

CHILDREN AT RISK?

HOSPITAL SOCIAL WORKERS' AND THEIR COLLEAGUES'

ASSESSMENT AND REPORTING EXPERIENCES

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Cover layout: Carl Ehrenkrona
Printed in Sweden by: Ineko AB, Göteborg 2016
ISBN 978-91-88267-00-9
ISSN 1401-5781

ABSTRACT

Title: Children at risk? Hospital social workers' and their colleagues' assessment and reporting experiences

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Keywords: Children at risk, child maltreatment, mandated reporting, hospital, hospital social work, health care professionals, discretion, assessment, decision-making, emotion, norms

ISBN: 978-91-88267-00-9

ISSN: 1401-5781

Internet: <http://hdl.handle.net/2077/42434>

This thesis explores factors that influence professional discretion in Swedish hospital professionals' assessment of children who may be at risk of harm. It is based on two data samplings, interviews with fourteen hospital social workers and a questionnaire with 295 responding physicians, nurses, nurse assistants and hospital social workers. The theoretical frame consists of theories of professions, sociology of emotions and normativity.

Although all professionals are mandated to report suspicions about children who may be at risk to social services, the findings show that a majority of the participants had never made a report. However, there were major differences between the professions: hospital social workers and physicians made most reports, while it was unusual for nurses and nurse assistants to report. This is explained by children at risk being everyone's but no single profession's responsibility within health care – which shapes an informal pattern of jurisdiction, split between physicians and hospital social workers.

The professional group to which a person belongs was shown to affect how other factors influence assessment. The lower the status of the group, the less knowledge about the issue and the available organisational support its members have, and the more emotions influenced the decisions not to report. While hospital social workers are less strongly affected by emotions in decisions not to report, the deeper qualitative analysis shows that assessment tended to follow a 'logic of normativity' where their worries stuck to 'warning signs' associated with gender stereotypes or unprivileged groups of parents. Critical reflexivity could disturb this logic as well as the silence of normality, meaning that children from privileged groups may not be given enough attention.

Hospital social workers were also found to take different positions in their inter-professional teams – active, reflective or passive – relating to three institutionalized norms of action – juridical, therapeutic and medical. A small number followed the medical norm, but that had the most dangerous consequences for children who sometimes were not dealt with appropriately despite severe signs of harm.

The overall analysis in this thesis suggests that theories of professional discretion should take into account factors such as the context, inter-professional relations, emotions and normativity to enhance the understanding of what influences assessment and decisions.

LIST OF PUBLICATIONS

This thesis is based on the following articles, which are referred to in the text by their Roman numerals.

- I. Svärd, V. (2014). Hospital Social Workers' Assessment Processes for Children at Risk – Positions in and Contributions to Inter-professional Teams. *European Journal of Social Work*. 17, 508-522.
<http://dx.doi.org/10.1080/13691457.2013.806296>
- II. Svärd, V. (2014). Emotions and normativity in assessments of children at risk. *International Journal of Work Organisation and Emotion*, 6, 369-382. <https://doi.org/10.1504/IJWOE.2014.068039>
- III. Svärd, V. (2016). Assessing children at risk: organizational and professional conditions within Children's Hospitals. *Child & Family Social Work*. E-publication: April 19th 2016.
<https://dx.doi.org/10.1111/cfs.12291>
- IV. Svärd, V. (coming). *Why don't they report? Hospital personnel working with children at risk*. Accepted for publication in *Child Care in Practice*.

ACKNOWLEDGEMENTS

Writing this dissertation thesis have been inspiring, developing and a privilege. Sometimes it has been hard work with much stress, but nonetheless: being paid for reading, analysing, thinking and writing is surely a privilege. Great appreciation therefore goes to the taxpayers for making research possible.

This is not one single person's work, although I am the responsible author. This work would not have been possible without the partaking and support of many people, though it is not possible to name you all. First, I would like to thank all of the interviewees, respondents and their door-opening directors for generously offering some of your valuable time, thoughts and commitment.

