Practising reflexivity in health and welfare
Making knowledge

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Preface

This is a book about making knowledge. It examines how professionals in various health and welfare settings make sense of and process cases. In the contemporary policy climate, with its emphasis on performance indicators, clinical audit and evidence-based practice, practitioners across the range of health and welfare agencies have become accustomed to evaluating and justifying how they make use of knowledge. We shall argue that these methods of ensuring quality have their place, but that they leave the messy business of categorization or ‘diagnosis’ unexplored. This process of screening and assessment is simply taken as read, or is assumed to follow unproblematically from eligibility criteria, or from procedural or clinical guidelines.

Alongside these policy developments, however, practitioners and academics have sought to try to reflect on decision making in different ways. This has notably been through the development of ideas about reflective practice, or in social work, about anti-oppressive ways of working. Again, these have been important developments, but both have their problems. For example, practitioners may know they should be ‘reflective’ or ‘reflexive’ (our use of these words is explained in due course) in their decision making, but they often have few ideas about how they may accomplish this, or even what it means. Similarly, there is a tendency for anti-oppressive practice to become a rather empty exercise in which practitioners assert their knowledge about various forms of ‘oppression’ or ‘disadvantage’, or simply gloss people into categories as ‘oppressors’ and ‘oppressed’ without understanding or interrogating how ‘oppression’ is brought about by practitioners in their encounters.

We are arguing, then, for a refocusing of ideas about reflexive practice. Instead of providing introspective accounts of inner thoughts and feelings, or ‘structural’ analyses of oppression, we want to emphasize the active processes of meaning making. We are certainly not suggesting that the other domains do not matter, but they are not the business of this book. Here, we
want to show how words and language have powerful consequences. Of course, the words may be driven by some internal emotion, such as anger or fear, or they may be oppressive in their effects, but it is with the performative aspects of the language – the work it does – that we are concerned here. Our intention is not to delete individuality or social ‘structures’, but to explore a further dimension, and one which we consider to be crucially important for practice.

The concepts and ideas we have used in this book were first brought together as part of the development of an MA module, ‘Critical thinking and reflexive decision making in health and welfare practice’, which was specifically designed to bridge what we perceived to be a gap in current professional education. We both have academic backgrounds in sociology and we have drawn upon literatures originating within that discipline, which have been added to and developed by the ‘discursive psychology’ movement. We have said that we wish to focus on the powerful effects of language, and these literatures provide a means to explore conversations (talk) and written documents (text) of various kinds: for example, they provide concepts and ideas to assist our understanding of the ways in which speakers or authors seek to establish the plausibility and believability of their assertions. This kind of analysis is of fundamental importance to health and welfare practitioners, who routinely have to make complex judgements about whom to believe in what are often messy and contested situations.

Some of the ideas we present may be new to you and we have endeavoured to write in an intelligible way and to illustrate what we are saying with examples from everyday life or professional practice. However, there is a danger that, in the act of translation from one discipline to another, or from academic research to professional practice, ideas become transformed and oversimplified. This oversimplification limits their utility as, stripped of their complexity, they cannot really be used or understood in the way they were intended. Therefore, whilst striving for accessibility we have tried to preserve the integrity of the conceptual frameworks. For example, some of the concepts used are tied to theoretical ideas which are essential to understanding what we are trying to argue and how it fits with other ways of thinking about practice. We think it is important to give health and welfare professionals access to ideas from other disciplines and we must undertake the translation carefully, so that practitioners will have the foundations to read further if they so wish. To this end, we have provided a brief annotated guide to further reading and a glossary at the end of the book.

Rather than concentrate on one professional group, we have looked at broad and transferable situations in which knowledge is made, such as in encounters with service users, or in meetings and conversations with other professionals. Similarly, we have drawn on European and North American literatures. It is our contention that the ideas we present apply across services,
occupational groups and western welfare regimes. Indeed, it is this general applicability that makes them so important for understanding health and welfare practice. However, clearly we have not been able to provide analyses of the specific organizational constraints or mandates of the different professions. Many of these (monitoring of performance, outcome measures, evidence-based practice, managerialism) are shared and they are all covered in other discipline-specific texts.

Part I maps out the conceptual ground and, in the first chapter, we argue that health and welfare practitioners are often confronted with competing versions of events, both lay and professional. This complexity and ambiguity cannot be addressed through evidence-based practice alone. There is a need to explore the ways in which protagonists in a situation put forward their ‘truth claims’, that is, how they warrant their position and attempt to undermine the claims made by others. We illustrate these arguments with a range of examples from practice. In Chapter 2, we examine arguments about the philosophical positions known generally as realism and relativism. At their simplest, these relate to questions about whether and how we can access ‘reality’. We explore the implications of these different positions for health and welfare professions. However, we also seek to avoid polarizing the perspectives and to explore some of the subtleties of the debates. In Chapter 3, we put some conceptual meat on these philosophical bones and begin to build a framework to analyse practice in the way we have outlined. We introduce the different ways in which various academic and philosophical traditions have analysed talk and text and give some examples of empirical work relevant to professional practice. In particular we examine the ways in which facts may be assembled to convey a particular perspective and to do ‘rhetorical’ work.

