care (CLA, 2014). Eventually the age of this participant group was increased up to 50 years. The decision, as stated earlier, was in part motivated by recruitment difficulties, but it did also address the grievance just mentioned. During the research, I was able to appreciate that some of the most articulate and staunch advocates within the 'care leaver' community were/are in fact older adults[30].

The criterion of having foster care experience eventually opened to the more inclusive criterion of any placement within the care system. The initial choice of foster care was due to my own professional experience prior to becoming a researcher. I was also mindful that fostering and residential settings offer very different experiences, the final aim being to examine the experiences in one setting in order to be able to compare them with the experiences in the other one. However, the number of recruited participants would not have been sufficient for such a comparison in any case.

Finally, although the original focus of the study was on psychiatric diagnoses, it was appreciated through the recruitment process that some children had had access to mental health services without having had a formal diagnosis; therefore, the criterion was changed to adults who had had access to mental health services and/or had received a psychiatric diagnosis whilst in State care. The wording of this latter criterion also changed throughout the recruitment process. Initially, advertisements asked for people who had had a psychiatric diagnosis whilst in State

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[30] Two of them, Ian Dickson and Paul Yusuf McCormack, sadly died during this study.

care. ‘Psychiatric diagnosis’ was intended in its medical meaning, as any condition listed in the DSM-5-TR/ICD-11 manuals. However, it was pointed by a participant social worker that the term might feel stigmatising, and that ADHD/ASD were not psychiatric diagnoses but neurodevelopmental conditions. It must be noted that since DSM-5 (APA, 2013) these two diagnoses appear under a new section on “neurodevelopmental disorders”. For the purpose of this study, I consider as a psychiatric diagnosis anything that appears classified as such in the DSM/ICD manuals. However, for recruitment purposes, I decided to adopt the wording that seemed to appear more acceptable to potential participants. Therefore, the wording was changed to “having had a mental health difficulty or condition (ADHD, ODD, etc.)”. Appendix I includes the final advertisement used in social media.

In addition to my professional networks and social media, I made direct contact with organisations working with adults with care experience: the National Association for People Abused in Childhood, The Care Leavers’ Association, Become, Coram Voice, and the Rees Foundation. Their response was in general sympathetic, but it yielded no interested potential participants. I consider now my initial position to be extremely naïve. I thought no longer speaking from a social worker role would in itself dispel the power inequality that inherently exists between professionals and children in State care and that these adults would have experienced. However, I discovered during the study that ‘care leavers’ are a research-mined community, who have felt their stories at times misappropriated, and promises of system and policy change unrealised by both researchers and organisations purportedly advocating on their behalf (Ellis and Sen, 2024). Without any research track record or without a person within the community backing my study there was, rightly so, no reason why adults with relevant lived experience should place their trust on me. I cannot be grateful enough for the ones who eventually did.

Seven young adults with relevant lived experienced, six females and one male, collaborated with the research in different capacities. Three of them were social workers themselves. Two were completing their own PhDs. One had already actively engaged politicians seeking system change within the care and mental health services. Throughout the course of this research one of them became a prominent activist for the ‘care leaver’ community. Their achievements are not due to any mildness of the adverse events they experienced as children. The stories that they shared with me were as painful as any I have heard during my time as a social work practitioner. However, I do think that their achievements may raise questions as to how representative they might be of the adults with care and mental health lived experience (gender representativeness aside).

Social workers with working experience of children in State care

The recruitment criteria for the social workers sample underwent similar changes to those of the adults with relevant lived experience. The initial criteria asked for social workers with a minimum of three years’ experience in a Children in Care team or equivalent who had experience working with children receiving a psychiatric diagnosis.

The wording on psychiatric diagnosis underwent the same change as detailed above. Due to difficulties in recruitment the criterion on a minimum of three years of experience was removed. In the end, participants’ working experience ranged from 2 to 30 years. For the same reason the criterion of being a social worker for children in State care was changed to social workers with experience of working with children in State care, regardless of whether they were the child’s social worker. There is a multiplicity of professionals/carers working with children in State care. The initial choice of social workers within Children in Care teams requires consideration. This professional group was chosen because it is the one to which I belong. This shared profession meant that, considering the critical approach I anticipated for the study, I felt more confident – and legitimised – in the possible scenario of criticising social work practice within the final analysis. This is a particularly sensitive point since so much research on social work practice is done without social work collaboration within the research team, and since in England our profession has a history of intense criticism in the media and by politicians. The particular role of the child's social worker was chosen since they embody the State's corporate parental responsibility over children in the care system. They are, so to speak, the parental figure in terms of decision-making. The main two social work roles within this participant group ended up being children's social workers, from a variety of teams, and supervising social workers, whose role is to supervise foster carers. Some differences in their views could be hinted at in their responses; however, the number of participants does not allow for definite conclusions on this point. For a holistic understanding of the study's matter the views of people in at least two other key roles should be researched: education staff and carers. Appendix II includes the final advertisement used in social media.

To recruit social workers, I used my professional networks, contacted professional associations and advertise in social media. I contacted the Social Work Action Network, which yielded no interest. The British Association of Social Workers magazine advertised the research, and this yielded two expressions of interest, one of which did not meet the participant criteria. Most of the participants came through responses from advertising the research in social work Facebook groups.

Table 1 includes a list of all participating social workers, with their role and years of professional experience at the time of the interview, demographic information and interview length. There were three male participants (10.3% of the sample) and twenty-one self-defined as White British (72.4%). In September 2023, there were 12.6% males and 74.7% White (of those known) within the children's social work workforce in England (DfE, 2024). I did not notice any salient differences between any gender and/or ethnic groups, but the small numbers render this conclusion speculative. Samantha, a Black Caribbean woman, was the only social worker to discuss racism as part of how social workers understand children's behaviour. I think it is reasonable to expect that this topic would have featured more prominently had more non-White social workers been interviewed. Two social workers had themselves lived experience of the care system. Several social workers had personal experience of psychiatric diagnosis through family members, including their own children.

Table 1. Participant social workers

Social worker	Current role	Years of practice	Age	Gender	Ethnicity	Religion	Interview length
Aarunya	Mental health practitioner (CAMHS)	11	43	F	British Indian	Sikhism	1h 35'
Allison	Supervises assessing social workers (IFA)	8	37	F	White European	None	1h 9'
Amy	Children in Care team	10	44	F	White British	None	51'
Beth	SSW - Deputy manager	5	40	F	White British	None	1h
Caroline	IRO + adoption assessments	22	53	F	White British	Christian	1h 23'
Cristina	Senior SW in mental health inpatient hospital	4	30	F	White Other (South European)	None	1h 46'
Danah	Referral & Assessment team	7	30	F	British Indian	Muslim	1h 18'
Diana	Self-employed	11	32	F	White British	None	1h 5'
Emily	Children with disabilities team	2	48	F	White British	None	47'
Gemma	SSW in IFA	7	42	F	White British	CoE	1h 4'
Hannah	Children in Care team	10	40	F	White British	Christian	1h 10'
Henry	Children in care team, Senior Practitioner	3	33	M	White British	None	1h 50'
Ivy	SSW in LA	7	41	F	White British	None	1h 14'
Jack	Children in Care team	2	32	M	White British	Atheist	1h 5'
Luisa	Mental health practitioner (CAMHS)	3	37	F	White other (South European)	Buddhist	1h 36'
Lydia	SSW in IFA	9	56	F	Mixed	None	1h 4' (recorded)

							[31]
Meg	IFA manager	25+	51	F	White British	CoE	2h 8’
Nathan	Children in Care advanced practitioner	5	27	M	White British	None	1h 27’
Olivia	CEO of her own co.	30	54	F	White British	Quaker	1h
Pippa	Children’s Safeguarding Team	3	25	F	White British	None	1h 17’
Rachel	Consultant SW Safeguarding Team	3	31	F	White British	None	1h 38’
Samantha	Emotional Health and Wellbeing Team (locum) + Fostering Panel member.	14	41	F	Black Caribbean	None	1h 43’
Terry	Child Protection team	18	50	F	White British	Non practising Catholic	2h 25’
Thea	Supervises private foster arrangements	11	44	F	White British	CoE	1h 1’
Thomas[32]	AMHP	8	-	M	White British	-	2h 22’ 1h 55’
Vivian	NHS Criminal justice liaison & diversion	8	41	F	White British	Buddhist	2h 28’
Wren	Children in Care team	5	30	F	White British	None	1h 28’
Yohanna	SSW	10	63	F	White British	None	1h 57’
Zuri	Children in Care team	18	39	F	Mixed: European/ Japanese	None	1h 10’

Notes	
	CAMHS Children and Adolescent Mental Health Service
	IFA Independent Fostering Agency
	IRO Independent Reviewing Officer
	SSW Supervising Social Worker
	AMHP Approved Mental Health Professional

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[31] Lydia took a break towards the end of the interview. To avoid recording silence, I paused the recording. At the end of the interview, I realised I had not restarted the recording. I immediately took notes of what had not been recorded.

[32] Thomas was interviewed twice. At the time of his first interview, he did not meet the participant criteria since he had not worked with children in State care; however, he agreed to be interviewed to discuss sectioning under the Mental Health Act 1983 (some of the adults with relevant lived experienced had been sectioned as a child). Thomas contacted me to let me know he had conducted the assessment of a child in State care as an AMHP and he agreed to be interviewed for a second time, following the social workers’ interview guide.

The originally anticipated number of social work participants was 40. I eventually conducted 29 interviews. For both participant groups sample size had been decided with the expectation that it would allow me to reach thematic saturation, when new information or relationships between themes are no longer identified (Rahimi and Khatooni, 2024), with the recognition that there is no magical procedure to calculate that number (Baker & Edwards, undated). Thematic saturation was reached with the social workers' interviews. However, as mentioned below, under analysis, it is likely that this saturation refers to one side of the spectrum of social workers' perspectives on the subject discussed.

Payment of participants: Coercion or recognition?

I started participant recruitment from a *prima facie* position of nonpayment to participants, against other researchers, who consider payment to research participants "a *prima facie* moral obligation" (Różyńska, 2022: 449). In retrospect, I consider my original position as rigid and not thoroughly examined. The recruitment struggles I have described forced me to reconsider this original position. As an incentive to support recruitment, I decided to offer potential participants a free screening of *Medicating Normal*[33] (Ractliffe and Cunningham, 2020). Besides the intrinsic interest that social workers might have on the documentary's topic, watching it could count towards their continuing professional development for their professional registration. Twenty-three social workers responded to the advertisement with this incentive, of whom fourteen became participants. This was still considered an insufficient

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[33] This documentary is currently freely available on internet, but that was not the case then. I contacted the documentary producers via the documentary's website and arrange screenings for the participant social workers. The producers provided individual links valid for 48 hours, so the social workers would have 2 days to watch the documentary. I funded the screenings from my own scholarship.

number, so I again had to reconsider the issue of payment of participants. Research on this topic suggests that financial compensation does increase recruitment (Warnock et al, 2021; Kelly et al, 2017; Head, 2009). My own perspective on this subject changed when I found myself considering how much to pay and how to justify the amount. I then reached four conclusions.

First, to assert that payment of participants commodifies research (Warnock et al, 2022) is questionable, when the researchers are themselves already being paid for it as part of their job (or the very least rewarded in the case of PhD students). Second, payment felt like an equaliser between researcher and researched; in the end we were both receiving some reward. Third, in the specific case of participant social workers, I did not consider this a vulnerable group for whom a small financial compensation could call into question freely given consent (Warnock et al, 2022). Finally, an interview in which social workers discussed their practice experiences could be considered a ‘compensable sacrifice’ (Belfrage, 2016). Following this latter consideration, I set up the financial payment at £20[34], to broadly reflect an hourly rate of social workers’ employment. Twenty-eight social workers responded to the advertisement with this incentive, of whom twelve became participants (one declined the payment).

However, introducing incentives for the participant social workers introduced resulted in comparisons with the adults with relevant lived experience, who had not been given any incentive to participate. This group had been sharing personal experiences with me and, although this arguably accounted for a greater emotional labour – time dedication aside – than was possibly required from social workers, I did feel this type of participation fell within an ‘incompensable sacrifice’ (Belfrage, 2016). Plainly said, it did not sit right with me to pay people to share their intimate pain. I did, however, offer already participating adults to take part in a group discussion after an individual screening of *Medicating Normal* (Ractliffe and

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[34] The payment was provided as a voucher, since this method was preferred by the Department, whose research fund provided the funds for the payment.

Cunningham, 2020). Two participants joined in this activity. Moreover, I did conclude that in my eagerness to make this participant group as actively involved as possible in the research process, I was offering them the possibility of taking roles ascribed to research assistants without providing any compensation for their labour. Therefore, when I approached participants to comment on extracts from social workers' interviews, I offered them a £20 payment in the same way participant social workers had had. Three adults with relevant lived experience join this part of the research.

Data collection methods

Here I describe the process of obtaining consent from participants as well as the impact of conducting data collection during the period of the COVID-19 pandemic. The research followed a different method of data collection for each participant group. In relation to adults with childhood experience of the care and mental health systems, my methods incorporated principles of participatory action research, whilst social workers were invited to take part in semi-structured interviews. Below, I examine each of these approaches. I finish this section on data collection reflecting on my position as insider researcher.

Agreeing to participate: Participant Information Sheet/Consent form

People from either group who expressed interest in the study were provided with a participant information sheet via email explaining the details of the study. They were offered a subsequent telephone or online meeting if they had additional questions. No participant took up this offer. Consent forms were sent via email and scanned and sent back with the participant's signature before inclusion in the research. The final information sheet and consent form for adults with relevant lived experience can be found on Appendices III and IV respectively. Those for social workers can be found on Appendices V and VI respectively.

Adults with relevant lived experience were told that the research aimed to study the role that having been given a psychiatric diagnosis as a child in State care may have had on their lives at the time of diagnosis and whether they thought it had an impact on them throughout their subsequent lives so far. I explained I was interested in exploring whether and how a psychiatric diagnosis had helped in understanding themselves and their behaviours and whether alternative explanations were considered, and that their experience would be contrasted with the views held by social workers. I explained that, outside my own declared topic of interest, I would welcome to hear anything they felt was relevant, and were willing to share, in relation to how professionals and carers understood them.

Social workers were told that the research aimed to study the views and practices of social workers in relation to the psychiatric diagnosis and treatment of children in State care and to compare these views with those of adults with experience of the care and mental health systems. No social worker raised any concern in relation to this comparison, and a few of them explicitly welcomed it.

All participants were informed about their entitlement to confidentiality and anonymity. Pseudonyms were given to each participant. Identifiable names in transcription were anonymised too, that is, names of geographical location were substituted by type (i.e. ‘rural village’) and people’s names, by role (i.e. ‘female foster carer’ instead of ‘Mary’). That said, social workers themselves anonymised the cases they shared. They provided information in general, non-identifiable terms or considered which information not to share. However, to stay on the safe side, when they did use pseudonyms, I substituted them with a different one.

COVID-19: Impact of the pandemic

The original plan was to give participants the option to meet face-to-face or through digital media, either via video conference or email. However, data collection took place when COVID-19 social restriction measures were still in place, so there were no face-to-face meetings. The purpose of including remote participation was twofold. On the one hand, I wanted to offer participants as much flexibility as possible in relation to the terms of their involvement in the research. On the other hand, remote participation allowed me to include participants from geographical areas that logistically I could not access for a face-to-face interview. The option of remote participation would also have the effect of maximising the sampling pool. In addition to these two considerations, I aimed to recruit social workers from a range of Local Authorities. In my own professional experience, different Local Authorities develop their own practice cultures. Therefore, I sought responses to offer a wide spectrum of professional practices, rather than reflecting the particularities of one or two Local Authorities.

Although it is not possible to be certain, I think that lockdown measures during COVID-19 supported recruitment of social workers for two reasons. Firstly, it brought familiarity with online meetings. Secondly, working from home allowed for greater flexibility and need/desire for social encounters. I did not sense it made a difference in the recruitment of adults with relevant lived experience.

Participatory Action Research

Participatory action research (PAR) should be understood more as an umbrella term (Bennett, 2004), an orientation to social research rather than a prescriptive methodology (Jordan & Kapoor, 2016; Kindon et al, 2007). There is not even an agreement in the name, with authors also referring to participatory research, action research, and community-based research, amongst others (Banks & Brydon-Miller, 2019; Kindon et al, 2007). Sometimes the same ideas are covered by different names, which simply recognise different traditions; at other times different names respond to the emphasis being placed on different aspects of the process. There is also disparity in the historical accounts of this approach due to its interdisciplinarity[35]. On conducting a literature search on community-based participatory research, the Durham Community Research Team (2011) encountered different degrees of community participation in the studies claiming to fall in this category.

There seems to be consensus in describing PAR as a "counter-hegemonic approach to knowledge production" (Kindon et al, 2007: 9) based on two commitments. Firstly, there is a democratic and emancipatory commitment to break the monopoly on who holds and creates knowledge (Fals-Borda & Anisur Rahman, 1991; Fine, 2008; Kindon et al, 2007; Maguire, 1987). PAR is about learning *with* as much as learning *from* (Jordan & Kapoor, 2016). At its heart there is a critical challenge to the dichotomy between researcher and researched (Jordan & Kapoor, 2016; McTaggart, 1997). The approach aims to establish a collaborative relationship with those traditionally considered the objects of enquiry. Secondly, the approach understands the relationship between theory and practice as intertwined (Brydon-Miller et al, 2003; Ledwith, 2007; Maglajlić Holiček & Baldwin, 2009), and this practice is necessarily political. The word action refers to the aspiration to contribute to social justice (Banks & Brydon-Miller, 2019; Fals-Borda & Anisur Rahman, 1991; Fine, 2008; Ledwith, 2007; Maguire, 1987), a social justice action that it is done *with* rather than *for* the research participants (Maguire, 1987). Here I address to which extent my research aligned with the democratic and emancipatory principles of participatory research. Issues of social justice in relation to this study are addressed below, as part of the study's limitations.

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[35] For historical overviews, see Jacobs, 2018; Kindon et al, 2007; McTaggart, 1997; for a social work perspective see Maglajlić Holiček & Baldwin, 2009; and Videmšek, 2009.

Within the typology of the degree of participation established by the Durham Community Research Team (2011: 6), my study can be situated as controlled by the researcher with a degree of community partnership. As a researcher I realised that, in trying to understand an adult's experience of the care and mental health systems, I could inadvertently reproduce the power inequalities the adult and I are so used to. Social work practice can resemble a meeting where the professional holds absolute power in the extraction of information – in how and which questions get to be formulated – and in its interpretation and transformation into prescriptions, the moment at which responsibility shifts to the service receiver, who, in turn, becomes the person accountable for carrying out the given prescriptions. Therefore, to minimise reproducing the usual power structures that pervade the social work and psychiatric encounters, I decided it was important to make an offer of collaboration and participation beyond mere information sharing. This decision was located within a wider orientation in social and psychiatric services towards greater participation and collaboration with people who receive services (Beresford, 2016; Moncrieff and Steingard, 2019).

In this way, adults with relevant lived experience were invited to actively participate in the project beyond information sharing. I endeavoured to make sure, however, that participants were clear that their level of involvement was to be decided entirely by them and could be withdrawn at any point in the project. At the stage of data collection, participation of adults with relevant lived experience involved three possible actions.

First, participants were invited to discuss whatever experiences with psychiatric diagnosis/es and treatment/s they had had, both as children in State care and throughout their life, that felt relevant for them to share. An interview guide was prepared reflecting the topics relevant for the study from my perspective. However, the start of the interview invited the adults to choose what to share and how from their experience, with the aim of the adult leading the conversation and myself just asking questions to check understanding. Adults could choose to share this information through a conversation, but they were also welcome to tell their story in a variety of different ways, including email conversation, diary or blog entries, personal photos, podcasts, literary or visual artwork. Participants could have also chosen songs, movie clips or text fragments from other artists that they feel represent moments of their life or feelings attached to life episodes. Appendix VII contains the interview guide for adults with relevant lived experience.

Out of the seven adults with relevant lived experience who participated in the research, six chose to share aspects of their personal experiences. One shared documents previously prepared for campaigning. One agreed to have a conversation over email which eventually moved over to WhatsApp. Four agreed to online conversations. Out of the latter, one chose to have their camera off whilst I kept mine on. Another one was happy to extend the conversation over four meetings. In addition to these conversations, one shared poems they had composed as a teenager and another one shared a digital drawing created for the research.

Second, participants could also give permission for me to access their social work files. No participant agreed to this. One adult did discuss their experiences about reading their files in adulthood. In retrospect, I am glad they did not agree. During this study I had the opportunity to learn more about the emotional experiences of adults with lived experience of the care system in fighting for and eventually accessing their childhood records. I was asking for something that required a greater level of trust than my onset as a strange researcher had.

Third, participants were also invited to help in creating material to be used to interview the participant social workers. The initial plan was for this set of participants to propose their own questions or to create scenarios for me to present to social workers for case-based ethical reasoning, or casuistry (Banks & Brydon-Miller, 2019), that is, to engage in ethical discussion through the particularities of different cases. I was particularly excited about this possible participation since I thought it gave service receivers the opportunity to question professionals on their own practice. Because recruitment of adults with relevant lived experience prolonged over time, only four of them had the opportunity to propose questions/material for the social workers' interview. However, none of them appeared as eager as I was at this opportunity, and I had to remind them several times of it. Eventually one proposed a couple of questions, which were, however, too late to be incorporated into the interview guide that I had already started to use. Of course, four adults with care experience are too small a number to generalise, but this somewhat unexpected reaction to the proposal raised reflections on the perceptions of people who take an advocacy-type role on behalf of others, on how we may define lives and experiences as outsiders in ways that do not coincide with the definitions reached by the ones owning the experiences, and on how definitions of vulnerability generate not only an urge for protection and empowerment but also potentially a paternalistic element. One of these four participants did go on to discuss their own social worker's practice in social work forums. This action raised new reflections on agency and the capacity to control one's story (and one's grievances). Given the right (safe and supported) scenario at the time in the person's life that feels right for them, people can and do stand up for what they think is right.

A fourth, not originally planned, method of data collection was the discussion group with two participants after watching *Medicating Normal* (Ractliffe and Cunningham, 2020), as described above.

How adults with care experience were invited to engage in the analysis of data is detailed in the next section, on analysis, after discussing the data collection from social workers.

Semi-structured interviews with social workers

I chose the interview as the vehicle for data collection from social workers because I aimed to develop detailed and holistic descriptions of their practices which included their personal interpretations and supported the bridging of intersubjectivities between them and adults with relevant lived experience (Weiss, 1994). I chose the specific format of a semi-structured interview to be able to keep the interview conversation focused on the subject matter of the practices and decisions around psychiatric diagnosis and mental health treatment of children in State care, whilst at the same time retaining a degree of flexibility for social workers to introduce topics that might not have been raised by my questions.

The social workers were encouraged to indicate if any question did not feel relevant to them. They were also asked at the end of the interview whether there were any topics I had not asked about that they felt were important. Appendix VIII contains the social workers' interview guide. A couple of changes were made after the first few interviews. In the initial guide social workers were asked how they challenged decisions that they had not agreed with. One interviewee provided a very long explanation as to why it was difficult to challenge, and I sensed they had felt they had been placed 'on the spot'. I realised social workers may not challenge all the decisions they disagree with (that is, the question was making a presumption), but, after declaring they had disagreed with something, they might not want to be seen as not challenging it. Therefore, I changed the wording to 'what did you do'/'how did you go about it', leaving the potential answers more open.

Interviews took longer than anticipated so I made three decisions to shorten them. First, I eliminated the third question about encouraging children's participation in decision-making and discussion forums, for similar reasons to the above question modification. I thought the question was too direct and explicit and encouraged self-justification. This area of practice could be elicited as social workers discussed their own cases. Second, I eliminated the last question on education. Third, not all scenarios included in the interview guide were discussed in each interview. I intuitively made the decisions ‘on the spot’ as to which scenarios I would present to each social worker. Sometimes the decision was made to avoid reiteration of similar situations already discussed; at other times it was made to have the opportunity to explore possible contradictions I thought there might be in the social worker’s statements.

As stated above, all conversations were conducted remotely. Although internet-based interviewing was relatively a new field with still a developing literature around it at the time, authors are generally positive about the possibilities that it creates. It has also been noted that the increased familiarity and usage of internet-based communication in everyday life means participants may now feel this to be a natural medium of conversation (McCoyd and Schwaber Kerson, 2006; Hanna, 2012; Lo Iacono et al, 2016). Researchers highlight the advantages of accessibility to geographically distant participants and of increased flexibility in choosing the time and place for the interview (Deakin & Wakefield, 2014; McAuliffe, 2003; McCoyd and Schwaber Kerson, 2006). Regarding online video interviewing, such as through Zoom, researchers have found it does not necessarily limit rapport (Deakin & Wakefield, 2014; Lo Iacono et al, 2016). Deakin and Wakefield (2014) used email exchange prior to the interview to establish an initial rapport. I did not think the initial procedural email exchange (to exchange and clarify the participant sheet and consent form) created any initial rapport in my study. I did, however, include an initial question (“What do you consider the three most important characteristics to make a good social worker?”) as an icebreaker, and as a way of gaining some initial understanding the vision (social work as imagined) and experience (social work as performed) they had of the profession (Langston, 2021). The question eventually proved very valuable. It allowed me to establish the high level of concordance between the interviewees in this topic, which contrasted with the lack of it in other areas of professional practice.

Interviews were audio recorded only. I thought video recording would have felt too intrusive, and it would have likely deterred potential participants. There were times, however, when I wished they had been video recorded since body language would have added another layer of meaning to what was being said. Interviews were initially transcribed using otter.ai and then I manually reviewed them, correcting errors. This allowed for reflection and ‘sinking in’ of the interviews, what Braun and Clarke (2022) refer to as ‘familiarisation’ and ‘immersion’ in the dataset. I found this preliminary step very valuable. All participants were offered a copy of their interview transcript. Two social workers stated they were not interested in it. One requested being informed which of her quotes would be used as part of the final thesis, which I obliged.

Participants were also given the opportunity to conduct their interview through email. Email has also been established as a valid interviewing medium in itself (Meho, 2006). In fact, although body language is lost in email communication, this technology offers other interesting qualities for data generation. Gibson (2010), McCoyd and Schwaber Kerson (2006) and McAuliffe (2003) conducted interviews as asynchronous conversations through a string of emails. McAuliffe (2003) termed her method Email-Facilitated Reflective Dialogue. Gibson (2010) and McCoyd and Schwaber Kerson (2006) compared the results with those from face-to-face interviews and both found the quality of the data was comparable. McAuliffe’s study (2003), however, is particularly pertinent to my own research since she interviewed social workers on ethical dilemmas in their practice. Herself a social worker, she considered email an optimum medium to engage social workers pressed for time due to heavy workloads. In addition to practicalities, it is important to recognise that the interpersonal dynamics of the interview are altered, since the transference-countertransference exchange (Roper, 2003) is no longer between two people facing each other. The researcher will be *in the head* rather than *in front of* the participant. However, this can be an advantage when discussing sensitive topics, such as ethical dilemmas, since the asynchronous conversation can allow for added reflexivity in the responses and the participant is not facing the researcher physically as a figure with the official power to judge their decisions (McAuliffe, 2003; McCoyd and Schwaber Kerson, 2006).

Ultimately, the research literature (Gibson, 2010; Hanna, 2012; McCoyd and Schwaber Kerson, 2006) agrees that, regardless of what may present as a priori advantages or limitations of each medium, different participants will feel more comfortable with different forms of establishing a conversation. In this research, one social worker interview was conducted via email. It is not included within the 29 participants since it was interrupted after the first email. I prompted the participant to respond to the second email, and did not insist any further after continuing without a reply. Two adults with relevant lived experience engaged in conversation via email (in one case the conversation moved to WhatsApp). In one case, the conversation developed into something similar to McAuliffe's (2003) Email-Facilitated Reflective Dialogue, to the point of continuing beyond what had originally been agreed. We continued the conversation with the agreement that I would not quote directly from the extra emails, but I could still use the conversation to inform my own analysis of social workers' interviews.

Researcher's insider perspective

Although there was a different methodological approach for each participant group, it could be argued that it is in relation to social workers that the study is more purely participatory since I am a social worker myself. From this perspective, according to the Durham Community Research Team (2011: 6) typology, my study would fall under degree 1: community-controlled and managed-research. This is a study undertaken by a member of the researched community as a member of the researched community. Spurred by my own professional experience, I decided to interrogate other social workers to gain and be able to provide a wider understanding of professional practices in relation to the psychiatric diagnosing of children in State care.

Below I detail further some aspects of my insider position.

In social science, the dichotomy of the outsider/insider position of the researcher has been defined according to the researcher's social position in relation to the researched group (Kirpitchenko & Voloder, 2014). The distinction is useful but there is rarely a clear-cut separation (Dwyer & Buckle, 2009). In relation to social workers, I am an insider to the professional group. I am also an insider in respect to the care system, albeit from a very different perspective from those who receive its services. Yet, differential access to power within the care system separated me not only from children in State care, but also from children's social workers, since in my professional capacity as supervising social worker I never had direct decision-making power over foster children. That is, my perspective on the care system is not only different from those in State care but might also be different from colleagues with different professional roles.

I adopt Dwyer and Buckle's view (ibid) that one position is not necessarily better or worse than the other. However, the dichotomy makes it necessary for researchers to state our positionality and to reflect on how it might affect the data we collect and the analysis we carry out. As Bourdieu (1999) stated, the difference is not between an objective and a subjective science, but between a science that acknowledges its subjectivity and another that does not. Having said that, Bourdieu and his team thought that the interviewer's proximity to the interviewee aided the encounter. In relation to my own research, I was wary of the possible impact on adults with relevant lived experience of the fact that I was a social worker. However, even though most shared experiences related to some appalling professional practice (including from social workers), I found these participants nothing but sympathetic towards me and what I wanted to achieve. Their generosity knew no bounds.

In relation to social workers, I took the decision not to disclose my professional background at the start of the interview to minimise ‘taken-for-granted’ knowledge and to encourage fuller explanations. During the interview, it was clear that some social workers took for granted I was ‘one of them’. Others enquired at the end. Initially, I had been preoccupied with the possibility of my making self-disclosures, considering that we would be discussing topics of which I also had experience. I had prepared myself to only include them as part of the interview conversation if I judged that mentioning them would build rapport and/or encourage a participant to share their own experiences in greater depth (Berger, 2015). In the end, disclosures were rare and brief, mainly simply acknowledging that I had had similar experiences in my professional life.

In relation to analysis, it is likely that I was more sensitised to certain aspects of the data (Berger, 2015). But I might have also been unduly influenced by my own views of the care system or how certain participants’ points of view made me feel. I adopted two strategies in this regard. My first coding was descriptive and line-by-line (detailed below). Second, to support reflexivity and increase self-awareness, I kept a log of encounters (ibid), to reflect on the emotional atmosphere of interviews, and what reactions it provoked in me.

A final aspect of being an insider within the social workers’ group is the recognition that, in analysing social workers, in analysing our profession, I am analysing myself (Bourdieu, 1999). In reaching my conclusions I had to scrutinise my own thinking and reflect on how much of me might ‘want’ a particular conclusion, to ensure that I arrived at them more as an outsider researcher and achieved that space between insider-outsider (Dwyer & Buckle, 2009). The process of data analysis is examined next.

Analytical lens(es) and procedure(s)

For the research analysis I followed an inductive thematic analysis (Braun & Clarke, 2006). This decision was both ethical and epistemological. For me, choosing a theoretical framework beforehand would be like presuming I already knew from which perspective the data could be best understood, independently from the data itself. My intentions are summarised in Hargreaves' words, "I have attempted to sustain a creative dialogue between different theories and the data, in a quest not to validate any presumed perspective, but simply to understand the problems in their social context, as experienced by" (1994: 122) in this case adults with lived experience of the care and mental health systems and social workers.

Kvale (2011) distinguishes two broad approaches to interview analysis, depending on whether the focus is on meaning or language. Due to my interest in the participants' perspectives, my focus was on meaning. However, language is the carrier of meaning so it cannot be completely ignored. For instance, the reluctance to criticise colleagues was commonplace in most of the social workers' interviews. When a participant found herself doing this, she moved from talking about "people" to speak in the first-person singular, "I", as if the criticism seemed more legitimate if it was directed to her own practice.

The analysis adopted some of the premises of constructivist grounded theory (CGT), beyond its inductivism. Procedurally, I did not separate collection and analysis into two consecutive stages, adopting an iterative and comparative approach instead (Charmaz, 2006). Analysis of each participant's data started as soon as their interview transcript had been reviewed. Epistemologically, I understand data as located within a context (Charmaz, 2006; see also Holstein & Gubrium, 2007; Larkin et al, 2006) and I acknowledge the influence of the researcher in co-constructing the data with the researched (Charmaz, 2006; see also Larkin et al, 2006; Rapley, 2007; and, re thematic analysis, Braun & Clarke, 2006).

I performed the analysis without the use of computer-assisted qualitative analysis software. Although CAQDAS is becoming widely used, its advantages and limitations are still the object of debate (Kelle, 2011; Séror, 2005; St John & Johnson, 2000). After a long methodological consideration, I decided that to gain a better understanding of how CAQDAS as a tool could aid me as a researcher, I first needed to do the job myself.

Regarding the analytical procedure, I took a two-stage approach (Watts, 2014) in the analysis of the data generated by both sets of participants. Braun and Clarke's book (2022) was published after I had started my own analysis, which did, however, adhere to their account of reflexive thematic analysis.

I took initially a descriptive approach, focusing on *what* was happening for the participant. Borrowing from grounded theory, I followed a line-by-line analysis to stay as close to the data as possible to avoid or, at least, constrain my own proclivities as much as possible (Charmaz, 2006; Watts, 2014). During this stage I aimed to understand each participants' point of view on their experience. At this stage I stayed on the surface of what had been said. This is the stage that Braun and Clarke refer to as semantic coding, reflecting "explicitly-expressed meaning" (2022: 57).

I then conducted a second stage of analysis, looking for implicit, under the surface, meaning (Braun and Clarke (2022) describe this as latent coding), searching for *how* the participants were constructing their experience (Watts, 2014). I described this stage as considering 'what the participants were telling me (latent) with what they were saying (semantic)'. Here I looked for conceptual relationships and connections with the structural contexts of participants' experiences (Ledwith, 2007). This is a difficult analytical stage, since there is a potential danger for over-interpretation or 'wild' analysis. However, the danger does not mean that it should not or could not be undertaken. In movies, stories are constructed with what is off camera as much as with what is shown; what can be seen cannot be fully understood without its relationship to what cannot be seen. But how to analyse what it is not said? I drew here from a psychosocial approach (Hollway and Jefferson, 2013). This approach requires a high level of ongoing reflexivity on the part of the researcher, and to pay attention to their emotional responses. It guides the researcher during this second phase of analysis to look beyond what is being said to how and why it is said in a particular way (ibid).

Ethical considerations

This research was granted ethical approval by the University of Essex (ETH1920-1008). Issues raised around consent and payment of participants, beyond ethical approval, have been discussed above. Here I consider the potential emotional impact of participation in the study for both participant groups, which I had to outline as part of my request for ethical approval, as well as dilemmas around the use of participatory approaches.

Regarding social workers, I anticipated that feelings of embarrassment or shame could arise during the interview if memories of practices and/or decisions they were not completely satisfied with were triggered. I was prepared, for the sake of their emotional wellbeing and for the honesty of their answers, to try not to make them feel judged, but understood as fallible humans. In the end, this aspect of social workers' responses developed to inform one of my findings from the research, and it is examined in chapter 5.

Regarding adults with relevant lived experience, the study matter could feel intrusive and painful. Beyond the procedural inclusion in their participation sheet of organisations that could support them, I took care in written and oral conversations to always remind participants that they were not obliged to answer any of my questions, reiterating that I was ready to be told if anything I said felt inappropriate. The wellbeing of this participant group was my greatest concern in doing the research. The potential impact of research participation cannot be understated, even when this appears to be a voluntary choice. My conversations with Donna and Laura could be paradigmatic in this sense. Both had university degrees and were in employment at the time of meeting, both also shared very painful experiences. But whilst Donna presented as confident in her narrative, from a place of having come to terms in her own way with her experiences, Laura was hesitant and struggled to recall, repeatedly apologising. I tried to reassure Laura and to remind her she was under no obligation to continue the conversation, but she insisted she wanted to. At the end of our first conversation, Laura proposed we met again, but this second one never took place. Laura provided reasons for her first two cancellations, but I decided not to continue insisting. Despite what appeared to be eagerness in participating, I cannot be sure that this was the best decision for Laura's emotional wellbeing.