My warmest thanks go to my wonderful supervisors, Peter Dellgran and Lena Sawyer. Your different and complementary knowledge has been interwoven with and contributed a great deal to the theoretical reasoning in the thesis. It has been truly developing and enjoyable to work with you – you have always give me inspiration, strength and great freedom. Your patience with my testing of ideas has not gone without recognition.

The work on the thesis ended up at the University of Gothenburg, but it started a few years earlier at the Mid Sweden University with the great support of my first supervisor Majen Espvall. During the years I have received advice, in-depth reading material and wise comments from senior researchers from both universities, including Siv Fahlgren, Hanna Wikström, Åsa Wettergren, Torun Österberg, Mikaela Starke and Helena Johansson – all of you have left your marks on the text. I have also received important inspiration and encouragement from the network of researching social workers within health care: thank you for inspiring meetings and discussions.

There are some, former and current, doctoral candidates around Sweden and abroad who have become especially important to me during these years, as vital support in my academic life, discussion partners and friends: Julia Bahner, Linnéa Bruno, Victoria Kawesa, Greta Sandberg, Marie Vackermo, Magnus Israelsson, Minna Lundgren, Ksenia Meshkova, Helénè Lagerlöf, Elisabet Sernbo, Nica Söderberg, Anna Ryan Bengtsson and Karin Boson. And my dear friends outside the

research society who give me happiness and are there when life feels impossible: Eliana Robatto, Helena Svensson, Linda Andersson Wallander, Elin Liss, Stina Svensson, Ebba Posse, Rebecca Vinthagen and all my other dear friends. You remind me that life is so much more than working.

The work on this thesis started with the painful message that my mother Gun-Brith Svärd had unexpectedly passed away. My beloved mother who always wanted to be an author and whose strength and strong support I always carry with me – this book is for you.

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1. INTRODUCTION

As a hospital social worker I, as well as my team of colleagues, have faced a range of situations that have evoked worries about children who might have been at risk. It struck me that we often (re)acted very differently to these worries. For example, one chronically ill boy with a disability told us that he was being subjected to severe bullying at school, a school that did not seem to take the bullying seriously. I remember one nurse asking if we should report the ongoing bullying to social services. It had made me unsure: yes, it was abuse and neglect, but was the school situation really a problem for social services to deal with? On another occasion, a nurse assistant came up to me and said, “I just want you to know that I saw the father hit that child a couple of weeks ago here in the department” and then continued explaining that no report had been made about the incident. That made me feel both angry and sad because the child was seriously ill and particularly vulnerable. I sat down and filled in a report to social services about what I had heard. That made me wonder why it is that different professional assessments end up in such different actions.

I also remember how I questioned myself, realizing that my colleagues and I would probably never have thought of contacting social services about a mother’s psychological illness and absence from the ward if the mother had been one of the many absent fathers. The fact is that this father took care of the child perfectly well, and I felt ashamed when I realized that my assessment was gender stereotypical. The years as a hospital social worker have made me reflect on the complexities of working with children who may be at risk and led me to crave a deeper understanding of assessment processes within health care settings.

As the above examples show, the process of assessing children who may be at risk involves emotions, social norms, team work, and knowledge of how to identify children at risk and how and when to act on worries: factors that may help or hinder the assessment process in different ways. According to the Social Services Act (SFS 2001:453), health care professionals in Sweden are obliged to report all suspicions

about children who are or may be at risk to social services. This law is supposed to make it easier to make decisions to report suspicions, yet some studies argue that health care personnel do not appear to report suspicions to the extent they should (Tingberg, Bredlöv & Ygge, 2008; Borres & Hägg, 2007; Coccozza, Gustafsson & Sydsjö, 2007; Östberg, 2010; SOU, 2001:72). Lagerberg (2001) found in a nationwide study that nurses in local child health services only reported one-third of suspected cases. This is problematic from a juridical perspective but even more so for children who may need support or protection. Child hospital professionals meet children with disabilities and long-term illnesses – groups that, as well as being regular attenders of health care institutions, are regarded as particularly vulnerable and who have been shown to be twice as likely to be exposed to physical violence as healthy children without disabilities (Janson, Jernbro & Långberg, 2011). Hospital professionals are therefore in a unique position to inform social services if they suspect a child may be at risk. What lies behind the professional's assessments and decisions not to report, however, has been sparsely explored in the Swedish context. Furthermore, there is no previous research on the differences between the experiences of health care professionals and those of hospital social workers of working with children suspected of being at risk in Sweden.