Chapter 4 provides a bridge to Part II. We develop the ideas from earlier chapters by examining how plausibility is established in everyday conversations of various kinds. We argue that in all aspects of our lives we construct facts to achieve certain effects in dialogue with other people. We explore how people establish a ‘credible voice’, how they protect their accounts from challenge and how they attempt to undermine the accounts of others. By Chapter 4, you will probably be much more aware of your own use of these devices. You should also be able to reflect on how they may impact on the ways you make sense of cases as a professional and on how clients or patients referred to your service establish their own credibility (or not).

In Part II, we undertake the task of applying the concepts and methods to the institutional contexts in which health and welfare professionals work. Chapter 5 examines the ways in which people referred to our services negotiate the ‘institutional talk’ of professionals, by working to establish their credibility or authenticity. For example, they may be trying to present themselves as worthy of receiving services, to resist some form of non-voluntary intervention, or to defend themselves against allegations.
of abuse, neglect or criminal activity. All this depends on their ability to establish their own ‘moral adequacy’ through their speech. In Chapter 6, we shift our attention to explore how professionals in health and welfare agencies engage and interact with service users. Our approach goes beyond treating such encounters as concerned simply with establishing the facts, devising responses, or conveying factual information, to a standpoint where we regard professional talk as a means to establish authority and to conduct the business of the organization. In particular we look at professionals’ strategies to maintain control of the interaction and at how clients may resist these. This raises important questions about the nature of professional power.

Chapter 7 shows how formal and informal conversations taking place between professionals, away from the encounter with the service user, can also have profound significance. We describe some empirical work in this area and ask you to reflect on the ways in which talking to your colleagues influences the interpretations you make about cases, and to think about what sorts of ‘knowledge’ you draw upon in so doing. We also argue that inter-professional talk can display, reproduce and reinforce aspects of professional identities. Talk about cases helps to differentiate particular professional identities from those of allied occupations.

In Chapter 8, we move away from talk to analyse various kinds of documents. Practitioners are accustomed to having their written records scrutinized as part of audit and accountability. Our approach is different. We are interested in how documents organize activity and are themselves organized by professionals. We refer to written materials as ‘time-travellers’, pointing to their capacity to simplify and ‘freeze’ events and transport them in a particular form into the future. We examine the ways in which schedules, checklists and proformas conceal information as well as ordering and recording it. They place particular demands on professional ‘form-completers’, which in turn have their own effects.

In Chapter 9, we have used the Louise Woodward case as an extended example to illustrate some of the ideas we have been using throughout the book. The case demonstrates that many situations cannot be resolved by the neutral application of formal knowledge. Rather, many diverse forms of reasoning must be drawn upon and these are illustrated in the judge’s thinking during and after the trial.

In the final chapter, we reopen some of the debates and issues we raised in Part I. We explore how our approach to understanding practice relates to other frameworks, particularly evidence-based and reflective practice. We argue that the concepts we have used can help practitioners to read these literatures more critically and analytically. We do not suggest that they discard other ways of thinking about and understanding practice, but that they must engage actively with what they read and subject it to scrutiny. It is for this reason that we have used the verb ‘practising’ (reflexivity), as
opposed to the noun (reflexive) ‘practice’ in the title of this book. We are suggesting that reflexivity has to be ‘done’, it does not simply exist. In the chapters that follow we hope to provide you with some concepts and methods to help you to practise reflexivity.
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Health and welfare professionals have important responsibilities towards service users. They are faced with difficult and complex decisions which can dramatically affect service users’ lives: for example, they may have to decide whether to remove children from their parents in cases of suspected child abuse; or whether to recommend that a person with mental health problems remains in hospital, despite their wish to be discharged. They may have to make judgements about whether an older person who appears to be frail and ‘at risk’ should return home after a hospital admission, or whether a particular treatment should be made available to a patient, despite its high cost and consumption of tightly rationed resources.

The external pressures upon professionals to make good judgements and decisions have increased in recent years. There appear to be three principal reasons for this. First, public enquiries into child deaths, the publicity surrounding violent acts perpetrated by mentally ill people, scandals relating to the residential care of vulnerable children and adults, and more recently, concerns about surgical practice with young children have all fuelled doubts about whether professionals can really be trusted to police themselves. Health and welfare professionals, then, are no longer assumed to be working unequivocally in the interests of service users.

Second, the last two decades of the twentieth century saw major organizational and procedural changes in health and welfare services in the UK. This was linked, in part, to the political agenda of the 1980s and early 1990s: the ‘marketization’ of welfare. The drive to make public services conform to the principles of the market and commercial institutions led to an imperative to pursue maximum efficiency and ‘value for money’ through the rational analysis of inputs and outputs. This is perhaps best exemplified by the purchaser/provider division within contemporary welfare, as a result of which public sector organizations ‘found themselves trying to deliver
more for less, simply because they were given less and asked to do more’ (Newman and Clarke 1994: 15). These changes led to increasing ‘managerialism’ in public services, exposing professionals to scrutiny within their own organizations, as well as from external bodies such as the judiciary, media, various inspectorates and government departments. Reaganite republicanism and Clinton’s welfare reformism have led to similar developments in the USA and some cross-fertilization of ideas across the Atlantic (see, for example, Clarke 1991).