Finally, because of the incorporation of participatory approaches, I was initially concerned about the potential blurring of professional relationships (MacFarlane & Roche, 2019) and issues of authorship. I do not think the first concern materialised, not necessarily because of any particularly skilful relationship management on my part, but rather because I felt participants were clear about the terms of our relationship. However, questions on authorship did arise, albeit, not in the sense I anticipated. The concerns I had originally envisaged related to not being able to fully acknowledge the contributions of adults with relevant lived experience due to the requirements of anonymity. However, a rather different concern developed instead. In 'analysing' people's lives, I found myself authoring a life that was not mine. As Stacey (1991) acknowledged, the greater the intimacy, the greater the danger in exploitation, but also, potentially, the greater the disempowerment. Who am I to author another's life? Can they not author it themselves? This question appeared early on in my mind, but came to the fore, when one of the adults with care experience who had taken part in the research, after their collaboration, published an autoethnographic article in an academic journal, sharing aspects of their life they had not shared with me, making me reconsider the extent to which I might not have managed to create a trusting and safe space for conversation. Yet, at the same time, some people may welcome another to tell their stories. I do not think there are definitive answers to any of these questions or reflections. They merely highlight the ethical necessity of engaging in active reflection not only with each research project but also in relation to each participant.

If research in social sciences in general, and in social work in particular, continues to move towards more participatory approaches, it is imperative that we do not lose early discussions (such as Stacey, 1991; Oakley, 1981) on power dynamics and exploitative relationships. Incorporating a participatory approach into the research is no guarantee that my values of democratisation and empowerment were automatically achieved (Nygreen, 2009-2010). A method is a tool to facilitate the researcher's work, not to do it for them (Watts, 2014).

In the end, although the participatory approaches adopted with adults with relevant lived experience aimed to avoid what Alcoff referred to as a "conversation of 'us' with 'us' about 'them'" (1991-1992: 7), I realised that I was far more cautious about discussing material provided by the adults with relevant lived experience[36] than by the social workers. I still consider it epistemologically important and socially just that service receivers and social workers perspectives are bridged within the same research, but I think that the bridge should also be mirrored in the research team. At the same time, it is important that decisions on research design are contextual, and different positions within participant groups acknowledged. I am mindful, for instance, that two social workers were not interested in receiving any further information from the research after their interview, so my 'qualms' about representation appear

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[36] During the research I discussed the information shared by the adults with relevant lived experience, contrasting it with the data from the social workers' interviews at the European Scientific Association on Residential and Family Care for Children and Adolescents Conference 2021. Beforehand, I shared the presentation with the adults with relevant lived experience.

somewhat irrelevant in relation to their position, unlikely as they are to read what I have written (Brettell, 1993).

Finally, the sharing of very intimate and/or painful memories on the part of adults with lived experience as well as the concomitant emotional toll – in addition to the time generously given – represents an additional layer of ethical responsibility for me, as the researcher. Ultimately, I could not (and cannot) help feeling that, if the study is not useful to my participant groups, the ethics of it could be called into question. After all, how could I justify my research requests on them if it does not report some benefit for future children in the care and mental health systems? This ultimate layer of responsibility weighed more on me than any of my words can convey.

Limitations

There are two important design limitations to which I would like to draw attention: in relation to sampling and to the self-reported nature of the data collected.

Sampling is a key part of the research process (Robinson, 2014). The relevance of data relies on the appropriateness of the sampling. In this research there are implications around sampling universe and size whose impact on the findings need to be acknowledged.

In relation to the sampling universe of adults with lived experience of both the care and mental health systems, the inclusion of the latter criterion excludes those with emotional struggles but who never received mental health services. In this regard, the sampling is likely to bias against teenage girls, those whose sexually risky behaviours are usually not considered symptoms of any psychiatric diagnosis and whose behaviours instead often continue to be framed as matters of ‘choice’, or those whose self-harming has only been included in the DSM-5 as ‘condition for further study' under Nonsuicidal Self-injury (APA, 2013: 803)[37]. The impact of not having one's emotional struggles recognised and validated also requires study, and the comparison with those who did receive a diagnosis and/or mental health services would offer very valuable insights, unfortunately it is beyond the scope of this project.

It is also worth reflecting upon the fact that the research questions were constructed in such a way that presented a psychiatric diagnosis as a core life theme for children in State care (McAdams, 1993). Yet it is reasonable to suppose that this centrality in a child's life would not be the case for all children in State care who received mental health services. And indeed, this was the case with the seven adults with relevant lived experience who collaborated in the research.

Regarding the sampling universe of social workers, at the beginning of the project, I suspected that the type of professional who would respond to my advertising would be the ones with strong views and interest in the research topic, and that it would be unlikely that I would recruit social workers with a dismissive or indifferent view towards it. This was eventually the case. Jones (2023) and Innes-Turnill (2023) exemplify clearly the impact on findings of the recruitment method. Both researchers broadly studied the relationship between poverty and parenting as perceived by social workers. Jones' participants directly responded to her advertisement (similar to my own recruitment method) and her findings concluded that those social workers held structural explanations of poverty. Innes-Turnill recruited parents first and then contacted the social workers for the parents' cases. In her study she found professionals focused on micro interpretations of poverty, as parenting shortcomings, as opposed to structural perspectives.

Regarding the data collected by the study, the implications of its self-reported nature, in relation

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[37] And now under 'Other conditions that may be a focus of clinical attention' in DSM-5-TR (APA, 2022).

to both participant groups, must be acknowledged. Care experienced adults drew on their memories when considering how they felt about their psychiatric diagnosis and/or treatment as children. Memories of childhood trauma have been shown to be problematic (Hardt & Rutter, 2004; Horwitz, 2018). The fragmented lives of children in State care compound their difficulty in remembering events accurately or with chronological consistency. Another property of memory systems should also be considered. The Dynamic Maturational Model (Crittenden, 2016), drawing mainly on Schacter's (1996; and Schacter & Tulving, 1994) work, describes the developmental conditions that impact on how people will remember events, depending on the emphasis they place on affective, cognitive or somatic information. Childhood experiences of abuse and/or neglect are likely to develop biased memory systems, relying more heavily on one system, affective, cognitive or somatic, at the expense of the others, creating further layers of distortion. For instance, the more a child learns to become compliant in order to try to be safe from an angry parent, the more they will learn to rely on the cognitive information that is keeping them safe at the expense of their emotional literacy.

Data provided by social workers is also limited by its self-reported nature. In disclosing their own or other colleagues' practices, social workers' accounts may be subject to unconscious biases or to self-censorship. Since social workers' actual practice was not observed, I cannot establish the level of accuracy of their reports. Other studies (Gibson, 2019; Langston, 2021; Gregory, 2023; Morrow, 2024) have overcome this limitation by adopting an ethnographic approach, which is a research method that I would like to incorporate in future projects, agreeing with recent support for the use of the method (Sinai-Glazer, 2024) within social work, while acknowledging, however, that this method would also limit research to the practice culture of one particular setting.

Acknowledging the impossibility of establishing accuracy in the accounts of both sets of participants – present in all social science research that relies on self-report – and without diminishing the impact that this may have on the findings – albeit an unknown impact, since we will never be able to establish the degree of distortion – it is also important to reiterate the fact that I have analysed participants' narratives about their personal and professional lives, not an accounting of the lives themselves (Plummer, 2001). This research considers less what happened, but what was experienced and its potential impact.

To acknowledge the impact of my limitations as researcher is also important, since I am the instrument, not only in the interviews (Pezalla et al, 2012) but also in eliciting participation and in analysing the data. The value of information collected partly relied on my ability to engage participants and to follow their statements with meaningful questions (see Bourdieu's comments on "distracted questions" (1999: 529) – I conducted one of the interviews when I was particularly tired, in the evening, and having been on Zoom for the most part of the previous two days. To my horror, during transcription I noticed I had asked questions about information that had already been mentioned). That the respondents' participation did not become a tokenistic invitation also depended on my skills as enabler and negotiator. My epistemological and methodological choices created a tension between conceptual analysis and participants' voices (Mills et al, 2006); the balance achieved has implications for the value of the research and depended on my choices as researcher and my ability to appreciate empirical-theoretical relationships.

Finally, in relation to participatory action research, it needs to be acknowledged that this research takes the form of a PhD dissertation. As such, the primacy of its academic purpose may constrain the participatory aspirations of creating change for social justice (Fals-Borda & Anisur Rahman, 1991; Fine, 2008; Kindon et al, 2007; Maguire, 1987). Nonetheless, my aspiration remains that this study should inspire social workers to incorporate action research to evaluate and transform their practice and that the study's findings can inform tools to support their professional development. Ultimately, despite its limitations, my hope is that my work "move[s] readers to act" (Fine, 2008: 129), or at the very least, makes readers uneasy with their lack of acting.

In the next three chapters I focus on one particular group of the adults responsible for children in State care: the social workers. I look at the attributions they made towards children's actions, as well as the circumstances and consequences of such attributions, with particular attention to the circumstances and consequences of making a mental health attribution in relation to ' child's actions. How social workers understand children's behaviour and, by implication, the children themselves will be the focus of the next chapter. In the following one I examine what takes place in practice in relation to supporting children's emotional wellbeing. Finally, in the third of these substantive chapters, I consider the ethical and human rights practice implications of the cases shared by the social workers.

3. 'MAKING SENSE'

I think a lot of the things that we look at, we see the behaviours without necessarily understanding the thoughts that go on behind because obviously, that's shielded in someone's head, and you only know what they tell you and you only know what you can see. Thomas

I often felt like [professionals] projected their version of me onto me…if that makes sense. Judith (care-experienced adult)

In chapter 1, I examined the social work profession's knowledge base, as well as the different frameworks to understand behaviour that have been considered by the profession. In this chapter I examine how social work practitioners make sense of children's behaviour. Five different possible explanations for a child's behaviour appeared in the social workers' interviews: as a form of communication; as a product of their relational context; as due to their past experiences (trauma); as a result of their socioeconomic environment; and/or as due to a psychiatric condition. All of them have in common what Thea named as a "massive positive shift" from blaming the child to "understanding it's not just the child's fault". This chapter considers each possible explanation in turn as presented by the social workers. These interpretations of behaviour were not necessarily exclusive, and social workers did reflect on the difficulties of discerning the correct explanation/s for the behaviour of a particular child. These difficulties will be addressed in the chapter's sixth and final section.

Throughout this discussion I use the term 'behaviour' to refer to any action or communication that potentially can be observed by another person and can be used by this observer to make inferences regarding the internal state (thoughts and emotions) of the person observed. For instance, we see a person in a room putting on a jacket and we deduce the person is feeling cold. But we do not see directly the person's coldness (or any emotion), we can only see the actions. Thomas made this point when he reflected "how do we find out what's going on inside someone's mind, if not through their behaviour". Likewise, Caroline (20) mentioned that "in some respects, everything is behavioural, isn't it? Because you're not actually inside someone's head".

Social workers in the study seemed to recognise this dichotomy between what can be perceived externally by an observer and what is happening inside the person, and stressed the importance of trying to access the latter. As Thea said, "it's trying to understand what's going on behind that behaviour", or Allison, "it's so important to make sense of those behaviours". Yohanna, who supervised foster carers, tried to pass this idea onto them: "[I] try to get carers to look at (...) what might be going on for the child rather than focusing on the behaviour." Social workers, then, operated under the same principle as psychiatry, from the observation and/or report of external signs (symptoms) into what might be going on for the person. However, social workers did not necessarily find the reasons for a child's behaviour in the child themselves, but rather in the child's experiences or environment. They also recognised that behaviour may not only express but can also serve to hide what is going on inside a person.

Behaviour understood as communication

Quite straightforwardly, social workers saw behaviour as a possible form of communication for a child. As Samantha succinctly put it, "every behaviour is a communication". Meg, a social work manager as well as a care experienced adult, expanded on what this communication may be about: "their behaviour is a communication, about their experiences, about how they're feeling".

This idea that children express their feelings[38] through their behaviour appeared several times in the interviews. Yohanna explained how she tried "all the time to look at the emotions behind the behaviour". For Diana "that's all behaviour is, really, isn't it. It's an expression of emotion, and how we're feeling at that particular time". However, Diana also stated that social work often does not "focus on looking at the behaviour as an expression of emotion", suggesting that understanding behaviour as a communication of emotion may not be a widely adopted position amongst social workers or within social work as a profession. Yet it is a form of understanding that at least some participant social workers did use to interpret children's behaviours. For Gemma, for example, "[s]ome of the boundary pushing is an example of a child saying, 'I'm not happy, I don't want this, I'm not happy, I want you to talk to me about it'". Gemma's statement is significant as a reflection of the "shift" described by Thea earlier. Gemma did not interpret “boundary pushing” as the child being 'defiant' or 'challenging', but as the child attempting to communicate unhappiness. However, Gemma used the qualifier "some", introducing the idea that different causes might be behind similar behaviour.

Social workers pointed at difficulties with language and/or emotional literacy as possible reasons for children using behaviour as communication. Nathan stated that the way children communicate is "through behaviour where they struggle to verbalise it". Meg mentioned that children "don't necessarily have the language to communicate". Some of the statements made in this regard refer to children in general, suggesting that social workers view behaviour as another way of communication and expression for any child in addition to language (Cross, 2011). However, other statements point to the distinctive experiences that children in State care have been through and that lead them to rely on behaviour as communication more than other children with more favourable upbringings. Vivian reflected on the consequences of having

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[38] 'Feeling' and 'emotion' are used interchangeably in this study.

caregivers who lack emotional intelligence and, therefore, cannot teach it to the children,

> What we take as a given with our children, that 'Oh, you look a bit sad, are you okay?' or, 'Oh, has that made you angry?' All those conversations you have with them when they're younger, sort of builds up, doesn't it, and they can name it and tell you when they're pissed off and or act it out. (...) And I don't think a lot of these kids have been taught those skills and can sort of articulate themselves. So it comes out in self-harm.

For Vivian, when a child cannot tell us how they are feeling, in this case because they have not been taught emotional literacy, those emotions might be expressed through harming behaviour. Social workers maintained this framework of understanding behaviour as an expression of emotion even when facing seriously harming behaviours. Consider, for instance, the example mentioned by Meg below,

> I remember one boy trying to chop his arm off, thumbs actually, with scissors. (…) He was in a PRU[39] special school. And he was, really it wasn't working for him that environment. (...) [H]e wasn't being managed very well. So I understood it at that level, that what he was communicating, but I was just puzzled by the methods in trying to, literally with a pair of scissors, cut his thumb off.

Despite the extremity of the child's behaviour, Meg did not consider the possibility of there being 'something wrong with the child'. For her this was an example of a child trying to express his distress about the environment through his behaviour. Finally, Ivy suggested that children in care may find it difficult to express themselves,

> I think a lot of young people find it hard, children in care find it hard to ask for help but do it in their own ways. It will come out in ways that [are] obviously quite maladaptive compared to what we would expect you to say, ‘I feel really sad and this is going on for me’. I think that happens less and it's more outbursts of anger

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[39] Pupil Referral Unit. This is an alternative education provision, mainly to cater for students who have been permanently excluded from mainstream school.

> or displays, or internalised emotions that aren't really communicated.

As Vivian concluded, when verbal communication fails, for one reason or another, “all they’ve got left is their behaviour”. The last part of Ivy's statement, however, points in the opposite direction to the discussion so far. Not all emotions are necessarily outwardly communicated, either through language or through behaviour. Communication can be used to express but also to hide information. Hence, behaviour might not necessarily reflect the person’s internal emotion/s. Behaviour can either express or hide emotions.

Behaviour understood through the child’s relational context

> [A]ny family unit, you all impact on each other. (...) [I]t's a dynamic between a family. Thea

Closely related to interpreting behaviour as communication is the understanding of behaviour as a product of the child's interpersonal relationships. Both frameworks of understanding require at least a dyadic relationship. Here I look at how social workers reflected on the relational nature of behaviour, which can be understood as synchronous and/or asynchronous. That is, the child's behaviour can be understood as a reaction at a particular moment in time to a particular adult, and/or it can be understood as the accumulated effect of reacting to particular relationship/s, past or present, a relational, adaptive pattern.

The interplay between these two temporal aspects of behaviour is illustrated by the following explanation of a child's behaviour,

> But it all started to come out that she would get physical towards her previous carers, because they were clearly triggering her to an incident that happened with her brother, when she was at home, by grabbing her by the arms. That was a trigger. So that's why you're getting the reactions you're getting.

Here Diana, a child's social worker, is describing how she understood a child's behaviour as a reaction to her carers' behaviour. However, that particular child's behaviour is only fully comprehended by the acknowledgement of a previous relationship (this child had experienced intrafamilial sexual abuse). The child's relational past was being enacted in her relational present.

Understanding children's behaviour as a reaction to the adults' helps to explain why the same child may present differently with different people. The child that Diana referred to above eventually moved to a different placement. None of the behaviours that she originally presented appeared with the following carers. Lydia offered another example of how the carers' approach can impact on the child's behaviour. Lydia recalled how a child changed, again after moving to different carers. Lydia supervised both set of carers and, therefore, saw the child in both placements. This is how she described the change,

> And I really see her [the child] come on, from literally just sitting down like this, like not even, like not even talking or looking at every (unclear) to doing this buzzing, dancing, cooking. (...) She got with good carers that really brought her out of her shell.

These differences in behaviours do not only apply to a home environment. They can also extend to professional relationships. Rachel described how a young person's reactions depended on the particular professional talking to him,

> [T]here were reports on the system about how he would present as distressed over the mention of certain people. When I used to mention that person to him, when we're driving out in the car, he didn't, and he eventually ended up saying to me, 'None of the other social workers used to take me for drives. They never used to take me for social [unclear], they never used to do any of that'. So he didn't want to talk to them. Or not just social workers, all the professionals, he didn't want to talk to them about anything, because it appeared obvious to him that they would just sort of go around sort of ticking a box.

Rachel had invested time in forming a relationship with this young person, leading to him trusting her, unlike other professionals, whose attempts at establishing a relationship he did not perceive as genuine. So the “outburst of anger” that Ivy interpreted in the previous section as difficulties in communicating emotions, might actually not be due to a lack of emotional literacy, but a lack of trust in the other person.

When behaviour is understood relationally, the unit of understanding is no longer the single individual, the child in this case, but the dyad or the relational context. And this relational context in which the child's behaviour is understood, incorporates not only the present context, but also previous ones,

> [W]e learn our family, social, emotional, relational language, way of being, and we take that to the world and the problem comes when the social and emotional language of a family is very different to that of other families, or school in particular.

This quote from Olivia, who trained social care professionals, could be seen as the general explanation of the example presented earlier by Diana. As the child moves between different relational contexts, their behaviour could be understood as a combination of what was learnt in the past and their reactions to their present relationships. This is particularly significant for children in State care, who move through a significant number of contexts, contexts that do not always communicate well with each other.

When the unit of understanding is a dyad the attribution of causality can be affected in two ways. First, when the relational context has been stable for a long enough period untangling cause and effect becomes very difficult, especially when the professional observing that relationship appears when the cycle has already been established. As Caroline reflected regarding a mother-daughter relationship,

> It was very difficult to understand whether [the mother] was anxious as a result of

> these several years of difficulties with her daughter, or whether that was what part of anxiety from the daughter. Really difficult to unpick, and we never will, because as a profession we didn't know about this young woman until she was 16.

Second, causality does not need to be evenly distributed. Social workers may place causation more heavily on the adult side of the dyad. Aarunya, for example, explained how "that care that I've observed is actually creating this in this child". Here Aarunya was referring to parental care, but it can also refer to foster carers, as in Gemma's statement: "But for me, as a social worker, I might go in and think, that's more about your capacity to manage the behaviours than really about the child".

When a child’s behaviour is understood as relational, other possible explanations which put the onus on the child might be discounted, as Ivy does: “I've worked with so many parents that say, ‘My child has ADHD’. And I'm thinking, ‘No, your parenting is terrible. The child hasn't got ADHD’”.

However, when the relational context of the behaviour is overlooked, it opens up the possibility of placing the onus of the explanation on the child. When I asked Lydia whether she had ever worked with a child whom she felt needed a psychiatric diagnosis, she explained how she had met a teenager a couple of weeks after being placed with carers she supervised. The teenager “said to the foster carer and I,

> 'If I want to leave a placement, you’d better let me go straight away, because if you don't, I'll set fire to your house'. So we were like, 'What do you mean?' (…) She said, 'Every time I leave a placement, if they don't let me go, or they don't find me somewhere straight away, I cause a fire and they get me out like that'. […] I said to her, like, 'Why do you do that?' She said, 'Because no one listens to me. When I want to go, I want to go. And they don't listen to me'.

Lydia concluded “there's something really, really wrong here, meant, you've got mental health issues that have not been diagnosed, 100% have that”. She thought of a possible Personality

Disorder. That explanation, however, obviates the relational context mentioned by the teenager: not feeling listened to, and resorting to the only effective way she had found to ensure that happened[40]. What the teenager in Lydia's story was telling her was that she communicated through behaviour not because the lacked the emotional literacy to express herself verbally, but because she felt her utterances were not listened to. Not taking into account this relational context paves the way to look exclusively within the young person for an explanation sufficient enough for such extreme behaviour – in this case, Personality Disorder.

Behaviour understood through the child's past experiences: Trauma

> Is her history of very significant trauma not story enough to explain her behaviour?
> Olivia

A child's life experiences featured prominently in the interviews as a key explanation to make sense of the children's behaviours. The significance of past experiences extended not only to the understanding of the child's behaviour, but to the understanding of their very identity. Rachel talked about past experiences as "shaping" "how they deal with things and who they are as adults". Using the child's life experiences as a causal explanation, social workers developed a narrative understanding of the child's behaviours. All 29 social workers saw a relationship between a child's past and their present behaviour. Their overall position is summarised by Luisa, "[n]ormally how they present, it's explained by whatever they went through, recently or not. And it's all connected to the past, really. It's always connected to the past."

In these narratives the key experience was trauma. Trauma was frequently used by social

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[40] Compare, for example, with the title book *Sometimes You've Got to Shout to Be Heard*, that gathers experiences of children in State care (Voice for the Child in Care, 1998).

workers to make sense of children's presentations. The word "trauma" appeared 319 times throughout the 29 interviews. For Nathan, knowledge about trauma was one of his three most important characteristics needed to be a good social worker. Diana stated that "if we don't understand trauma, then how do we understand our children in care. (...) You see the behaviours and you see the traumas".

In terms of experiences, there were two ways in which social workers used trauma to make sense of a child's behaviour: trauma as a trigger and behaviour as adaptation to trauma. A trigger works by associating something in the present with a past event, as Beth explained: "So if someone gets triggered by something, it's because that's related to something that's happened in their past, a bad experience". The notion of a “trigger” was an important concept for social workers to understand a child's behaviour, to the point that a behaviour was considered difficult to explain when no triggers were identified, as in the following account by Lydia,

> I found her behaviour really challenging. (…) She'd be friendly sitting there and then all of a sudden she just jump up and bite someone in the head. (…) I found it quite challenging the way she done that with no build up. No, there probably was build up and triggers but she would just be, in her head there was build up and triggers, but towards everybody else there wouldn't be.

Lydia corrected herself and allowed for the possibility that there were triggers for this girl's behaviour, although they had not been identified by the adults working with her, rendering the behaviour unintelligible and difficult to work with.

The second way in which life experiences were used to understand children's behaviour was by looking at behaviour as an adaption to those circumstances. Meg explained this process for children in State care, “their past experiences inform their current experiences in terms of the way that they have adapted, the way they've learned to relate”.

Zuri extended this understanding to all of us, "whatever you have experienced makes you who you are now, and how you then engage with the world around you, how you're going to deal with things". Beth offered an example of a specific behaviour, lying – with which “a lot of carers struggle”, that she considered a survival mechanism,

> To me children lie, or tell untruths, or however you want to frame it, because it's a survival strategy because of the trauma and the abuse and the neglect that they've been through. So they lie to keep themselves alive a lot of the time. And to me, that's a learned behaviour that they've developed in highly challenging surroundings, and it takes many, many years for them to unlearn that.

Beth's example opposes the circumstances of the child being in State care with their prior circumstances under which their behaviours were developed. A particularity of the situation of children in the care system is that the circumstances under which those adaptive behaviours were developed potentially (hopefully) change dramatically by the act of being placed in State care. Earlier on, when considering behaviour as a form of communication, we saw Ivy explaining how these children may have "maladaptive" ways of asking for help. Beth took this further by observing that a behaviour is adaptive to the circumstances under which it was developed, and it is through a change of circumstances that the behaviour becomes maladaptive. Paradoxically, if we understand behaviour as adaptation to trauma, we need to consider the possibility of a child initially struggling more under the new non-abusive circumstances, as Cristina explained below,

> [T]hey have been coping fine over those years because they just need to survive, that was a survival mode. But then, when everything got calmed, and everything gets settled, then you have a lot of time to think, so then is when everything explodes in your head, and then you started to have flashbacks, you started to remember things and everything's coming from what you have had before. So your coping mechanism doesn't work anymore.

Olivia summarised this position of behaviour as survival strategy,

> I don't think there's any such thing as bad or good behaviour. I think there's behaviour that serves you in lots of different ways. And one of the things that happens with the children who we might call their behaviour challenging, or we struggle with, is that behaviour may have served them, it may be out of date. It may be anachronistic, in that growing up in a particular sort of family they developed in a particular sort of way. (...) It may not be comfortable for us as adults, workers or carers or parents, but it's not- we may experience it as challenging, but it's fit to the circumstances or fit to the child's either internal or external needs.

For some social workers, behaviour might develop to fulfil a purpose, the child's physical and/or emotional survival, and the conflict comes when the circumstances to survive change.

There are two further points to consider in relation to child's behaviour and experiences. First, although, in this relationship between behaviour and experiences, it is the earlier or past experiences that were overwhelmingly discussed by social workers, some also named being in the care system as bringing its own difficult experiences. Zuri acknowledged that children's behaviour may come from a traumatic experience or from "years of being in care". Nathan reflected that "for children in care, we've removed them from what they know, where they belonged, into an environment that sometimes they struggle to adapt to".

Second, as when considering the child's relational context, using the narrative of trauma moved the social workers away from interpretations that placed the onus on the child. Consider, for example, Luisa's reply to the question of whether she had ever worked with a child who needed a diagnosis,

> More often than not, the diagnosis is trauma. They just experienced trauma and then it comes out in various ways. So not so much like a diagnosis, but a formulation[41], I would say. I like more the formulation, because then you can explain this is a person that presents like this, possibly linked to this and that. And that makes more

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[41] Formulation appears in the literature as an alternative to psychiatric diagnosis (Johnstone, 2018).

> sense to me than just a label.

Luisa, who worked for the Child and Adolescent Mental Health Service, favoured a narrative approach to understanding a child, based on their past experiences. We can compare the differences in social workers' accounts depending on the extent to which they used trauma to interpret a child's behaviour. Consider these two extracts from Allison and Lydia, who both worked with foster carers,

> In my early days, there was quite a few occasions where I just went, what are these kids doing? Like urinating in bottles in their bedrooms, that kind of thing, when you're just going, what is this about? I think I didn't quite get that was all because of the trauma. I think at the time, you would see that more as a kind of rebellious act, (...) but actually [it] goes much deeper than that. And I think that took a couple of years to get that understanding. (Allison)

> You'd say to him, 'Don't do that', and he'd spit out the window. And the foster carer showed me. She said, 'Look', and there was (sic) all spits. And as I stand in there, he spit out the window as if to say, ‘I don't care what you two say, I'm still gonna do it’. (Lydia)

Lydia described the child’s behaviour as a "rebellious act". Allison explained she moved away from this understanding once she started to take trauma into account. There is a negative relationship between the use of the narrative of psychiatric diagnosis and that of trauma. The more a social worker relied on the narrative of trauma, the less they relied on, and the more they criticised, the narrative of psychiatric diagnosis, a position encapsulated by the “enough” in Olivia's opening question to this section.

Behaviour understood through the child's environment

> I don't think I've ever had anyone having a behaviour that doesn't make sense in the context of their environment, or their life story, really. Luisa

Interpreting the child's behaviour through their environment does not appear here because of the frequency of mentions, but rather to note the opposite. Taking into account that the interviewees were *social* workers, the consideration of the child's wider social or structural circumstances was conspicuously absent. Nonetheless, social factors had a handful of scattered mentions throughout the interviews.

Yohanna, for example, reflected how it is not children's behaviours per se, but the cultural expectations on them that influences how adults cope with them. For her, "it's what we criticise as a culture in children" that carers struggle with, such as lying or "taking things". Olivia referred to culture to point out how its understanding can be necessary to make sense of the other person's behaviour. Having worked for "a long time" in "a place of moderate social and economic issues", Olivia conducted research in an area of "significant social difficulties", where she found,

> …the kids were all sort of slightly obsessed with their mobile phones. But there was one in particular that I could barely get into putting it down. And I was irritated by it. I thought it was a bit rude.

She explained how somebody else mentioned to her some work on gang culture, and she came across the idea of "personal collateral",

> …where your personal standing was on the street in order to protect yourself from danger, from basically getting stabbed. And that part of your street collateral was to know exactly what was going on at any moment. And the way you knew what was going on at any moment was to be on your phone every minute of the day. It wasn't a mental health problem, it was very sensible, but because I came from a

> different cultural environment, I hadn't understood it.

Terry, who worked as therapeutic social worker, and Vivian, working for the NHS, distinguished between medical and social perspectives. Vivian considered how she talked of “people of multiple disadvantages”, whilst her nurse colleagues referred to “choosing to live a chaotic lifestyle”. Vivian extended her perspective to that of social workers in general. However, as stated at the beginning of this section, this might not be the case, considering the limited mentions of wider social conditions within the interviews. Wren, alongside Caroline, who referred to contextual safeguarding, and Olivia, whose example was discussed earlier, broke the monopoly of understanding children through their family environment (relational context), by considering the wider systems in which children develop their lives. For Wren, “understanding the impact of their experiences on their presentation is [not] always about just understanding their trauma. It's about understanding their general context as well”. In the case of teenagers, for example, she felt “a lot of people make the mistake of thinking that all of their behaviour must be related to something at home, and they spend the majority of their life at school”. Wren and Olivia were the only social workers to mention examples of how they arrived at understanding a child's behaviours through recognising wider social factors.

Wren discussed the case of a young child who “had a lot of negative emotions around home” but professionals “didn't really understand where [child’s negativity towards home] was coming from, and the parents were feeling really judged”. She reflected how the parents’ lack of cooperation was starting to turn professionals against them when she was allocated to the case. The family lived in a high-rise building. Wren addressed the situation by reading studies on the impact of living in this kind of buildings on children and families, "and found that actually, children often develop fears that things are going to fly into the building". The boy lived "right by a hospital, so there were helicopters going past all the time". In addition, the building's lift had been broken and the boy "had heard about, from someone, that lifts when they break, they could fall right down to the bottom". The child’s fears were starting to make sense. Wren also accompanied the family in and out of the building “because I wanted to see what it was like going up all of the stairs with them. And it was tiring.” But when playing in the flat the parents had to deal with a neighbour that "kept effing and blinding through the walls at them whenever they were playing loudly". Again, it started to make sense why the child was so negative about home. Wren concluded by emphasising "the impact of situational poverty on [the child] rather than their parents".

Behaviour understood as the result of a psychiatric condition

> [W]e know that in, especially with the children in care population, many of them have diagnosable mental health conditions. (...) All range, everything. Caroline

All social workers accepted, explicitly or implicitly, a psychiatric condition as a possible explanation behind a child's behaviour; however, the extent of this acceptance varied across the interviewees. The social workers' position towards psychiatric diagnoses could be classified as either ambivalent or critical. For instance, 20 out of the 29 social workers used the term "label" to refer to a psychiatric diagnosis at some point within their interviews. Jack was the only social worker to name psychiatric diagnosis as one of the possible frameworks that informed his understanding of children's behaviour. Consistent with this statement, the example that he provided of a behaviour that puzzled him was resolved once the child received a psychiatric diagnosis, Reactive Attachment Disorder, which helped Jack to "understand how he [the child] sees the world around him a bit more".

Other social workers questioned the extent to which a psychiatric diagnosis can help adults to understand a child. Henry referred to it as a "shorthand for professionals". Pippa stated that a diagnosis "can really help" to work with a child; however, this help might not be that straightforward, since the same diagnosis might be applied to very different presentations,

> I think it can really help the professionals around them in knowing how to work with that child. But obviously, it's not a one size fits all. So you could have two children with bipolar and then be presenting in completely different ways.

Two points can be highlighted in relation to social workers' position towards psychiatric diagnoses, both points relating to the social workers’ knowledge base. First, there was a general positive relationship between the level of criticism of psychiatric diagnoses and the additional knowledge possessed by the social worker. In general, the more knowledge of mental health, neuroscience and/or trauma studies, as demonstrated through the interview discussion, the more critical the social worker's position was towards diagnosing, and vice versa.

Most of the social workers in the less critical or more ambivalent positions showed a more superficial knowledge of psychiatric diagnoses. Zuri summed up this position when she explained that, in relation to the possibility of ever challenging a treatment, "that's not my professional background, so I'm sort of always led". Following with this theme of being led, Terry reflected on how her position had changed over time,

> [B]efore I worked in the therapeutic social work team, (...) I would be very much led by the parents, the school, by the other professionals that were closely involved with a child. And if they were saying to me, 'We think this child got autism or ADHD or whatever', then I would make a referral directly into CAMHS.

Since becoming a therapeutic social worker, Terry started to make her own appraisal of the child’s presentation. Within the group of social workers critical of psychiatric diagnosis, Aarunya – working within CAMHS, and with psychodynamic training – felt that "the whole system wants to pathologise because that's where we get our security from". Henry, who belonged to the Group for the Advancement of Psychodynamics and Psychotherapy in Social Work, made a similar reflection, adding a “refusal to work with ambiguity or with complexity".

Diana, who was critical of diagnostic practices, had knowledge of trauma studies as well as neuroscience – mentioning mirror neurons in her discussion. However, there was a diagnosis that she did support. For her, “not enough of our kids are diagnosed with Complex Trauma[42], […] which nicely encompasses what everyone's been through, albeit the symptoms will manifest slightly differently”.

There is a correspondence between Diana's support of the narrative of trauma and the diagnosis that she advocated. However, Terry, a therapeutic social worker, took this position one step further. If the child's "problems" were related to trauma, no diagnosis was sought,

> I probably sent very few children across for diagnosis, because a large majority, the problems were more related to trauma rather than issues needing a diagnosis. The thing is what people today classify as Post-Traumatic Stress Disorder, we were fully equipped to deal with and trained to work with children.

Olivia, a trainer and consultant, and Thomas, an approved mental health professional (AMHP), referred to psychiatric diagnoses as "clusters of behaviours", which, for Olivia, render diagnoses “meaningless” because,

> all they are is a list of behaviour. Do you tick off those behaviours? You get the label. […] You're not interested in the meanings of those behaviours (...), all you're interested in is ticking a box, and you tick enough boxes and you get this thing.

For the social workers critical of psychiatric diagnosis there was a tension between the logic of diagnosis, as explained by Olivia, and the social workers’ search for meaning, communication or a narrative behind a behaviour.

The second point to note on the social workers’ knowledge base is that they actually differed in their knowledge of psychiatric diagnoses. On one hand, all social workers provided examples

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[42] The diagnosis is Complex PTSD, and it was introduced for the first time in ICD-11 (WHO, 2019). There is no equivalent in DSM-5-TR (APA, 2022).

of having addressed their lack of knowledge when directly confronted with it by a case. That is, social workers dedicated time to acquire knowledge on particular diagnoses when working with children who had received them. Thus, Jack read about Reactive Attachment Disorder when a young person was diagnosed with it. Zuri looked into pseudo non-epileptic seizures when one of the teenagers she worked with presented with them. On the other hand, there were differences in how up-to-date social workers' knowledge was, or how they understood particular diagnoses. Caroline stated, "we haven't used that phrase [Münchausen] for a long time now", whilst it did appear in other interviews[43]. Not all social workers were familiar with Complex PTSD either. Luisa, one of the critical social workers, was very clear that ADHD and ASD are not "mental health conditions", but "neurodevelopmental conditions". This distinction was not applied by all social workers.

There was a final divide between the social workers who saw psychiatric diagnoses as "a physical diagnosis" and those who did not, as Olivia stated, "it's not like diabetes, it's not like kidney disease, it's not". These latter social workers emphasised the fact that there is no organic test for a psychiatric diagnosis or even a proven organic cause[44].

Difficulties in interpreting behaviour

> We're never going to be able to unpick what is attributable to what. Sam

Albeit with differences in their preferences, in making sense of a child's behaviour, all social workers acknowledged and accepted the different perspectives considered above – with the already noted minimal reference to the child's social circumstances. Therefore, I finish this

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[43] Both DSM-5-TR and ICD-11 no longer refer to Münchausen Syndrome, but to Factitious Disorders.

[44] Critics of psychiatric nosology raise the same argument. There is a known organic base, however, for dementias and a few other conditions (Timimi, 2017).

chapter by considering how social workers decide which explanation/s are the best one/s for each child and the possible difficulties in doing so. Three factors involved in this interpretation process are discussed: the child, the interpreter and the 'symptom'-cause overlap.