The assessment and reporting practice is also related to knowledge about which situations should be identified and reported. *Children at risk* is a broad concept based on an understanding that possible risk factors (e.g. abuse and neglect) may involve negative development for the child (National Board of Health and Welfare, 2014a). However, there is no common universal understanding of what the risk factors are, as the concept children at risk is given different meanings in different contexts. Even though this thesis does not draw a clear boundary around a specific understanding of who and which situations are included in the concept children at risk, there are some institutionalized definitions in Sweden deliberated on by welfare professionals and policymakers as well as this thesis. The recently published national guidelines (National Board of Health and Welfare, 2014a) include all types of abuse, neglect, exploitation, familial relational problems, own risk behaviour and social difficulties in the school situation that lead to actual or potential harm to a child's health or

development. This broad definition is related to the preventive and family-oriented approach of the Swedish child welfare system – an approach that differs, at least to some extent, from the child protection systems in Anglo-Saxon countries.

OVERALL AIM OF THE THESIS

The overall aim is to explore factors that influence professional discretion in the assessment by Swedish child hospital personnel of children who are or may be at risk of harm. Here, assessment is seen as a situated process that begins when personnel notice signs of risk, and it involves inference of the situation and the actions that should be taken. This thesis does not use a formalized definition of assessment, instead the focus is on exploring factors that may influence the discretion and assessment process in a broad sense, for instance social norms, feelings and social factors such as the education, knowledge and experiences of the personnel, as well as the available support and professional relations. The thesis focuses on the professional discretion of hospital social workers (HSWs) as they often seems to be involved in assessments and reports on children who they suspect of being at risk, and they share education and thus have a certain intra-professional connection with social workers in social services. The experiences, work and role of HSWs in the assessment process are therefore explored in a qualitative study. The thesis involves physicians, nurses, nurse assistants as well as HSWs in a quantitative study that explores the different experiences of and the relations between the professional groups, as well as a range of factors that may have an impact on their discretion. The specific research questions are formulated around the following themes:

- 1. Experiences of reporting and reasons for not reporting.** As social services seem to receive relatively few reports from health care institutions, this thesis explores the experiences of physicians, nurses, nurse assistants and HSWs of reporting children suspected of being at risk. How many reports have they made and how common is it for them to decide not to report despite having a suspicion? And what factors have influenced their decision not to report despite having a suspicion? These questions are addressed in Article IV.

2. Organizational conditions and support. Most hospitals offer some kind of organizational support in the work with children suspected of being at risk, such as a child protection team, children's advocacy centre or supervision. Helpful organizational conditions may be crucial to the work, but what support do the different professions at the four largest children's hospital in Sweden say they have access to? This question is addressed in Article III.

3. Work experience and education on children at risk. Previous education, training and work experience are very likely to have an effect on the professionals' ability to identify children who may be at risk. Do the participants believe they have had sufficient education? How long is their work experience? What differences are there between the professional groups? These questions are addressed in Article III and, in part, in Article I about HSWs.

4. Emotions and normativity. Emotions are imbedded in assessments in various ways, but in what ways are they involved in the assessment by health care professions of children at risk? Are emotions such as insecurity, ambivalence, trust, fear and stress involved in the identification and decisions to make a report to social services? And do emotions become stuck to different categories of parents in HSWs' assessment processes? Or, in other words: how are emotions linked to social norms, based on gender, nationality/culture, class and (dis)ability in HSWs' narratives about parenting in children at risk descriptions? These questions are addressed in Articles I, II and IV.

5. Role and position of the hospital social workers. Although some practitioners seem to believe that HSWs often have an important role in the work with suspected at-risk children, there are no previous studies on their professional role concerning children at risk in Sweden. What is the HSWs' contribution to the assessment processes of children suspected of being at risk? How do they construct their professional role and draw boundaries in their inter-professional teams? What institutionalized norms influence the HSWs' assessment process in the hospital setting? These questions are mainly addressed in Article I, although Articles III and IV

outline some characteristics of the work and role of HSWs compared with the other professions.