Third, alongside the ascent of market principles in health and welfare agencies there has been a growth in the language of ‘consumerism’, reflected in managerial and professional concerns about whether service users/clients/patients (or citizens) are receiving ‘quality’ provision, and in the implementation of complaints procedures. Whilst professionals have often been ambivalent or critical about some aspects of marketized welfare, it seems that the language of the new consumerism has been embraced; as Newman and Clarke (1994: 21) note: ‘the language of quality, putting customers first and valuing front-line staff represents the possibility of reasserting a value base for public services’. Thus, over the past decade, the requirement for services to incorporate user perspectives and to measure satisfaction has become ubiquitous in policy and planning documents of various kinds.

Professional practice in health and welfare is, therefore, characterized by a greater degree of anxiety about its goals and outcomes, and by a perceived need to demonstrate to inspecting bodies, and a sceptical wider public, that practitioners and clinicians are ‘doing the right thing’ in the circumstances, and are using resources efficiently and effectively. This trend has been fuelled by Labour’s ‘modernization’ programme (Department of Health 1998b, 1998c). The dominant answer to this uncertainty has been a technical, procedural, and often, bureaucratic one.

Within social work, for example, there have been introduced various schedules and proformas intended to improve, and render more consistent, the performance of assessments in child care and work with adults (Lloyd and Taylor 1995; for examples see Department of Health 1988a, 1999; Department of Health et al. 2000). This has been supported by legislation and policy change, for example the Children Act 1989 and the National Health Service and Community Care Act 1990. There can also be noted an increased focus on the evaluation of services, the measurement of outcomes of service inputs and the audit of health and welfare provision. In addition, in both health and welfare contexts, there is growing attention being paid to the concept of evidence-based practice, and within medicine, of clinical governance. It is suggested that clinicians, for example, aided by computer technology, would seek out research-based knowledge in order to improve their assessments and diagnoses and to make better-informed decisions about treatments and interventions (see, for example, Gray 1997; Ridsdale 1998).
It is easy to see why this approach may seem to be an attractive remedy to the multiple pressures affecting contemporary health and welfare practice. It seems to offer managers the security that those they manage have the best possible rational foundations for their decisions, it appeals to external evaluators of practice on the same grounds and to the champions of consumerism as a means to ensure both equity and ‘best value’.

Whilst we would acknowledge the pressures which confront professionals and share these aspirations towards ‘best’ practice we want to urge caution about an unquestioning acceptance of a technical/procedural approach as the only answer to perceived credibility problems for health and welfare professionals. The attraction of such an approach lies in its appeals to scientific evidence, which, it is suggested, can offer greater authority to professional decision making. Professional judgement is thus cast as a careful, neutral process of weighing up information and applying its results to practice situations. Consistency and precision, it is argued, replace the ad hoc, arbitrary and ‘common-sensical’ processes – opinion-based practice (Gray 1997) – which allegedly have applied in previous decision making. Outdated knowledge, or lack of knowledge, and outmoded practices are replaced by up-to-date, factual information and more rigorous procedure.

Our concern is that such a search for certainty and truth can apply only to discrete components of professional activity, the remainder of which is characterized by uncertainty and complex qualitative judgements. We aim to demonstrate that, armed with the comfortable belief that they have sure and certain knowledge, health and welfare professionals may be less likely to reflect appropriately on their judgements and decision making, thus making error more, rather than less, likely. Health and welfare professionals need to acknowledge the uncertainty, ambiguity and complexity that lie at the heart of their practice (Parton 1998). From our perspective, health and welfare work is a messy and complicated business in which there are often no right or wrong answers. Workers are confronted by situations in which risk and uncertainty prevail. Our central argument is that, in the world of health and welfare practice, the pursued ideal of dependable scientific knowledge may well prove elusive and that other approaches which foreground understanding rather than explanation and prediction may more fruitfully be explored.

**Using knowledge and making knowledge**

The problem with evidence-based practice and the production of outcome measures is that they are concerned exclusively with how knowledge is used. They pay scant attention to how knowledge is made, produced or ‘constructed’, by professionals themselves. They do not allow access to the ‘sense-making’ processes of practitioners. For example, they do not explore
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how cases are actively categorized by professionals as this or that type of problem or one type of problem or another. It is to these complex reasoning processes that the concepts and methods introduced in this book are directed. They are not intended to replace other forms of knowledge or enquiry. However, if professionals are serious about practising ‘reflexively’, then we suggest that these processes are an essential component of ‘practice wisdom’ (Sheppard 1995) or ‘clinical judgement’. The concept of reflexivity and the different ways in which it is understood are topics explored in later chapters. However, we want very briefly now to move away from using ‘reflexivity’ to denote a form of reflection or ‘benign introspection’ (Woolgar 1988a: 22) – a process of looking inwards, and thinking about how our own experiences may have influenced our thinking – to argue that there is more than this to ‘practising reflexivity’. Practitioners also need to examine and become more explicit about the kinds of knowledge they use in their practice and how they apply these to make sense of events and situations they confront. This might be seen as a process of destabilizing taken-for-granted ideas and professional routines.