The importance of knowing the child

There was a general consensus amongst social workers regarding the importance of knowing the child in order to be able to understand their behaviour. Two main reasons for this were presented. First, different reasons can be behind the same behaviour, or vice versa, the same reason may be behind different presentations. As Danah stated, "every child responds differently"; therefore, "it's really getting to know the child to understand kind of what's what". Rachel reached the same conclusion when reflecting how to recognise whether "challenging" behaviour is "distressed" behaviour, “I think you would understand, which one it is, if you understood the child or young person. (...) I think it depends on how well you know the child or young person to be honest”.

Second, as already mentioned, behaviour may not only reveal the child's internal state, but also hide it. For instance, Danah remarked that "[s]ome children are resilient, so it's really difficult to see the distress". Meg commented on her experience as manager of a Leaving Care service and similarly reflected on how children may hide their distress, so the absence of 'problem' behaviour did not equate with the absence of distress for the child,

> I remember when I was managing the leaving care service, we would get children that would transfer from the looked after team to leaving care at the age of 16. These children would be deemed as model children and really good, and there are no problems whatsoever. And actually, then, because they've come to us, to leaving care at 16, things will start to unravel, because they've held it together for so long. And because they're not presenting with challenges that make people aware, then

> they are overlooked, because the focus would be on those children that are in crisis and clearly demonstrating the crisis. And actually a lot of the time those children would be the most distressed, because they've held on to it for so long, and they haven't owned that or demonstrated distress really.

Knowing the child well can have significant advantages for the child, as illustrated by one of Terry's interventions. Terry discussed how she used to work with a young person who was "quite a serious self-harmer and had been sectioned on two different occasions" because of this. During one of his medication reviews, he told his psychiatrist, "he was going to go and jump off a bridge basically because he just had enough of living". Terry had not attended that review. The psychiatrist requested a Mental Health Act assessment with the view to sectioning him again. The young person was locked in a room, prevented from leaving the building until the assessment could take place. In the meantime, Terry arrived at the office. She disagreed with what was happening,

> Because I've been working with him quite closely. I knew that something had happened that day. And it had kind of lifted [raised] his anxiety. And all we needed to do was bring his anxiety down. That's all we needed to do. We didn't need to section him.

Terry asked him about what had “brought this on? (...) And so we just talked, and it turned out he had an argument with his mum. (…) And he didn't want to go back home because of the arguments he'd had with his mum”. The young person agreed Terry could phone his mother, and eventually,

> [h]e spoke to his mum, both him and his mum were crying. He said he wanted to come home and that he loved her and that he wasn't going to kill himself. And so we de-escalated the situation and we took him home.

This situation could have had a very different outcome had Terry not appeared.

The observer's interpretation

It's all about interpretation, right? Meg

The communicative and relational aspects of behaviour as identified by the social workers have already been discussed. In all communication encounters there are two roles, the speaker-emic and the listener-etic, in our case, child and adult respectively. However, when behaviour is understood as communication and/or relationally, the observer may also be causally involved in the behaviour they are trying to interpret. Three points are considered here: the discrepancies between observer-observed perspectives, as acknowledged by the social workers; different interpretations by different observers; and the role of the child’s own interpretation.

What the child may try to communicate is not necessarily what the adult experiences. The adult, too, may interpret something differently from the original purpose behind a behaviour. Samantha reflected how carers may experience behaviours as challenging that are actually signs of distress. Similarly, Beth pointed out that behaviours developed by children as survival mechanisms can be interpreted as challenging by their carers. Parallel to the discussion presented by Olivia on the challenge of understanding a child's behaviour when there are cultural differences, Yohanna reflected on the difficulty for "fairly securely attached" carers to recognise "not very sophisticated" children's attempts at "connecting" with them.

This attribution mismatch may not only happen in relation to a child's behaviour, but also in relation to the child's experience of their life events. The cases below show that the adult/s also interpret which experiences can be considered traumatic or could justify a lack of emotional wellbeing on the part of the child. Cristina recounted the story of how it transpired that a young inpatient had been left severely traumatised by a car accident that had taken place in their pre-school years. This was only learnt when the young person eventually "wrote a note of events that for her was very traumatic”. However, her family had been very surprised since this had been a minor accident where nobody had been physically injured. Danah discussed the case of a young man with criminal and aggressive behaviour, with a long history of ineffective involvement of both social and mental health services in his childhood. Danah did not have concerns with the parents and concluded that this was an "example of a child who it's indicated that he's not had any negative past experiences. (…) That's the lifestyle he's chosen, if you like, because he came up with a good start". However, three events had happened when he was five years old: a new sibling and a change of both home and school. Concerns around his behaviour had started at 6 years of age, suggesting the possibility that the impact of these events on him were overlooked as in the case shared by Cristina.

These discrepancies in interpretation did not happen only between child and observer, but also when several observers were involved, inevitably the case for children in State care. This can be exemplified in the different explanations social workers put forward in relation to case scenario 3[45]. Twenty-six social workers were asked to comment on this scenario where a teenager diagnosed with ADHD, ODD and ASD moves to a new foster placement due to the breakdown of the previous one. The symptomatic behaviours did not appear in the new placement. Terry took it as evidence that the child's difficulties were due to attachment, whilst Allison and Meg attributed it to past experiences, rather than the psychiatric diagnoses. Aarunya, Emily, Pippa and Zuri thought the change was possibly due to the positive effect of the new carers. As Zuri stated, "clearly, something's going right there, whether she now feels settled and secure in a placement". Six social workers remarked on the coincidence that the teenager’s behaviours disappeared at the same time as she changed foster carers. Caroline, Diana, Jack and Danah added the possibility that the child's behaviours were due to the previous carers, instead of the diagnoses.

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[45] See question 16 in the social workers’ interview guide (Appendix VII) for the full list of scenarios presented to them.

All the social workers mentioned above saw the teenager’s change in behaviour as a positive sign, albeit attributing different reasons to it. Lack of disruptive or distressed behaviour seems to mean here lack of distress for the young person. Samantha, however, made a different assessment of the situation,

> I guess six months is really, really early into a placement. And is not necessarily at that point where that child feels safe and secure, particularly given that there's been a breakdown of a previous placement. There could be a lot of masking of emotions.

Samantha refers to the possibility that the behaviour here is hiding rather than communicating an emotion. In the same scenario, with the same child, the same behaviour is considered in opposite ways by different social workers. Danah set a list of questions that could clarify what had been happening,

> I would obviously want to know, first why her previous placement broke down? Was that her first placement? How long does she have the diagnosis for? And what was the concerns which led to the diagnosis?

However, although Danah said "obviously", considering that only a few social workers asked some of those questions, it did not seem to be obvious to most social workers that these questions may need to be asked.

In this scenario of discrepancies between observers, it is also important to establish who is the observer and what is their relationship with the child. We can see this in social workers’ comments on the completion of the Strength and Difficulties Questionnaire[46]. Social workers necessarily rely on foster carers’ reports on the child’s behaviour. Yet, the interviewees’ discussion about the SDQ showed that they thought carers’ observations could be subjective. The social workers’ general comment was that the SDQ “is the foster carers’ perspective”

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[46] The SDQ is a brief emotional and behavioural screening questionnaire for children and young people. It has been used in research, in epidemiological surveys, and in social services.

(Lydia). For social workers, the carers' personal characteristics, played a part, as Ivy said, "everyone seems to have different thresholds". But also the carers' approach had a role in how a child's behaviour was viewed,

> It all depends on what personality the foster carer has. If the foster carer is really therapeutically minded, the behaviours that are presented will not be somewhat as bad as if they're not. (Lydia)

The circumstances under which the SDQ was completed could shape the outcome. The same person could potentially score a child differently on different days. For Meg, "questionnaires are massively subjective in that the foster carer could have had a bad morning and actually they might fill that questionnaire in based on that very difficult morning". Meg's statement was confirmed by Wren's story about once receiving an SDQ that highlighted unexpected concerns. For Wren, it was the timing of completion that revealed this,

> [W]hen everything's kind of tickety boo for them, it meant that they felt better able to cope with those behaviours, so therefore I wasn't being told about them. But then on the day that they were doing the questionnaire, they had had a bad day, which then meant that they told me about it.

Henry "hazards a guess",

> You could get a child's network together and give them all an SDQ questionnaire, and they'd all come out with different things about the same child, wouldn't they, depending on what way they were with the child and in what way they saw them in the relationship they have with them.

The rationale on which Henry predicted the different scores was the nature and quality of the adult-child dyad, not just the professional role but the relationship. And in the particular relationship between carer and child, several social workers felt that carers are "too involved in it" (Yohanna), feeling that the significance of a behaviour will be viewed differently by the person who has to deal with it on a daily basis as opposed to the social worker's perspective, who only visits. Gemma concluded the discussion on the SDQs, stating that they "are more about the person completing them, than about a child sometimes".

So what about the child and their interpretation? Does that play a part in the observer’s understanding? As we saw, social workers stressed the significance of getting to know the child. They also emphasised curiosity, “unpicking”, “digging” as important social work characteristics. Allison, however, talking about SDQs, casted a doubt on how far a child’s version can inform an understanding of what is happening,

> I think a lot of the time, the child won't be able to make sense of it themselves. They don't have the awareness and insight into their own emotional wellbeing to be able to answer the questions, not truthfully, but I suppose accurately.

Allison’s reflection echoes some comments from the care experienced adults who collaborated in the study. Looking back as adults into their childhood, they contrasted their adult perspective, with their experience at the time. They recognised they would not have been able to verbalise then what they could see now as adults. However, that feeling ran parallel to Judith’s experience, included in the chapter’s opening quote. None of these adults felt they had experienced, as children in State care, the curiosity and unpicking that these social workers advocated and strived for. In some way or another, the adults formerly in State care felt their versions were silenced. And their stories raise another important distinction: it not only matters who is the observer, but who is the observed. These adults reported how their adult abusers knew how to behave publicly – in a way that they as children did not – and how professionals ended up colluding with or, in one case, even praising the abuser. It becomes important, therefore, in terms of the interpretation of a child's behaviour, to determine which observer's version is being accepted, and whether there has been some degree of active involvement on the child's part in the construction of that version, especially considering the following remark from Zuri, in whose service both carers and children complete an SDQ: “[W]hat I find interesting is the difference, (...) the carers and the children's are very different, can be very different".

Besides the difficulties related to the actors involved in this interpretation process, there were also difficulties highlighted in relation to the behaviours themselves. I conclude this chapter with an examination of them.

The 'symptom'-cause entanglement

> A lot of the times, there's something wrong with this child, there's something not right. But it's really difficult to establish whether it's attention seeking, whether it's maybe self-fulfilling prophecy of them being belittled and put down so much in their life that they start imitating that behaviour, or is there something there? Dannah

I have already noted that the reasons behind a behaviour may be multiple, as the above comment from Dannah acknowledges, and the actual one/s may not be easy to determine. Reflecting on the difficulties of attributing the appropriate cause/s to a particular behaviour, the recurrent comment amongst the social workers was the overlap between the symptoms listed under some psychiatric diagnoses – mainly ADHD and ASD – and the effects of trauma. This overlap was mentioned by 23 out of the 29 social workers. Meg formulated the questions that confronted social workers in making sense of the children's presentations: "[A]re they autistic or are they traumatised? (...) [I]s this ADHD or is this symptomatic of their experiences of living at home?" Because "trauma and ADHD can present similarly" (Luisa) and "[s]ometimes trauma can get confused with ADHD" (Lydia).

What some social workers recognised was that, with psychiatric classification based on symptom lists, when there had been trauma, the children were likely to present with a diagnosable mental health condition. As Nathan explained, “[t]hese children have suffered trauma and neglect and you know that it's going to impact on them and their behaviour and, unfortunately, it will tick the boxes for them to give a diagnosis”. Luisa, working in CAMHS, explained the difference that being aware of trauma can make in how a child’s presentation is understood,

> I worked with mental health practitioners who perhaps were not very trauma informed practitioners. I think they probably diagnosed based on the symptoms, ‘Oh, he presents as low mood, he’s depressed’. Yes, that’s true, but then there’s trauma. And I think that the trauma is the big thing. That’s what’s causing the low mood. Low mood is a symptom.

Caroline seemed to adopt a pragmatic acceptance of the “nature/nurture” conundrum,

> I think it's really difficult, isn't it, with diagnosis. And mainly where there's diagnosis issues, I think, is around where a child has had a lot of early trauma, lots of abuse, and then it's very complicated, because then there may be some profound autistic type behaviours. And there are some children where I'm not sure whether it's the early trauma that's producing this behaviour, or whether it's autism. But the reality is that how the child is functioning now would fit this particular diagnosis.

However, earlier on in the interview Caroline had stated that there was “quite clear criteria for ADHD”. For Gemma too, who had worked with both children with ASD and children affected by trauma, the difference was clear,

> [T]he behaviours in relation to attachment and early neglect and all of that trauma can often present similar to behaviours to children with ADHD. I'm sure you've heard this 100 times, ADHD and autism. And yeah, there's often a lot of misdiagnosed [children]. What I see is a child with trauma, I wouldn't necessarily put a label of autism or ADHD on them at all, their behaviours to me are often trauma based. And to me that's really clear.

Gemma felt she had worked with children who had been misdiagnosed "quite often, all the time". This view was shared by other social workers too. Gemma's comment that she was sure I had heard "this" before seems to imply that this overlapping of presentations is commonly recognised, which appears to be confirmed by the frequency with which social workers mentioned this point throughout the interviews.

Conclusion

I have described the main frameworks used by social workers to make sense of children’s behaviour: communication, relational context, trauma, socioeconomic environment and psychiatric conditions. These five potentially interacting explanations have one point in common, they remove blame from the child. More than one may be behind one specific presentation, which leads social workers to deal with a range of difficulties in attributing causation. Social workers, however, are not qualified in England to diagnose psychiatric conditions. And this was recognised by some social workers. Others, however, as we have seen, did have views on the subject. In reality, social workers cannot avoid a certain amount of diagnosing. Confronted with a child whose behaviour worries adults, social workers, at least, must decide whether the presentation requires a medical opinion. That, in itself, requires favouring, or at least incorporating, a potential medical explanation. Social workers, however, had a tendency to favour trauma and/or relational explanations, whilst at the same time criticising or showing ambivalence towards diagnosing psychiatric disorders. Social workers’ views only aligned with acceptance of a process of medicalisation to a limited extent.

In the next chapter I examine how these frameworks are actually implemented in daily practice, and I consider the different consequences when it comes to planning interventions to support children. Here we see a gap between psychiatry and interviewees, whilst the former tackles symptoms, social workers stressed the importance of addressing the cause/s behind those symptoms.

4. IN PRACTICE. Deciding on additional support and accessing it

We shouldn't go for what we can get, we need to go for what is right for that child. Thea

In the previous chapter I examined the range of lenses through which social workers understood children's behaviours. Social workers explicitly moved away from placing responsibility on the child. Instead, behaviour was understood as either a) a form of communication – expressing or hiding information; and/or b) a result of their relational context (past and/or present); and/or c) due to the child's past experiences; and/or d) as a result of their socioeconomic environment; and/or e) an indication of a psychiatric condition. More than one explanation might be appropriate at the same time, implying also that the same behaviour could be attributed to different causes, which could lead to different adults making different attributions in respect to the same child. Making the correct attribution behind a child's behaviour was important for social workers because, as Lydia said, "understanding a child's behaviours helps carers [and, by extension, any adult] to know how to react to them". For the social workers, the best way to eventually understand each child was by getting to know them.

The child's social worker embodies the corporate parental responsibility that Local Authorities (LAs) have for children under their care. As such, these social workers are ultimately responsible for making key decisions on the child's life. This includes decisions on whether and which support may be required. The present chapter explores this decision-making in practice. However, when it comes to specialist support, social workers also depend on which services are available in their specific area and on these services' own admission criteria.

The chapter is divided into two sections following those two decisions: whether support is needed and, if so, which type. Three themes emerge. First, social workers describe a practice landscape where adults' (individual or institutional) needs can supersede consideration of children's needs. Intervention can be triggered by the adult's experience of the child's behaviour, rather than the child's wellbeing. At the same time organisational considerations can influence the decision-making and access to support away from the child's best interests. Second, contextual explanations of children's behaviour recede to the background and the focus of the intervention becomes the child. Third, social workers report a bias towards "pathologisation", that is, towards diagnosing of children and psychotropic drug prescription.

Deciding whether support is needed

In terms of deciding on whether external support is needed, we saw already social workers emphasising the importance of knowing the child and their experiences to be able to ascertain what exactly could be behind their behaviour, which would be their guidance for decisions about intervention. In practice, however, social workers listed significant barriers to acquiring that knowledge. In this section I examine how understanding of a child's behaviour may take place in a practice context, considering the difficulties discussed by the social workers. This understanding of an individual child is essential to determine whether additional support is needed and which kind. Here I consider three types of barriers to obtain information of individual children and, therefore, aid an as accurate as possible understanding on their behaviour and experience: barriers in accessing present information; barriers in accessing historical information; and procedural barriers determined by the children's legal status.

It is not possible to ascertain from the interviews whether these barriers have any causal effect on it, but, following the social workers' accounts, it can be observed that, contrary to some of their statements presented in the previous chapter, behaviour, and not what might be behind it, becomes the focus of adult intervention. Instead of addressing the child's emotional needs, their behaviour becomes something ‘to be managed’. The driver of seeking support becomes the fact that the child's behaviour is problematic for the adults, rather than the actual child's experience. This aspect of the decision-making constitutes the fourth and last point discussed in this section.

Accessing present information

For the social workers, the child was their primary source of information, emphasising the importance of trust for information to be shared. As Lydia acknowledged, without trust people “don't tell you things that they should be telling you”. Earning trust required being able to spend time with the child. Ivy summarised this process as,

> getting alongside them [the children], getting to know them, just getting to be a regular figure and getting to trust you, before you can really start digging, and trying to find out properly about what the issues are.

However, in practice, time availability was impacted synchronically (at any one point in time), due to caseloads, and diachronically (over a period of time), due to staff turnover and team transfers. Time restrictions imposed by caseload were a common complaint. For Rachel, "a barrier to a lot of things in social work is caseload". Rachel explained the "rushed" practice derived from excessive caseloads,

> I've done it, I'm guilty of it myself (…). And it comes down to business, doesn't it, and how much work we've got on. I get that a lot with families as well. Last social worker, she just used to come round for 10 minutes at like five o'clock. So for me that social worker is gone on her way home, just to say that she's visited.

But trust also required a relationship that is built over time. As Rachel said, "they're not going to open up to the carers that they've only known for two days". Sam reflected on the perseverance required for relationship building,

> [P]ersistence is a big thing that's needed, because, rightly so, no child or young person owes you their time, their attention or to tell their story instantly. That's something that has to be built and earned. And rightly so, when they've been let down by a lot of the adults in their lives.

However, social workers repeatedly referred to the frequent changes of social workers in children's lives, acknowledging how these changes hindered the establishment of a trusting relationship. Persisting becomes impossible if the worker is no longer there to persist. As Sam explained, the children are "just like, why should I, why should I open up and tell you what I'm feeling when you're the sixth social worker that I've had". Hannah described her efforts to establish a working relationship with a teenager who “already had very difficult relationships with her own family members” and had had “something like 12 different social workers [in 2 years]”. Reflecting on this case, she added “I'd like to say that is extraordinary, but it isn't, unfortunately. Within the local authority, unfortunately, that does seem to be, it's a profession where there is a high turnover of staff”. Hannah hinted both at the fact that social workers’ turnover is a structural situation within social work and also at how it can compound existing relational difficulties. Staff turnover, however, was not the only reason behind worker changes. Interviewees explained some LAs organised their teams in such a way that a child under social services transferred teams as their status changed. Aarunya explained her experience of this team compartmentalisation,

> [W]hen I joined [LA 2] the adoption team did the adoption work. So you took it up to the final care order. And then you'd hand over, which I always felt was a bit odd, not following a child's through to actually being placed with an adopter. (...) [A]t [LA1] I was able to see it right through from child in need, Child Protection through to court through then until the adoption order.

Aarunya's "seeing it through" points at a sense of accompanying, of continuity, being there for the child through some of the most significant changes in their life as opposed to a relationship that is "shut off" by compartmentalised organisation. Here, team organisation appears not to take into consideration the need to maintain a supportive and trusting relationship between social worker and child. These changes of social workers can compound, as mentioned in chapter 1, with placement breakdowns and changes of educational setting, leaving children in State care with no other consistent adult throughout their childhoods other than, perhaps ironically, their birth family (if the family keeps in touch).

However, staff changes and lack of time to dedicate to children delay (when they do not destroy altogether) the possibility of earning a child's trust and, in doing so, understanding the child's experience from their perspective. This delay can have dire consequences for the wellbeing of children, as Rachel's case illustrates. Rachel explained how she had been supervising a colleague working with a girl who Rachel suspected was being sexually abused. To earn the girl's trust so that she might disclose, Rachel advised her colleague to frequently visit the girl in different settings. However, sessions were irregular, "because it comes down to time, because the social worker had to cancel some sessions because of court hearings and stuff like that". And "[n]ow the social worker's leaving, so somebody else is gonna have to start from scratch with it". In this case, barriers to get to know a child delayed any potential intervention. In other cases, inaccurate and/or incomplete knowledge may lead to ineffective or even damaging interventions.

Accessing historical information

For the above girl at least, her case continued to be overseen by the same person. However, the changes in social worker bring a fragmentation to the child's history that makes it important to be able to access their case records, as some social workers recognised. "[R]eading the file for me", Thea said, "is very, very important, very important. Because how can I understand that childhood experience, if I don't read what we already know". That is, of course, "if you have time" to read them (Amy). Besides the time constraints already discussed, two further barriers specifically related to historic records were named by social workers: accessing the file itself and, once access is achieved, inaccuracy in the records themselves.

Henry provided an example from his LA of how organisational changes made access to archived information more difficult. The introduction of a new recording system meant that previous information was left in a "legacy" system that was not readily accessible. Ultimately, access barriers might mean files were not properly read, as Sam admitted. This could lead to a fragmentation of the child's history, with social workers feeling “you're always getting just a couple of pieces of the puzzle” (Henry). This fragmentation could include children's medical history. Gemma recalled how a child recently placed with carers she supervised was taking circadin[47]. When Gemma enquired about the prescription, “[n]o one seemed to really know where the diagnosis came from, how long she had been on it for”. The child was receiving a medical intervention for which no professional could account.

Another frequently mentioned access barrier derived from lack of information sharing between organisations. Lack of, difficulties in and/or inconsistent information sharing continues to be a recurrent concern in children’s safeguarding (Children’s Commissioner, 2022; NSPCC, 2024). Information sharing concerns appeared common at the point of placement searching, when referrals are sent to Independent Fostering Agencies. Interviews showed that IFA practitioners felt LAs did not share everything about a child in the initial referral. For instance, Yohanna

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[47] Circadin is one of the commercial names of melatonin, a naturally occurring hormone in the human body, which, in synthetised form, is used for the short-term treatment of primary insomnia in adults aged 55 and over. Specialists may prescribe it for long-term use in children and younger adults (NHS, 2023).

explained that, "if there's anything really bad, then it's generally reframed, so it's not so bad". Allison felt this was so "because it's hard to find a placement for [the child]". Henry and Nathan, both children's social workers in different LAs, confirmed Allison's explanation. They both referred to the "market of looked after children". Henry reflected that “when we write placement referrals, it's putting [the children] (…) in the shop window, it's about selling them in a sense”. For Nathan, "some foster agencies can pick and choose. And if you look at the young person, (...) they're going to pick that one over my one, because the behaviour is so extreme". The care system appears organised in such a way that it allows organisational interests (LAs' in finding a placement, and IFAs' in accepting 'easy' children) to take precedence over children's interests in finding the placement most suited to their needs.

This initial lack of information sharing can continue even when the child remains in placement as a direct consequence of the privatisation of fostering services. When foster carers are employed by LAs, their social workers have the same access to the child's file as the child's social worker, but that is not the case for IFA social workers. Meg, who was a manager in both LAs and later in IFAs, compared both experiences and how being in an IFA limited the knowledge she had on the children she worked with, since it meant she had not been involved from the beginning in the children’s cases, and it was “very difficult to get documents and paperwork”.

The lack of collaboration extended to other organisations. Ivy mentioned how "if they come across County, they don't share all the information on their database with us”. When social workers could not access the authority’s database, they relied on their colleagues to share information, as Yohanna explained,

> You're relying really on your dialogue with a social worker. But sometimes the social worker is fairly new anyway. So the social worker doesn't have a huge amount of information either. So as you go along, you pick it up from children's

> reviews and things. (...) Some children's social workers are much easier and much more open to work with. (...) But some aren't. Even some IROs are just not very forthcoming either.

Cristina, in a mental health hospital, echoed this experience, explaining how sometimes she needed to persevere to obtain information from social services, “you need to repeat yourself nonstop”. In Cristina's role, this lack of information sharing was particularly significant since her hospital team required it to make a formulation on the child's mental health difficulties. Danah, on the other hand, shared a situation where it was the hospital's social worker who did not share information with her, the child's social worker. This dynamic could also be present within the same agency, as Ivy, a LA supervising social worker, reported: "it's not widely given to share by the social worker to either myself or the prospective foster carer". These latter comments suggest that the lack of information sharing is not only due to organisational barriers. There seems to be at times a lack of cooperation between social work colleagues. It does need to be considered, however, that a structural factor – high caseloads and the concomitant time restrictions – might be behind this lack of cooperation between professionals.

These multiple factors causing fragmentation of information compound with its (lack of) quality. Social workers were aware of this. Wren did not "read the file and assume[d] that that's exactly how it is. Because I think that how things are and how they read are quite often different". Zuri “always ha[d] to take that with a pinch of salt, because it’s written by I don’t know who. I can’t take it for facts”. For Henry, “you're limited by the quality of the recordings on the child's case file”, and “sometimes, you feel like you've built a picture of a child up (…) which when you meet the child, you think, 'Oh, gosh, that's totally a different child than the one I've read about'”. Structural factors (i.e. time) were again mentioned to account for recording quality, but also individual ones. Sam pointed to how professionals are also affected by their working relationships and how this trickled into the writing process: “what's written on a file, it can come with people's own energies and experiences, particularly if I've had a difficult working relationship with a family”.

The lack of knowledge on a child's history poses serious difficulties for those social workers who understand a child's behaviour through the child's experiences. As Allison explained, "until you know these things it's hard to help the child to make sense of it and therefore it's hard to help the carer help them make sense of it as well". A piecemeal knowledge on a child's history could have very serious consequences for their wellbeing. Thea, who supervised private fostering arrangements, recounted the process of putting together a child's chronology over a six-month period because, “information was held in different places. (…) [A]ll the pieces of the puzzle were in different places. So it took a really long time”. In this case, the child's father was insistent that she had mental health problems. Thea's chronology helped to established that the child was being abused and she was removed. This process took Thea six months, something that she was able to do because she had "a bit more time" than the child's social worker.

Children's legal status

One further turning point in terms of accessing a child's experience when they are under social services is their legal status. Removing children from their parents represents a change of legal status, becoming a ‘looked-after child’. Unless a voluntary agreement, the decision has to be made in court. It is at this point of initiating court proceedings, that access to the child's experience changes. Aarunya explained that "especially when you come into court, that's the time when you do a really in-depth assessment". Rachel illustrated this situation further,

> This is probably going to sound awful on the Local Authority but, when we're that concerned about a child or young person's mental health, it's usually at the point of it escalating to proceedings that will get agreement for psychological assessments

> or something like that. It's very rare for us to have such an in-depth assessment when they're on a child protection plan. (…) It’s usually when we’re in proceedings that it will be the guardian’s view that they need a psychological assessment. The social worker usually said it all along, but trying to fight for managers to agree that money is difficult. But once you are in court proceedings, well, it's like Christmas, you can get any assessment that you want sort of thing.

This can also extend to the child’s parenting experience. Nathan mentioned how it was again at the time of initiating court proceedings that his LA requested “a [parental] psychological assessment to understand more about their functioning”.

That is, in some cases, additional assessments are requested during court proceedings, rather than earlier on to inform a better understanding of the child’s experience and its impact on the child. According to Rachel and Nathan, the decision to request the child’s removal was already made without those additional assessments. It was only when LAs instigated court proceedings that a new avenue to better understand a child's experience opened up. I refer to this as the LAs practice, rather than social work practice, since Rachel's words – "the social worker usually said it all along" – indicate that this procedure may not be supported by social workers.

These compounding barriers to access information on children's lives have potential detrimental consequences in how they are understood and/or supported by the adults around them. Without time to understand who the child is and how they see their life, children can become defined by their behaviour and, when this is disruptive for the adults, as we shall see, medicalisation can ensue.

Emotional wellbeing, or the management of behaviour?

In the absence of knowledge on the child's history and the child’s experience of it, what the adults around the child are left with is the child's behaviour. There is a disjuncture here between how social workers understood a child's behaviour (following their statements in the previous chapter) and how social workers perceived other people understood it. Social workers repeatedly referred to other adults seeing the problem lying exclusively within the child – particularly adults not seeing themselves playing a role in the child's behaviour. Vivian described how she and her colleague had calmed down and had a conversation in a care home with a teenager that the police had handcuffed prior to their arrival. Vivian, who had not worked previously with this girl, explained that in her file it stated she did not like to be touched, and that that had not been respected by the care home staff or shared with the police. Vivian concluded that "what the police consider to be challenging behaviour is often their [police's] behaviour". Aarunya was not surprised "that a foster carer or a parent, or any other carer, would think the problem lies within the child". Vivian identified this position as "scapegoating", acknowledging, nonetheless, that for parents/carers it was "not always easy to think 'I got that wrong'".

Social workers also found some adults attributed the child's behaviour to the child's choice. Thus, Diana reported that "[e]veryone turns around, and most notably, the police will turn around and go, they're making choices". Ivy provided an example within a school setting: "[H]is outbursts were seen as him choosing to be that way, when actually the poor lad was in an environment [school] that was just uncopable (sic) for him." However, there are also references within the interviews indicating that some social workers too thought a child's behaviour could be their choice. For instance, Jack reflected in relation to a teenager that "[her risk-taking behaviour] might never stop, she might carry on doing stuff out of choice." In the previous chapter we saw Danah describing another young person's behaviour as "the lifestyle he's chosen". Ultimately, in practice, in most interviews, children's behaviour was described as something that needed to be managed,

> I would struggle to manage that young person in my home. Ivy

> [W]hat support has been put in place to manage that behaviour. Nathan
>
> [S]upport the foster carers in managing the behaviour. Terry

What is referred to as ‘behaviour management’ is either suppression of behaviour or the minimisation of its consequences. The consequences of this approach depart significantly from the discussion in the previous chapter. There, social workers acknowledged that a possible explanation behind a behaviour was a child's survival strategy, that is, a child using their behaviour as an attempt to manage their feelings and/or their environment. Here, in practice, social workers and, according to them, other adults adopted the position of behaviour as something to be managed (as opposed to something that manages). And in doing so, its purpose for the child went unacknowledged or became disregarded, as illustrated by a foster child’s case discussed by Lydia,

> She wouldn't sleep, she'd stay up all night. Have her telly really loud. She said she was trying to drown out the voices that were telling her to hurt people. So she'd have her TV really loud. Then it got taken off of her.

This situation, of adults removing a noisy TV, shows a disjuncture between the thinking and the action about behaviour. Whilst behaviour is thought in terms of the child, it is the adults' experience of the child's behaviour that determines the action. The behaviour managed is the behaviour experienced as disruptive for the adult/s. Lydia did not specify whether an alternative was provided to the child. However, the point raised here is that, regardless of any solution, the behaviour being addressed was the behaviour disruptive to the adults. The same child also overate, “three bowls of ice-cream in one day, which is no good. But if she didn’t get it, that would really set her off”. Overeating remained unaddressed. This potential disjuncture has consequences when determining whether a child requires support for their emotional wellbeing. What determines that decision might not be the child's emotional state, but the adult's experience of the child's behaviour. That is, intervention might depend on the adults’ level of tolerance for the child’s behaviour. On the opposite end, in the absence of disruptive behaviour, children’s distress could be missed as Nathan recognised,

> Unfortunately, when we look at behaviour, if a child has high level of behaviour, then we start going around putting fires out. But if a child had similar lived experience in the past, but don't display the behaviour, then their needs could be missed, potentially.

This finding echoes Goodman’s (1999) and Bonfield et al’s (2010) conclusion in their studies (see chapter 1) that referrals to mental health services were determined by the burden experienced by teachers and foster carers respectively. Bonfield et al (ibid) were surprised at finding foster carers who had a foster child with normal functioning but nonetheless using CAMHS had a higher degree of mental health literacy. The authors considered the latter would mean the carers would be using CAMHS more appropriately, implying that using CAMHS for a non-functionally impaired child is not appropriate, and aligning with the psychiatric nosology position in terms of functional impairment. However, an alternative explanation could be that these carers, due to their higher mental health literacy, were able to discern emotional distress even in the absence of behavioural difficulties and took the child's experience as their incentive to seek support.

One last case to finish this section, discussed by Yohanna, illustrates the difference between managing, suppressing, behaviour and supporting a child with their emotional wellbeing. Yohanna explained how a young foster child started to soil and smear during lockdown. He had already done so in his previous placement. The previous carer “had stopped it because she told him off in no uncertain terms”. The new carer took a nurturing approach. She provided the consistency, predictability and reassurance she would provide to a toddler on potty training. The new carer did try to find out "what was going on for him". She "started talking about what he might be worried about. She used a lot of curiosity". Through these conversations Yohanna and the carer realised the child had become anxious during lockdown and concluded soiling and smearing were his coping mechanisms when not feeling safe. So even though the child eventually stopped their behaviour, they were prepared for potential relapses if the child felt unsettled again in the future. When the child was asked to write a comment on his carer, "he said that she was the best thing ever, because she'd stopped him pooping his pants", suggesting this had never been an act of wilful misbehaviour. Yohanna explained the success in this case through availability of time, and a supportive and trusting group of adults around the child,

> I'm lucky because my manager was with me as well. (…) I'm lucky because we don't have massive caseload so we can give time and we can give reassurance. And there was a time when I was talking to [the carer] every day because she was finding it really, really hard. And I think that is so important. It's really, really important. (...) And I think it was just my level of trust in her and her level of trust in the child and it just worked.

In the process of establishing a relationship with and getting to know the child, we have seen how institutional needs (staffing issues, team organisation or filing systems, for instance) can supersede children's needs. We have also considered an array of factors mentioned by the interviewees that lead to a departure from how social workers considered behaviour theoretically to how it is addressed in practice. From the social workers' perspective, it was common to locate the reasons behind the behaviour exclusively in the child.

In scenarios where the child's previous experiences are unknown or ignored, and where the influence of context (i.e. school) or relationships (i.e. parents/carers) is disregarded, it is plausible that it becomes easier, or simpler, to see a child's behaviour as the product of the child. Without tools to understand the behaviour, it is not the child's experience or their behaviour but the adults' experience of the latter that becomes the first gatekeeper of intervention. This has several implications. First, if what is attended to is whether the behaviour is disruptive for the adult, the same behaviour will or will not be addressed depending on the adult's tolerance of it. Second, when a child does not display disruptive behaviour, their lack of emotional wellbeing can be missed. In Pippa's view,

> almost all the children we work with have some form of mental health difficulty (…). We have these children go through really intensive experiences of domestic abuse and domestic violence or physical abuse. And it's then just put into care, and it's never really spoken about, and it's just expected to crack on with it.

Third, two explanations are left when the behaviour is attributed to the child. As Henry explained, when "that puzzle's not been put together then it becomes 'They must have a personality disorder', or is then their issue, that's their own style and how they interact with society". That is, behaviour becomes a choice or a dysfunctional condition. The former may lead to criminalisation, the latter, to medicalisation. Both routes can be incorporated into the deviance ascribed to children in State care. In practice, these explanations reached by professionals to make sense of a child constitute the first step to guide any possible intervention, including seeking additional support. I examine this second aspect next.

Accessing specialist support

What happens then when a child's behaviour worries or disrupts adults beyond their own capacity or resources to address it? The first conclusion to be drawn from social workers' accounts is that deciding support is needed and accessing it are two very different things. Three reasons for this discrepancy appear within the interviews: a geographically variable landscape of services, evidencing a lack of a nationwide or systematic approach to address the emotional needs of children in State care; lack of available resources; and disagreements within the adult network on how to address a child's behaviour. At the same time, social workers identified difficulties in implementing their preferred intervention, therapeutic parenting. These discrepancies could lead social workers to a potential series of compromises, all of which coincided on an eventual medicalised understanding of children's behaviours. In this section I examine the role in providing or supporting access to specialist support, first of the LAs and second of mental health services; third, I consider social workers' preferred intervention; lastly, I examine the differing views within the adult network and the resulting compromises. Some of the findings reported here echo those discussed by Phillips (1997), who interviewed social workers whose allocated children had been seen at the Maudsley Hospital between 1989 and 1991. Despite a high perceived need of mental health support for the children, the social workers had made only a small number of referrals. The reasons provided by the social workers for this were placement instability, inadequate child mental health resources and insufficient LA funding. Acknowledging that both this study and Phillips' include a small number of participants, the similarities in the findings three decades apart suggest that we are reporting on deeply entrenched structural conditions.