6. Inter-professional relations and perceived accountability. The Swedish Social Services Act states that all health care professions have the same responsibility to make reports to social services, but who do they believe are accountable for making reports? Which profession do the different professionals primarily choose to consult when they have a worry that a child may be at risk? These questions are addressed in Article III.

7. Implications of the overall findings. The Swedish child welfare system is described as a preventive and family service-oriented system in which all health care personnel are obligated to make reports to social services. The thesis explores the role of health care professionals, particularly HSWs, in the system. What are the consequences for the health care institutions' possibilities of meeting the legislative demands? And what are the consequences for the children? Moreover, by deepening the analysis of the overall findings, with theorizations of professionalization, discretion, emotion, normativity and risks, the theoretical implications of the thesis are discussed. This discussion takes place in the overall summary of the thesis called 'kappa' in Swedish.

2. CHILDREN AT RISK: BACKGROUND AND PREVIOUS RESEARCH

This overall summary contextualizes the thesis by placing it in a broader discussion of the Swedish child welfare system and the health care professionals' role in this system. The articles briefly mention the context, previous research and theoretical concepts helpful to understanding the personnel's assessment process of children suspected of being at risk, while the thesis summary aims to give a more detailed description of the context and theoretical concepts, strengthen the links and deepen the overall analysis.

The thesis aims to explore factors that influence the health care professionals' assessment of children who are or may be at risk of harm. The ranges of factors, which are specified in the research questions, will be discussed throughout the thesis summary. There are also concepts and contextual factors that need to be described and discussed to understand better what underpins health care professionals' work with these children. This chapter therefore focuses on how the concept children at risk has been constructed and how it may be understood, and it discusses the child welfare system, and the health care professionals' role in the system and their experiences of facing children at risk. The case of Sweden is set in an international context by describing what characterizes the Swedish child welfare system, its legislation and approach to children at risk. It starts with a critical discussion about constructions of children at risk and the thesis's approach to this concept.

CONSTRUCTIONS OF *CHILDREN AT RISK*

Children at risk is a concept with many connotations, such as child abuse, neglect and maltreatment, which take on different meanings depending on the time and context. Children at risk is understood as something constructed in this thesis, which does not

mean to question that it is about something real that involves pain; rather it is about the idea of children at risk. Hacking (1999), who studied the idea of *child abuse*, stresses the importance of distinguishing between objects and ideas, and fact, truth and reality, and suggests that the way actions are described and perceived depends on the descriptions available to us.

Concepts and categories do not just exist in language but also in institutions, laws, policies, practices, research and the material interactions with objects and people (ibid.). Although the concept of children at risk is continuously developing in the interplay between research, and policies and legislation, this section does not describe the juridical or policy perspectives (these are discussed in the section ‘Sweden’s approach to children at risk’), instead it focuses on how the ideas of children at risk have been understood and constructed differently within different fields of research, such as medicine, psychology, social work and sociology. The following section gives a brief picture of the rise and development of some common ideas and ends with a discussion on this thesis’s approach to the concept of children at risk.

The rise and development of risk definitions in research

Children have always faced risky situations in and out of parental care, but what has been considered as risks and appropriate ways to protect and support children has shifted depending on the time and place. In Ferguson’s (2004) historical review of child abuse and child protection, he shows that new ideas of child protection emerged during 1870-1914 when new agencies like societies for the prevention of cruelty to children emerged in the United States, the United Kingdom and Ireland that recognized the need to prevent the death of and severe harm to children caused by caregivers’ cruelty. At this time in Sweden, it was children who behaved unacceptably who were described as a problem and who should be separated from their parents and placed in institutions or foster homes (SOU 2009:99). Alongside societies starting to discuss different risks to children, so did the researchers.