We propose that, instead of concentrating exclusively on a ‘treasure hunt’ or ‘mining’ (Kvale 1996) model for the identification and application of knowledge to health and welfare (hereafter HW) practice, clinicians and practitioners can fruitfully explore different approaches to knowledge use. The approaches we discuss open up to scrutiny the questions not only of what knowledge is generated but also how it is generated in day-to-day practice. This allows us to acknowledge the existence of competing versions of events, both lay and professional, and to explore the ways in which protagonists in a situation put forward their ‘truth claims’, that is, how they warrant their position and attempt to undermine the claims made by others. In effect, we are taking several steps backwards from evidence-based approaches because we are considering the processes of sense making and categorization themselves. These categorizations affect what type of evidence is deemed appropriate to the case.

In later chapters we look at the strategies employed by professionals and lay people to construct plausible accounts and to justify their (in)actions. Before we do so, we need, as it were, to construct a plausible account of why and how the concepts and methods introduced in this book can be useful to HW professionals. A consideration of a practice example will help to illustrate the difference between ‘the quest for (a single) truth’ approach and our own. The following comments were made by a ward sister on an acute medical ward.

**Extract 1.1**

Take Jessica. She came to us as a purely social admission. She’d fallen at home and is incontinent. She had turned against her home help, refused to answer the door to let her in. She didn’t become ninety-one overnight, she’s been old for a
long time. She had been going downhill. She's been here ever since. She didn't have any medical problems.

(Latimer 1994 cited in Latimer 1997a: 143)

What are we to make of this description of 91-year-old Jessie? We could just accept it as the objective truth about Jessie: on an acute medical ward there is a very old patient who should not really be there (except that she has had a massive stroke), but is vulnerable and at risk living alone. The task for HW professionals might then be to work together to assess Jessie to see whether a return home is feasible and, if so, what is needed to secure this goal. For example, a different home carer or carers might be arranged who can meet Jessie’s needs; alternative home support systems might be mobilized. If a return home was not wanted by Jessie or deemed impossible because of the risk in which it would place her, then alternative arrangements would need to be made in either a residential care home or nursing home. Decisions about Jessie’s future might be made on the basis of tacit knowledge (Polanyi 1967) about what would be best for the patient in the circumstances (which would include the constraints placed upon the situation by resources), or by recourse to research-based knowledge about what is the best course of action in these circumstances: what sorts of care work best or are most appropriate for the old-old (the term frequently used in the gerontological literature for people over the age of 80)?

Alternatively, we might want to acknowledge that this is one way of describing Jessie, a patient on an acute medical ward, but not necessarily the only way of doing so and, indeed, it is a way of describing her that does particular things. The ward sister’s account suggests that Jessie is ‘out of place’ on an acute medical ward – her problems are ‘purely social’ (note the emphasis here) rather than medical (‘she didn’t have any medical problems’ [emphasis added]). Indeed, Jessie’s problems are presented as being, to some extent, self-induced: it is Jessie herself who has rejected the services of the home help, placing herself in a vulnerable situation. This serves to imply that Jessie is perhaps less worthy of treatment than someone who is more cooperative with service providers. In other ways, her problems are deemed to be biological, part of the inevitable process of decline that accompanies old age. Her incontinence is part and parcel of this process of aging and decline. It does not warrant medical intervention (as it might do in a younger adult) because it results from this inevitable and unstoppable process of biological decline and therefore nothing can be done about it.

Using the twin devices of drawing on her age and her lack of cooperation, the ward sister is constructing a version of Jessie as less worthy of, less entitled to and less likely to benefit from treatment on an acute medical ward. In essence, the ward sister is arguing that Jessie should not have been placed with her and that she is now stuck with her despite the inappropriateness of this as a solution. Jessie is a ‘bed-blocker’, a problem for an acute
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ward because she is not fit to go home and there is nowhere else to place her. Jessie is thus a problem and a nuisance for nursing staff and the organization.

Seen in this light, Jessie is not deserving of respect as a person with rights, wishes and feelings that need to be taken into an account. Here we might add that the use of the patient's first name, rather than the more formal use of her title and surname, adds to the negative/dismissive tone of the ward sister and the making of Jessie into a problem. She is someone who is in the way, who needs moving on so that the 'real work' of acute nursing can occur with a 'proper' patient allocated to that bed. In effect, the ward sister is disclaiming responsibility for her – Jessie should not be her problem.

We are not suggesting that the ward sister is necessarily having 'bad thoughts' about Jessie. Rather, the specific institutional context of an acute ward has affected her descriptions, and her words have powerful effects. What is noticeable here is that Jessie's voice is denied. She, no doubt, would have a rather different version of the situation but her view is not acknowledged. The ward sister is attempting to put across the definitive version of Jessie. However, by offering this different reading of 'Jessie' (or rather of the ward sister's account of Jessie) we want to argue against the idea that there is only one way of seeing a situation which is the objective truth. In contrast we suggest that it is more helpful for practitioners and clinicians to work with the notion that there are multiple accounts of situations. This allows us to acknowledge more explicitly that the task for professionals is to make sense of these differing accounts and to determine for themselves which one of these is the most convincing rather than to assume their own objectivity.