The support the same child would receive varies so much depending on the stage in their care journey, their geographical area and the network of adults involved in their case that we need to talk of a multiplicity of trajectories or pathways. However, in studying these possibilities, the same set of themes remains. Children's needs typically continue to be superseded by organisational considerations. If in the previous section understanding of children's presentations could be reduced to behaviour management, here, this reductionist approach coherently translates into an intervention that focuses on the child, with the potential disregard of contributory contextual aspects of their lives. This focus can then become both cause and effect of a medicalisation of children, that is, of the labelling of their presentation via a psychiatric diagnosis. However, this medicalisation is not necessarily or always due to the view of professionals or carers, but also to organisational structures geared towards this medicalisation. At times it appears that it is what service is available, and the criteria needed to access it, that shapes the adults' narratives around what is going on for the child. That is, it may not be always the assessed problem guiding the search for a solution, but the available solution shaping how the problem is viewed so the latter can fit into the former.

Local Authorities gatekeeping

As potential commissioners of services, LAs act as gatekeepers to access specialist support, according to what they are prepared to fund. Findings echo what was seen in the previous section, organisational structures do not necessarily align with children’s best interests. For Gemma, LAs’ funding depended on what foster carers were able to tolerate and the financial cost to the LA if the placement was to breakdown,

> If I'm honest, it’s more about the stability of placements and the money it's going to cost the local authority if the placement breaks down than it is a diagnosis in getting the services. (…) In social work it’s more about the money it’s going to cost them in keeping the child in the placement they're in. (…) It's always about the money it's going to cost as to whether they'll put the services in.

In many situations, it seemed to depend on how much the child’s social worker was willing/able to pursue funding with the LA, their own employer. A fight that had no guarantee of success, as Diana’s case of a teenager who came into care already pregnant, illustrated. The mother and baby placement where she was originally placed failed, and her baby was taken into care. But eventually,

> …we managed to calm her right down. And then they said, (...) 'She needs therapy'. So (…) we referred her to try and get this therapy. From when she was seen, which was August, come January, CAMHS were still saying it was going to be likely six months until therapy could start. By this point, she's already in an abusive relationship (…). So at that point, I went to our own panel and said, 'This child has not got time to wait. She doesn't have a formal diagnosis of anything. But everyone

> has said the trauma is so significant that nothing is going to change for her until she has therapy. She's now 17, we're running out of time'. I begged at panel for us to pay for it. I said 'We've got a care order. We have parental responsibility. We need to not wait, let's get it done'. ‘No, no’.

By the time therapy was available, the teenager’s situation had deteriorated further, eventually finding herself pregnant again, with a second turn of care proceedings. For Diana, “[i]f somebody in senior management would have said ‘Yes, you can have that money’. I can’t. It’s all ‘shoulds’, ‘woulds’, ‘ifs’, ‘buts’. We could have given her a better chance”. Although Diana does not mention it as a contributing factor to the situation, it is possible that the teenager's age played a part in the LA decision. Other social workers referred to the transition to adult services as creating a limbo situation, with services reluctant to start working with a 17-year-old since they would soon be transferred to adult services.

Diana invoked the LA’s parental responsibility as a duty to support this teenager. In other social workers’ accounts it is precisely this legal status of being in State care that aided children’s access to additional support. As Pippa explained, "[t]hings are a lot easier to access once the child is in care. It makes a massive, massive difference"[48]. Being in State care can also mean additional support for the school (Caroline). This preferential support did not necessarily extend to children in child protection, as Wren found out.

> I found since moving into a service specifically working with children in care, that you've immediately got access to psychotherapeutic interventions most of the time. And then, when you're working with children who aren't in care who would really benefit from some preventative work, there's nothing available to them. (...) It's really hard to access psychotherapeutic interventions for children that are still living

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[48] Within this scenario, teenage girls appear as an exception. In some LAs (as in the case of Pippa’s) their access to services was not so much determined by their legal status, as by their prospective motherhood. Although this approach may appear preventative, this prevention is only in relation to the about-to-be-born baby. It is not preventative in relation to the mothers, still children themselves. The emotional wellbeing of these teenage girls would not be a priority if they were not about to become mothers.

> at home. It generally comes once they're already in care.

Here Wren recognised that support was needed already before a child enters the care system; however, this was not necessarily available. From the social workers' point of view, LAs' decisions on whether to provide support was not always based on what the interviewees identified as the children's best interests. Besides their own LAs, social workers also had to deal with mental health services' own admission criteria. I consider this next.

CAMHS: "Everybody's go to"

When looking at access criteria to mental health services, I focus on the only nationwide service addressing children mental health, mentioned by all social workers, the Children and Adolescent Mental Health Service (CAMHS). However, a significant variability in discharging their responsibility can be observed within different CAMHS. Following social workers' accounts, they differed both in their access criteria and the services they offered. Despite this, there was a consensus amongst social workers in recognising that, for most professionals, CAMHS was "everybody's go to". In some areas, where no other services were organised either by the LA or by private initiative, they were the only option.

When discussing access criteria, four words were used by social workers to explain CAMHS' acceptance or rejection of a referral: “organic”, “behavioural”, “trauma” and “environmental”. In what follows, I consider the use of these terms as access criteria and the consequences in addressing children's emotional wellbeing. Before examining these criteria, however, it is also important to recognise the effect that placement breakdowns could also have in accessing support when they are accompanied by a move to a different catchment area. Children may need then to start afresh in a new waiting list or may find the service they were receiving is not provided in their new location[49]. Placement moves also affected children's therapeutic support in another way. Social workers reported how some therapists would not accept a child until they were 'settled' in their placement. Social workers, however, thought therapeutic support would actually help the child in settling into their placement, creating a "chicken and egg" situation. The frustration provoked by this situation can be heard in Gemma's reflection, "[s]ometimes it feels it's any excuse really, to be honest, because all our children are never going to be settled enough. Does that mean they're never going to get any help?". Overall, social workers found access to CAMHS "really, really difficult".

"Organic"

There was a consensus amongst interviewees on all CAMHS accepting presentations deemed as "organic". There was not necessarily a consensus on what could or should be considered "organic", though. Most social workers seemed to equate the term "organic" with a diagnosable psychiatric condition. Here I examine how social workers viewed the diagnosing process.

Although social workers appeared to have a peripheral or no role at all during the diagnostic process, most did have definite views on it. Social workers valued in an assessment the same elements already discussed in relation to getting to know a child – time and information – with the same barriers identified. However, predominantly, the social workers' position towards diagnoses was not based on the assessment process, or in the accuracy of the diagnosis itself. Rather, it was an instrumental position, that is, diagnoses were valued inasmuch as they were "helpful" or "beneficial", mainly as resource gatekeepers. I look first at the social workers' perspective on the diagnostic process and then their position towards a potential or actual

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[49] The situation is further exacerbated by the fact that LAs and CAMHS geographical borders do not always coincide.

diagnosis.

Social workers valued an assessment that depended on taking time to know the child, that was collaborative with the adult network and completed by an assessor with holistic knowledge. For Emily, good diagnostic practice required getting "to see [the child] in person, and actually, over an extended period of time". Allison praised a case where the assessor wanted to wait six months before assessing to allow the child to settle in their placement, with the idea that this would help to distinguish whether the presentation was organic "or whether it's because of his previous placement and what he's undergone in life"[50]. For social workers diagnosis also depended on the information assessors received. Therefore, Beth, when “involved in any form of work to inform a diagnosis”,

> I always make sure that everything, all information, is available. Because when it's not, you can get a really one-dimensional view of the young person, and they can be diagnosed with something that's not necessarily correct.

Hannah praised recent experiences of diagnosing for being "a much more multi-agency approach", with "everybody's sitting around the table to share some of the experiences of working with that child". This contrasted with her past experiences of diagnoses given by CAMHS led by what schools said. At the same time, social workers recognised barriers to their ideal assessment process. Emily reflected that "probably medical professionals can't do that [see the child over an extended period of time] anyway, because they've got such limited access". Allison, who praised a 6-month wait, recognised that "[u]nfortunately, sometimes the placements don't last that long". In terms of accessing information, Beth stated that "crucial information" can be "lost or missed out, especially for young people that move foster placements a lot, it can be difficult to have all the information". Cristina stated that CAMHS

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[50] Note here the different approach: social workers did not want to wait for a child to settle to receive therapeutic support but wanted to wait for a child to settle before looking at a potential diagnosis.

“will need to speak with people who knows the child properly”. Yet, as we saw earlier, for some children in State care there might be nobody fitting that description in their lives. For Luisa and Beth, it was important that the assessor had a good understanding about trauma. For Luisa, who worked in CAMHS, the presence or absence of this knowledge could mean a "different outcome".

Social workers also experienced a lack of consistent diagnostic practices. Nathan compared his experience of having had children diagnosed in two different hospitals. He found that Hospital B, besides performing screenings and tests on the child, had observed them in different environments, including school and family time; whilst assessment completed by Hospital A had been limited to the time the child spent in hospital. Disparities, however, were not just a matter of “thoroughness”. Social workers felt there were differing positions across different mental health services on diagnosing itself. For some social workers there was a reluctance to diagnose and/or medicate children. Hannah, Luisa and Henry felt this was the effect of the opposite, being “quite easy to label the ADHD diagnosis”, having happened in the past. For other social workers, however, the latter position was not a past matter. Terry compared her experience of working with two different CAMHS with opposing approaches. Whilst in Town A they "were very much opposed to diagnosis", Terry found in Town B "CAMHS give diagnosis on the drop of a hat". Pippa described a similar experience between different teams within the same CAMHS, where there was,

> …like this trendy breakaway group from CAMHS. They are so anti diagnosing ADHD or autism. And they really fight hard with the rest of CAMHS to say, 'You are not looking at trauma, you are not looking at the child being in care, you are not looking at all the different elements of it' (…). They take great frustration with normal CAMHS for the labelling and the diagnosing without looking at the history in more depth.

Other experiences of lack of consistency reported by social workers referred to individual practice. Cristina, who worked in a mental health hospital, explained how children could end up with a string of different diagnoses in their file after being seen by different psychiatrists. This comment is significant if we consider that one of the aims of the overhauling of the diagnostic system brought by DSM-III (APA, 1980) was precisely to reduce inconsistent diagnosing.

Beyond the differing views and experiences on diagnostic practices, support for diagnoses was widespread amongst interviewees when they saw them as beneficial for the child. This benefit could be practical and/or psychological. A few social workers referred to the potential psychological benefit for the child in terms of helping them to understand who they were. Thus, Meg mentioned a child who welcomed their autism diagnosis “because it may help him to understand something about him, and why he doesn't fit in, why he's different”. Overwhelmingly, however, diagnoses were praised for the practical benefit of facilitating access to resources. Social workers supported diagnoses because "sometimes it can open up doors, or it can secure funding for them" (Henry). Social workers talked about diagnoses in terms of how "useful", "beneficial" or "helpful" they were. That is, interviewees saw diagnosis more as means to an end, as something whose value rested on its capacity to open access to resources, rather than on its explanatory capacity. Caroline epitomised this position when she acknowledged that, regardless of whether a trauma explanation could better explain a child’s presentation, if a diagnosis was “going to bring them the services they need, then let's go for it”.

The interviews showed that this gatekeeping capacity was felt as much on education as on mental health support, as Meg admitted,

> I kind of know why it [seeking a diagnosis] happens. Because there are other times (…) where you almost wish they get a diagnosis, because without that diagnosis, you can't tap into the resources, especially education. That's the biggest one. (...)

> And so I often, I'm not proud to say this, but sometimes I think I wish they would get a diagnosis just so that they could get [help].

Several social workers provided examples of children being able to access resources, or schools accepting adjustments, only after a diagnosis. Rachel shared the case of a girl with several indicators of anxiety, including diarrhoea; however, her school put this down to "germs and COVID". It was only after receiving a diagnosis of anxiety and stress-related Irritable Bowel Syndrome that the school provided her with pastoral support and a pass to be able to go to the toilet whenever she needed.

I consider this position, diagnosis seeking due to its gatekeeping power, a pragmatic compromise. In some cases, an instrumental use of a diagnosis was accepted without further questioning. Beth explained that,

> …there was one young person that I worked with that we did get a diagnosis of disorganised attachment for. And that was really useful, because it meant that she could have very specific therapeutic work, that wouldn't have been available without the diagnosis.

For others, as in Meg's earlier statement, it is a compromise "not to be proud of". Luisa shared how,

> …when I was in child protection, I did work with children who perhaps needed an autism diagnosis, simply because with that diagnosis they would get more support than they do without. So in those cases, I did push for it, because I knew in the longer term, they would benefit from it. If I thought they wouldn't benefit from it, I wouldn't even go there.

Some social workers took this compromise position to its logical limits. Beth herself, later in her interview, questioned whether "we have to label [young people] (…) if there's not going to be any benefits". The pragmatic compromise gets complicated, however, by the waiting lists to have an ADHD or ASD assessment (consistently reported by social workers to be about two years). This may lead to the ‘as if’ compromise. This compromise refers to professionals trying to get the child's school to provide support 'as if' the child had a diagnosis, generally of ADHD or ASD, whilst waiting for the official assessment. Luisa, working in CAMHS, reported having done this herself, calling a school and explaining to them that she thought “this young person has ADHD, the diagnosis is going to take two years, we cannot wait two years for the support. So we need to put the support in place now”.

Not organic: “trauma”, “behavioural”, “environmental”

The significance of the pragmatic compromise becomes clearer when we consider what happened when the child’s presentation was attributed to non-organic causes using terms such as “trauma”, “behavioural” or “environmental”. Beyond the “organic” criteria, there was no consistency in terms of what other presentations CAMHS would treat. At the same time, social workers complained of a lack of resources beyond what CAMHS offered.

The general experience by social workers (with exceptions, such as Luisa’s) was that CAMHS did not treat trauma. The common complaint amongst the interviewees was that "it’s very tough to get interventions that are trauma based and trauma focused, really, really, really tough" (Pippa). Nathan described the process of being rejected by CAMHS,

> Nine out of ten, they will say, 'Well, this is because of their trauma’, and they don't specifically provide services for loss and separation and things like that. They put on the focus on kind of behavioural in terms of anxiety, and anger management, so we tackle the symptoms, but not the root.

Similarly, Luisa explained that in her CAMH service "we literally teach them how to cope with the things they're coping with". The term “behavioural” appears in Nathan’s quote both as something symptomatic and treated by CAMHS. However, this was not a consistent experience amongst interviewees. Caroline and Luisa offered opposing views commenting on the same interview scenario, a teenager who self-harmed who was rejected by CAMHS. Luisa knew “a lot of CAMH services [would] say things like that”, but she supported the fact that in her CAMH service the referral would have been accepted. For Caroline, that was “behavioural information”, “not mental health information”,

> We have lots of children who behave in a certain way, that doesn't mean that they have a diagnosable mental health condition, it means that they've learned those behaviours, or these are behaviours that are happening to soothe themselves in some way. Or these are behaviours that are saying, 'Help me', 'Look at me'.

In her explanation, Caroline seems to equate “mental health” with psychiatric diagnosis, separating it from behaviours that indicate struggles with emotional wellbeing: self-soothing or saying, ‘help me’. However, Wren complained nobody did “the behaviour stuff”, adding that she had “seen young people end up sort of slipping through the net a bit, because we're being told that it's a behavioural issue”. That is, social workers reported lack of services for those behaviours deemed “behavioural”, i.e. not attributed to a diagnosable psychiatric condition.

So far, we have seen social workers complaining of lack of CAMHS support when the child’s presentation was understood as “trauma” or “behavioural”; however, when social workers understood it as “environmental”, it was they who moved away from considering CAMHS as the best service to address the child’s wellbeing. Thus, in the scenario of the teenager who self-harmed, Terry felt that "the issues are very linked to social aspects of this child's life, and therefore, I think need more of a kind of social approach, rather than a mental health approach to it". Some social workers disagreed with what they saw as a CAMHS focus on the child. They opposed this focus "because the child doesn't live in a vacuum" (Henry). Allison thought "there's this issue where the CAMHS worker will kind of take over and focus on the child”. Vivian questioned the usefulness of long-term psychotropic medication when "the circumstances in somebody's life are what's causing them distress".

However, the social workers interviewed may not be indicative of the full spectrum of views within the profession. Both Luisa and Aarunya, both CAMHS employees, thought that social workers themselves, and not CAMHS, were the ones who pathologised the child. Luisa, for instance, stated that social workers were the ones who did not see the issue as systemic. Aarunya commented,

> As CAMHS, our place and position is to help professionals get a sense of the child, especially where they're trying to pathologise by thinking purely about the child, and not playing into filling them up with assessment information on how to categorise and tie this child down.

However, what Luisa and Aarunya identify as individual practice might be a response to systemic and structural factors. Two trends meet at this point. Seeing the child as the problem, as some adults appeared to do, translates into seeking services that only address the child. However, as we have just seen, when services are organised in such a way that only criteria around the child are considered to access them, this also translates into professional practice that seeks to reconceptualise the child and their presentation in such a way as to be able to fit through that hole, so that the child can receive the support adults have already identified as needed.

When services – mental health and education alike – are organised in such a way that diagnosis acts as a gatekeeper, organisations, in this case CAMHS, can act as engines of medicalisation/pathologisation, sometimes against the view of the professional/s involved. Music (2011) concluded that one of the effects of organising CAMHS clinics to only treat diagnosable disorders was a large proportion of children within the care system with high level of emotional needs could not access mental health support. An incentive is created whereby professionals (or parents/carers) seek a diagnosis to access the resources, or simply the flexibility, as in the case of the girl who was allowed to go to the toilet – that they feel the child requires. Olivia pointed that more diagnoses are sought for children in secondary education precisely because primary schools "can be a lot more flexible, they have a lot more of a relational approach". In addition, the interviews show that there was no straightforward or standard translation of a particular understanding into a specific intervention, except for behaviour attributed to a psychiatric condition. Social workers, however, were clear on what their preferred intervention was. To this point I turn next.

The case for therapeutic parenting

Consistent with the emphasis placed by interviewees on experiences and relationships to understand a child’s behaviour, the intervention praised by most of the social workers was therapeutic parenting, or trauma informed parenting. Therapeutic parenting refers to a particular parenting style that emphasises nurturing, consistent and empathic responses to support the child to develop self-regulation and mentalisation skills (Naish, 2016). That is, relationships could not only be the cause of children’s suffering, they could also be a source of healing. However, as much as social workers emphasised the need for therapeutic parenting, they also pointed at the difficulty in working with foster carers to implement the approach.

The relational aspect of supporting a child was emphasised in several interviews. For Aarunya, “the only other way [besides medication] to work with your [parents’/carers’] child is through your relationship”. Thea stressed how the way to change a child was through considering the adult’s response to their behaviour. For Henry, the effectiveness of an intervention came down to two characteristics: the child’s sense of safety, and the ability to establish therapeutic relationships. For Gemma what was needed was "a whole family systems kind approach" because “the child can’t make the changes on their own often”, so “successful therapy” required the active involvement of “the whole family unit”. Diana and Yohanna reflected on the artificiality of taking "a child out of an environment, put them in therapy, and give them however an hour, and then put them back in the other environment and something's going to improve?". For Yohanna, it was “a big ask for an insecure child to sit with somebody they don’t know very well and say anything meaningful”; instead, carers, as the child’s trusted adult, could be “upskilled” to respond to the child. Olivia explained why she considered this “upskilling” was necessary,

> What we know is that, if you just take a child out of a chaotic abusive situation and put them in a caring calm situation, they do not immediately become (…) calm and responsive and they don't go immediately from speaking emotional Chinese to speaking emotional English. And it's not even a process of putting them in a different environment and they gradually learn that language, from my experience. You need to put very specific things in place around what I would call therapeutic parenting in order to reparent children. (…) With good therapeutic parenting, you can make quite a lot of difference. (…) Ordinary sort of good enough parenting and good enough schooling probably won't create that much difference.

According to social workers, carers required training in therapeutic parenting. A few social workers mentioned some CAMHS provided it. However, social workers recognised therapeutic parenting depended on carers who understood and were able to follow this practice. According to interviewees this was not a frequent scenario. For Henry some carers were unable or unwilling to look at their own caring practices and expect, instead, a therapist to sort out the child for them. Social workers acknowledged as a possible barrier to therapeutic parenting how difficult it was to care for children who had been exposed to trauma and neglect. Beth considered it was easier to understand a child in terms of their trauma when one was not living with them, and how one might focus on the behaviour not its causes when living with it, with its "massive wear down" effect (Yohanna). However, as undeniably hard as carers' job is, social workers felt their quality varied[51]. For Henry reparenting a child was a painful process, and he admitted he "couldn't be a foster carer", contending that foster carers are "very special in that sense, if they can do it, but so many of them don't do it". Nathan shared this view, stating that "you got foster carers that are proactive, you got some foster carers that really invest in some of the children. But they're rare. They are rare".

Coinciding with Olivia's justification for therapeutic parenting seen above, Sam reflected how offering a nice home and nice dinners was not enough, yet it was difficult to work with carers on their parenting, as they “can really take it personally, when it is suggested, let’s focus on you”, “a bit of a defence goes up where they are feeling really attacked, I think sometimes”. For Caroline this was not a criticism or a lack of recognition that carers were trying their best, but a realisation that carers may need guidance in their approach. However, Beth, a supervising social worker with five years of practice experience, admitted that "very few carers that I've worked with have the level of insight that I'd like them to" and "there's very few that can give that true trauma informed parenting that we really want". In Beth’s experience, “very few” carers “push themselves to learn all the stuff we want them to learn”, adding that “most of the parents I’ve worked with find it a real barrier to understand a need for it”. Even when carers understood the concept of therapeutic parenting, Beth also found that “applying it is really difficult, I don’t know whether it’s because sort of behaviourist models are just ingrained in all of us to some extent”.

However, carers not understanding the need for the therapeutic parenting advocated by the social workers created a discrepancy of views which for Sam was "one of the most common situations that there can be", with foster carers asking, "Why are you focusing on me when we're telling you this, it's the child that's got the problems". Beth concluded that carers can "feel

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[51] Of course, had this research interrogated foster carers, it is expected that they would have made similar comments regarding social workers.

helpless, because they can't see why the children can't be diagnosed or treated". On the other hand, Diana reflected on the need for social workers to also receive training, not only because "it can't just be down to one person to try and sort out all these problems, it's got to be done by a group of professionals", including schools, but also because "if you've had a foster carer that's gone and done a six day intensive trauma related parenting course, but then their supervising social worker hasn't, how do they then get adequate supervision on providing that therapeutic care?".

Whilst most social workers commended therapeutic parenting, there was less consensus on the social worker's potential for taking up a therapeutic role. Some interviewees did not see this role as falling within their professional responsibilities. Thus, Nathan was very clear of different professional responsibilities when discussing the situation of a teenager barricading in their room, threatening to end their life,

> I spoke to CAMHS, and they said, 'Well, have they followed through?' And I'm like, 'Well, no, because if they'd followed through, they'd be dead' (…). And then there's, 'Well, he's not acting on the things that he's saying'. And I'm just like, 'Okay, but what we're gonna do about?' 'Well, if he feels like that take him to A&E'. (...) And then the next breath is, the right to consultation within 10 working days. And some carers don't want that responsibility and then give notice, and then you've got a child that is in mental health distress, CAMHS not getting involved, a carer that has just given up on them, it's going to make them feel even more crap, really, and then go to another placement, somewhere new. (...) And obviously, they're going to be in more distress.

Nathan concluded that he "would love to go down now, knock on the door. But that's not really my remit. I'm not a mental health practitioner". In fact, what Nathan was describing was a scenario where no adult was taking active responsibility for the teenager's emotional wellbeing. Rachel seemed to reluctantly accept this professional boundary. After successfully establishing a relationship with a teenager that felt let down by multiple professionals before her, she had to introduce the idea of therapy to him,

> He just used to say all the time, 'Can't you just do the therapy with me?' 'I wish I could, but unfortunately, I can't'. 'Well, why, you sort of counsel me anyway, though, don't you?'

However, Thea provided therapeutic support to a teenager "in the context of our relationship" whilst waiting for CAMHS intervention. Even more assertively, Aarunya “wouldn't rely upon CAMHS to do the work that I think I'm more than capable to do with this kid”. Compared with the discussion on therapeutic parenting, there was only a handful of interviewees stressing their desire of a more therapeutic role for social workers. The support that a child ultimately receives is not only dependent, therefore, on the services available, but also on the different views of the team of adults around them. In the next section I look precisely at this professional relational context.

The adults around the child

In the previous chapter I discussed how the observer (adult) is the one that interprets the child's behaviour. The situation is further complicated by the fact that one of the possible explanations is the child's relational context, that is, their relationships with the very same adults who are interpreting the child's behaviour. The observer is potentially part of the observed phenomenon. We also saw how there may be discrepancies amongst different adults’ interpretations.

What happens then when there is a discrepancy of views within the professional network? More precisely, where does lie the power to control the narrative on what is to be done? In discussing how these discrepancies are ironed out, I focus on three roles – social workers, parents/carers, and medical professionals. Power has been traditionally understood as the capacity to control an outcome or another player's action (Lukes, 2021). What can be concluded from the interviews, however, is that power in this scenario does not belong to a particular player, but to a particular narrative. And that the player who is most likely to hold power in each case – that is, the player who imposes their narrative – depends not on the player's role, but on who adopts one particular narrative: the medicalisation narrative[52].

There was a consensus amongst the social workers about being a differential status between them and medical professionals. Vivian, who worked in an NHS team, felt "sometimes that my opinion wasn't as valid as the nurses". Gemma felt that "[s]ocial workers aren't viewed in the same way, to have the same power and authority as the medical profession". Terry, who had worked for CAMHS, expressed a generally shared view amongst social workers,

> In social services there has been this kind of perception that CAMHS is up here and are these gods that can perform miracles, well, they're not. I even thought that before I went to work [in CAMHS], then I realised.

Regarding diagnosing and psychotropic drug prescription, there were several comments acknowledging reliance on medical professionals. Luisa offers a good summary of this position,

> When I was a frontline social worker, I felt very much like, that's not my role to be considering medication. So, if they were on medication, then I wanted to believe that whoever put them on medication that that was like the last resort, like they really needed to be on medication. (…) You would think, or at least I did, if they are the mental health services, they know what's best for this young person. And it's their job to make that distinction.

Since working within CAMHS, Luisa was formulating her own professional views on the appropriateness of prescribing psychotropic drugs for individual cases. Knowledge influenced the social workers' confidence to formulate their own professional views, or solely rely on medical professionals. However, in a case of disagreement, how much capacity did social

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[52] The small amount of data from the interviews in relation to schools is also consistent with this statement.

workers have to challenge medical decisions? For Danah the ability to challenge professionals was an important characteristic of a good social worker. However, some interviewees questioned the extent to which they would be able to do that. Gemma considered how this capacity depended on the social worker's role (i.e. whether it is the child's social worker or involved in a different capacity), and on the child's legal status,

> Unless you have a child on a care order, then you've got [parental responsibility], (…) that's probably the most power you have then to challenge and the most time you're listened to. But if (…) the child's living at home, or they're section 20[53], you have a lot less say.

Terry thought this ability diminished due to social work's public position, "vilified within the media", leading to "quite low self-esteem and low self-confidence as professionals", which, for Terry, made "us feel that we can't assert ourselves in relation to another professional (…). So we just sit back and we keep quiet".

However, despite the perceived higher status of medical professionals in general and CAMHS in particular, social workers shared their concerns that medical professionals followed parents/carers' view on the child and, at times, yielded to their quest for a diagnosis. Lydia also felt that sometimes it was the carers' complaints on the child's behaviour which got the latter medicated. This feeling echoes closely Emily's reflection,

> I think a lot of the professionals just listen to the parents. And I'm not sure, I'm quite torn at the moment, I can't figure out if they're just, the parent is saying, 'I'm exhausted, this child is beyond my control, I need some help, you need to medicate them'. I don't know if they actually just listen solely to the parent, or they actually spend a lot of time with the kid. So, I don't know. It's the honest answer.

Pippa explained how high turnover amongst medical staff could lead to the scenario feared by

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[53] Section 20 of the Children Act 1989 refers to voluntary agreements to enter the care system. Parents, therefore, retain full parental responsibility.

Emily above. In a situation of changing professionals, where the case is considered by "someone that doesn't know the child inside out, there's just always quite a reliance on what the adults in that scenario think is okay, so if the adult's saying they need more medication to sleep at night, doctors tend to think 'Fine'". So, despite all the power attributed to medical professionals, social workers thought these professionals may at times simply follow what parents/carers requested. This was not dissimilar from how social workers also described their own relationship with carers. Terry explained how before working in the therapeutic social work team, she "would be very much led by the parents, the school, by the other professionals that were closely involved with a child". And she would make a referral to CAMHS if she was being told they suspected ADHD or autism. In her new role, Terry no longer "rushes into it" and instead took the time to form her own view.

Social workers' reports, however, show that the relationship between parents/carers and medical professionals went beyond the latter being led by the former. Parents/carers could also successfully challenge medical recommendations against diagnosis or medication. Aarunya described the process,

> [It's] really difficult when parents don't like what CAMHS say, they don't agree, and then the parent goes and gets a private diagnosis and comes back to CAMHS, or a parent (…) puts a complaint in and then they may have their child medicated anyway.

All social workers who worked within CAMHS reported the same pattern. Other social workers also shared experiences of foster carers successfully disputing the workers' recommendations. Beth, for example, did not agree with assessing a child for ADHD or autism since she thought the child's presentation corresponded to the effects of trauma. The carers then reached out to a senior manager and took the child for a private assessment that provided the double diagnoses of ADHD/ASD[54]. More dramatic was Henry's case. Early in his career he decided to "stick to [his] guns" and not put therapy in place for a child because he did not think the child needed it. Henry thought what the child required was a different parenting approach. However, this was in opposition to the carers' wishes. Eventually, the situation was resolved by removing Henry from the case. These scenarios appear consistent with social workers' reflections on the power that foster carers hold by virtue of being the decision-maker in terms of placement termination. We saw already how Gemma thought LAs would fund services if they felt the placement were at risk of breakdown. For both Beth and Henry ultimately, this was the reason behind the resolution of the aforementioned cases. For Beth, the LA thinking that “another placement would be hard to find” for the teenager gave “a lot of power” to the carers. Henry concluded that, as the case holder, he was not as "powerful" as he would appear to be: "I think you can do your social justice thing all you want and try and stand up [for] children and that machine overtakes you a little bit, doesn't it?". What is even more significant in these cases is that Henry and Beth were indeed "standing up" for the children. Neither of them wished to go to therapy or to be assessed for a diagnosis.

Carers, however, were not always as powerful as the above cases make it appear. When parents/carers challenged the medicalisation narrative, their position was the one being questioned. Terry stated that, "if the child's in care, obviously, the foster carer has no option but to adhere to the treatment plan". This is so "because they're forced to, because they have to, because they're seen as professionals, and their capacity as foster carers will come into question if they challenge that treatment plan". This was a situation that Terry had experienced when supporting carers. She also reported being involved in cases where parents had been referred to social services by schools/CAMHS for not adhering to the treatment plan for their child,

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[54] This case is discussed in more detail in the next chapter.

> But quite often when you unpick it with parents, you'll find that they're really worried about their child's eating disorder. But the proposed treatment plan that's been put on the table doesn't fit for that family.

Holding power to control the narrative does, therefore, not depend exclusively on the adult's role or professional status. What all the cases shared by interviewees had in common was that the position of power was held by whoever supported the medicalisation narrative[55]. Parents/carers challenged successfully social workers and/or medical professionals when supporting this narrative; however, when the carers/parents were the ones opposing the narrative, they were the ones being questioned. For Nathan, trauma explanations were "not strong enough in this country". In practice, however, this situation could lead those social workers opposing a medicalisation narrative to the most significant compromise: 'there's nothing I can do about it'. In the other two compromises, there was a sense of some kind of trade off, of reaching a solution that may not be felt as ideal but had some benefits. When it comes to this compromise, social workers had a sense of lack of control over it.

The power of the medicalisation narrative was so strong that, even when a diagnosis became disproved or no longer agreed, it stayed. Most social workers thought, like Gemma, that "once a child has a diagnosis, the power of that diagnosis, of the medical profession, is exceptionally difficult to overturn". As we have seen, however, it appears it is the medicalisation narrative, rather than the medical profession, which has such power – there were examples shared of medical professionals not supporting diagnosis and being superseded. Interviewees reported struggles to get a child reassessed, even when the diagnosis was found to be questionable. Hannah shared the case of a young child eventually diagnosed with ADHD, with multiple

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[55] This discussion has referred exclusively to dynamics within the adults around the child. The question remains as to whether the medicalisation narrative would prevail if it was the child propounding it, against adults' views. There was only one such example within the interviews, shared by Luisa, whilst working in CAMHS she had refused access to psychotropic drugs to a teenager who was requesting them. When the teenager called to report a deterioration, Luisa then facilitated the process.

episodes in and out of care, whose mother claimed she couldn't manage his behaviour, whilst the school reported the same. In line with earlier discussion on recording, Hannah stated that "if you read his files, you would see a very disruptive child who is extremely challenging". However,

> Once he came into foster care permanently, that's when we started to see a change in those behaviours. It was later recognised that it wasn't ADHD at all. (…) But [CAMHS] wouldn't change that diagnosis, unfortunately. But what we were then able to see was, actually, an abusive mum, extremely abusive mum, who was very manipulative, and actually convinced the local authority, and the school and everybody else, that it was the child that was the problem.

In Beth's case shared earlier, the placement eventually broke down and the teenager remained with the diagnosis but "not really been treated for it. Because it's kind of felt that it's not a real diagnosis".

So far in this section I have examined how the adults around the child may negotiate or iron out discrepant views without actually considering who might be 'right'. Here, it is necessary to point at another consequence of staff turnover/team transfer, beyond hindering knowledge of the child and relationship building. Short-term working also leads to a social worker's inability to evaluate the long-term outcomes of their decisions. Allison tried "to think through if I [was] seeing that journey through". She was discussing the case of a teenager who had "to go through a lot in order to get that diagnosis and access the right treatment"; however, Allison couldn't tell "the outcome for her, because I left the service around this time". Without being able to assess the outcome/s, Allison's evaluation that the treatment was "right" for the teenager, relies on beforehand information rather than the actual results, which may or may not coincide with what Allison was expecting. Knowing what exactly goes 'right or 'wrong' for children is precisely what is affected due to staff turnover. Henry referred to "testing hypotheses about interventions". However, that "testing" requires a longitudinal approach that is prevented by staff turnover and/or team transfer. It becomes difficult to evaluate progress when one has not been present from the beginning. And it is equally difficult to evaluate fully the impact of an intervention if one leaves before its end. Social workers are, therefore, limited by their very working conditions from fully evaluating the effects of interventions on children in State care.

This chapter has moved from the social workers' theoretical conceptualisations discussed in the previous chapter to examining social workers' accounts of what happens in practice. We have seen how the aspect they most emphasised – getting to know the child – was hindered by structural organisation. In practice, with limited time and knowledge, the focus of intervention can shift towards 'managing behaviour', rather than understanding the child's experience. It is in fact the adults' experience that can gatekeep intervention since 'management' refers to managing behaviour that is disruptive or distressing to the adult/s around the child. In this pursuit, with resources often reported as inadequate or insufficient, the social workers did not generally use psychiatric diagnosis in the way it can be expected from a medical diagnosis – to understand what's happening to the person to guide treatment – but instead to access preidentified resources. There is no sense from the interviews that social workers felt in ultimate control of decisions made about a child. They either managed to pragmatically work with the system, as in the instrumental use of psychiatric diagnosis, or were overruled by it, having to work with decisions that they felt ran counter their social work values. This gap between aspirations and reality caused distressed to the social workers, none more poignantly expressed than by Ivy, when she admitted "your heart is broken everyday cuz you're seeing a disservice to young people". In the next chapter I examine how social workers account for their decision-making and how they manage this gap between the values and the realities of practice.

5. CONSEQUENCES. Who are we understanding and supporting?

Uff, ethical, the thing that we've been really talking about is, 'does the problem lie within the child?' Aarunya

I just think that this whole hour of questions is really part of the ethical part of it, isn't it, really, because it's about whether it's right. Whether we're looking at the real and true reasons behind why children are medicated, really. I think that's a big ethical dilemma, where there's enough thought and consideration about the child's trauma and history. And whether we're really thinking about that, or whether it's just easy. Gemma

As seen in chapter 1, social workers, as part of upholding their regulatory body standards, are expected to "respect and promote the human rights, views, wishes and feelings of the people" with whom they work, as well as "ensuring that [their] interventions are always (…) in people's best interests" (SWE, 2019: 3). In the previous chapter we noted how adults' experience of the child's behaviour can become the first gatekeeper to intervention, and how the social workers identified situations where organisational interests took precedence over the interests of the children. Here I explore further those situations where social workers identified decisions they felt were not made in the children's name (that is, in their best interests and/or following their wishes).