Health and welfare practice and the problem of versions

We have argued that many of the judgements that HW professionals are required to make cannot be resolved by the neutral application of objective theory, or formal bodies of knowledge. In particular, we have suggested that professionals frequently confront competing versions of the same set of circumstances. In many cases, different interpretations of events may be offered by several members of the same family, by other professionals, by any number of interested parties, or by witnesses to events. In these situations, complex judgements must take place in which professionals decide whom they should believe and whose account they should treat with scepticism. In the case of Jessie above, the different versions are obscured by the particular account produced by the ward sister. The ward sister’s story is perfectly accurate and ‘factual’ within its own terms of reference, but we have tried to show how it constructs Jessie in a particular way and hence facilitates certain courses of professional action, whilst making others less likely.
We should stress again that we are not suggesting that facts and evidence are irrelevant to professional activity, or that our approach renders them redundant. In making their judgements, practitioners need to concentrate their attention upon the objective facts before them. If a patient who has mobility problems and is unable to move about in bed has a pressure sore, it is essential that the nurse knows what treatment works best. That is, that she possesses or obtains formal knowledge about the management of pressure sores. Most HW professionals have similar needs for fairly stable and uncontested knowledge. For example, social workers and doctors assessing a case in which a child has been injured may need to refer to X-rays or blood tests in order to decide whether they believe a parent’s story about how the injury occurred, or whether the child has a medical condition which could account for the injury. We are not suggesting that professionals abandon their knowledge base and instead simply choose arbitrarily between ‘versions’. However, imagine either that the medical evidence in the child protection case is equivocal, or that you know that someone caused the injury, but that each parent is accusing the other. In these circumstances textbook knowledge is not likely to prove very helpful.

Let us stay with the example of child protection practice for the moment, as it is helpful in illustrating the kinds of professional activity that rely on other types of knowledge. As a consequence of high-profile child abuse enquiries during the 1980s (see, for example, London Borough of Brent 1985; London Borough of Greenwich 1987), practice in this area has been particularly affected by the quest for certainty. This has encouraged a preoccupation with establishing risk factors and determining ‘dangerousness’ and a proliferation of schedules and checklists aimed at prediction (see, for example, Dale et al. 1986; Munro 1998). If we can predict who is likely to abuse, runs the argument, then resources can be directed more efficiently and effectively at this group. Such an approach has its limitations, as several commentators have indicated, notably because it is much easier to establish in hindsight the existence of risk factors than it is to predict which particular people with a number of characteristics will commit significant harm to a child (Dingwall 1989; Corby 1994).

More problematic still is the fact that there is often no measurable, forensic or medical evidence to prove conclusively whether a child has or has not been abused. This is particularly so in suspected cases of emotional abuse or sexual abuse: indeed the Cleveland Inquiry demonstrated how problematic a reliance on physical evidence could be (Department of Health 1988b). However, it is also a problem in suspected cases of physical abuse where it can be exceedingly difficult to determine precisely how an injury has occurred to the exclusion of all other possible explanations.

Even where there is clear medical and forensic evidence, this will need to be carefully weighed and evaluated. It may help to ascertain what happened (for example by establishing how bruising would most likely have been
incurred) and rule out other possibilities (for example that a fall is unlikely to be the cause of a particular pattern of bruising), but it is unable to determine other important issues such as who did it (for example which of the parents was it, or could it have been someone else who had care of the child?), whether the child is still at risk (for example, do the parents acknowledge the harm?), and whether the child is likely to be protected in the future. An unquestioning dependence on external knowledge will not be helpful in such circumstances as it will offer neither conclusive proof nor categorical answers. It will not establish the right way to proceed (knowing that a bruise was inflicted by a parent does not lead to an invariant response within the child protection process) and it will not encourage a questioning and sceptical approach to a worker’s own practice.

Generally speaking, in child abuse cases, social workers, alongside other professionals, are required to appraise the veracity of the statements made by the various participants. The social worker must piece together the various statements and so produce their own coherent professional account about what, in all probability, has occurred and what risks there are of further harm to the child. In short, the worker will be faced with a number of options and will need to make judgements about what should be done and to put together a case supporting and justifying their position. This might be a justification for a particular intervention or, in many cases, for non-intervention (see Department of Health 1995 for a discussion of the ‘filtering out’ of cases from the child protection system). This process, we suggest, involves not only the use of knowledge but also the production, the making, of knowledge.

Facts vs facts

We have suggested that many professional judgements involve an active choice between versions of events presented by different interested parties. These different versions are often intrinsically contradictory. That is, they do not simply state the same set of propositions from different perspectives but give instead different accounts of what may or may not have happened. They blame different people, or sets of circumstances and mobilize competing ‘facts’ in different ways. In social theory this is known as incomensurability, that is, the competing ideas are not measurable by the same standard. This means that no matter how hard a practitioner tries to obtain a consensus view, it will stubbornly evade them. They are left with no option but to judge the believability of each account against the others.

Sometimes HW professionals are confronted with only one account of a situation or set of circumstances, for example if a therapist is working with an individual, or if a psychiatrist, nurse or social worker is assessing a person who appears to have a mental health problem. In these cases too, as is shown
in some of the examples below, professionals routinely make judgements about whether the person’s account is plausible or morally persuasive. We suggest that without such judgements the professionals find it difficult to intervene. That is, professionals generate their own reading of the case which often differs fundamentally from that presented by the client or patient. We want to show here that this process is not dependent on the assessment of facts alone, but depends also on the complex processes by which plausibility, persuasiveness and morality are woven into the story presented to the professional and subsequently by the professional. An understanding of this is essential to the development of critical thinking in health and welfare.