The chapter is divided in four sections. The first three are each illustrated by a case study and consider the social workers' three most repeated sources of feeling unsettled – understood as a questioning of and uncertainty as to whether the child's interests were being served: the extent of children's involvement in decision-making; the impact of diagnoses on children's identity;

and the social, or non-medical, functions of diagnoses. The chapter closes with a final section that considers the barriers to social workers framing situations from an ethical/human rights perspective and/or to uphold an ethical/human rights-based practice.

Children’s consent, choice, or voice?

In this first section I consider where social workers feared that the child’s best interests might not be followed within the referral, assessment and treatment processes. I examine a case presented by Beth, a supervising social worker, to address two questions. By whom are these decisions made and how? And what is the child’s role within this process?

Sandy was a teenager placed with carers under Beth’s supervision. Through the carers’ actions, and against Sandy’s wishes, she was diagnosed with ADHD and autism and prescribed psychotropic drugs. Beth thought Sandy’s presentation corresponded to the latter’s history of trauma and had opposed an assessment. However, the carers “got agreement from a senior manager to go privately, which had a lot of ethical challenges for me anyway”. This is one of the rare explicit mentions of ethics within an interview. When I asked Beth what had challenged her ethically, she named three points. “The main one”,

> …was that they'd been allowed to seek a private opinion. But, as holder of PR[56], the local authority, I feel, should have had a say in who was chosen. And we didn't, they just went ahead and did it.

Second,

> … [the assessors] weren't in the field. What I've learned is there's so many different people that can make a diagnosis of ADHD and autism. (…) They didn't know anything really about trauma. You could see why that, if you go to someone who

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[56] Parental responsibility.

> specialises in ADHD, you’re probably going to get an ADHD diagnosis. (…) Because they didn’t know anything about trauma. And that, to me, that isn’t a holistic assessment. And it isn’t a good way of diagnosing.

Third and finally,

> …the young person didn't really want a diagnosis. And this young person was a teenager, so that was difficult for me, because she didn't want them and she's old enough, and she has mental capacity to say that and make that decision.

Later, Beth added Sandy was a,

> …very intelligent young person, and she didn't want to be medicated for ADHD. But she was kind of almost coerced into it. I didn't think that was right. What message is that sending her? To me, that is sending the message that you just do what an adult tells you to do when you’re a child, or you defer to a medical professional or social care professional. But that’s not giving the young people the credit that they know themselves better than we do.

Beth “felt like the foster carers had a lot of power there”, “because this young person was seen as challenging, because of her trauma, and it was considered that another placement would be hard to find”. Beth acknowledged that the carers saw the situation in a different way,

> They would see it as them advocating (…). I don't doubt that they cared for that young person, but they're very focused on the medical model. They wanted to get medication to treat her to make her better. I (…) explained them (…) the trauma is still there, we still have to respond to that. (…) But they were absolutely just focused on medication. And then, when it didn't work, they didn't really have anywhere to go from that. And the placement did break down, which is really sad.

Beth attributed the medication’s inefficacy to the fact that the trauma was “being swept under the carpet”. She concluded that Sandy had “the diagnosis now, but not really been treated for it. Because it's kind of felt [by the current professional network] that it's not a real diagnosis, or a true diagnosis”.

The irritation at having been superseded might be what led Beth to name choosing the assessor as her first ethical challenge. However, dealing with the third ethical challenge – not having Sandy's consent – could have meant not proceeding with the assessment, hence I consider it first, before I examine carers and social workers' roles.

Beth felt ethically challenged because the diagnostic process was against Sandy's wishes and Sandy "had mental capacity". Beth did not specify Sandy's age, but to have mental capacity she must be 16 or over (Mental Capacity Act 2005, s.2). If she were a younger teenager, capacity would not be presumed, and Beth would have had to consider whether Sandy was 'Gillick competent'[57]. She could have argued that this case should have never gone as far as discussing who should choose the assessor. If Sandy had capacity, she could have legally rejected assessment and treatment like any adult; therefore, what Beth or Sandy's carers considered the best intervention would have been irrelevant. Beth presented the case of a person with capacity whose decision was overridden, against her legal rights as per the Mental Capacity Act 2005. If this lack of consideration of a child's wishes happens within a clear legislative framework in terms of mental capacity, what happens when guidance and legislation require interpretation, as in the case of children younger than 16? Article 5 of the United Nations Convention on the Rights of the Child (UNCRC) states that parental guidance "must be done in a way that recognises the child's increasing capacity to make their own choices" (UNICEF, 1989). Article 12 asserts the child's right to express their view, "being given due weight in accordance with the age and maturity of the child" (ibid). This is in line with section 22 of the Children Act 1989, which requires LAs to ascertain the child's wishes and give them "due consideration having regard to his age and understanding". Legislation, therefore, recognises an undetermined gradient from care to autonomy for people under 16. Thomas, a social worker and Approved

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[57] Gillick competency refers to the child's (under 16) capacity to understand the consequences of a medical treatment and, therefore, be able to provide, or refuse, consent.

Mental Health Professional, acknowledged that, when it comes to mental health and children, there is a "fine line that you have to tread between protecting, and enabling, or empowering". So where do social workers draw that line and how do they "tread" on it? If consent is not always respected for young people who legally are to be presumed to have capacity (as in Sandy's case), how are younger children's wishes weighed and considered?

All social workers agreed that no mental health treatment should be undertaken without the child's consent. Most of them named the child's consent, and to a lesser extent involvement, as an ethical or human rights issue, making references to Gillick competency and mental capacity – as Beth mentioned in her case. However, this consensus on the importance of consent was only apparent, hiding how problematic the concept is, both in its interpretation and implementation. Involvement and consent can be considered along a continuum, but representing distinct stages, of which consent is the final one. Cristina described this continuum distinguishing between transparency in information sharing, followed by involvement in decision-making, with the ultimate right to consent. However, respect for a child's right to consent does not necessarily mean they have been involved in the decision-making process that concluded that a certain intervention is the most appropriate for them. Two points are discussed below: to what extent are children involved in practice in the decision-making process and how their views, including consent, can still be shaped by the adults around them.

For Thomas, the person's (adult or child) involvement in the assessment and decision-making process "is key. It's what we want, because the less involvement you have from that person, the more oppressive the intervention becomes". However, in Sam's experience,

> If you're experiencing distress, mental distress, it can be very difficult to get your voice listened to as an adult. And it can be very easily dismissed or have other people tell you what they feel is right for you. Now, you then make that service user, for want of a better term, a child, and then a looked after child, you then very

> much are into territory whereby it is very much ‘doing to’ sometimes.

Sam’s statement recognises the same two elements identified by Thomas earlier – mental health and children – adding a third one – being in State care. For Sam, each of these conditions separately creates a situation where it is easy for the adult in charge to think that they know what is best for the person, sidelining “enabling or empowering”. Within birth families, parents do not involve children in every decision made about them, and this depends on the subject matter and the child’s maturity (in accordance with UNCRC, article 5). Sam, however (as Thomas earlier), questioned the extent to which this “increasing capacity” is recognised and upheld. In relation to children in State care, Zuri felt “protecting” “often” took place without consulting or involving the children to be protected,

> As a corporate parent, we often do what we think is in the child's best interests, whether they agree to it or not. We take on this PR role (…). And we take a lot of things not necessarily for granted, but we kind of just are, ‘Right, this is what we feel is in the best interest for this child’, and we just go for it and just carry on sort of thing, without asking, ‘Do you want this or that?’

“Without asking” are significant words. Most parents, and indeed the law, would agree on the active role of adults in the final decision making over a child, the more active the younger the child. However, “without asking” implies that the child’s wishes are not given “due weight” (UNCRC, article 12) or “due consideration” (as Children Act 1989, s.22 requires LAs to do). “Without asking” implies these wishes are not even gathered. “Has the child actually asked to be assessed and diagnosed?”, as Zuri questioned. The absence of this question could be seen at times in some of the interviews. Nonetheless, Zuri stated “we often do what we think is in the child's best interests”. Corporate parents must pursue the child’s best interests. However, we need to remember here what was already discussed in the previous chapter. Corporate parenting is executed by adults who have a limited/fragmented knowledge of the child and who have limited investment in the child’s future (due to staff turnover and/or team transfer in the short to medium-term).

Social workers were asked to give their views on a series of scenarios (see chapter 2) that did not include the child’s perspective[58]. In providing their views on the situation, what the child’s views were was not consistently considered by the social workers. And, compared with consent, fewer social workers discussed the child’s involvement. Even the most energetic defence of the principle of consent can already be severely limiting a child’s involvement if they were not part of the decision-making process leading up to whatever needed to be consented. Beth stated that teenagers have “got a right to be an active participant in deciding what is and isn't given to them”. However, in her experience, young people were not always listened to “because they’re seen as children” – indicating she felt younger children were not listened to either.

What the interviews show is that, despite the agreement in principle on the importance and desirability of involving children in decision-making, this does not appear to be regularly sought in practice. In the case under discussion, Beth was uncomfortable with Sandy’s right to consent being ignored, yet even though we are told Sandy disagreed with the diagnosis and treatment, we still do not know what her alternative understanding might have been.

Regardless of how much children are involved in the decision-making process, eventually they will have to consent, or not, to whichever intervention has been decided. How then is consent elicited? Beth stated that Sandy’s consent was disregarded. How common is this situation? Sam explained how consent might be restricted by lack of choice,

> If you've got a child that's actually saying, ‘I really do not like that therapist’, (…) that child doesn't really have a choice, not really[59], particularly if we're talking about public health services that are overrun as it is already. You're lucky you've got through the doors, never mind not liking the therapist, you need to crack on with

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[58] All scenarios indicated the child’s age.

[59] Zuri does mention, as an example of good practice, how they managed to change professionals in a case where it was viewed that child and therapist were not getting along.

> this.

As Sam puts it, “How do you record that that young person is really enthusiastically consenting to this?”. However, consent is not just limited by resources. To be able to consent, one needs to understand, and the interviews show that social workers were sensitive to how understanding can be shaped. A continuum appeared in their responses. Whilst Aarunya described as “the most poignant” situation not forcing children to attend CAMHS, even when she would in her “heart’s heart think that would be good for them”, most social workers explained how acceptance of a diagnosis or treatment depended on how it is explained to the child. Other social workers thought there was a role for the adult to proactively elicit acceptance. Amy’s response to how a child makes sense of their diagnosis was a typical one: “I think it depends how it's presented to them, how it's done, and who's there as well”. Jack was more specific, explaining that “we’ve got to time it right […] Don’t just give the news. You need like strategy around it first.” Highlighting these answers does not intend to imply that there is anything wrong with having a “strategy” to present information, we all – including myself right now – have. But it does intend to reveal that the apparent involvement of a child in these matters is affected from the start by how adults approach the situation. As Jack concluded, “it depends on how you deliver it as to how the reaction will be”. The power to shape the narrative can still be retained by the adult.

Some social workers appeared to remain a step back, focusing on the information sharing stage and allowing the child to decide on their own. Thus, Diana did not think she “would ever force a child to take medication that they didn’t want to take”. She explained that she would “tell them that it’s just about outweighing the risks and benefits. And if they say they’re not going to take the medication, then we’ll support you in that”. At the opposite end, Amy criticised those who do not encourage children to take prescribed psychotropic drugs,

> We have had at times children located in children's homes, and they've said, ‘Oh,

> (…) we can't force them to have it, it's their human rights’, which I kind of see. But we're also the parent, we are the corporate parent, and we should be encouraging them to take medications. Because there is a medical diagnosis, and it's there to help them. Children cannot be forced to take their medication, but they can be explained and encouraged to do so.

Danah took this a step further. In the case of a 13-year-old admitted to a psychiatric hospital who refused to take his medication, she “really struggled” with the hospital’s response at the suggestion of mixing the drugs with the food unbeknown to the teenager: “It’s unethical. We wouldn’t do that. We’d have to get a court order”. Her response was to question the child’s capability to decide: “You then look at Gillick competency and you think, well, actually, okay, that child is capable of making their own decision. But then, would a normal child not bathe for three months?”

Diana and Amy are distinguishing between a child’s rights and their best interests. Both admit that what is recognised as a right – the child’s right to consent to medical treatment – may lead to a decision that is not in the child’s best interest, from the adult’s point of view. They differ, however, in what they prioritise. Diana would uphold a child’s right to consent even if it did not coincide with the adult’s decision. Amy would actively engage the child to try to align their decision with what the adult thinks it is best. Amy probably sees herself as advocating and protecting the children she is responsible for by encouraging medication use, similarly to how Beth felt Sandy’s carers understood their role (although Amy appears more respectful of the ultimate right to consent when the child has capacity or is deemed competent).

However, there is yet another difference between the Diana and Amy that may explain their positions: their differing views on psychiatric diagnosis and prescribed psychotropic drugs. In the extract above, and throughout the interview, Amy was supportive of the medical model. For her, a psychiatric diagnosis, and its consequent medication, “it’s there to help” the child. It is a common experience for many parents to have to encourage, cajole, and even coerce their child to take Calpol when they have a fever. It would be surprising to hear an adult respecting their child's right to consent here. Amy aligned her position to this situation. Diana explicitly did not. Diana made a clear distinction between physical and psychiatric diagnoses,

> Let's face it, it's not like cancer. It's not like, 'Right, I'm gonna give you this pill and you're gonna get a guaranteed cure, you're gonna be fine'. You give them a pill not really knowing the outcome of it.

For Diana, the situation is not as straightforward as for Amy: psychotropic drugs have risks and benefits. For Beth, a history of trauma is more significant and addressing it will, she contends, have more impact on Sandy's wellbeing than a possible psychiatric diagnosis and medication.

Other social workers, in making the distinction between "where the child is" and the adult's "view of how we think the child should be" (Yohanna), stressed the importance of starting any conversation at the former position. Luisa, for instance, adopted this stance and, although she also recognised "a lot depends on how we professionals explain it to [the children]", she described a collaborative conversation to support a child to make sense of their diagnosis,

> I always put it as a hypothesis (…), 'It seems to me that you've been feeling low since you were bullied five years ago. Is that right?' (…) We make sense of it together (…). They need to make sense of it for themselves. It's not you telling them 'This is what you've got' (…). I can do my best to explain to them, but it's up to them to make sense of it the best way they can. And you need to meet them where they are really.

But even in this collaborative approach, respectful of the child's point of view, the power of the adult to shape the final story is still present. As Luisa acknowledged, "they just trust you". Or, as Yohanna reflected, "children would generally look for adults" to decide what is best. However, an additional reason for the social workers' stress on the right to consent needs to be considered. Decisions about a child can easily be taken without the child's involvement, regardless of whether their participation is desirable, or even legally expected. However, child's consent is usually needed to implement interventions that involve therapy and/or prescribed drugs[60]. The repeated discussion on consent might be related to the fact that it is unavoidable in practical terms, unlike other forms of participation/involvement during the decision-making.

In the end, all social workers claimed they were ultimately respecting the child's right to consent. Yet, as has been discussed, this statement hides a wide range of positions within "the fine line between protecting and enabling". Far from being a 'yes or no' question, consent appears as a field of shading greys. There is one other point, mentioned in the previous two chapters, to consider: adults' differing explanations for a child's presentation. These explanations may be presented to the child simultaneously, from different adults within the network, or sequentially, as professionals change. How does a child choose between different explanations provided by professionals? What happens then when those different explanations (for instance, Beth's and Sandy's carers') lead to different proposed interventions? How does a child choose between different professionals "encouraging" them to take different, contradictory even, actions? Next, I consider the dynamics between carers and social workers as shared by the interviewees in terms of decision-making over the child, following from Beth's first ethical challenge – the fact that Sandy's carers, and not the LA, with parental responsibility, chose her assessor[61].

Outside of State care, birth parents take initial health decisions in relation to their children. But who takes on the role of a birth parent in the case of children in State care? For these children, the power to decide on their lives and their daily care falls on different people. Here we can see the practical difficulties of that dichotomy between decision-making and caring responsibilities. In this case Beth feels it was part of the LA's parental responsibility to decide who would assess

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[60] Sectioning under the Mental Health Act 1983 being the exception to this.

[61] Whilst in State care, parental responsibility is legally always shared with birth parents, so, besides the LA, parents should also have been involved in this matter.

Sandy. However, in fostering there is the figure of Delegated Authority, which, as its name indicates, delegates certain decision capacity onto the carers. Beth's manager could simply state that they were delegating this decision. The usual reason for this delegation is that carers know the children best. In Sandy's case, both Beth and her carers had known her for the same length of time[62]. But most social workers recognised that carers know the child best because they live together, as Amy stated,

> They have our children every single day, they know these children inside out. So I always listen to them really well and try and work with them very closely for the benefit of the children.

The situation, however, is often more complex due to placement breakdowns and staff turnover. It will be different for each child in State care. And let's remember that whoever the person is who knows the child best, being in that position was considered determinant by social workers to be able to assess a child accurately. But if we consider the statistics on placement breakdown given in chapter 1 and the social workers' statements on staff turnover (chapter 3), Beth's words of "not giving the young people the credit that they know themselves better than we do" acquire a new significance, since we need to consider that for some children in State care there is no adult who knows them "properly". This potential scenario was not raised by any of the social workers. Sandy's legal rights on consent to medical intervention were trampled on, and decisions were made by adults who only partially knew her.

We could consider this a case of different professional opinions based on the same information. However, what led to Beth's view being overridden by management without a joint discussion? For Beth, the answer was not related to Sandy but to her foster placement: "this young person was seen as challenging (…), and it was felt that another placement would be hard to find".

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[62] One professional conspicuously absent from Beth's telling of the story is Sandy's social worker, who would be the one representing corporate parenting.

This situation needs to be considered in conjunction with Nathan's explanation, "moving a child from placement to placement is not helpful. And we will do as much as possible to keep children in placement". And here lies the dilemma. What may look like just a difference of opinion, something that most professionals experience regularly, becomes an ethical dilemma: to ensure that the child receives an appropriate diagnosis and treatment or to support the placement's stability? For the social worker, when their view does not coincide with that of the carers, supporting a child's best interests becomes a matter of choosing what they consider the lesser of two evils.

This dilemma can also present itself to the social workers when working with parents, as Aarunya explained when considering what to do when parents press for their children to be medicated (unduly in her view),

> But unfortunately, I would say it's really difficult when parents are with the children 24/7, and they do end up getting the child to see the benefit of medication. And it would be very hard putting in a safeguarding referral about that, be very difficult. It would cause more harm than good than to just work with the family.

In Henry's case (discussed in the previous chapter), however, he was willing to risk a placement breakdown. He thought that outcome "was going to be really difficult for the child". He was prepared to "own it" in front of the child, to explain to the child the actual reasons behind decisions. And this is a point to consider. Nobody appears to have told Henry's child or Sandy (neither of whom wanted mental health interventions): 'We are going ahead with it because your carer wants it, and we fear otherwise the placement will breakdown'. The discrepancy between what the child is told and the discussions that take place backstage can be significant in relation to how a child will understand what is happening.

Finally, Beth (and Henry) used the word 'power' to refer to foster carers within this case. It would be a mistake, however, to conclude that foster carers are more powerful than social workers. Who holds more control over the narrative is determined by an array of factors whose particular constellation is specific to each case. However, as seen in the previous chapter, where the medical narrative was involved, it was a determining factor in the cases shared by the social workers.

I have considered a case, Sandy's, where the child's views were disregarded (possibly illegally so). What happens with younger children, who rely on adults' narratives to come up with one of their own? I consider this scenario with the next case, one where the foster carer did not support the medical narrative.

Who am I?

Olivia recounted the case of a primary school age girl, Jasmine, who had been with her foster carer for about six months. Olivia considered the carer to be "very good", "thank goodness", and said that the carer had "been able to work out the sorts of triggers that leaves the child to dysregulate", as well as "the sorts of things she can do in advance" to prevent it. Yet, "the thing has been bubbling up about, has she got ADHD, has she got ASD". At an annual medical review,

> …the person doing the medical, who was very thorough, (…) grabbed hold of the ASD, ADHD. And it's like, well, some of what she does shows some of those things sometimes. But there's lots of things she doesn't show that don't tick those boxes, (…). And is her history of very significant trauma not story enough to explain her behaviour? Why do we need additional labels, particularly the long term and fixed? But social services were pushing around this. So she ended up seeing a paediatrician, who (…) went, 'Oh, no, she hasn't got autistic spectrum disorder, it's an attachment issue'. This is what the foster carer comes and tells me. And I said, 'Well, I tend to agree with him, but he hasn't done an assessment. (…) And one of

> the difficulties is that mentalisation difficulties can be linked to both ASD and significant trauma. So you end up with misdiagnosis, but actually this chap had diagnosed without doing any type of diagnostic, so it's like... Then I'm speaking to the manager of the fostering provider, and I find out the push for the diagnostics is from social care because if this child has these labels, she has a bigger costing to her. She can have more finances in her placement, she's worth more. This is how it is. Very, very uncomfortable. If she doesn't have the labels, she doesn't get the additional funding. What does one say about that?

Later in the interview Olivia reflected on what the child might be making of her diagnostic process,

> From this child's point of view, from what I understand from the carer, I think the whole process of assessment has been between annoying and distressing. I don't know what sense she makes of it. I suspect, very little. I think she knows she does some behaviours that other people fine odd like, particularly chewing lots of different things. I don't know to what extent she thinks it's a problem. And, as long as she's not chewing anything terribly dangerous, how much of a problem is it? Who decides it's the problem?

Olivia, like Beth, questioned the diagnostic process. As seen in chapter 3, Olivia and Beth feared misdiagnosis because of the overlapping symptomatology between ADHD/ASD and trauma. These points mattered to Beth and Olivia because they thought the child's best interests might not be served by their subsequent diagnosis. Beth considered ADHD and its treatment diverted from the problem that needed to be addressed, "you still have to respond to the trauma". Olivia questioned why it was considered necessary to subject Jasmine to an assessment process when there was already an explanation that fitted her presentation. Beth and Olivia both felt strongly that what happened to the child sufficiently explained how the child presented at the time.

In line with what has been examined in the previous two chapters, two different narratives can be distinguished in the social workers' interviews: 'what happened to you?' and 'what is wrong with you?' (Perry and Winfrey, 2021). Some social workers, like Beth and Olivia, made a clear distinction between the two, rejecting the latter narrative in favour of the former; whilst for other social workers there appeared to be a degree of fluidity between the two – as in Luisa's explanation below,

> I had a young person who was very much Borderline Personality Disorder. It's now called Unstable Personality Disorder. I was seeing her for a while. And she said to me, 'I just want to know what I've got'. And in that case, I felt she needs to know. It would help her to know what's going on for her. And so she was turning 18, was leaving the service and I said, 'We don't do that diagnosis until someone turns 18, but I want you to know that to me and to my colleagues, you come across as someone who presents with this diagnosis and considering your life experiences that you mentioned to me, these, these, these and these, that would make sense, because that's how it's developed'."

In this example, Luisa, who generally avoided giving diagnoses to young people, was explaining an exception to that position. In her description of the case, the two narratives are not exclusionary, one leads to the other. Biographical events crystalise as an individual's disorder. Similarly to Luisa, Nathan linked a child's experiences to their eventual ADHD diagnosis: "I know why they have the diagnosis, because obviously, their lived experience". However, for him, the diagnosis, defined by symptoms, obscures the effects of that experience:

> But it's sometimes difficult to say to the child, 'Well, no, because your mum, dad didn't do X, Y, and Z, so this is how you are'. It's more around, it's awful to say, but it's about 'Because sometimes you struggle to sit still for a long period of time, or you struggle to concentrate. Take this medication or whatever this is, and this is there to help you concentrate or help your diagnosis of ADHD' (…) So it's more around explaining their medication is there for the symptoms of their diagnosis, opposed to the real reasons why they got a diagnosis.

For Ivy, and several other social workers, this explanatory movement from a child's experience to a child's symptoms could lead to "the young person internalis[ing] it as something wrong with them". For Ivy this was a reason to be cautious about seeking diagnoses, because of the detrimental psychological impact they may have on the child. Olivia also pointed at this potential effect of psychiatric diagnosis, "which will impact on how other people see them, how they see themselves and how the world interacts with them, and they interact with the world". These social workers saw diagnoses as shaping the narrative around a child's identity. Most saw the effect of diagnoses extending beyond being potential explanations of behaviour to affecting identity formation. Several expressed their concern that diagnoses created a "self-fulfilling prophecy" for children, setting expectations on their behaviour that were limiting rather than enabling.

Not all social workers, however, saw this process of identity formation through a diagnosis as negative. For Caroline, a diagnosis might bring "validation" to the young person,

> I think it is helpful for young people sometimes to have a diagnosis, because it helps them understand that there's nothing wrong with them, in a way, even though there kind of is if you're giving a diagnosis, but it's a validation that they should be feeling and thinking in the way they're thinking because of what's happened to them in the past. And here's the proof in this diagnosis now. So there's a bit of validation in there. For the young people.

Caroline conflated both 'what happened to you' and diagnosis as sources of validation. However, the "proof" comes from the diagnosis. Nathan, on the other hand, complained that trauma is not explanation enough. Other social workers, as seen in the previous chapter, questioned "why you need a label?" What is significant here is that diagnosis is not merely seen as an explanation of the child's behaviour but as becoming part of their identity (their way of understanding themselves and justifying their "feeling and thinking"). Whilst for some social workers this could have a positive effect of validation, for others, it obscured the child's experiences, and it might limit or constrain them by transforming the symptoms of the diagnosis into a set of expectations on their behaviour and a particular idea of who they are. Yet both narratives are supported on the same grounds, what is best for the child, though not necessarily, as we have seen, with the child's involvement.

There was significantly less discussion from social workers on consent in relation to younger children, as opposed to teenagers, with some of them recognising how much easier it was to obtain compliance from a child. From Olivia's perspective, in Jasmine case, she was subjected to an intrusive assessment process – reminding us of the 'done to' mentioned earlier by Sam – when there is already a sufficient explanation for her presentation. Jasmine, in this story, appears as an object of observation and extraction of information, not as a person who can express themselves. She required protection from the assessment process (the carer "has to set her up" with sensory tools and send her out of the room). This is not just an adult-led process. Olivia's question, "who decides it's the problem?", recognises that the problem is identified and defined by adults. This is an adult-constructed and adult-centred process, a process in which the adults involved may have multilayered conflicts of interest.

Confirming Caroline's feeling, some social workers mentioned having worked with teenagers who, unlike Sandy, actively sought a diagnosis, who wanted to know "what was wrong with" them, as a way of validating their present experience. However, the diagnostic narrative may not only support the child in thinking that "there's nothing wrong with them", as Caroline stated, it may also make adults less likely to question their own caring practices. Most social workers emphasised the impact of the relational environment on the child's behaviour. Luisa explained how "we never consider a child on their own, because that's rarely what it is, it's normally the family". However, the most critical social workers were concerned that what a diagnosis did was precisely to disregard this relational influence as having any significance. That is, it is not only the child's identity that might be at stake with a diagnosis, but the adults' too. In the final case I consider the functions that a child's psychiatric diagnosis may serve for the adults, beyond its potential explanatory medical value.

The social functions of a psychiatric diagnosis

We put problems onto the children for different reasons. Henry

There is a point in Sandy’s case that has not been considered yet: her presentation changed with her second carers. I use Diana’s case below to examine this scenario – a child’s changing behaviour with different carers – in more detail, examining the social functions that a diagnosis and/or psychotropic drug may serve.

Diana, a child social worker, presented the case of a nine-year-old child, Alfie, diagnosed with ADHD. Diana’s favoured explanation was trauma. The placement broke down. The new foster carer “had done therapeutic training” and “was much, much more able to manage” Alfie. Whilst Beth simply concluded that Sandy was no longer treated for her ADHD, Diana offers details of the conversation that led to the same outcome for Alfie. At a care planning meeting, professionals,

> …said, ‘Look, we don't think this child's got ADHD at all’. And then everyone else asked the question, mainly to me, as the corporate parent, ‘Can we stop the medication?’ And I said to the foster carer, ‘Is [he] asking for it?’ She went, ‘No’. and I went, ‘Are you managing [his] behaviour without it?’ ‘Yeah’. ‘How does [Alfie] feel without it?’ She said, ‘[He] feels really better and not sick’.

After discussion with the paediatrician, the medication was discontinued.

Diana discussed this case as one where diagnosis and medication should not have happened and considered the ultimate outcome as a positive one. Unlike Beth, Diana was the child’s social worker, and she was asked directly for a decision on medication. Following the principles of the Children Act 1989 and the UNCRC, Diana inquired about Alfie’s view and experience before reaching a decision. Yet she asked the foster carer whether she was managing Alfie’s behaviour without it. What would have happened had the answer been negative? Is the carers lack of ability to 'manage' a child's behaviour a reason to medicate a child? For whose benefit is the medication prescribed? If the medication is not there, at least not solely, to treat the child therapeutically, what are its other purposes? Do diagnoses – the gateway to medication – have similar nontherapeutic purposes?

Those social workers critical of diagnoses were concerned that they and/or the prescribing of psychotropic drug responded to motives other than the child's best interests, specifically, that they served the best interests of the organisation and/or adults entrusted with looking after them. Here I consider three such motives named by social workers: financial, managerial and psychological. These functions need to be considered alongside the compromises already discussed in the previous chapter. Together, they detail a tapestry of "competing agendas" (Henry) where the child may recede into the background.

Financial

Olivia's case illustrates an example of a financial motive: some organisations attach a larger budget to a child with a diagnosis. This is presumably because it is assumed that a diagnosis indicates the child has greater needs; however, this decision can create a spurious incentive to obtain a diagnosis for a child in order to receive more funding. Henry described the same situation in relation to foster carers. In some agencies/LAs, carers received a higher allowance if the child had a diagnosis – presumably because their work is considered more complex – again potentially creating a financial motive to seek a diagnosis. When carers/organisations receive a financial increase following a psychiatric diagnosis, rather than (or in addition to) facilitating access to resources, the arrangement creates a direct conflict of interest when carers or organisations advocate for a child to be assessed.

Managerial: Behaviour

Diana’s question on behaviour points at the management function, specifically “behaviour management using medication” (Vivian). Most social workers felt there were times when adults relied on prescribed psychotropic drugs to manage a child’s behaviour. Cristina reported having had to challenge overmedication in some of the children’s homes she had visited. Terry thought some schools pursued medication since the child becomes easier to manage. In Jack’s experience there was “always a tendency for people that are supporting children on medication, if they're still challenging, to just up the medication”, rather than considering the possibility that (more) medication may not be the solution. The social workers expressing these concerns thought that the child’s environment and parenting/caring approaches should be addressed before considering psychotropic drugs. Social workers also considered that at times children might be offered psychotropic drugs because it was easier and cheaper than psychotherapeutic support.

It must be noted, however, that even social workers who were cautious or critical of psychotropic drug prescription mentioned cases where they agreed they were needed. Thus Terry, with a very critical position, described a case where she had insisted on medication for a teenager which eventually, in her view, had prevented him from entering the criminal justice system. However, there was a consensus amongst most social workers that psychotropic drugs addressed symptoms, rather than their cause, “if we prescribe someone medication, we just gonna mask the issue, rather than tackle the core of the issue” (Nathan). Diana took it a step further and linked this prescription with Western culture: “That’s not that different to Western society; in some ways it’s a quick fix. Let’s fix and let’s put a sticky plaster on it and let’s move on”. With the prescription of psychotropic drugs, a child’s presentation is seen as a problem to be solved, not to be understood, as noted in chapter 4. However, amongst the causes behind a child's behaviour that medication might be masking could also be the shortcomings of the adults and/or organisations to support the child appropriately and effectively, leading to the third and final social function of a diagnosis.

Psychological: "Exoneration"

For some social workers, however, addressing a child's behaviour through diagnosis and prescribed drugs might not only have the practical functions of accessing funds or making easier to manage a child's behaviour, but it can also have the related psychological functions of creating greater certainty and "exoneration" of everybody involved, adults and child. A diagnosis seems to identify a neatly and clearly defined problem. Henry was one of the few social workers to reflect on this sense of "clarity" and "security" that a psychiatric diagnosis might bring, dispensing with the need to work "with ambiguity or with complexity". But most social workers reflected on how a diagnosis allows the 'problem' to remain within the child, "rather than the world around [the child] that hasn't responded correctly to their needs". That is, the adults' (parents, carers) or organisational (schools, social services) shortcomings are recast as a condition within the child.

For some social workers, children also felt this "off the hook" (Henry) effect. Some social workers questioned the understanding that teenagers had of their diagnosis, but teenagers would, nonetheless, still put their behaviour down to it. Henry described this position as using a diagnosis as a "social shield". However, Nathan pointed out that even when a behaviour was explained by a diagnosis, the behaviour still needed to be addressed, and the diagnosis only made the latter more difficult, since it was seen as beyond the child's control.

A diagnosis might shield parents from considering the possible consequences of their parenting struggles and shortcomings, as Terry explained,

> I think a lot of the diagnoses, especially around ADHD, is more about parents who are just finding parenting, and being a parent, difficult. And actually, rather than be able to look in, and we're all like that, we're all humans, rather than being able to look in the mirror and kind of say, to ourselves, 'I find parenting difficult' (…), they try and seek somewhere else to blame (…), so that they don't have to look inwards.

It would be an error, however, to extend what is one possible explanation, that children's behaviours develop as an adaptation to parental shortcomings, to all, or "a lot of", cases of ADHD (or other diagnosable psychiatric conditions). Social work has already been questioned for relying on the category of 'disorganised' attachment as evidence of parental abuse (White et al, 2019). Disagreements within attachment theorists about such category aside (Crittenden, 2016), even those who support the category have written against its use within child protection since it does not provide conclusive evidence of maltreatment (Forslund et al, 2022; Granqvist et al, 2017). There starts to be a recognition of the existence of different pathways towards a disorganised attachment, not all involving parental abuse (Duschinsky, 2018). For instance, in their meta-analyses of attachment in maltreating and high-risk families, Cyr et al (2010) concluded that an accumulation of socioeconomic risks could also result in children's disorganised attachment.

For some social workers, a similar situation to the one described above in relation to parents could be found with carers, "it can sometimes be more comfortable to label that child as having an issue, rather than digging really, really deep" (Sam) and reconsidering one's own caring approach. Henry described how this could be due not just to the carers' possible shortcomings but also exacerbated through a deficient fostering support system. For him, we treated the child instead of admitting that,

> …we've got a carer that's terrified and doesn't know how to do the right thing. And she doesn't know how, or he, doesn't know how to intervene with that, or they're not confident enough, their social worker's been off on sick leave for months, and they've just been struggling on their own. (…) So we project that professional anxiety on children and it becomes their problem to own then, when really it wasn't.

Olivia extended this organisational perspective to the educational environments, where she reflected on how the different approaches between primary and secondary schools determined that more diagnoses were sought at the latter. For her, "people think that if the child doesn't fit with the system, that there's something wrong with the child and not the system". In considering the ethical implications of this situation, Olivia asked the question, "should we not change the social requirements, rather than call a child something, so we can let them off the hook?" It is unclear whether "them" refers to the social requirements, the child, or both. In any case the child's labelling through a psychiatric diagnosis potentially has the same effect in both.

However, no social worker considered the potential psychological effect for children of a 'double exoneration'. That is, from a child's perspective, a diagnosis may "exonerate" both themselves and their parents/carers. In ambivalent emotional relationships (as children in State care potentially have with both birth parents and carers) a diagnosis allows the child to keep the 'goodness' of the adult (i.e. they do love me), whilst pushing the difficult part (they are hurtful/unhelpful) out of sight. It might be easier to accept a psychiatric diagnosis than certain parenting/caring shortcomings. In this way, a diagnosis may not only be psychologically protecting the adult and/or the child, but also their relationship. Henry described the case of another teenager for whom his mother had sought different diagnoses at different times, and he was eventually diagnosed with Bipolar Disorder. Now in State care, the professionals involved would like the teenager to be reassessed since they believed his presentation was due to the abuse he suffered. However, the teenager accepted his diagnosis – in Henry's view, identifying with his mother's narrative – and refused to undergo a new assessment[63].

The concern around exoneration was only mentioned around psychiatric diagnoses. No social worker discussed that the trauma or 'what happened to you?' narrative could potentially exonerate adults too. Yet, emphasis on a child's past trauma may remove attention from the care children are receiving in the present. This can be observed in how Beth and Diana narrated their cases. Both shared their concern about diagnosis erasing the child's experience of trauma. However, even if that was the case, past trauma was unlikely to be the only explanation for the children's presentations (potential ADHD aside too). In both cases the child's behaviour was reported to improve when moved to another carer. Diana mentioned the new carers were able to manage Alfie better; however, as Beth argued, the causal explanation remained in recognising the role of trauma instead of focusing on symptoms and diagnosing, diluting the potential effect that carers had on the children.

If trauma and/or diagnosis were the only explanation/s, we should expect similar, if not the same presentations, from placement to placement. Social workers did recognise the influence of adults on children's behaviour, as we saw in chapter 3. They recognised that context "makes such a difference", as Olivia described in relation to a "good" primary school. Yet, when confronted with the story of a child who was in their view wrongly diagnosed, and then moved to another placement where there were no concerns, most only stressed the importance of recognising the effects of trauma. But why did the same child present so differently in two different placements? In fact, here the medical narrative and the trauma narrative serve the same purpose, they obviate the effects of the child's present relationships. Both narratives respond to a similar formula:

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[63] This case also illustrates the contradictory approaches that social workers had towards diagnoses. Earlier we saw how Luisa justified a Bipolar Disorder diagnosis precisely because of what had happened to the teenager.

MEDICAL CONDITION (within the child) = CHILD’S PRESENTATION

TRAUMA (within the child’s past) = CHILD’S PRESENTATION

Or their combination:

MEDICAL CONDITION (within the child) + TRAUMA (within the child’s past) = CHILD’S PRESENTATION

Both point at something that it is not within the control of the adults who currently work with the child. However, a placement breakdown affords us a quasi-randomised control trial. We have the same child subjected to two different care experiences, one immediately after the other. A placement breakdown shows that there is at least a second factor influencing a child’s behaviour.

TRAUMA/DIAGNOSIS + RELATIONAL CONTEXT = CHILD’S PRESENTATION

Discussing this type of scenario (the child’s behaviour raises concerns in one placement but not in the next), some social workers mentioned the importance of finding a good match between children and carers. “Sometimes they’re just not in the right placement”, Beth said. However, that may be only part of the situation. As mentioned already, a significant number of social workers expressed their concern that children were misdiagnosed due to the overlapping symptomatology between trauma and conditions such as ADHD and ASD. That is:

CHILD’S PRESENTATION + IGNORED TRAUMA = (MIS)DIAGNOSIS

Social workers only considered this route. Yet, these comments on the importance of the quality of caregiving reveal a second, unmentioned, pathway to a possible misdiagnosis – particularly if we consider discussion on the previous chapter on how it is the adults’ experience that triggers support seeking for the child’s behaviour.

CHILD’S PRESENTATION + UNSUITABLE CARERS = (MIS)DIAGNOSIS

Social workers talked about the effects of trauma being misdiagnosed as ADHD/ASD, but in describing how the child presented disruptively in one placement and not the next, what they are revealing is that what might be indirectly misdiagnosed as ADHD/ASD are the adults’ shortcomings (as well intended as the adult may be) in caring appropriately for this child. And as mentioned in chapter 4, social workers did identify shortcomings in some carers. Vivian stated she had met some “wonderful” carers, others she “would not have left my dog with”. Caroline noted that “we do have bad foster carers”. Diana stated “sometimes people say, ‘Oh, they’re safe because they’re with foster carers’. No, no, no, no, no, no, no, not always the case, not always the case”. Ivy concluded,

> I think with children in care that they have a huge disadvantage because we remove them from a terrible, terrible environment. And quite often we put them in one that isn’t that much better.

Schools were mentioned less frequently, but the same “mixed bag” was appreciated, with Diana summarising the social workers’ views on them: “I’ve come across some really good pastoral support. I’ve come across others that just blame kids”. However, as we have seen above, if schools/carers apply “an informed way to work with a child” (Pippa), the disruptive behaviour may not even be manifest. If children are placed with therapeutic, trauma-informed carers who manage their behaviour, concerning/challenging (to the adult) behaviours may not appear, and children may not be diagnosed. If children are placed with carers who simply tolerate or cope with their behaviours, those behaviours might not be reported, or be minimised, and children would not be referred to mental health services. It is unlikely that Alfie or Sandy would have received an ADHD diagnosis had they been placed initially with their second set of carers.

But it also leads to a second consideration. In the last chapter, we heard Nathan and Meg reflecting that just because a child does not manifest it in their behaviour, it does not mean they are not suffering from the consequences of their trauma. That absence of symptoms, however, could lead to obscuring the extent of the effects of trauma. It again opens the question raised in the preceding two chapters. Are we addressing a child's emotional wellbeing, or managing their behaviour to ensure it is neither disruptive nor disturbing for the adult?

Ethics and human rights: The profession's Magic Mirror Gate[64]

I don't know how deep those conversations are being had [sic] within local authorities. Sam

Before starting this final section, it is important to establish that all the social workers came across in their interviews as deeply caring for the children with whom they worked. In some cases, it was clear that they viewed the interview as a vehicle to shed a light on unsettling experiences, and so far in this chapter we have discussed some of them. Yet, when asked explicitly for an ethical and/or human rights (HR) perspective on those experiences, generally social workers were surprised by the question and/or struggled to answer it. Danah did not think that question was "linked to what I do". Nathan had "not used human rights myself". Others found the question "difficult", "quite tricky", "quite technical" or didn't know. Aside from discussions around consent and capacity, there was limited consistency in responses across the interviews. This contrasts, for instance, with the consistent responses around the qualities of a good social worker or, around their theoretical frameworks. Some struggled to answer this latter question, but none were surprised by it, and a few stated they had been expecting it. The interviews show that social workers felt they could not always implement their version of ethical practice within the organisational structures that employ them. Below I discuss the three types of barriers towards an ethical and human rights-based practice that appeared within the

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[64] In *The Neverending Story* (Ende, 1984), Atreyu, a boy, must cross the Magic Mirror Gate. To cross the Gate, said to have driven some heroes into madness, one must face their true self.

interviews: educational, organisational and professional.

Educational

The principles under the global definition of social work state that "[a]dvocating and upholding human rights (…) is the motivation and justification for social work (IFSW, 2014: no page). Yet, despite national and international professional organisations' efforts to frame social work as a HR-based profession, social workers did not appear to be familiar with or use HR legislation. Pippa stated that "it's more the Children's Act that we use rather than the Human Rights Act". Thomas, an Approved Mental Health Professional, was the only one who regularly referenced HR legislation throughout his interview to discuss professional practice. In the rest of the interviews, any reference to HR appeared in general terms.

In relation to children, an important document is the United Nations Convention on the Rights of the Child (UNICEF, 1989). Social workers did not use it to frame their grievances. For instances, one of the most repeated complaints by all social workers, the lack of adequate resources to support children in State care, was never discussed in relation to article 39 of the UNCRC, which binds States to "take all appropriate measures to promote physical and psychological recovery and social reintegration of a child victim of: any form of neglect, exploitation, or abuse".

Ivy – who was "a bit stumped with" the question on HR –, towards the end of the interview, discussed the consequences for children when not being able to remain with their families due to lack of support from the State,

> Sometimes they're better off staying in situ with the support services than bounced around foster care homes, and their world falling apart, leaving their family, their friends. (…) I think we just do a huge disservice to young people. And it's really

> sad. Because I think (…) the support services could have kept that family ticking over. (…) It's all been squeezed, and it just filters down and then the young people feel punished and they're the ones that we remove. So therefore, it's their fault. (…) And that's their lifelong impression. And we've set them up to fail. And, you probably know this, is probably irrelevant. It just leads on from that when we talk about budgets and talking about mental wellbeing, and what do we expect, of course the young people are going to have mental health issues.

Ivy could have supported her argument with article 18 of the UNCRC: "Governments must support parents by creating support services for children and giving parents the help they need to raise their children". Caroline, an Independent Reviewing Officer, was the only social worker to mention having used the UNCRC to challenge LAs in their practice. As part of the same conversation, she stated,

> Usually, if you say, 'Are you looking forward to a legal challenge on this when the child engages their own solicitor because they have a right to do so?' That can be really effective, but it's usually the last chance, I've usually tried all sorts of things before getting to that point.

Social workers appeared to be upholding those human rights referred to by the global definition of their profession without specific knowledge of their official formulation. Equally, social workers did not seem to frame their concerns within an ethical framework. When it came to ethics, for instance, Yohanna was not sure what "went into" it.

Organisational

Yet, without that explicit reference to ethics or human rights, social workers nonetheless felt they were working within organisational structures that did not support the kind of practice they would like to pursue. For these social workers, these structures – which in most cases were their own employers – did not align with their professional values. What characterised these situations is how little control social workers felt they had over them. In the fray of day-to-day practice, logistical compromises appeared unavoidable to social workers, children needed to be placed, and cases had to be allocated, as Thea reflected in relation to placement finding,

> …because if there's no placement, the child has to go where they have to go, don't they? (…) As much as we try and be child led and child focused, the system sometimes doesn't allow us to be, does it?

For Sam, it was the assessment of carers which did "not meet the needs of looked after children". Specifically, she pointed at the lack of focus on developmental trauma during the assessment process, potentially creating a lack of common understanding and expectations between carers and social workers from the beginning, with carers feeling scrutinised and blamed when social workers were trying to look at their therapeutic parenting,

> It's almost like, there's this assessment process and then we're trying to upskill these carers with what therapeutic parenting is all about. That's not the point. That (…) has to be from that initial inquiry point.

Sam thought the logistical need of having carers to be able to place children was responsible for shortcomings in the approval process of foster carers, adding that local authorities' "targets [to approve carers] and trauma do not go well together". Ultimately, like Thea, Sam took an unavoidability position in the tension between the child's interest and the need to find placements,

> From local authorities and agencies' perspectives that can be this, 'We need these carers, we need them all in, needs to get them to panel, getting them approved and all the rest of it'. But it's just like, 'Well, hold on a second, let's think about the needs of these children'. But then you get that other argument where it's just like, 'Oh, we've got all these children and need a placement, we can't have them just kind of languishing'. But then this is where I think the whole system is just flawed, because there's lots of things that are at conflict at play there.

It should be noted, however, that although Sam conflated LAs with independent fostering agencies, their position is fundamentally different. LAs are responsible for the children in their care and, therefore, responsible to find them accommodation. IFAs do not share that responsibility. They only approve and supervise carers; therefore, the pressure argument should not apply to them. In their case, carers' approval might be a question of financial gain.

A similar unavoidability position was taken by social workers in relation to their working conditions. For instance, Rachel stated that caseload targets are good, "but a case has to go somewhere". Yet, excessive workload could act as an ethical barrier. A few social workers linked high caseloads with the inability to have time to think critically and reflect on practice. Henry thought we don't "see enough of [being analytical and critical] in social work at the moment" because social workers are "limited by the fact that you've got so little time, you've got so many children on your caseload". Sam thought excessive workloads helped the managerial culture since it stopped workers from having the time to question practice,

> …because it doesn't allow that space for thinking if you bombard and you bombard and you keep piling on and piling on (…). People do get so overwhelmed with all the process and bureaucracy, that they're not going, 'Hold on a second, what is going on here?' (…), which I find really frightening.

Several social workers welcomed the interview as a chance to reflect on their practice. For Henry "we must find a way to be [critical], otherwise it will keep going wrong, the stuff that we're trying to do for children". Other working situations could also be construed as unethical or impinging on children's rights. For instance, if understanding behaviour depends on a good knowledge of the child, and if supporting a child appropriately depends on a good matching, the lack of interagency information sharing at the point of searching for a placement, reported in chapter 4, could be considered unethical inasmuch as it is potentially at odds with the child's best interests.

Although these logistical conundrums were considered from a viewpoint of unavoidability, and the planning capacity or recruitment and retention policies of LAs were largely not scrutinised, social workers did question other aspects of their employers. Social workers described themselves as employed by bodies whose organisational ethos was against their own professional values. Thea reported she “found that most battles are sometimes within the organisation not outside the organisation”. A few social workers focused these battles on resources and finance. Lydia reported on her experience within an IFA as “working somewhere where they were very money orientated. They were bringing me down to a level where it was all about money. […] And my ethics weren't as good as I wanted them to be”. Lydia eventually left her employer. Meg, a manager within a LA, was similarly ethically challenged,

> It was very much about money. We became more focused on that rather than the children (…) I remember in my office, I had these cards, like little different daily affirmation cards, and one of them was like, ‘Does this decision move you closer to or further away from your values?’ And in the end, I was like, ‘What values? Where are they? What were they?’

Diana reflected that the organisation’s and the child’s best interests might not coincide,

> I do think you do need quite a strong personality. Because there are ethical issues that crop up quite regularly across my career that, if you’re not strong enough, to challenge them, to whistleblow, or to walk away from a role, then that can lead you, I think, into your own ethical difficulties, too much affiliation to the organisation, rather than to the child.

This statement potentially situates social workers in a difficult position. It suggests that supporting the children’s best interests might at times be against the interests of the social worker’s own employer. Diana’s suggestions to solve the ethical difficulties (to challenge, to whistleblow, or to walk away) lead to the third and final barrier, the social worker as an employee and as a professional.

Professional

Social work, as with other professions in its dual position of a job and a profession, might also present barriers towards an ethical practice, this time opposing the child's interests against the social worker's. As employees, Sam spoke of finding fear amongst her colleagues,

> I don't know what's happened to the profession, Ana. I just don't know whether everybody's too burnt out and too busy. But I think there's an element of fear as well within social work. (…) I do sense that there is a real fear, it seems to me, of workers, speaking, or questioning. (…) But I've definitely been in places and sensed people don't want to, just get your head down and do what you got to do.

Here we find that it is professional risk that may act as a barrier against ethical/HR-based practice. Social workers are, of course, human beings with families and mortgages/rents, children's schools, sometimes the same struggles as the human beings they engage with as service receivers. And, as Henry realised when he challenged the entire network to support the teenager who did not want therapy, "in a big local authority you are quite easily replaceable". Therefore, it might not just be the organisation's interests that are against that of the child's, the social worker's interests as an employee might also be.

Besides their condition as employees, social workers' status as professionals could also create dynamics conducive towards over intervention, or, on the opposite end, facilitate deflection of responsibility and/or justify inaction. Several social workers reflected on the differences in decision-making processes within birth families compared to professional networks. Some reflected that not all parents would seek the medical route when their children displayed symptoms compatible with a psychiatric condition, if they were "functioning in society", or if they considered the support already in place to be enough; "whereas when a child is in care, I think that question is rarely discussed" (Allison). Henry agreed with Allison and pointed at professional safety as one of the possible reasons for a tendency towards medicalisation within a professional network,

> If that happened for one of our looked after children, at least a CAMHS referral or a GP appointment. (…) The reasons for that are so wide, aren't they (…). And I think it's about defensive practice as well, that if a child was experiencing sadness or fear or harm, and they hadn't made that referral, or they hadn't sought help, how bad that would look on them. There's that risk aversion, isn't there, around that. So, it's not always just to locate it within the child, it's to defend against other professionals as well sadly, or scrutiny.

"And what if something happened?" asked Thea having experienced one of those situations of professionals focusing on protecting themselves,

> It was just horrible with the people arguing and battling it out and trying to blame, that kind of thing, who takes responsibility. And it was just very difficult when, in the middle of it, there's a young girl that's really struggling.

Henry pointed at scenarios where the decisive factor in decision-making might be the professional's safety, rather than the child's interest, with the professional wanting to be seen to do something. Thea, on the other hand, describes a situation of deflecting responsibility. Professionals could use professional boundaries to justify that a particular decision was not theirs to make. When they were asked these questions – on ethical and human rights considerations – besides surprise, the other common response was that this was not their professional remit. This answer came at the end of some interviews where social workers had clearly and explicitly discussed their views on psychiatric diagnoses and treatments. Henry, who fought for what he felt was best for a child, thinking that he might be risking his job, and who was one of the social workers who devoted more time to discuss how diagnoses served different purposes for the adults rather than the child, when asked about ethics responded: "I guess it's hard because I don't make a diagnosis". Yet, throughout the interview he had expressed very clear and reasoned views about them. Even though it is undeniable that he was right at pointing out he is not qualified to medically diagnose, it also needs to be acknowledged that, as a child's social worker, he, and all other social workers in that role, are representatives of the LA's corporate parenting and, therefore, responsible for the overall child's wellbeing.

Henry, who described the function of a diagnosis as a "shield" for teenagers, might here be using professional boundaries as his own "shield". Why might he need it? A lack of training on ethics and human rights might not be the only reason behind the limited articulation of practice in their terms. Even if an ethical/HR education was present, social workers would still face organisational structures and professional dynamics that would make it difficult for them to uphold such practice. Within the interviews some social workers provided examples of advocating for what they felt were the child's best interests, but there were also clear examples of "walking away" to avoid ethical difficulties, as Diana suggested earlier. Lydia and Meg had left their employers because they felt they were money driven. Vivian had left child protection because "morally and ethically [it] wasn't for me". Diana became an independent social worker so she could write reports to LAs and make recommendations rather than beg in panel to fund recommendations made by somebody else. Nathan was happy to move to a position where he would no longer be responsible for cases, "because I go to the same reviews, talk about the same problems, talk about the same recommendations, talk about the same thing over and over again".

Sam was interviewed during a break in her agency positions. Considering whether she would be returning to a social work job, she asked herself,

> But sometimes I wonder if by I'm being part of it, I'm also colluding, because as much as I'll be that person, like, 'What about this' (…), when you're just that lone voice as well, it then becomes like, am I colluding with a bad system by being part of it? It's the question that I have.

Each interviewed social worker was trying to find their way to earn a living, support the children and families/carers under their responsibility, and uphold their professional values without colluding with what they identified as ‘bad’ systems or practices. Yet, deflecting responsibility, either by placing it on somebody else or by “walking away”, does not imply a change of the circumstances that led to the ethical difficulties, nor does it remove from professional ethical responsibility. But it does mean social workers no longer face the cognitive dissonance that distressed them.

In this chapter I have examined the scenarios that unsettled the social workers, as shared by them. Social workers identified adult dynamics around the child as well as organisational structures that worked at times towards a medicalised understanding of children that social workers disagreed with. Social workers showed their uneasiness at the potential dislocation of responsibility that a psychiatric diagnosis could afford the adults responsible for the child. Less so they identified that a trauma narrative could have the same effect. Equally, although they did recognise the medicalisation bias of certain organisational structures, there was less reflection on how a medicalisation narrative could also exonerate those structures from their responsibility of effectively supporting children and their families. Finally, those same structures that can contribute to the medicalised understanding of children’s behaviour, do at the same time constrain social workers in their ability to address their concerns. These three areas, the position of the adults around the child as well as organisational structures in relation to the medicalisation of children’s behaviour, as well as the social workers’ perceived lack of capacity to address their concerns that children’s best interests are not respected, are discussed in the final chapter.

6. DISCUSSION

And that, saying it out loud, does not sound right at all. Rachel

This study has focused on behaviour that departs from social expectations: children's behaviours not adhering to adults' expectations and social workers' practice departing from professional codes. This study considered how (deviant) behaviour in children in State care is understood and addressed from the social workers' point of view, but also how they may manage their own professional behaviour, when it diverges from their aspirations. The study argued that both processes are interrelated, since the former can be part of the latter, concluding that the framing of children's behaviour cannot be separated from social workers' practice, and both need to be situated within their relational and sociopolitical context.

Departure from normative behaviour highlights the notion of responsibility. In turn, responsibility leads us to consider notions of agency and relational and structural constraints on that agency. When the narrative of responsibility and agency is proposed by social workers in relation to children, notions of power and ethics should also be incorporated. Social workers must navigate these notions in order to maintain a moral career (Goffman, 1984[1963]) and account for it. This study has considered some of the potential "unacknowledged conditions, unintended consequences (…) and unconscious motivations" (Bhaskar, 1998: xv) social workers may deploy in their accounts of making sense of children's behaviour and, at the same time, manage their own moral distress.

The study's premise was that to understand another, adult or child, we only have what we can observe (the person's behaviour) and what the person reports (their utterances). Social workers made references to both sources of information, emphasising the importance of getting to know the child – since the same behaviour can respond to different causes – and forming a trusting relationship – so the child feels comfortable enough to share their experiences. Social workers recognised the child's behaviour was likely to be attributable to a multi-layered causation, reflecting on the difficulty, or impossibility, of disentangling different potential causes, particularly when behaviour patterns had settled by the time a social worker appeared in a child's life. Social workers also reflected that causal attributions could also be shaped by the observer's own interpretations, adding an element of subjectivity. On this point, social workers referred more to the subjectivity of others, than their own.

In practice, understanding the child presented as an endeavour fraught with obstacles. Systemic conditions prevented social workers from developing trust and sustaining relationships with the children. In this scenario, the management, rather than the understanding, of behaviour appeared as the focal point – 'managing' understood as the behaviour's suppression or minimisation. Of course, behaviour not only shows, but can also hide emotional states; therefore, if a child can 'hold it together', they will not exhibit disruptive behaviour and, therefore, the extent of their emotional needs may go unnoticed. Thus, support was not always sought based on the child's emotional wellbeing or even their particular behaviour, but on the adults' capacity to tolerate or manage that behaviour.

In practice, two biases towards the diagnosing of children were identified. Social workers reiterated their complaint that a diagnosis was required to access support, either in school or through the Child and Adolescent Mental Health Services (CAMHS). They spoke of diagnoses less as causal explanations for behaviour and more as "beneficial", "useful" or "helpful", since diagnoses allowed access to the resources already identified as needed by professionals[65]. Under these circumstances, some social workers took the pragmatic approach of accepting or seeking a diagnosis, to access resources, even if they themselves felt a different explanation for the child's presentation was more appropriate. That is, diagnoses were not treated as guides for treatment, but merely its gatekeepers. A further bias towards the diagnosing of children was appreciated whenever discrepancies within the adults around a child were discussed by social workers. In the cases shared by the interviewees the power to control the narrative of the explanation for a child's behaviour lied with whomever favoured the diagnostic narrative, regardless of their role or professional status, which changed from case to case.

At the same time, social workers expressed their concerns towards diagnoses. First, social workers felt diagnosis could minimise or erase the impact that trauma had had on a child's life, and lead professionals to address (stop) symptomatic (disruptive/distressing to the adult) behaviour rather than its underlying causes. Second, several social workers worried that some children could be misdiagnosed with ADHD/ASD due to the similarity of their symptoms with the sequalae of trauma. Third, social workers felt diagnoses had the potential to remove responsibility from the children, but also from the potential impact of adults' caring practices. Trauma explanations, placing causation on the child's relational past, can also remove responsibility from children's relational present. But this potential effect was not identified by social workers, who, in general, favoured a trauma narrative. The practice landscape described by social workers led them to question whether children's best interests were always being upheld. Yet these questionings were not always articulated through an explicit human rights and/or ethical perspective. An ethical perspective would directly address the social worker's

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[65] One social worker, however, pointed at a change in trend is this respect, in relation to schools, since children's diagnoses are becoming more frequent.

professional responsibility towards professional standards and code of ethics. The lack of ethical framing potentially can serve to reduce the social workers' professional responsibility.

This final chapter examines interpersonal, structural and individual aspects involved in the process of managing behaviour in social work practice with children. I consider the relational nature of behaviour at three levels: within oneself, connecting behaviour with identity; interpersonal, considering behaviour as re/action within relationships; and sociopolitical, in as much as our behaviour positions ourselves in relationship with the structures within which we live, as citizens or members of professional bodies. First, I consider how the understanding and governing of children's behaviour is not only an adult-led process, but it may serve the adults' identity needs as much as children's needs, consequently, there is in this process a potential conflict of interest. Second, I consider how professional dynamics and structural organisations not only constrain social work practice but may also serve as engines of children's medicalisation. Finally, I consider the limited articulation of social work practice in this area from an ethical/human rights perspective as another identity process, in this case, a defence against deviant professional practice. After enumerating the study's limitations, I conclude the chapter with some final reflections for future social work education and practice.

The pathologisation of children: Addressing adults' needs

Who decides it's the problem? Olivia

Social work with children in England is articulated on a child-centred and child-led practice discourse (see chapter 1). The Children's Social Care National Framework reiterates that children's views "should be sought and heard at every stage of support, and they should contribute to decisions made about their lives, wherever possible" (2023: 14). This is in line with article 12 of the United Nations Convention on the Rights of the Child (UNICEF, 1989), which the Framework references. However, in the previous chapters we have seen that child-centred and child-led practice does not always happen. In the field of children social services, children are but one set of players amongst others (local authorities, social workers, carers, schools…), each with their own set of interests. This study argues that at times adults' interests can take precedence over the child's. What has been observed is that practice can be constructed to address the adults', rather than the child's, needs – identity needs being the focus of this study. In this section I examine the potential extent to which the understanding and addressing of a child's behaviour is sometimes adult-centred, from defining what behaviour needs to be understood and address, the mechanisms for reaching causal explanations and how they in turn affect the adults' identity.

From the start, finding an explanation for the child's behaviour centres the experience from the adult's perspective since the process becomes one of explaining, and addressing, behaviour, rather than inner wellbeing. What is addressed is the child's behaviour, that is, what directly affects the adult/s, not necessarily the child's overall wellbeing. Social workers recognised that all children in the care system, by virtue of the experiences that would have led them to being in State care, would have had their emotional wellbeing affected; however, not all the children expressed this behaviourally.

Following Burke's (1969[1945]) motivational grammar (which distinguishes five elements: the act, the scene, the agent/s, agency and purpose (the actors' motivations) – see chapter 1), when an adult sets forth to try to understand a child's behaviour, they need first to decide on the act (the deed, the action, the behaviour) that requires understanding. Thus, the process is further led by the adults as long as it is the adults who choose which behaviour/s require explanation, and management. At this point, even if the child was to participate in conversations about their behaviour (why it might be, how to address it…), they would be sitting at a table set by the adult/s. I do not mean to imply that this adult-controlled narrative is necessarily an oppressive process. Of course, the younger the child the more need for support and protection from adults who, hopefully, would be part of the child's attachment network. And, as the child grows, it is expected that they themselves will gradually take greater initiative. Comments from social workers indicated that some children in State care did also welcome an explanation for their behaviour, indicating they did share with the adults around them a concern for the same behaviour. What this study shows, however, is the potential for this process, of understanding and addressing a child's behaviour, which does necessarily require adult input, the more so the younger the child, to become adult-centred, rather than child-centred, serving adults', rather than child's, needs.

This potential is clear when we examine, from the social workers' cases, which behaviours required understanding and/or managing. The behaviours that required examination and support were those behaviours that appeared to be distressing or disruptive to the adult/s. There was a general complaint that, in the absence of distress or disruption to the adult/s, no intervention was sought. This could lead to the same behaviour, self-harming for instance, being addressed differently depending on how the adult experienced it, that is, their level of tolerance and coping. Given this, it could be argued that social work practice may at times not be organised around the wellbeing of children, but of adults. Of course, adults also have emotional needs, and nothing here should be interpreted as an argument against addressing them; however, even though the adults' emotional needs are part of the scene, these should be addressed through self-care and in supervisory relationships, they should not take the lead in addressing children's wellbeing. These selection criteria, distress or disruption to the adult/s, also meant that the primary focus was on managing, rather than understanding behaviour – managing understood as the control or minimisation of selected behaviour.

The selection of the act also reveals a disjuncture in the adult network around the child. The child's social worker personalises corporate parenting and, as such, is responsible for the overall decision-making in relation to a child's life. However, they are not responsible for their day-to-day care and, therefore, do not necessarily witness or experience directly the behaviours they become responsible for addressing. This does not necessarily mean that the child's carers and/or school would know the child 'best'. Due to placement breakdowns, in some cases the child's social worker would have known the child for a longer period. It does mean that the social workers heavily rely on third party accounts when making sense of children's behaviours.

Once the behaviour that is to be the object of understanding and intervention has been identified, an explanation for it can be sought. In examining which potential explanations were considered by social workers and how, from these, the one/s relevant to a particular child were selected, this study highlighted that this selection is necessarily not a neutral process from the adults' perspective. In chapter 1 we saw how self-identity formation is a relational process inasmuch as it incorporates how we are, or would like to be, perceived by others. We also noted that the materials used to construct one's self-identity are the same as the ones used by others to construct an external identity of the person (Goffman, 1984[1963]). Thus, self-identity formation is a process that does not entirely depend on the person. As discussed in chapter 1, the self is at a crossroads between one's possible selves and the external identities proposed, or imposed, by others. However, what is not sufficiently highlighted is that the relational nature of identity also means that the explanations I propose for another's behaviour have a direct impact on the explanations I can propose for my own behaviour, the more so the more involved I am on the other person's circumstances, that is, in that person's scene (following Burke's vocabulary (1969[1945])). When we consider the adult's identity needs alongside the understanding of a child's behaviour, we realise that the choice of one explanation over another is not a neutral process from the adult's perspective. Any understanding of a child's behaviour implies in turn an appraisal of the adult's role in it. Thus, the act of choosing an explanation for the child's behaviour may entail a conflict of interest for the adult.

Referring to foster children, Buchanan argues that "young people in turmoil are exhausting, stressful and demanding" (2005: 97). When looking after a child is experienced as difficult or painful for the adult, a scenario of cognitive dissonance may appear: 'I want to help this child, yet I seem to be failing'. A split in Kleinian (Klein, 1946) terms may present itself to the adult: 'If I want to help, I cannot possibly be doing harm'. That is, I cannot possibly be part of the reason behind the behaviour object of concern. However, the adults around the child are part of the child's circumstances (part of the scene, in Burke's terms (1969[1945])) and, as such, may be part of the reason behind the behaviour. At the same time, the adults around the child are also meant to be part of the child's support system, helping the child to address their concerning behaviour. The adult's identity as a 'helper' is thus potentially threatened twice: as part of the causes behind the behaviour and/or, if the behaviour persists, not being able to support the child in addressing their behaviour. If carers, schools, social workers, are not 'helpers' to the child, who are they? In chapter 1 we saw how statements on self-identity are also linked to statements on self-esteem (Stets and Burke, 2014). Much is at stake for the adults around the child here, their sense of professional/caring worth, a potential gap between their aspirations and the actual effects of their own behaviour. An adult's explanation about a child's behaviour is necessarily not a neutral act from the adult's self-identity perspective. The explanation proposed has the potential to solve this split and safeguard the adult's sense of identity and self-esteem. Following Burke's vocabulary (1969[1945]), in finding a causal explanation for the child's behaviour, adults can control the narrative around the scene (circumstances) as well as the child's agency and purpose. But how such an explanation might be reached?

In chapter 1 we considered three possible mechanisms that may guide explanations on children's behaviour (medicalisation, attribution bias and psychological defences), as well as examined five potential frameworks used within social work to propose causal explanations (attachment, trauma, socioeconomic context, neuroscience and psychiatric conditions). From the social workers' interviews we can see that both attribution bias (through psychiatric diagnoses, in this case) and a developmental understanding of the child (that is, the significance of the child's early years combined here with a trauma perspective) can provide the adults with the type of explanations that they required to dislocate their own (possible) responsibility from the child's behaviour or the difficulty in addressing it.

Attribution bias highlights the point that observers often have a poor awareness of their own contribution to the other's behaviour (Gilbert & Jones: 1986), that is, in defining the scene, the adult may tend to exclude themselves from the circumstances that potentially influence the child's behaviour. A possible reason proposed for this bias was the lack of historical perspective on a subject (Jones & Nisbett, 1972). The realities of practice presented in chapter 4 describe scenarios where social workers, and other adults around the child lack such biographical information. In addition, the degree of pressure the observer experiences, may lead them to "less effortful automatic process" (Jones, 1993a: 660), in turn such mental states increasing the chances for attribution bias to appear. Again, chapter 4, we saw how social workers complained about the lack of time to reflect due to high caseloads. From this study it is not possible to assert whether any of these conditions contribute to the presence of attribution bias within social workers, or any other adult around the child. It can be stated, however, that conditions conducive to attribution bias as identified by its proponents are present within the care system.

'Blaming' the child for their behaviour, stating that they are wilfully choosing to behave in a certain way, however, might be at odds with an adult's 'helper' identity. There were few indications of this kind of attribution within the interviews, and most of them were attributed to carers or other professionals and rejected by the social workers. I argue that a psychiatric diagnosis provides a narrative supportive of, and consistent with, a 'helper' identity, whilst, at the same time, committing a form of attribution bias. A psychiatric diagnosis follows this bias's mechanism, dislocating responsibility from the adults around the child and placing it firmly onto the child, without at the same time blaming the child, since it also dislocates responsibility from the diagnosed person. At the same time, a psychiatric diagnosis can reinforce the adult's 'helper' identity, who now has the role of supporting the child in overcoming any difficulties created by their diagnosis. It this respect, inasmuch as a psychiatric diagnosis contributes to solve the adult's cognitive dissonance removing causal responsibility from them it acts as a defence mechanism (Timimi, 2002). In general, interviewees did not favour a diagnostic narrative, but they feared it was at times inappropriately propounded by carers and/or schools due to the above reasons. Social workers did highlight a significant difference between carers and schools and themselves: the former are in daily direct contact with the child, whilst the social workers can take more of an outsider's perspective on the child's behaviour. Because of the limited number of interviewees, and the fact that no carers or schools took part in the study, it is not possible to state whether this difference in the favouring of causal narratives about children's behaviours indicates a general tendency, or simply the fact that only social workers who were critical of the diagnostic narrative were interviewed and, therefore, their accounts emphasised their frustration with adults who did favour this narrative, or whether this is a manifestation of a projective defence mechanism (others are the 'bad' professionals; Taylor et al, 2008)).

However, attribution theory has found empathy to be a mediating factor, shifting the causal attribution of behaviour from the subject to the context (Jones, 1976). This is precisely what the social workers did most frequently, favouring a narrative based on the child's adverse past experiences. They adopted a developmental trauma narrative, emphasising the importance of early childhood experiences in understanding future behaviour. However, in favouring this narrative, social workers might create the same dislocation of responsibility but through a different mechanism. Without disputing the significance of the first years of life, this emphasis may lead to an oversight of the causal effects of present circumstances, and relationships, on people's behaviour (Boyle, 2011; Burman, 2017). As examined in the previous chapter, the trauma narrative can also create the same exoneration effect that social workers attributed to the diagnostic one. Both trauma and diagnosis firmly place the cause of a child's behaviour away from the child's present (Boyle, 2011), therefore, dislocating the responsibility from the adults involved with the child at that current time. By this means, social workers located the causes of a child's behaviour firmly away from them, the adults in the child's present. It has to be noted that, although it might appear that these two narratives can contribute to a greater exoneration of carers/schools since they had the greater involvement with the child, a diagnostic narrative, nonetheless, can also contribute to a displacement of responsibility – in relation to treatment – from the social worker to the medical professional. It must be noted, however, that some social workers placed responsibility firmly on the adult/s, including themselves, through understanding behaviour as a dyadic-level construct (Crittenden, 2016; Watzlawick et al, 2011[1967]). These social workers understood behaviour (action or reaction) as a dialogical and circular phenomenon, where the child was not just communicating something *to* the adult through their behaviour, rather the child was *in* communication *with* the adult, in a dialogue where the adult had an active causal role – inasmuch as they responded and elicited certain responses, and not others – rather than as mere listeners. From this perspective, addressing a child's behaviour included the adults changing their own too.

In discussing this process of which one/s of the different possible narratives to understand a child eventually succeeds in each case, social workers appeared at times as passive witnesses of a process over which they did not have control, including children's social workers, who are officially the ultimate decision-maker on a child's life in the care system. This passivity is examined below, when considering ethical and human rights-based practice. Here I would like to highlight the fact that social workers considered carers and other professionals' positions and potential (unconscious) motives and benefits from particular understandings of behaviour; social workers reflections on their own possible (unconscious) motives and benefits were rare. What also appeared frequently absent or unheard within case discussions was the child's perspective: how they themselves understood their behaviour. Ferguson has studied how children become 'invisible' in child protection work. He found "evidence that the time spent with children was dictated more by organisational requirements and timescales than the amount of time the worker needed to spend with the children to try to fully understand and meet their needs" (2017: 1018). This process of invisibility is the more significant if we consider the realities of practice seen in chapters 1 and 4 in terms of how often the adults around a child in State care have so little direct knowledge on that child. In this case of epistemic injustice (Fricker, 2007) the version that prevails is constructed from a fragmented and indirect knowledge of the child. Rose (1999) includes social workers amongst the professionals that he describes as 'engineers of the human soul', and here we can observe elements of that engineering process. Here, however, there seems to be a departure between the effects of a trauma and diagnostic narratives. From the social workers' discussions, trauma explanations had a potential of being revisited and retold which did not appear in the case of a diagnostic explanation. In the latter case, diagnosis presented as a kind of 'black box' that stuck to and followed the child even if future adults around them no longer agreed with that explanation.

An illustrative scenario that shows the consequences of an adult-centred process where responsibility is displaced from the adults, in this case, carers, is the situation of a placement breakdown and success of subsequent placement. A common reflection from this situation was the importance of good 'matching' for placement success. Placements were seen as part of the treatment process – carers in the new placement were seen as being able to manage the child in a way that previous carers had not – rather than playing a causal role in behaviour. However, if relationships can be a causal factor of behaviour, there is also the possibility that, if the child's behaviour changed, it may be because one of the causal factors had been removed. This is particularly significant in those cases where the child was diagnosed whilst on the first, failed, placement, and was no longer exhibiting diagnosable symptoms in the second, successful, one. The diagnosis placed on the child might reflect the adult's shortcomings as carer (a similar discussion could be had in relation to education placements), yet the diagnostic label will accompany the child in their future, and in their understanding of themselves. Adults' shortcomings may become psychiatric diagnostic labels placed on children. The dislocation of responsibility in this process doubles in the case of foster carers, since it not only affects the carer but also their supervising social worker and their fostering agency, whose responsibility it is to assess and support the carer.