We hope that the following examples will help to persuade you that our version of professional activity in health and welfare is convincing.

**Multiple versions: working with couples and families**

There are some situations in which competing versions are particularly likely to occur. Any work with couples or families may well involve attempts by individuals to recruit the professional into their own particular version of events. This is a fertile arena for individual parties to blame or to hold each other responsible for whatever is presented as the problem.

The discourse of relational problems often takes the form of the teller describing him/herself as reacting to the unjustifiable actions of his or her spouse - 'You (actively) did something to (passive) me and I (having no choice) had to respond as I did' (Lannamann 1989).

(Buttny 1993: 66)

At its simplest, this may involve one partner blaming the other for relationship problems, but children may also be involved and coalitions between different family members may be evident.

In the example below, a family are talking with a therapist (Th) about their problems. The father (Fa) and mother (Mo) are having relationship difficulties. The father thinks that the children’s unreasonable behaviour is causing these. The mother, however, thinks that the problems in her relationship with her husband were already there and may be contributing to their difficulties in parenting their children. The teenage daughter Kirsty (K) has also taken a position. She has been spending time at her friend’s house, and is comparing her own parents negatively with those of her friend. The therapist has just asked Kirsty how the friend’s parents would respond if their children were ever rude to them (an accusation levied at Kirsty by both her parents).

**Extract 1.2**

K: They don't hit them or ground them or anything
Th: Right
Fa: But we don't hit you
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We suggest that, in the absence of any medical evidence of 'hitting', or of confirmatory accounts from impartial witnesses, there is no way of the therapist knowing for sure whether Kirsty is hitting her parents when they try to restrain her, or whether she tries desperately to get away from home because her father is violent towards her. The purveyors of each version try to recruit the therapist into their particular account of the case. A judgement could be made between competing versions; however, this would be based on the therapist deciding whom she most believed, or on moral or political criteria such as a belief in child-centred practice (children and young people are vulnerable and therefore should be believed when they make allegations of abuse).

Competing versions: professional meets patient/client

The following extract is taken from an interview between a psychiatrist and a person detained in a prison psychiatric hospital in the USA. It has been analysed in detail by Mehan (1990). In the extract, the psychiatrist is making an assessment of the patient. We can see that the patient (Pt) is trying to persuade the head psychiatrist (HP) that he is being adversely affected by hospitalization. However, the psychiatrist reads his protestations as evidence of his continuing illness.

K: Yeah you do
Fa: We do not
K: Yeah you do
Fa: I'll show you what hitting is sometime. There's no way I'd ever hit you two girls. I have to physically restrain you when you're kicking us.
K: You have
Th: Are there times that you're thinking of, because your dad seems very clear that he hasn't hit you and you're saying that he has, you remember when he's hit you?
K: He has, when I'm going out. He hit me
Fa: When did I last hit you?
K: He just says that. He grabs me and he hits me as well.
Fa: I don't hit you as well
K: Yeah you did
Fa: I suppose I hit you this afternoon did I?
K: No
Fa: Oh
Mo: And so do you think dad shouldn't hit you when you hit us, Kirsty do you?
K: I only hit you because you hit us
Th: But you get into physical fights with your mum and dad somehow
Mo: No you mean when we try to stop you from doing something you hit us. You were trying to get out of the house and I was trying to lock you in and you kicked me really hard.

(J. Stancombe, personal communication 1999)
Extract 1.3

HP: Okay now Vladimir as I've promised you before, if I see enough improvement in you.

Pt: How can I improve if I'm getting worse? I've been trying to tell you, I can tell you, day by day, I'm getting worse, because of the circumstances, because of the situation. Now you're telling me uh how can I until you see an improvement each time I get worse. So, it's obviously the treatment I'm getting or it's the situation or the place or or or the patients or the inmates or either of them. I don't know which. I want to go back to the prison where I belong. I was supposed to only come down here for observation. What observation did I get? You called me up a couple of times. You say 'well take some medication'. Medication for the mind? I am supposed to take medication for, if I have some bodily injury. Not for the mind. My mind's perfect. Cause I'm obviously logical. I know what I'm talking about. There's no – and I am excited. Yes, that's the only fault you might find with me. I have a perfect right to be excited. I've been here for a year and a half, and this place is doing me harm. I come in here, I, I uh, every time I come in here you call me I'm crazy. Now that's if there's something you don't like about my face, that's I mean, that's another story. But that has nothing to do with my mental stability. I have an emotional problem now, yes, which I did not have.

(Mehan 1990: 174)

The psychiatrist and the patient continue their conversation in this way for some time, with the psychiatrist insisting that the patient has a mental health problem and the patient insisting that his only problem is the psychiatrist. Ultimately the patient is asked to leave the room, and the head psychiatrist and two other doctors (DR2 and DR3) discuss the case.