Since the understanding of a child should guide the support provided, when such understanding is adult-centred, intervention is approached from the start from an adult-centred perspective. Adults' identity needs may then continue to be addressed through the intervention. Even though trauma and diagnosis may operate the same mechanism in relation to a child's past, they do not necessarily do so in relation to their future and to the adults' role in it. There was, in general, a greater demand on the adult's role when trauma, rather than diagnosis, was favoured as explanation. When social workers felt that trauma was the primary explanation behind a child's behaviour, they advocated for therapeutic parenting/practice as the best intervention to support the child. That is, they considered that the child's recovery required an active involvement of those caring for them. They generally criticised professionals who adopted a more passive approach towards supporting the child, expecting, for instance, that one therapy session a week already performed that role. A diagnosis, on the other hand, provided less room for discrepancy. In the social workers' experience, a diagnosis either ensured adjustments (social workers reported some schools only afforded accommodations for the child once a diagnosis was given) and/or brought the use of regular medication. A view that social workers put forward was that diagnosis tended to support a more passive adult role in addressing the behaviour, since psychotropic drug was usually seen as the primary solution. The role of the social worker is affected by either narrative. The worker's responsibility to ensure that the child receives a care appropriate to their needs changes from mere overseer to ensure that medical advice is duly followed, to a more direct responsibility if the cause of the child's behaviour was to fall on the quality of care received.

In the understanding and addressing of children's behaviour, both the identity needs of children and adults are at stake. That is, adults control a process in which they are not neutral. There is a conflict of interest in the process that is led by asymmetrical relationships. The child's needs for care and protection make this asymmetry necessary. However, whilst ideally for most children the process of narrative formation around a child's behaviour (and identity) is led by family members who know the child well and have a long-term emotional investment in the child, this is not the case for all children in State care, where knowledge is fragmented, and relationships are fragile. Social workers described dynamics where adults sought to supress or minimise the behaviour that distressed or disrupted them, and a tendency to do so via a diagnostic narrative. In this way, not only psychiatry, but social work became part of the structures that make up 'governable subjects' (Rose, 1999). Perhaps ironically, it is the adults' emotional wellbeing and sense of self that may be addressed and, in that way, serve as another engine of medicalisation, by providing a mechanism that allows adults to resolve a fundamental cognitive dissonance, 'I mean well/ I want to help, but I cause harm/ I am struggling with this kid'. Social workers, however, identified another, structural in this case, engine of medicalisation, which I examine next.

The pathologisation of children: Addressing structural needs

Freud listed three sources of human suffering: nature, the body’s feebleness (arguably we could include psychiatric diagnoses here) and “the inadequacy of the regulations which adjust the mutual relationships of human beings in the family, the state and society” (2002[1930]: 15). According to Freud, we accept the first two as inevitable, whilst we attempt to mitigate them, as indeed happens with psychiatric diagnoses. Regarding “the social source of suffering”, however, “our attitude is a different one. We do not admit it at all. We cannot see why the regulations made by ourselves should not, on the contrary, be a protection and benefit for every one of us” (2002[1930]: 16). However, this latter statement is not correct in relation to the social workers who participated in this study. They were keenly aware of organisational constraints to their practice. The social workers did not always experience their employer’s organisation as supportive of their practice or of the children’s interests. In relation to the subject of this study, a few social workers explicitly named an organisational bias towards the children’s “pathologisation”. Through the interviews this bias towards medicalisation can be appreciated, both indirectly, as a collateral effect of certain organisational elements, and directly, through organisational procedures that incentivise the psychiatric diagnosis of children. Thus, the very structural organisation of children social work can act as an engine of medicalisation.

In chapter 4 social workers described working conditions that contributed towards a fragmented knowledge of the child, as well as organisational pressures that constrained critical reflection. These organisational conditions may create a bias towards less effortful explanations and interventions and, therefore, indirectly act as an engine of medicalisation. However, social workers also identified two further organisational conditions that appeared to act at times directly as engines of medicalisation: the absence of support without a psychiatric diagnosis, and the financial incentive for the Local Authority (LA) or the carer if the child received a diagnosis.

It is precisely when examining diagnosis from a treatment perspective that its actual role in social workers' practice experience becomes clear. Although social workers discussed psychiatric diagnoses as explanatory devices, they were rarely used as such in their practice. Psychiatric diagnoses were more often referred as "helpful", "beneficial" or "useful", because they provided a justification and/or a way to access a predetermined intervention considered desirable. That is, in the social workers' discussion of actual cases, psychiatric diagnoses were used neither to understand a child's behaviour nor to guide how to address it, rather they 'helpfully' provided a *post hoc* explanation that justified, or helped to access, whatever intervention was already in mind. Thus, diagnoses were at times referred to as 'magic bullets', either because they persuaded school to implement requested adjustments, or because a diagnosis was a requirement to be able to access CAMHS.

Coulter (1979) discussed how psychiatric labels are applied to behaviours already identified as problematic. More recently, Moncrieff (2010) has examined how this particular deployment of psychiatric diagnoses is still relevant. She referred to this mechanism as the use of psychiatric diagnoses as political devices, since 'it allows behavioural control to be presented as treatment' (2010: 380-381). Coinciding with Moncrieff's conclusion, psychiatric diagnoses appeared to contribute to 'the framework that supports the existing social response to certain problematic behaviours' (2010: 381). Psychiatric diagnoses help to socially legitimise the response to certain behaviours – in the case of the situations covered by this study, most commonly, the suppression of certain behaviours through the administration of psychotropic drugs. However, it should be noted that whilst Coulter (1979), like others, considered psychiatric diagnoses to be social judgements, this is not a sufficient explanation in the case of children in State care. It is true that they are subject to the expectations of what is acceptable behaviour for a child, particularly in school, but whether their behaviour ends up labelled with a psychiatric diagnosis also seemed to depend on the particular adults who were looking after them and what they could manage/cope with, as already explained.

But these adults may also have a direct incentive to seek a diagnosis for a child. As noted in the previous chapter, some social workers reported their experience that, in some agencies, a diagnosis meant an increased allowance for the carer. One social worker reported a case where the LA received an increased budget when children were diagnosed. No doubt, this procedure is meant to reflect the fact that a child with a psychiatric diagnosis is likely to require additional support (which will require financial investment) or be more complex to care for (therefore, the carer receiving a higher allowance to reflect the increased difficulty in their job). However, by attaching this increased budget to a psychiatric diagnosis, it creates the pernicious effect of incentivising the "hunt", as some social workers put it, for a diagnosis and it sets the children in a direct conflict of interest with those in charge of looking after them. It must be noted that this was not the only example in the interviews of LAs' budgetary considerations potentially overruling the children's best interests.

It is beyond the scope of this study to consider the LAs' identity needs, which has been done elsewhere (Gibson, 2019). Children social services can be considered players in their own rights and, therefore, also as having their own identity needs. These needs do not necessarily draw from social work principles but can be shaped according to external players (media, politicians and/or inspectorate bodies) (ibid). The child's wellbeing could be situated at the centre of a triangle at whose corners we can find the identity needs of the adults around the child, of the LA, and of the sociopolitical discourse of the time. Because a diagnostic narrative not only dislocates responsibility from the adults and organisations around the child, but also from their socioeconomic circumstances – the "depoliticizer" effect of diagnoses that Zola identified

(1972: 500). It is for this reason that we can appreciate that psychiatric discourse not only creates docile children, but also docile adults.

Diagnoses can be used as a form of social control toward children (Isobel, 2024). Many of the current diagnoses mirror behaviours difficult to manage or disruptive for the adults (i.e., Oppositional Defiant Disorder, or Intermittent Explosive Disorder, besides the most frequently cited ADHD). In addition, the DSM-5-TR (APA, 2022) includes a functionality clause in most of its diagnoses. Diagnosis is to be given only when symptoms cause 'clinical significant' impairment in functioning, which, in the case of children, requires adults' judgements of how children should function. A diagnosis can act then as a black box that focuses the attention on the child's behaviours which now need to be managed by self-discipline strategies, and/or through environmental adjustments and/or medication.

However, diagnoses can also create docile adults in relation to societal power structures, inasmuch as diagnoses also dislocate responsibility from them. Explanations based on trauma, relationships and/or broader social conditions would lead to, or add weight to existing, enquiries into schooling practices and expectations, foster carers' assessment and training (as indeed one participant did), social workers' role and/or into the social conditions of parenting, amongst other areas, and potentially could indicate social reforms, not just individual management, were required. The dislocation of responsibility, "exoneration", as the social workers called it, from sociopolitical structures can create docile citizens, accepting of the *status quo* – as in the social workers' acceptance that cases "have to go somewhere" despite an already existing high caseload, instead of questioning whether families could be supported better, thereby diminishing the number of 'cases' (of children in the care system), and/or questioning their LAs' hiring policies, increasing the number of social workers. An explanation on a person's behaviour not only has potential psychological effects on their identity, but also on their political selves, as citizens (Ferguson, 2017).

This political dimension of psychiatric narratives increases the significance of a third medicalisation bias, beyond organisational structures, that could be observed in the social workers' shared cases. This third bias points at the power of the psychiatric discourse itself, considered in chapter 4, despite the power dynamics of the adults around the child. Chapter 4 considered three groups: the social workers themselves, and medical professionals and foster carers as per social workers' accounts. Following social workers' comments, it appeared as if it was the social workers themselves who never, or rarely, prevailed even though a child's social worker is the representative of corporate parenting. From social workers' perspective, mental health professionals had a superior professional status and hence more power for their views to prevail. It has to be acknowledged, however, that mental health professionals appear in a child's life only when additional support is sought. Professional hierarchies aside, it would be an awkward situation to ask for help just to respond, 'I do not agree with it'. Formally, foster carers appeared to have less overt power. They do not have a professional status and, although able to take decisions on the child's daily care, the overall decision-making power rests on the child's social worker. They do, however, have a significant 'power to' (Lukes, 2021), that is, the capacity to make one decision which is only theirs to make and cannot be prevented from being executed: to terminate a placement. Without formal, procedural, power, carers still have power in the form of capacity to achieve their goals (Parsons, 1963). At times, for social workers, there was a trade-off between agreeing to measures in relation to the child with which disagreed, in order to support permanence in the placement. However, following social workers' cases, when these three players meet to discuss a child's potential diagnosis, no player prevailed, but instead it was the psychiatric diagnosis itself, independent from the player who supported it that held the power (Foucault, 2009[1975]).

Medical narratives, and in particular psychiatric narratives, can dislocate responsibility from every player, yet, at the same time, they maintain a causation narrative that sees the problems as lying within the individual, the child in this case. However, this causation, since no longer due to a wilful choice, not only takes away responsibility but also agentic power, ultimately supporting the sociopolitical structures to preserve the *status quo*. Yet, social workers are employed within those structures, whilst, at the same time, their profession seeks to engage both people and structures in the pursuance of social justice (IFSW, 2014). That is, the profession's official discourse creates the expectation on social workers to exercise agentic power in the form of professional practice to alter that sociopolitical *status quo*. In the next section I consider the social workers' position between agency and structures in relation to the profession's ethical and human rights principles.

Social workers: Between professional identity and State role

> I just think that this whole hour of questions is really part of the ethical part of it, isn't it, really, because it's about whether it's right? Gemma

In discussing the interview topics of understanding of children's behaviour, psychiatric diagnosis and mental health interventions, social workers evidenced a high degree of moral distress, yet there was limited framing of this distress as ethical stress, when explicitly asked about their ethical and human rights perspective on the discussion. Furthermore, there was also a limited common professional discourse on ethics and human rights, besides a high level of deflection in response to the explicit question on it. This discrepancy opens two questions for the practice of social work. How do social workers cope emotionally and professionally with failures that they may experience as beyond their control? And to what extent are codes of ethics and human rights declarations an effective support for a social work practice that seeks to uphold the best interests of its service receivers?

In this last section I consider what might be behind the discrepancy between the presence of moral distress and the apparent absence of ethical stress, linking this discrepancy to the social workers perceived powerlessness, that is, lack of agentic power to influence case intervention. I argue that this perceived powerlessness to proactively address the cognitive dissonance between their professional values and their actual practice might be leading social workers to resort to psychological defences, namely, an implicit denial that the practice they witness, or are involved in, amounts to unethical practice and/or human rights breaches. I finish the section proposing a way forward to break what social workers seemed to experience as an insurmountable impasse between their values and the structural constraints on their practice.

However, I first need to make explicit a distinction between morality and ethics and, therefore, between moral distress and ethical stress, which tend to be used interchangeably in the social work literature (Fenton, 2019), but not so here. Both morality and ethics act as a guidance for human behaviour distinguishing between ‘right and wrong’. However, for the purpose of this discussion morality refers to the individual’s code of right and wrong conduct drawn from social representations of the values and habits of a particular society, and so are geographically and historically contingent, and not necessarily systematically or consciously articulated. Ethics, on the other hand, are understood here as a set of reflexive and systematically articulated principles on the right and wrong conduct that aims to transcend historical and geographical contingencies. Moral distress, therefore, refers here to the perceived discrepancy between the personal moral code of a social worker and the realities of their professional practice; whilst ethical stress refers to the perceived discrepancy between a professional ethical discourse and the realities of professional practice. The former, the personal moral code of a social worker, is an idiosyncratic representation, drawn from personal views, social norms and professional education. The latter, a professional ethical discourse, is an agreed and systematically articulated discourse on the ethical principles of a given profession.

The interviewees clearly attached moral meaningfulness to the cases shared, that is, they recognised that the situations discussed during the interview had a moral dimension (May, Luth and Schwoerer, 2014, cited in Fenton, 2020:12). First, in relation to psychiatric diagnosis, most social workers felt it was not just a question of the benefits of reaching the most accurate explanation/s for a specific child's behaviour, but they also worried about the potentially deleterious long-term consequences of a psychiatric diagnosis for the child. Social workers thought a diagnosis could provide an account to the child akin to what Scott and Lyman (1968) identified as excuse by invoking biological drives. That is, a diagnosis may bring exoneration not only to the adults, as discussed above, but to the child as well. At least some of the child's behaviours are consequently seen as brought about by their psychiatric condition, so the child themselves may express a diminished sense of responsibility towards those behaviours. Social workers also worried that receiving a diagnosis could lead to an erasure of the impact of the child's earlier experiences on their sense of self, that is, that the child understood themselves in terms of deficits (psychiatric symptoms) with no role ascribed to their earlier experiences of trauma. The psychiatric diagnosing narrative could act, in this way, as an erasure of all other narratives (Mehl-Madrona, 2010). Similar concerns have already been expressed in the literature (Isobel, 2024). More widely, as we have seen, social workers shared scenarios where they felt the best interests of the child were not upheld, yet, according to current child social care policy, "decisions about help, protection and care for children *must* always be made in [the child's] best interests" (DfE, 2023: 14, emphasis added).

However, despite the shared experience of moral distress, this did not articulate into ethical stress when social workers were asked about their ethical and human rights perspective on the topics discussed. Ethics and human rights were seen but simultaneously not seen (Hingley-Jones and Ruch, 2016). Two aspects of the social workers' responses can be highlighted. First, their moral meaningfulness did not correspond with an ethical one, that is, there was intrainterview low level of consistency between what caused social workers' moral distress during interview discussions and what they eventually named as ethical/human rights aspects of their practice. There was also low-level inter-interview consistency between social workers' responses – with the exception of consent to medical treatment. This contrasts with the consistency amongst social workers regarding theoretical frameworks that guided their practice (the theory question) and, even more so, in naming the three most important characteristics to be a good social worker (the practice question). The high level of consistency in their responses to these latter questions suggests, as one would expect, a process of acculturation into a common professional ethos, derived both from their common professional education and experience. However, there was no apparent common professional discourse on ethics and human rights shared by the interviewees. Not only there was no common discourse, but even the individual one faltered. Most social workers stumbled when asked explicitly about their ethical/human rights perspective and seemed initially uncertain as to what to answer. This contrasts with how national and international social work organisations promote the construction of social work as a human rights profession (as detailed in chapter 1), besides the fact that social workers in England must abide by their regulatory body's (Social Work England) professional standards, which include the promotion of ethical practice, if not its own code of ethics. Why, then, did the social workers' moral distress so limitedly translated into ethical stress?

An answer already considered in the literature is the importance of social work education and training (Fenton, 2016). The implication being that we have identified a shortcoming in the education of social workers and that, with improved academic learning and/or practice placement preparation, and a greater explicit focus on ethics, social workers would be able to better uphold a reflexive ethical and human rights practice. One certainly cannot support a practice based on ethics and human rights, if one does not have knowledge of them (of course, one's morals may well coincide with them, but, in that case, alignment with ethical/human rights practice would be a serendipitous coincidence that can equally disappear at any point). Perhaps Social Work England could ensure that the importance of human rights and ethics are more effectively stressed in social work degree programs and/or as part of the professional standards. In this study, considering what the social workers said, without further education they were already able to identify certain situations as problematic – and there was consistency on these types of scenarios; however, greater emphasis on ethics and human rights education could have provided them with tools to frame and understand their practice more explicitly from an ethical and human rights perspective. Nonetheless, I would like to suggest that lack of appropriate education is not the only explanation for the social workers' limited ethical and human rights articulation.

Fenton (2016) found that social workers' identification with neoliberal narratives led to reduced ethical stress (she uses moral distress and ethical stress interchangeably). Gibson (2019) also found that those social workers who aligned their professional identity with their agency's policies and procedures experienced fewer negative self-conscious emotions (shame and guilt). But the social workers interviewed for this study were generally wary of individualistic explanations (i.e. psychiatric diagnosis) characteristic of neoliberalism, and they did question organisational procedures.

I would like to argue that there might be another possible explanation for the limited framing by the social workers of what they experienced as moral distress into ethical stress: the deployment of a psychological defence to prevent the conversion of the former into the latter, which would actually be parallel to the potential use of a psychiatric diagnosis as a defence, as identified by the social workers. In this case, the use of the defence would be driven by the perceived sense of powerlessness they expressed. Social workers described situations and structures that they experienced as largely out of their influence or control, including direct decisions on interventions related to children in their caseload. There was a sense of despondency and powerlessness that the social workers in the cases shared, indicating a perception that an explicit adherence to an ethical/human rights code would not have made a difference, as indeed it did not in some of the cases shared. Discussing professionalism, Evetts (2011) considered how occupational professionalism was being substituted by organisational professionalism, that is, control of the work was becoming exercised less by the professionals and more by the organisation. Fenton applied this distinction to her study on criminal justice social workers in Scotland, stating how organisational professionalism was characterised by “the redundancy of a working theoretical and ethical knowledge base” (2016: 199): a redundancy that seems to be felt by the study participants. Within this ‘irrelevant adherence’ scenario, or “redundancy” in Fenton’s terms (ibid), naming practice they witness and/or were directly involved in would have compromised even further their professional identity. Feeling there was ‘nothing they could do’ about it, these social workers had to ‘unsee’ it to preserve their professional identity. Another alternative that some shared was their considerations of leaving the profession, or their actual move to other professional roles where they felt more in control, or with less case responsibility.

It is recognised how anxiety provoking settings, such as children social work, can lead to organisational defences (Whittaker, 2011) and/or defensive practice (Trevithick, 2011; Whittaker and Havard, 2016). In the case of these social workers, we could be witnessing the unconscious strategic ignorance of ethics/human rights frameworks as a defence to survive or cope with the cognitive dissonance between aspirations, such as their initial motivations to go into the profession, and the realities of practice, realities that they too often experienced as beyond their control, such as panels disagreeing with the proposed intervention because of funding issues, managers agreeing with carers in an attempt to prevent a placement breakdown, etc. In proposing strategic ignorance as a psychological defence, I am modifying McGoey’s concept of strategic ignorance, which is “tactically deployed to avoid the repercussions of inconvenient evidence" (2019: 2). Here, I do not mean to imply that social workers, interviewed or otherwise, are making use of any conscious strategy or tactic. I argue that their use of ignorance is unconscious, in the manner of a Freudian defence mechanism, but it is, nonetheless, strategically deployed to avoid the repercussions of inconvenient knowledge, repercussions that would be too onerous both in a psychological and a practical sense. Strategic ignorance in this sense would be part of social workers' emotional labour (Hochschild, 2012) to avoid a spoiled identity (Goffman, 1984[1963]) from a self-concept perspective.

The interviewees deployed strategic ignorance resorting to utterances of 'useful unknowns' (McGoey, 2019) to avoid identity liability and professional responsibility. These 'useful unknowns' are akin to what Scott and Lyman termed excuses by "appeal to defeasibility[66]" of knowledge (1968: 48) within accounts theory. An excuse is a particular type of account whereby the actor acknowledges the action as wrong, "but denies full responsibility" (ibid: 47). In an appeal to defeasibility of knowledge, the player rejects or downplays responsibility precisely by alleging total or partial lack of knowledge, as in not understanding what it is meant by ethics or what is included under human rights. Strategic ambiguity, another dialogical strategy to save face (James-Hawkins and Jozkowski, 2024), was also used by some social workers who resorted to vague and generalist language, even though they had shared concrete cases with which they had clearly felt dissatisfied. Scott and Lyman also identify strategic identity change (1968: 60), which, in this case could be termed as 'strategic identity delegation', as when social workers shared clear views on the diagnosing/treatment of children during the interview but when asked about their ethical or human rights perspective on this responded that diagnosing was not their responsibility – certainly so, though it is the social worker who enacts corporate parenting. Elsewhere other social workers have argued that they are "a civil servant with a legal obligation to uphold the civil law" (Banks, 2016: 57) and need to respect professional

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[66] Capable of being annulled or made void.

boundaries, even when they do not agree with a case outcome from an ethical/human rights perspective.

Scott and Lyman (1968) also suggest that organisations generate their own repertoire of accounts for their employees to use. This is particularly evident in the social workers' narratives, where their working conditions were used as a significant reason why they could not practice in the way they would like; therefore, constructing an excuse by appeal to defeasibility of will, that is, my will is constrained by bureaucratic procedures and excessive workloads. Menzies also (1959) identified that turnover and transfers between teams could act as a social defence, since they potentially created a psychological detachment between nurses and patients and fellow team members.

If the strategic ignorance hypothesis is correct, more ethics and human rights education for social workers on its own may not only fail to provide a solution, but it could also create further problems. As long as cognitive dissonance persists between a professional's values and their practice, an improved education would either continued to be superseded by ever increasing strategic ignorance, that would require more cognitive and emotional investment, or would place even more psychological pressure on social workers, increasing the risk of experiencing moral injury, burnout, or the professional just leaving the profession. Whittaker (2011) has already pointed out that defence mechanisms do serve a purpose and, therefore, dismantling them must be done with care[67]. This could explain why organisational changes may fail, if they disrupt the system that contains the professionals' anxiety (Krantz, 2010). Seeing the social workers' responses through the lens of strategic ignorance also allows us to understand certain reactions to whistleblowers (Kenny, 2023). These individuals are not only uncovering the truth;

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[67] There is another parallelism here with how children's behaviour can be addressed effectively as well as respectfully for the child. If a child's behaviour does indeed serve a purpose to the child, then the aim of the intervention should not simply be to supress the behaviour, but to find a healthier alternative for the original purpose.

they are also potentially destroying strategies of ignorance, not only in relation to those within the organisation who control information, but also in relation to their own colleagues, whose identity may rely, at least partly, on this ignorance.

However, given that all the interviewees expressed some degree of moral distress this may lead some readers to question the significance of distinguishing it from ethical stress. Is not this stress on an explicit ethical and human rights perspective actually irrelevant since the 29 social workers interviewed for the study already showed a moral compass guided by children's best interests? Sadly, the lived experience of receivers of social work services provides evidence that not all social work practice aligns with the profession's professed ethical and human rights guidance (Carter and Maclean, 2022; Voice for the Child In Care, 1998). We could also interrogate whether advocates would be needed by service receivers if social workers' practice always followed the ethical principles of promotion of human rights, participation and self-determination (IFSW, 2018). The lack of an explicit professional discourse on ethics and human rights and the deployment of defences can potentially lead to dangerous practice inasmuch as it leaves practice unexamined. Even amongst the interviewees, they did not all identify the same situations as problematic, and their positions were by no means identical. In some cases, as in relation to the matter of children's consent to medical treatment, extending to the adults' role in shaping children's views, they were in direct disagreement.

This latter issue, the differing interpretations on an apparent agreement over a general issue, the right to consent to medical treatment, also shows that beyond ethical codes or professional standards, there does need to be an ongoing professional discussion on such guidance. Uncritical adherence to a code can also result in social workers following procedures without questioning, perhaps through aligning their identity with that of their organisation. We considered in chapter 1 how this position could eventually align with Eichmann's defence of following orders (Arendt, 2006[1963]). As mentioned in chapter 1, organisational procedures can redefine practice away from professional ethics (Balfour et al, 2020). Social work and its practitioners do have a history of aligning with oppressive political structures, including Nazi Germany (Kuhlmann, 2023; fascist Spain: Martínez Herrero, 2023; colonial states: Dettlaff and Copeland, 2023; Noble, 2023). Furthermore, as emphasised previously, interviewed social workers' reported fragmentation of practice. The fact that it is rarely the same social worker who sees a case from beginning to end can dilute the social worker's perception of the impact of their own individual actions, and fragments knowledge in a way that makes it very difficult, if not impossible, to attribute the causation of any outcome to any particular professional intervention/s. Fragmentation, division of labour, potentially serves to dilute responsibility (Arendt, 2006[1963])).

Social workers' strategic ignorance does dilute their responsibility to act. If social workers named they were witnessing unethical practices or human rights breaches, even if they felt powerless to change the situation themselves, they would still have a professional duty to raise concerns. The professional standards of Social Work England demand social workers to promote ethical practice and report concerns (2019). The British Association of Social Workers' Code of Ethics (2021) is more stringent in its duties, stating that:

> Social workers are expected to bring to the attention of their employers, policy makers, politicians and the general public situations where resources are inadequate, and/or where distribution of resources, policies and practice are oppressive, discriminatory or otherwise unfair, harmful or illegal. (2.2 principle 4)

Through ignorance and ambiguity, social workers can attempt to dilute their responsibility to act, faced with what it is certainly a demanding task. Social workers were describing the struggle to practice ethically within unethical structures. These structures refer to both the most immediate reality for the social workers, the microsystem of their employer, but also to the location of their practice within larger social, and more immaterial, ones – in the case of this study, discourses on the framing of children's behaviour and their possible medicalisation.

Within this position, social workers need to find a justification for their practice choice, their professional behaviour. In this sense, their situation is not dissimilar from that of the children whose behaviour social workers attempt to make sense of. They face the same disjunction between agency and structures, between personal choice and circumstances. In the case of children, social workers identified how diagnostic narratives dislocated responsibility from social, political and economic structures and relational circumstances by locating causation within the child. In the case of professionals, social workers emphasised the constraining power of structures, diminishing their own responsibility and, with it, also their own agentic power to effect change within those structures. However, as discussed in chapter 1, without agency there can be no ethical behaviour (Gray, 1995). In surrendering their agentic power, social workers surrender too their capacity for ethical practice. The redundancy of ethical and human rights discourses becomes complete. At the same time, when social workers did take action, and this was successful, the success positively affected only the particular case at hand, it did not translate into systemic change. Yet social workers combined discussions point at systemic patterns, not anecdotal cases, as discussed in chapter 4. When ethical and human rights disruptions are structural, individual action, either overt or covert (Fine and Teram, 2013), even when successful, generally will only mean singular case success. Our understanding of what constitutes ethical practice is thwarted if we do not account for the structural conditions within which such practice takes place (Weinberg, 2010).

Adherence to ethical action is, however, an individual responsibility (Young, 2013). No matter how constraining (or threatening) structural conditions might be, the option of behaving ethically is always there, as evidenced by the fact that some people do (even though Fine and Teram's (2013) decision of referring to the latter professionals as "heroes" is likely completely justified in most, if not all, cases). Our position might be delimited by structural conditions, but each of us is nonetheless “responsible for how we take up these conditions” (Young, 2013: 19). But what is the most effective way to address them, to “take them up”? The inconsistency is that we expect individual action, an ‘agency model of ethics’ (Yuthas et al, 2004) even when the sources of ethical and human rights breaches are structural. Young (2013) offers a resolution to this inconsistency. Following Arendt (2006[1963]), she distinguishes between moral and political action. Moral action, being private action following own’s moral code, is what can be observed in the interviewees. Covert ethical behaviour would also fall under this category (Fine and Teram, 2013). This action could mean that the individual social worker is not participating in the unethical structures, but nothing is done to change them. Political action, however, not only must be public, but it also must aim at *collective* action to intervene in the structural conditions, not just individual cases (Young, 2013: 88-89). Ife at al state that for a rights-based practice, social workers need to be trained “not only on specific practice methodologies but also on the contexts [political, historical, social and cultural] within which their practice is located” (2022: 63). If the sociopolitical structures within which social work practice is embedded create unethical situations, social workers do not only need ethics and human rights education, but also knowledge on how political and economic structures operate in their professional life and in the lives of service receivers. At the same time, if we are locating the ethical disruption within organisational and political structures, then individual ethical professional practice alone will not solve the disruption. Moth et al (2024) have called for an ethico-political professionalism, reclaiming practitioner agency at both the individual and collective levels to sustain a social work practice that advances social justice. Yet, the wording of Social Work England Professional Standards (2019) and the British Association of Social Workers Code of Ethics (2021) places exclusive responsibility to address the situation onto individual social workers. In the case of Social Work England, the organisation surveils whether professionals are ‘fit to practice', but it does not surveil whether their working conditions are. The contradiction in holding an 'agency model of ethics' within unethical structures, needs to be acknowledged.

Limitations and future research

My premise as a researcher is inspired by critical theory's understanding that neutrality is not possible in the search for 'truth', and that the knower is historically situated (Freyenhagen, 2017). As discussed in chapter 1, science becomes a political approximation to 'reality' inasmuch as exposing oppressive sociopolitical structures may lead to their transformation (Houston, 2001). I share critical realism and critical theory expectations that greater knowledge should move us towards greater social justice (Bhaskar, 1991; Horkheimer, 2002). Beyond the limitations that my own position may have created – attempted to abate following the procedures detailed in chapter 2, the findings from this research, as well as their analysis, need to be considered within the limitations of the study, which centre around who was asked – participants – and how – data collection method (detailed in chapter 2). I finish this section acknowledging four caveats, related to criminalisation, culture, power and the researcher's insider perspective.

This study set out to examine social workers' understandings of children's behaviour, with an emphasis on psychiatric diagnosis. Most of the social workers who were eventually interviewed clearly had an interest themselves in the mental health of children in State care, and most had felt troubled by it in one way or another. This is likely to be due to the recruitment process for the interviewees, which mainly relied on social media (see chapter 2). So, whilst I do think I reached discourse saturation with the 29 interviews, I equally think I reached saturation of a particular group within the spectrum of social work professionals.

It would be good to interview children social workers for whom mental health is not necessarily their topic of interest both to understand their ideas and to have a clearer idea of the full spectrum of social workers' positions. Doing a similar recruitment campaign with more resources might yield a larger number of participants, but it is likely to produce the same results in terms of attracting professionals with relatively similar views. Securing the support of at least three different LAs which were willing to encourage their workers to participate in the study would potentially overcome this limitation, since it is unlikely that all children social workers within a LA would share the same interest or perspective in children's mental health. However, LAs, as any kind of organisation, develop their own cultures. So, to be able to recognise whether any particular findings related to the general social work profession, rather than the LA's organisational culture, more than one LA should participate in the study. There would be one potential benefit derived just by virtue of a greater sample of social workers, though. A greater number of participants would allow us to see whether there was any relationship between the social worker's views and their particular role in relation to the child – such as supervising social workers, Independent Reviewing Officers, social workers in a Looked After Children team, or in child protection, etc. –, as Orgaz et al (2023) were able to ascertain in their study on social workers' discourses and ideologies.

During their interviews, most social workers put forward clear views on other professionals they worked with, mainly schools, carers and CAMHS. A couple of social workers were actually employed by CAMHS at the time of the interview, and another one had worked there previously, so they did offer a perspective from within CAMHS and were able to distinguish between their views as social workers prior to and after their CAMHS experience. Another social worker, prior to her degree, had been employed in a children's home, and she considered whether her greater knowledge as a social worker would have made a difference in how she approached a particular child whilst working in the children's home. However, the study offers no insight into the perceptions of teachers and carers, either in foster or residential homes. Since outcomes both in terms of understanding and addressing a child's behaviour seem to depend so much on interprofessional discussions, triangulation of all professionals' views of the situation is required to fully and more accurately grasp how we are looking after children taken into State care. It would be desirable, therefore, to conduct similar research amongst education and care professionals.

Views on parents and parenting also featured in the interviews. If we understand children's behaviour as a product, at least partially, of their relational and social environment, we need to locate the study within current parenting practices, conditions and expectations in the broader society. Parenting, not just professional practice, is also constrained by economic and political structures, limiting shared time in parent-child relationships, for instance. Following Winnicott's famous quote (1960), if children cannot be understood in isolation from their parents, it follows that we need to consider findings from studies such as the present one in relation to parenting discourses and broader sociopolitical context. In the same way that the original idea that started this research, the psychiatric diagnosing of children in State care, led to a step back to consider the wider phenomenon of how social workers actually understand children, when examining how we, the adults in a society, understand children, we need to take a further step back to consider parenting: practices, conditions and expectations.

Finally, and most importantly, no way forward on how to support the wellbeing of children in State care can be proposed without incorporating the view of those with lived/living experience of the care system. There are some studies on how a psychiatric diagnosis may affect children's identity (O'Connor et al, 2018; Woodgate et al, 2017); there are also studies on the identity formation of children in State care (Colbridge et al, 2017; McMurray et al, 2011), but if the effect of a psychiatric diagnosis on children in State care is an area of concern, then we need research that explicitly considers it, ideally comparing it with alternative narratives. The incorporation of adults as well as children’s perspectives is important since narratives on one’s own life are likely to change over time, hence the importance of studying this phenomenon from a life-course perspective, particularly if we consider that professionals involved in their lives, due to the issues already discussed, are likely to have a more synchronic perspective on the child’s life and, therefore, identity formation. It is not only the understanding of the effects of different types of narratives on the identity of children in State care through their life-course that requires more research attention and practice discussion, but also the effects, through the child’s life-course, of multiple and at times contradictory narratives being presented as ‘truth’ to the child. How and to which extent do children adopt, adapt or disregard these narratives about themselves? Crittenden (2016) proposes a category, the ‘assembled self’, for those whose attachment pattern was developed over time through a patchwork of professionals’ views. This is a question that needs to be examined alongside the narratives that children adopt to make sense of their lives with their birth parents and why they came to be in State care.

In relation to the second aspect of how participants were asked, or how data was collected, the semi-structured interview allowed social workers flexibility in shaping their answers. They were invited to reject or challenge questions if they did not feel they were relevant to their practice, or to incorporate topics they felt were significant that had not been covered by questions from the researcher. A significant number added topics at the end of the interview, pointing to other very important lines of future enquiry and showing the breadth of systemic failures towards children (this was the common aspect behind all additional points raised). However, an interview format means that the information we have access to are the social workers’ perceptions on their practice, not their practice per se. In this regard, the use of ethnography to research social work needs to be considered.

Ethnography is a time consuming and emotionally demanding research method on the part of the researcher. It is equally demanding on the part of the researched, since they may find themselves exposing levels of intimacy they had not anticipated and which they could have kept undisclosed in the more controlled exchanged of an interview. Yet ethnography allows us to understand what is actually happening, whilst at the same time developing an insider's perspective. There is, nonetheless, an inherent imbalance of power in traditional methods to carry out ethnography, a colonisation of experience, whereby the ethnographer unilaterally interprets participants' expressions and authors the text of their lives. Ethnographic research of social work should pursue the democratisation of authorship and transform ethnography from the acquisition of an insider perspective to a dialogue between outsider and insider perspectives, where both can broaden their understandings. This type of research would create an immediate value to participants, without having to wait for possible or potential elusive societal or political changes that would slowly trickle down back to them, since it would support them to develop as practitioners. In this regard, some of the social workers commented on how useful the research interview had been since it had afforded them the space to reflect on their practice so far and had created new curiosity.

Finally, four caveats in relation to the findings and analysis presented here need to be mentioned. First, this study, in approaching the understanding of children by social workers, had a recognised interest in particularly examining the possible medicalisation of the former and the mechanisms by which this was done, if at all. One of the study's findings is that medicalisation allows adults to exonerate children ('it's not your fault'), whilst at the same time keeping the problem within the children. However, some interviews hinted at that, when behaviours are not recognised as effects or expressions of (relational) trauma and/or a psychiatric condition, but attributed to wilful behaviour, this can lead to children being dealt through the criminal justice system. Through its focus on mental health, the social workers' interview obscured this aspect, that criminalisation needs to be considered alongside medicalisation in terms of examining how adults understand children's behaviour[68]. More research is required to consider possible conditions or factors that favour one or the other interpretation/pathway.