Extract 1.4

HP: He's been much better than this, and he's now, he's falling apart, now whether this is some reaction to uh his medication, is certainly something I'll have to look at. However, uh, he was looking a lot more catatonic and depressed before and sometimes we find that, I mean, uh, antidepressants, you remove the depression and you uncover the paranoid stuff, and we may have to give him larger quantities of tranquillizers just to tone this down. So he's not looking ready to be able to make it back to prison.

DR2: He argues in a perfectly paranoid pattern. If you accept his basic premise the rest of it is logical. But the basic premise is not true... I think he's terrified of leaving.

HP: Um, the louder he shouts about going back the more frightened he indicates that he probably is.

DR3: This is known as Ganzer Syndrome

HP: Well not quite

DR3: Almost. Close

HP: Well I think what we have to do with him is, uh, put him on a higher dose of tranquillizers and see if we can bring the paranoid element under a little
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bit better control and see if we can get him back on medication. If he's taking it now, and I'm not even sure that he is . . .

(Mehan 1990: 176)

The extracts do not, in themselves, help us to decide which version we should believe. Yet both versions may be considered factual. The doctors' version mobilizes a set of psychiatric 'facts', about symptomatology ('he was looking a lot more catatonic and depressed before') and diagnostic categories (for example, Ganzer Syndrome) whilst the patient gives what is also a factual account of his experience which relies on a more social understanding of distress (for example, 'it's obviously the treatment I'm getting or it's the situation or the place or or or the patients or the inmates or either of them').

It is clear that the two versions are radically incommensurable. Mehan calls this 'oracular' reasoning, which he defines as follows: 'Oracular reasoning . . . is a process of arguing from and defending a basic belief. People maintain the truth or efficacy of a belief by denying or repelling evidence which is contrary to or opposes the belief' (1990: 161). They do not approach opposing views with an open mind.

Clearly, in this case, the patient's account is easily dismissed. He has a formal diagnosis of mental illness, and is also a prisoner. The psychiatrist has the formal power to adjudicate on the boundaries between normality and deviance and his version therefore 'wins'. We show in due course that ascribing deviant attributes (for example, she's mentally ill, a drug user, a neglectful mother) to a person is one of the ways in which professionals make decisions about the veracity of that person's version.

A further example of incommensurability is given in the following extracts. The first is taken from letters written by a child psychiatrist about the mother of Wendy (aged 8), a child with severe learning difficulties.

**Extract 1.5**

I found mother to be evasive and at times I thought she was deliberately covering up information. For example she did not know anything about her husband's experiences in early childhood and subsequently let slip that paternal grandfather was a very critical man and this has influenced her husband's attitude towards Wendy . . . She [child] has no speech, she does sign for some objects using Makaton. She is restless and ritualistic and does not sleep properly . . . She is incontinent and I was quite surprised how mother seems detached, leaving her in a smelly condition throughout the consultation until I prompted her. I found the mother detached and flat in her mood.

(Adapted from White 1997a)

The professional formulation here is clear: the mother is, in a number of ways, considered to be at fault. There is a common-sense presupposition that wives know in detail about their husband's childhoods and because
she denies any such knowledge, whilst making some statements which appear to contradict this, the mother becomes defined as evasive. The description of the child’s ‘smelly condition’ serves to reference the mother’s culpable neglect of her parental duties.

The following account was written by the mother:

**Extract 1.6**

She [Wendy] climbs, jumps at windows, pulls out plugs... She seems to have tremendous mood swings, going from being completely wound up, almost wild to violent bouts of crying for which there is no explanation... She is still suffering terrible diarrhoea... and has had to be cleaned 3–4 times a day for the last 3 years... Wendy is so demanding that I am concerned about the other children. I feel I have no time for them and that they are really suffering, not only from this, but from the stress of living with a child who is so unpredictable... Wendy is a very confused little girl who desperately needs help. We love her.

(Adapted from White 1997a)

This is a powerful account in which the mother refers to her commitment to the child, and also talks about her fears for the other children. This and the psychiatrist’s account are competing versions of the same case. Moreover, like the psychiatric interview in Extracts 1.3 and 1.4 above, they both mobilize different sets of facts. In later chapters, we will say more about the use of facts to produce accounts which are rhetorically potent, that is, which generate powerful effects and are difficult to resist.

**Talking together: professionals and versions**

We have shown that HW professionals are engaged in a range of activities that require the exercise of qualitative judgement. When we look at professional conversation in detail, the competing versions can often be seen, but the story will be delivered in such a way that some possible readings are edited out. Thus, messy reality becomes ordered in particular ways and some readings become buried. In the following extracts, a team of childcare social workers (SW) are talking about a case that has been referred to them (this transcript is discussed in greater detail in Chapter 7). The team leader (TL) begins by telling the team that an education welfare officer (Kate) has reported hearing a rumour that a teenage boy is reported to be ‘shagging’ (having sexual relations with) a 10-year-old girl, believed to be Sophie Byrne. It also transpires that Sophie has been found with a friend wandering around a local shopping precinct at 2 am.

**Extract 1.7**

TL: Kate managed to identify the child as Sophie Byrne through statements the children made and by reference to the accounts from [school] of Sophie being met by older boys from school. Actually, it looks as though from the
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onset Kate put two and two together from what the pupils at [school] said and spoke to the Head of [school] and she confirmed accounts of Sophie being met by older boys. The children often arrive late for school and are not really collected. Oliver is 7, is he 7? . . . There were no major concerns at the previous school. However, there had been one incident outside school where Sophie had been with a group of older boys who were smoking. That was when she was about 8. So what happened as a consequence of this, after all the checks had been done, it was allocated to Jan and Dawn was on the child protection bleep on that day. You can take it over now Dawn . . .

(Adapted from White 1997a)

The social worker continues the story describing the father’s account:

SW: Mr Byrne initially said that he felt it was just boys talking, the concern about Sophie being shagged was just playground chit chat and he had no concerns about Sophie

(ibid.)

At this point the social workers seem to accept the plausibility of Mr Byrne’s story and are reassured. However, the mother reacts to the suggestion that Sophie is being ‘shagged’, which is reported by the social worker as follows.

SW: Yeah Trish [team leader] we went out to talk to Mrs Byrne who gave quite a completely different view of things and basically is very worried about Sophie erm mainly around the Gemma Anderson family erm because she says that it’s notorious round their way and she doesn’t want her daughter mixing with them . . . Well anyway Mrs Byrne is obviously quite upset that Sophie is mixing with these children

(ibid.)

As a consequence of this reinterpretation, the social workers begin discussing previous history and focus on the risk to Sophie. The idea that she is being sexually abused by an older boy gains increasing currency. The father’s version (Sophie is a bit of a handful but there are no real problems) becomes buried. The possibility that Sophie may be a ‘naughty girl’ is not discussed, although it is clearly available as a version. Instead, Sophie is interviewed and the possibility of a gynaecological examination is discussed. In this case, the social workers have made a case together. Although they are all agreeing with each other, their conversation has an argumentative quality (cf. Schwitalla 1986). There is almost an invisible audience to whom they are relating the case. This has the effect of solidifying their particular reading of the case and extinguishing any doubts. So, ‘the original situation has now been “given” or “lent” a determinate character . . . which it did not, in its original openness, actually possess’ (Shotter 1989: 149).

These data from diverse settings demonstrate that making judgements among different versions is a central and unavoidable aspect of professional practice. Such a perspective allows us to acknowledge more explicitly that
the task for professionals is to make sense of these differing accounts and to determine for themselves which one is the most convincing.

‘Facts’ and their construction

In the examples above we have shown how the participants are attempting to claim their own version as true. We have also made it clear that, in stressing the existence of multiple versions, we are not suggesting that knowledge is redundant. Clearly, it is central to the work of HW professionals. Collectively, across their various specialisms, HW professionals need to understand illness and disease, mental distress, family relationships, children’s development and a host of other issues and problems. Moreover, in order for ‘truth claims’ to be successful, they must appear to be factually correct, that is, they must achieve some congruence with objective reality as it is seen by others. Facts and their assembly by professionals and those for whom they provide a service are of fundamental importance. If an individual cannot support their case with facts, they will simply fail to convince anyone of anything.

However, as we have seen above, objective reality is often extremely malleable and people may assemble facts in a particular order to produce a certain reading of events. At its simplest, this might involve lying by omission – missing out a crucial part of a story in order to convince others of the veracity of one’s own version of events. In professional practice, this might also involve asking questions or making observations that support one’s own reading of a situation or one’s own theoretical preferences and paying insufficient attention to other possible explanations (Sheppard 1995; White 1997b).

Within the social sciences, the view that there is a single reality which, given the right procedures, can be captured and explained, and the view that there may be any number of plausible explanations for the same phenomenon, have been characterized respectively as realism (or objectivism) and relativism (or social constructionism). Both standpoints have their avid supporters and critics. Indeed, it is easy for these positions to become ridiculously polarized, with each camp accusing the other of quite implausible beliefs. Our intention is to propose a sustained argument in favour of a relativist or social constructionist position. Before doing so we must define our terms precisely; we shall also clarify what we are not arguing. This will require a brief excursion, in the next chapter, into some philosophical debates. For those of you immersed in the complexities of practice, this may be rather unfamiliar and daunting territory, but it is essential that these positions and their implications for professional practice are explored before we engage in a more detailed exposition of our approach in subsequent chapters.
Summary

In this chapter we have explored the imperatives which currently exist for HW professionals to examine their practice critically and reflexively. We have argued that the contemporary preoccupation with evidence-based practice can only take the practitioners so far. In many circumstances professional judgements are just that – judgements. We have given examples of the various circumstances in which HW professionals must grapple with competing versions of events. The following points are crucial and will be developed in later chapters:

- Many judgements and decisions are based on the professionals’ assessments of the veracity of particular versions presented to them. These assessments rely on reasoning processes which are often thought of as intuitive or based on ‘gut feelings’.
- In arguing that in many circumstances there may be multiple valid readings of the same set of circumstances, we are not suggesting that facts do not matter. Choice between competing versions is not arbitrary.
- In social theory, the view that there is one incontrovertible, stable, independent reality, which given the right techniques we can capture and explain, is often known as realism, and is often associated with objectivism, positivism and the ‘scientific method’.
- The view that there are rarely any neutral means by which to access reality, because human beings are always interpreting and reinterpreting what they find, is known as social constructionism, and its proponents are often called relativists.
- There have been a number of attempts to break down this either/or version of realism and relativism.