Second, the role of culture in two of the important areas of this study, psychiatric nosology and human rights, has been largely unaddressed. Both areas of knowledge have been criticised for their Eurocentrism and their imperialist exportation, or imposition, of European ideas to other cultures (Samson, 2020). The discussion of psychiatry as culturally biased has featured in anthropology for a long time (Benedict, 1934, Kleinman, 1987, 1988; Gaines, 1992) and by psychiatrists themselves (Timimi, 2002)[69]. The lack of discussion here on those points does not imply disagreement with such criticism. Rather, this aspect has gone purposefully unmentioned in order to focus instead on examining both areas within the European culture in which they originated. In relation to psychiatric nosology in particular, discussion of its cultural bias becomes secondary to the examination of how problematic it already is within its own culture. In relation to human rights, ideas expressed in this study will have to be complemented by examination of their implications for professional practice outside of European countries, within different cultural practice contexts.

Third, the notion of power has been appearing and disappearing within this study without ever my dedicating a meaningful reflection on it. I have concentrated here on psychological experiences and how these are incentivised by and/or reinforced by structural conditions. However, I do strongly believe that this study can also be analysed from a power perspective, which would not only shed further insights over its findings, but could make a meaningful contribution to the literature on power. Power relationships, both sociopolitical and intimate, between individuals in close relationship, are present throughout the study: power to frame behaviour as problematic, both children's and social workers', power dynamics between adults

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[68] One diagnosis, Conduct Disorder, could be considered the medicalisation of criminal activity.

[69] DSM-5 (APA, 2013) was sensitive to this latter area of criticism and added "culture-related diagnostic issues".

around the child, power between adult and child, power in authoring narratives of the self, including other's self. Findings in this study could help examine aspects of power neglected in literature. Most of the literature on political power centres on being able to go against somebody else's interests and ensure yours prevail (Lukes, 2021). Here, however, we meet adults who must make the child's best interest as their paramount consideration, yet, we still find potential for oppression and epistemic injustice, since here we are presupposing that the target population, children, do not know what is best for themselves. Yet Lukes (ibid) reflects on the patronising pitfalls of putting this argument forward in relation to adults.

Finally, on the topic of power, psychiatry (and criminal justice) has remained the classic scenario where to study Foucault's concept of disciplinary power (2005). However, since Foucault considered the family the last bastion of sovereign power, studying children in State care who encounter the mental health system, could allow us to explore the intersection of both disciplinary and sovereign power – the latter specially in relation to how disciplinary power, represented by the care system, might adopt aspects of sovereign power, in acquiring the caring functions of birth families. In relation to disciplinary power, Foucault centred his attention on the effects of such power on those who constituted its residue. For instance, he interprets the behaviour of hysterics as a 'simulation', a lie within their madness, as a form of resistance against the psychiatric power that subjugated them. Here we would have to examine the notions of disciplinary and sovereign power within adults who should be invested in the children's welfare. Also, this study has considered how, within intimate/close relationships, the authorship of one's self implies authoring the other's self, and vice versa. The influence and the dependency are mutual even when one side has more 'power over' or 'power to'. So, is the man in Foucault's panopticon aware of how his own presence influences what he sees, and how much his view of himself actually depends on what he sees?

Lastly, this study was conducted by a researcher with an insider perspective (supervised by two sociologists with outsider perspectives). I have over a decade of professional experience as a social worker working with children in State care. Some social workers took for granted that I was a colleague, others enquired whether I was. I do not consider my insider perspective a limitation on the study, but I would like to acknowledge that, without it, my analysis of the data would have likely been different. There are two further points, however, that I would like to mention in relation to this. First, my status as a social worker has made me both more conscious and, at the same time, freer in relation to how I have analysed and presented the data collected. More conscious, because I am an expert by experience on how difficult it is to practice in England, and I did not want to appear to collude with spurious narratives on the profession. At the same time, it is undeniable that social work as a profession, as well as individual practitioners, have at times caused serious harm. Whilst we do need to claim strongly for a narrative that does not take ideological shortcuts and shy away from complexity and uncertainty, we equally need to recognise our mistakes and shortcomings if we want to do better by the people whom we serve. And it is precisely the fact that I can use the first-person plural that has made me feel freer when tackling this point, since I include myself in every reference to the social work profession. No criticism has been shed on social work that I do not shed on myself, as one of its professionals. Second, being a social worker supervised by sociologists has highlighted the benefit of combining an insider-outsider perspective. It is regrettable, therefore, that so much research on social work is done from an exclusively outsider perspective. Our understanding of areas of social work involvement would be greater with a more extensive collaboration between social work and other disciplines, such as sociology. Afterall, and particularly from a critical theory perspective, social work is nothing more than applied sociology to the service of creating a more socially just world.

Conclusion

I asked social workers to share how they made sense of children's behaviours and, in the process of analysing their answers, I found explanations for social workers' own behaviour, whilst, at the same time, recognising how interrelated both pools of explanations are.

Social workers voiced their concern that the explanation/s chosen to understand children's behaviours would have implications for the children's identities, for how children understood themselves and their life experiences. However, most immediately, those explanations have implications for how social workers, and by extension adults around the child, understand themselves. There is a conflict of interest here that cannot be avoided. The explanation chosen to understand a child's behaviour is necessarily linked to the narrative around the adults caring for and/or working with the child.

Another point of confluence between the children and the social workers is the parallelism in their situation. If children are trying to survive following experiences of interpersonal trauma, social workers are also trying to survive within organisational structures they do not experience as supportive. This needs to be considered alongside the extent to which carers and schools may have similar feelings. If and when they did, we would be having children trying to achieve a sense of safety supported by a group of adults who themselves are not feeling safe. This argument should also be considered in relation to parents. Do parents in deprived socioeconomic situations feel in control of their lives? Ultimately, the organisational conditions of practice not only affect social workers as employees, but they also affect the service provided to children, that may not align with the child's best interests. The irony, and the danger, is that, in a situation where social workers are meant to be helping children to overcome extreme adverse experiences, it is the social workers who may find themselves struggling for (psychological) survival.

These parallels, however, take place within a non-symmetrical relationship within an unequal distribution of power. Children and social workers face unequal conditions to choose a narrative, at least the official one, to understand the child. I have examined how adults' shortcomings can become reified as diagnosis for the child. But I argue that a trauma narrative, generally more favoured by the social workers, can have a similar effect by placing those shortcomings in the adults from the child's past, away from the adults in the child's present.

Both discourses, psychiatric nosology and trauma have been the subject of criticism, and both have had their evidence-base questioned. I have tried to show that, as devices, there are more common points between diagnosis and trauma than is apparent. Both can potentially serve spurious purposes. Regardless of their scientific merits, we need to examine the potential purposes and consequences of each narrative both at a sociopolitical level and for the individual human being. This is the more significant since social workers' accounts of their practice experience evidences the lack of a nationwide coordinated approach to support the emotional wellbeing of children in State care and that of those living with struggling families.

Of course, there is now the diagnosis of Complex Post-Traumatic Stress Disorder in ICD-11 (WHO, 2019). Developmental Trauma Disorder could have also addressed concerns in relation to comorbidity and overlapping symptomatology between the sequelae of trauma and some current psychiatric diagnosis (van der Kolk, 2005). There appeared to be no knowledge of either diagnosis amongst the social workers I interviewed[70]. Both diagnoses, however, have been criticised for medicalising trauma, and one could question the logic of referring to something as disorder that it is acknowledged as a biological adaptative response. However, considering the potential detrimental long-term effect of psychotropic drugs, the extent of pharmaceutical corruption in producing and marketing them and the overmedication of children which we

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[70] With the exception of one social worker who mentioned "complex trauma".

already know it is taking place in the USA (van der Kolk, 2015), it should be a government's priority to gain an up-to-date knowledge of diagnostic and drug prescription rates amongst children in State care, currently unavailable.

The disagreements between different adults around the child, not just between those currently working with the child, but also between successive social workers involved in a case allow us to appreciate the complexities of day-to-day social work practice. But these disagreements also show that this reality it is not as absolute or homogenous as differing sociological interpretations may appear to portray. If sociological thinking such as diagnosis as political device or disciplinary power were the only causal explanation behind the deployment of psychiatric practices, we should find a higher degree of consensus amongst the adults who operate within such discourses and structures. That was, however, not the case in multiple scenarios shared by social workers. I argue that we need to consider that such sociological explanations are mediated through psychological processes, some of which have been considered in this study.

Beyond the potential consequences of any narrative, or the assemblage of multiple often contradictory narratives, one reflection I hope emerges from this research is the recognition of the need to support children in State care to be active authors of their own lives. This recognition should be based, amongst other points, on the acknowledgement that no professional has a comprehensive knowledge on the child and the fact that these children, once they become adults, are likely to have a much more limited access to adult support than their counterparts raised within birth families. Supporting children to author their lives could be achieved through epistemic humility – that is, offering reasons rather than black boxes: "Because of A, B, C, we feel X is the most likely reason why you behave this way" instead of "X is the reason why you behave this way" –, and through epistemic democracy. As a social worker described doing, potential explanations can be presented as suggestions to children for them to think about and incorporate, adapt or altogether disregard. This should also highlight the importance of adopting within professional practice a narrative life story conversation with the child, revisited over time, making adaptations to reflect the child's changing developmental stages and emotional maturity.

But perhaps even more important would be to overcome the frequent displacement of emotional wellbeing in favour of behaviour. The focus of the discussion should be on supporting children's emotional wellbeing (and that of the adults in charge of their care), rather than 'managing' their behaviour. What the social workers' stories left clear is that the latter is not synonym of the former. That a child does not disrupt or distress an adult does not mean that they themselves are not suffering. We need children social services that support sustained relationships that allow for the development of trust. Any kind of thematic team fragmentation will hinder this. Equally, a more nuanced use of attachment theory that is not simply relegated to the child's early relationships with their primary care givers, could support the functional understanding of behaviour and guide professionals in supporting children's wellbeing and a healthier expression of their emotional worlds. But it would also illuminate the understanding of behaviour as relational; therefore, demanding the examination not only of the child's behaviour, but also of those significant figures around them, hopefully leading towards a more reflexive professional attitude.

At the same time, listening to the social workers and analysing their responses highlights the need to have a more explicit and practical discussion on their role in relation to their actual possibilities to exercise it. Regarding children in State care, children's social workers are the representatives of their corporate parenting and hold decision power; supervising social workers are meant to oversee and support foster carers, and they are also expected to engage with the child. However, neither is involved in the day-to-day care of the child; rarely do they witness the concerning behaviours that are reported to them; and their position in the power relations amongst the adults around the child does not always correspond with the official responsibilities of their role in terms of decision-making. We do need to engage in a discussion on the social worker’s role in particular and the dynamics within the adults around the child in general. The profession also needs to engage more fully on what actually the best interests of a child are. This seems to be a taken-for-granted expression, which does not have a statutory definition, contrary to other relevant terms. Social workers were clear that most of the time they were engaged in balancing acts: risking a placement breakdown and respecting a young person’s decision over their medical treatment or sustaining the placement following the carers’ wishes; seek a diagnosis to access support and let the child grow with the potential handicap of a psychiatric diagnosis or forego the support.

The answers to these dilemmas are likely to be specific to each case, but they do highlight the need for an ethical and human rights reflexive dialogue. However, in the study, an ethical and human rights label appeared as an antithetical device to a psychiatric diagnosis. If social workers thought a psychiatric label might remove responsibility from adults and/or the children themselves, an ethical/human rights labelling would achieve the opposite effect, increasing the weight of responsibility. However, in both cases (even though through opposing mechanisms, labelling in one case, not labelling in the other) the removal of responsibility implies a removal in equal measure of agency, which can dangerously contribute to an apathy towards social injustice that would affect children, their families and carers and the professionals in charge of supporting them.

If social justice is the justification of social work (IFSW, 2014), this gives the profession the responsibility of being an agent of change, that is, of fully embracing our agentic power; however, this also requires accepting the responsibility for when we are not so. Yet, as I have pointed out, rather than demanding individual professional actions to address unethical structures, professional organisations should encourage and support concerted collective action.

We need to move away from the ‘zone of interest’[71] perpetuated by individualising discourses and direct the limelight firmly on those hostile environments, those social conditions that are not conducive towards family thriving, noting that children cannot thrive without their parents doing so too, and professional fulfilment. The ‘authorship of the self’ (Scott, 2015) becomes the site to re/claim agency and the right to tell one’s story, yet, one’s story is inextricably linked to the stories of those around, and to larger cultural and political ones. The more honest we are with our own story, the more power we give back to others to tell their own.

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[71] Following Glazer’s movie (2023), I refer as ‘zone of interest’ to those spaces where life passes by routinely and ordinarily at the expense of situations of social injustice. We social workers certainly do not benefit from the placid accommodation of the Auschwitz camp commander, but we do accept salaries for jobs that we know go against our values.

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Appendices

Appendix I. Recruitment advertisement for adults with childhood experience of the care and mental health systems

Hello. My name is Ana Olea Fernández and I am a PhD researcher from the Department of Sociology at the University of Essex. I am exploring the experiences of adults with care experience of having had a mental health difficulty or condition (AHDH, ODD, etc.) in childhood.

My research aims to develop a better understanding of the significance of mental health conditions for children in care as they grow up from the perspective of those who have been through this experience themselves, and compare it with current children's social workers perspectives on the same subject.

My research aims to actively involve people with care experience in the research process itself, by inviting them to participate in creating the interview materials to present to social workers, and to take part in the discussion of study responses.

If you had a mental health difficulty or condition - such as depression or ADHD - whilst you were in care, are between the ages of 18 and 50 and born in the UK, I'd be really interested in having you participate in my study.

You can contact me for more information at psychiatrystudy@essex.ac.uk or 07757 669

370.

What's involved? You can choose any or all of the following activities:

Telling me your story in whichever way you choose: face-to-face, poems, email, podcasts, art work, quotes from movies, songs... You choose.

Reading your social services files, if you give me permission.

Creating and choosing which materials will be presented at interviews with social workers.

Commenting on the social workers' responses.

University of Essex

Appendix II. Recruitment advertisement for social workers with working experience of children in State care

Hello. My name is Ana Olea Fernández and I am a PhD researcher from the Department of Sociology at the University of Essex. I am exploring social worker views of the impact for children in care of having a mental health difficulty or condition (i.e. ADHD, ODD).

My research aims to develop a better understanding of what a mental health condition means for children in care from the perspective of those who have been through this experience themselves and compare it with current children's social workers perspective on the same subject.

If you are or have been a children and families' social worker, and you would like to share your reflections and experiences in the area of children's mental health, I'd be really interested in having you participate in my study.

You can contact me for more information at psychiatrystudy@essex.ac.uk or 07757 669 370.

What's involved?

One interview of about an hour to two hours, depending on your availability. You can choose whether you would like it via videoconference or email.

University of Essex

Appendix III. Participant Information Sheet for adults with childhood experience of the care and mental health systems

Participant Information Sheet:

Psychiatric diagnosis of foster children: care leavers and social workers' views

My name is Ana Olea Fernández and I am a PhD student in the Department of Sociology at the University of Essex. I would like to invite you to take part in this research project. Joining the study is entirely up to you.

Before you decide, you need to understand why the research is being done and what it will involve for you. Please, take time to read the following information carefully. Once you have had the chance to think about it, I will then answer any questions you may have to help you decide whether you would like to take part.

What is it about and what's involved for you?

This research seeks to understand the impact that psychiatric diagnoses may have in the lives of foster children from their own perspective (Phase One) and compare it with the views that children's social workers have on the same subject (Phase Two). The research project is scheduled to finish in Summer 2022. Anyone born in the UK up to the age of 50 with care experience who had a psychiatric diagnosis whilst in foster carer can take part in the project. This research study has been granted ethical approval by the Social Sciences Ethics Sub-Committee at the University of Essex.

I would like any person with foster care experience who chooses to take part in the study to become actively involved. In practice, this means there are several ways you can become involved in the research: by sharing your story and/or by preparing the questions for social workers and/or discussing their answers; you can choose how you would like to take part in either of these activities and you will choose how much time you would like to invest in the project. Before you take part in the project, you'll have the opportunity to indicate in the consent form how you would like to participate.

If you choose to share with me your story, you can do this however you like. For example, you may participate through: a face-to-face or Skype/Facetime interview, sending me emails or podcasts, diary type entries, pieces of your art work, or movie clips, song lyrics or images that you feel express what you experienced. Whatever activities you choose will take place at a time and place suitable to you. I would also like to ask you for permission to access your social work records, so I can see how social workers described your story, but you don't need to agree to this access in order to participate in the study.

Before any interview, I'll ask for permission to audio record the interview. You can choose for the interview not to be recorded. If you tell your story through any kind of video recording, you can choose whether you want it to be saved in its entirety, only the transcript or nothing at all. If you choose any art expression, I will ask your permission to take pictures of anything you create, but the original art work will remain yours.

In Phase Two of my research I'll be interviewing social workers. You can choose to participate in the research by suggesting materials for use in these interviews – be it a question, a statement or an image. If you choose to take part in this, you can do so individually – only communicating with me - or join a media conversation with other people with care experience taking part in the research. Please, note that, if you choose the second option, this may compromise your anonymity in respect to the other participants. You are welcome to engage in the online conversation using an alias.

Another way for you to be involved could be to participate in what is called the data analysis of the research. In order to do that, after I have interviewed the children's social workers, I'd share some fully anonymised extracts from their responses with you, so you can comment on them. You can choose to do this in direct communication with me or via media conversation with other participants with care experience. I am able to offer a £20 Amazon voucher (or an equivalent of your choice) to the first five adults with care experience who join the study to comment on the social workers' responses, in honest appreciation of your time and valuable knowledge.

I'm happy for you to see, and comment on, draft versions of the analysis, if you wish.

How will your data be used?

I will use an anonymised transcript of the material you create and share for research purposes. As I work through my analysis, I will anonymise any identifying details, such as your name or historical locations.

Materials from all participants will be analysed together for common themes in relation to the views and experiences of people with care experience regarding psychiatric diagnosis of foster children. I may also wish to include in the doctoral thesis examples in the form of quotations or pictures of your art work that you have shared with me.

All digital files will be saved on a password-protected computer and all paper documents will be stored in a locked cabinet to which only I have access. Digital files will be backed up in a securely stored Box folder.

I'll personally transcribe any audio or video recordings, and you may request a free copy of the transcripts from your interviews or interactions. Throughout the project, I will be the only one with access to un-anonymised data, although in the event of a complaint or other problem, my supervisors may also have access to un-anonymised data.

I am obligated to report anything that you report which indicates that you or another person are at immediate risk of harm.

What will happen when your participation finishes and with the results of this study?

The goal of the project is to produce a doctoral thesis. In addition to this, I may also produce other academic publications which may include anonymised anecdotes or quotations you have shared with me. I am happy to share a copy of my thesis and resulting publications.

Once the research is completed, all paper documents will be digitalised and subsequently shredded. All digital documents will be securely stored in a Box folder.

What are the possible disadvantages and risks of taking part?

Every effort will be made to anonymise all participants' data and maintain confidentiality.

Recounting your story, regardless of the format you choose, may put you in touch with painful experiences in ways you had not anticipated. Before your participation starts, I will ensure I am aware of the support locally available to you. At the end of this form there are some organisations that may be able to provide some support if you feel you need this.

What are the possible benefits of taking part?

Whilst I hope there will be benefits to the social work profession and future foster children, honestly, I cannot anticipate there'll be any benefits to you individually.

How to withdraw if I want to do so? How can I complain/express a concern if I want to do so?

Participation in this research project is voluntary and it depends exclusively on your choice. You are free to withdraw without any detrimental consequences. To withdraw you just need to contact me via email, text, or phone. As soon as you have withdrawn, I will not contact you any further nor will I use any data collected.

Once you have read all this information, if you would like to participate or you have further questions, please, contact me:

Ana Olea Fernández

PhD Student, Sociology Department

University of Essex

Email: ao19443@essex.ac.uk

Tel: 07757 669 370

Should any issues arise where you feel you must make a complaint, include the ERAMS reference number that can be found at the foot of this page and contact:

Supervisors

Dr. Laurie James-Hawkins
Email: laurie.hawkins@essex.ac.uk
Tel: 01206 874 885
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Research Governance and Planning Manager

Sarah Manning

smanni@essex.ac.uk

University of Essex

Wivenhoe Park

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SUPPORT LINES

Become. The charity for children in care and young care leavers (Formerly The Who Cares? Trust)

Webpage: https://www.becomecharity.org.uk

Advice line: 0800 023 2033

Opening hours: Monday to Friday, 10am to 5pm.

NAPAC (the National Association for People Abused in Childhood)

Webpage: https://napac.org.uk

Support line: 0808 801 0331

Opening hours: Monday to Thursday, 10am to 9pm; Friday 10am to 6pm

Samaritans

Webpage: https://www.samaritans.org

Telephone: 116 123 (open 365 days, 24 hours)

Email: jo@samaritans.org (response within 24 hours)

Address: Write to Us
Chris
Freepost RSRB-KKBY-CYJK
PO Box 9090
Stirling FK8 2SA

Appendix IV. Consent form for adults with childhood experience of the care and mental health systems

Consent Form

Psychiatric diagnosis of foster children: care leavers and social workers' views

Research team

PhD student:	Supervisor:	Supervisor:
Ana Olea Fernández	Prof Joan Busfield	Dr Laurie James-Hawkins

Please read each statement carefully and, if you agree, place your initials after the statement.

Taking part

I have read and understood the Participant Information Sheet for the above research project dated 7th March 2021. I have had an opportunity to consider the information, ask questions and have had these questions answered satisfactorily.	
I understand that my participation is voluntary and I am free to withdraw at any point without having to give any reason. I understand that any data collected up to that point will be destroyed.	
I agree to participate in this research project via the following methods (please initial each method you are willing to engage with):	

Skype/Facetime/Zoom interview.	
Email interview.	
Creating/sharing audio/visual material.	
I give permission to Ana Olea Fernández to audio record my interview.	
I give permission to Ana Olea Fernández to take pictures of any art work.	
I agree that Ana Olea Fernández can access my social services file.	
I agree to assist in creating material to be used in interviews with children's social workers via the following methods:	
Communicating with Ana Olea Fernández.	
Participating in an online group with other people with care experience.	
I agree to take part in commenting anonymised extracts from interviews with children's social workers via the following methods:	
Communicating with Ana Olea Fernández.	
Participating in an online group with other people with care experience.	

Use of the information

I understand my personal details, such as name or historical locations, will be kept confidential by the principal investigator unless there is immediate risk to the participant or other individuals.	
I understand that the identifiable data provided will be securely stored and accessible only to the researcher's supervisors, and that confidentiality will be maintained.	
I understand that any data collected will be used for research purposes and may be quoted in the doctoral thesis and other research outputs.	

Participant Name	**Date**	**Participant Signature**
______________________	________	______________________

Researcher Name	**Date**	**Researcher Signature**
Ana Olea Fernández	________	______________________

Appendix V. Participant Information Sheet for social workers with working experience of children in State care

Participant Information Sheet:

Psychiatric diagnosis of foster children: care leavers and social workers' views

My name is Ana Olea Fernández and I am a PhD student in the Department of Sociology at the University of Essex. I would like to invite you to take part in this research project. Joining the study is entirely up to you. Before you decide, you need to understand why the research is being done and what it will involve for you. Please, take time to read the following information carefully. Once you have had the chance to think about it, I will then answer any questions you may have to help you decide whether you would like to take part.

What is the purpose of the research and what does it mean for you?

This research seeks to understand the impact of mental health issues in the lives of children in care from their own perspective (Phase One) and compare it with the views that social workers have on the same subject (Phase Two). Any social worker with experience working with children in care can take part in the project. This research study has been granted ethical approval by the Social Sciences Ethics Sub-Committee at the University of Essex.

We can conduct the interview via zoom, skype or email. I anticipate that each interview will last 60 minutes or less, but the length of the interview is up to you. The interview will be audio recorded with your permission, taking place at a time that suits you. During the interview I will ask about your experiences in supporting children in care mental health.

In appreciation of your time, the first 15 social workers interviewed will receive a £20 Amazon voucher (or an equivalent of your choice).

How will your data be used?

I will use an anonymised transcript of your interview for research purposes. All interviews will be analysed for common themes in relation to the views and experiences of social workers regarding the mental health of children in care. Potentially identifying information will be removed. I may include anonymised excerpts from your transcript in my doctoral thesis or in future academic publications. If you agree, I will share quotes from your fully anonymised interview transcript with the care leavers involved in Phase One to comment on, but you do not have to agree to this to participate. I will transcribe your interviews myself and can provide you a copy if you wish. The only other people who will potentially have access to un-anonymous data would be my doctoral supervisors, and then only in the event of a complaint or problem.

What will happen when your participation finishes and with the results of this study?

The goal of the project is to produce a doctoral thesis. In addition to this, I may also produce other academic publications which may include anonymised anecdotes or quotations you have shared with me. You can request a copy of the thesis and resulting publications if you wish.

All digital files will be saved on a password-protected computer and all paper documents will be stored in a locked cabinet to which only I have access. Once the research is completed, all paper documents will be digitalised and subsequently shredded. All digital documents will be securely stored in a Box folder.

What are the possible disadvantages and risks of taking part?

Every effort will be made to anonymise all participants' data and maintain confidentiality. There are no anticipated risks related to your participation.

What are the possible benefits of taking part?

While there are benefits for the social work profession more generally, future children in care, and society at large, there are no anticipated benefits to you individually.

How to withdraw if you want to do so? How can you complain/express a concern if you want to do so?

Participation in this research project is voluntary and you are free to withdraw at any time without consequences. To withdraw you just need to contact me and then I will not contact you any further nor will I use any data collected.

Once you have read all this information, if you would like to participate or you have further questions, please, contact me:

Ana Olea Fernández

PhD Student, Sociology Department

University of Essex

Email: ao19443@essex.ac.uk

Tel: 07757 669 370

Should any issues arise where you feel you must make a complaint, include the ERAMS reference number that can be found at the foot of this page and contact:

Supervisors

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CO4 3SQ

Appendix VI. Consent form for social workers with working experience of children in State care

Consent Form

Psychiatric diagnosis of foster children: care leavers and social workers' views

Research team

PhD student:	Supervisor:	Supervisor:
Ana Olea Fernández	Prof Joan Busfield	Dr Laurie James-Hawkins

Please read each statement carefully and, if you agree, place your initials after the statement.

Taking part

I have read and understood the Participant Information Sheet for the above research project dated 7th March 2021. I have had an opportunity to consider the information, ask questions and have had these questions answered satisfactorily.	
I understand that my participation is voluntary and I am free to withdraw at any point without having to give any reason. I understand that any data collected up to that point will be destroyed.	
I agree to participate in this research project via the following:	
Skype/Facetime/Zoom interview.	
Email interview.	

I give permission to the researcher to audio record my interview.	

Use of the information

I understand my personal details, such as name, address or employer, will be kept confidential by the principal investigator unless there is immediate risk to the participant or other individuals.	
I understand that the identifiable data provided will be securely stored and accessible only to the researcher and the researcher's supervisors, and that confidentiality will be maintained.	
I understand that any data collected will be used for research purposes and may be quoted in the doctoral thesis and other research outputs.	
I agree that fully anonymised extracts from my interview/emails will be shared with people with care experience for them to comment.	
I understand that the data collected will be used to support other research in the future, and may be shared anonymously with other researchers, under the terms agreed on this form.	

Participant Name	**Date**	**Participant Signature**
____________________	________	____________________
Researcher Name	**Date**	**Researcher Signature**
Ana Olea Fernández	________	____________________

Appendix VII. Interview guide for adults with relevant lived experience.

Interview guide – Care leavers

Participant care leavers will be asked to tell their story in the format of their choosing, so their participation may not entail an interview. If they choose an interview, this will be unstructured, inviting the care leaver to choose the "editing" of their own story, following whichever aspects of their childhood are felt as more salient for each individual participant.

Below is a script of the start of the interview and the areas that, given the study subject, could be reasonably expected to be covered. Throughout the interview I will actually aim to ask as few questions as possible, with the exception of seeking clarification. I will aim my questions to be worded in the language that the individual participant is using at the time of the interview. My questions will follow whatever I happened to feel more relevant, thematically, for each participant at that moment of the interview in terms of understanding, and sharing with another, their own story. Therefore, the questions presented below are only a sample of what could be asked, or a representation of the subjects that the participant may cover without having to be asked about them. Equally, the order of the questions presented below does not necessarily imply the order in which they would be asked.

Thank you for meeting me. Before we start, do you have any more questions for me? Can I confirm that I have your permission to record? OK, I will turn the recorder on now then.

I really appreciate you taking part in my research. As I have explained, all of your answers will remain anonymous. You choose how much detail you want to provide in them and you can choose not to reply. If at any moment you want to take a break, please, do let me know. I apologise if I ask you something that you have already told me; if I ask you to repeat it, it will be for the purpose of the interview.

As we have already talked about, I am interested in understanding the impact, if any, that

you feel your psychiatric diagnosis has had in your life, at the time you were in care, but also into your adulthood. But most of all, I would like you to share your story in your own words. It would be a privilege to hear from you what has led you to the person and the place you are today.

[In the event of “I don't know”/ “What actually do you want me to tell you?” / “Where do you want me to start?” replies]

As you were growing up, how did you make sense of what was happening to you: coming into foster care, moving placements, your psychiatric diagnosis?

Do you feel there was ever any adult available to offer you explanations or to answer your questions?

Looking back, what events/people from your childhood feel most important to you now?

Present demographic information:

Age, occupation, marital status, general area of residence.

Childhood demographic information:

Age taken into care, number of placements, number of social workers, which other professionals were involved, siblings.

Present identity:

i.e. How would you describe yourself now? What do think your foster carer/s or social worker/s would think/feel if they saw you now?

Childhood memories:

i.e. Can you tell me about your first memories as a child? What are your happiest and not so good memories? How was childhood memorabilia kept for you? What was your experience of what social workers call “life story work”?

Care journey:

i.e. As a child, how did you make sense of being taken into care? How did that view change over time? Could you give me examples of carers or social workers explaining decisions to you? How did it feel no longer being in care?

Friendships:

i.e. What are your memories of friendships as you were growing up? Can you give me examples of when you made new friends? How did you keep in touch with your friends if you had to move school/address? How do you find making friends as an adult? And keeping them?

Childhood physical and emotional wellbeing:

i.e. How did it feel growing up? Can you explain me your history with psychiatric diagnosis? How did your initial psychiatric diagnosis come about? How was your psychiatric diagnosis explained to you? What did you think about it at the time? How were you involved in choosing any treatment? How was any treatment explained to you? Can you explain me your treatment history, therapy and/or medication? What did you think about either of them? In what ways did you notice any difference whilst in therapy or under medication?

Present physical and emotional wellbeing:

i.e. Can you tell me about any diagnoses or psychiatric care that you may be currently receiving? [If they no longer have a diagnosis/treatment] Can you tell me how did that come to an end? How was it for you at the time? How do you relate your present or past feelings or behaviours to the events that you experience as you were growing up?

Contact:

i.e. Can you tell me how has contact with your birth family has been throughout your life? When you were a child? Once you left care? How has your relationship with different members of your family change over time?

i.e. How has been the relationship with your foster carers once you have left a foster placement?

i.e. How did you take when a social worker stopped working with you? How did you get used to the new one? Could you tell me of any particular social workers that you still remember? What has made them stick in your mind?

Closing questions

Are there any other things that you would like to share or that you would like me to consider? About your story or this interview?

Can I ask you what made you decide to take part in this study?

Before closing, I will also ensure I clarify as much as possible details of biographical events, such as years, places or professionals involved.

Appendix VIII. Social workers' interview guide

Thank you for meeting me. Before we start, do you have any more questions for me? Can I confirm that I have your permission to record? OK, I will turn the recorder on now then.

I really appreciate you giving up your time to take part in my research. As I have explained, all of your answers will remain anonymous. I may ask you something that you have already told me. I apologise for making you repeat it, but I need to ask you again for the purpose of the interview.

Demographic questions

First, I would like to ask you a few questions about you and about you as practitioner.

How do you identify yourself in terms of gender, ethnicity and religion?

How old are you?

When did you get your social work degree? Where?

How long have you been working as a social worker? In which roles?

What is your current role? How long have you been working in that role?

What is the caseload expected in your current role?

Are you affiliated to any social work organisation?

1. What do you consider the three most important **characteristics** to make a good social worker?

2. How do you establish a **relationship** with the children and young people in your caseload?

How do you familiarise yourself with the **child's history**? Do you read their file? Is it a service expectation that you will read their file?

3. What do you do as a practitioner to encourage **participation** from children in care? Could you give me an example where you included a child in the decision-making process? And an example where you tried to do so but did not succeed?

4. What would you consider to be **challenging** behaviour? Can you give me a couple of examples from your experience?

5. What would you consider to be **distressed** behaviour? Can you give me a couple of examples from your experience?

6. Can you tell me about an instance of behaviour that has **puzzled** you the most from a child in care? How did you make sense of it? And a behaviour that you had to explain to a foster carer?

7. What do you think is the relationship between a child's **previous and present experience** and their current presentation? Could you give me examples?

8. Have you ever had a child or young person in your caseload who you thought needed a psychiatric diagnosis? If so, how was the process of getting them a diagnosis? Who was involved in assessing the child? Who spoke with the child about it?

9. Have you ever felt that a child or young person on your case load had been **misdiagnosed**? If so, what made you think that and what did you do?

10. In your experience, how do health professionals reach a **decision in regard to diagnosis**?

11. How do you find **SDQs** in terms of helping you to make sense of a child's mental health and emotional wellbeing?

12. What do you think is the relationship between a child's **previous and present experience** and their psychiatric diagnosis? Could you give me examples?

13. How do you think a **child in care makes sense of their psychiatric diagnosis**? Can you tell me about any experiences you have had discussing a psychiatric diagnosis or treatment with a child you were responsible for?

14. How has been the mental health support offered to the children and young people you have worked with? How was it decided? **In which ways have you found that therapy or medication has affected the child?**

15. Have you ever **questioned** the type of **treatment** offered to any child you have worked with? If so, what made you question it and what did you do?

16. What are the thoughts that the following scenarios bring to your mind?

> K is an eight-year-old boy. He has been in placement for 9 months. He has minor behavioural problems at school. His carers complain about his behaviour at home and take him to the GP, who refers K to CAMHS. CAMHS sends questionnaires to both carers and school and subsequently K is diagnosed with ADHD and put on a low medication dose.
>
> G is a fourteen-year-old girl. She self-harms on a weekly basis and she engages in unprotected sex. She frequently absconds. The local CAMHS states she does not meet their criteria and no support is offered.
>
> J is a fourteen-year-old girl. She is diagnosed with autism, ADHD and ODD. She is on medication for this. She moves into a new foster placement following the breakdown of her previous one. Her new carers acknowledge she requires more support than another child her age, but they report no problems with her behaviour. Six months into the new placement, J's psychiatrist considers her on remission from ADHD and ODD and discontinues her medication. Six months later the diagnoses of ADHD and ODD are taken from her file.
>
> V is a 13-year-old boy. He is in therapy. His carers have shared negative comments about his therapist. They are not available to take him to therapy, transport has to be provided for this. V is monosyllabic during therapy sessions and he has already mentioned he does not want to attend.
>
> M is a nine-year-old boy. He attends a specialist school. He is diagnosed with autism, ADHD and ODD. He is on two different medications for this: one he takes

> morning and evening; another one he takes at midday. Both school and foster carers struggle with his behaviour. His carers mention to the social worker they would like his medication upped in order to get through the day.
>
> D is a 15-year-old girl. She has been in the same foster placement for 18 months. And she has been going to art therapy for a year. She enjoys the sessions and looks forward to them. Her self-harming and her risk-taking behaviours remain the same at the end of her first year of therapy.
>
> S is an eight-year-old girl. She is diagnosed with ADHD, and she is on medication for this. Both school and foster carer struggle with her behaviour. Her psychiatrist increases the dosage and gives leeway to her carers to change the dosage as they see appropriate in the future.
>
> H is an 11-year-old boy. He has been in the same foster placement for almost two years. He is in therapy. His carers struggle with his behaviour at the foster home. H's carers are offered to attend sessions fortnightly with the therapist, but they decline this suggestion because there is "nothing wrong with them".

17. What **theories** or models do you use as a practitioner to understand a child's presentation, in terms of behaviours, emotional wellbeing and mental health?

18. What are the **ethical** points that you take into account when considering the psychiatric diagnosis and treatment of a child? Could you give me a case example?

19. What are your **human right** considerations in relation to the psychiatric diagnosis and treatment of children in care? Could you give me a case example?

20. How do you feel your university **education** prepared you for supporting children in care with their emotional wellbeing?/for understanding their behaviours? Since then, what other training have you had in this area?

Closing question

Are there any other things that you would like to share or that you would like me to consider?