Although some researchers had noticed the existence of *child sexual abuse* in the late 1800s, Freud was the first to describe its pervasive psychological effects in 1896. Olafson, Corwin and Summit’s (1993) historical literature review shows that in the

decades around 1900, many psychologists considered sex between adults and children to be relatively harmless, and even though Kinsey's report in 1955 showed that every fourth woman had been approached sexually during her childhood and that it was most often remembered as a frightening experience, this result did not receive attention in the public debate. It was not until the growth of the feminist movement and studies in the 1970s and early 1980s outlined that 40 million adults in the United States and every third Canadian woman had experienced sexual abuse during her childhood, with long-term consequences, that it was recognized as a substantial problem (ibid.). Since the 1980s, research on child sexual abuse has widely expanded (see, e.g., Finkelhor, 1994; Stoltenborgh, van IJzendoorn, Euser & Bakermans-Kranenburg, 2011), and several studies show that in a majority of children subjected to sexual abuse it was perpetrated by other children, adolescents or non-relative adults (Cawson, Wattam, Brooker & Kelly, 2000; Munro, 2011; Landberg et al., 2015). However, the differences in the definitions are varied, with some studies including non-contact sexual abuse such as sexual propositions and exhibitionism, while others do not.

As mentioned, the recognition of cruelty against children arose in the late 1800s, although such descriptions can be found many years before that (Williams & Griffins, 2008). Child abuse attracted more attention in the 1950s (Gough, 1996), though Hacking (1999) points out that the explicitly formulated idea of *child abuse* arose in discussions about abused infants between paediatricians in 1961. He describes the historical development, and the extension and expansion of the concept, and refers to the paediatricians claiming that the problem of child abuse required medical expertise and thus argued for paediatricians being the profession with leadership responsibility for this issue. Physicians are described in different documents as the profession that 'discovered' child abuse or 'the battered child syndrome' (Kempe et al., 1962) during the period 1940-1960, and it was then directly related to child abuse being discussed as a medical diagnosis based on medical findings of bodily injuries (Jansson, Långberg & Svensson, 2007; Hacking, 1999). This contributed to increasing knowledge production on the issue within the medical as well as nursing research field, resulting in, for example, new medical diagnoses such as shaken baby syndrome (see, e.g., Donohoe, 2003) and Munchausen syndrome by proxy (see, e.g., Meadow,

1995). Less medicalized child abuse definitions have also increased. In, for example, prevalence studies from later decades, some researchers include actions such as pushing, roughly grabbing and shaking children, as well as other forms of physical punishments used in child rearing (see, e.g., Janson, Jernebro & Långberg, 2011). Within the social sciences, the concept of child abuse has expanded even further from the medical-psychological perspective, often including abuse caused by persons outside the family, and some including institutional abuse, societal abuse and child protection intervention abuse (Gough, 1996).

The concept of *child neglect* was also discussed as a risk phenomenon for children during the 1900s. Proctor and Dubowitz (2014) argue that even though child neglect is the most common and fatal form of maltreatment, there is less research on child neglect than child abuse and sexual abuse – studies also show that child neglect is more often a concern for investigation and that it is suggested that it is at least as damaging to children as physical abuse (Polonko, 2006; Gilbert et al., 2009b) and causes significant developmental delays (Crittenden, 1985). While child abuse is characterized as an action, neglect is characterized as inaction or failure to provide, which seems to be more difficult to define. Rose and Meezan (1993) point at neglect originally being conceptualized as an omission in parenting leading to a lack of adequate care of the child, whether or not such omission was intended. Initial attempts to define neglect focused on the conditions necessary for the child's development and the obverse conditions as neglect. Due to the complex and intertwining relationships between the numerous factors determining children's development, the concept of child neglect involves an inherent ambiguity (Rose & Meezan, 1993), and Proctor and Dubowitz (2014) stress that the definitional disagreements obstruct the knowledge production. Neglect is moreover described as existing on a continuum ranging from optimal to unacceptable care (Dubowitz et al., 1993) and a concept that needs age-sensitive definitions as needs differ at the various stages of childhood (Stein, Rees, Hicks & Gorin, 2009).

Rose and Meezan (1993) found that the consensus on the definitions of neglect during the 1900s was about inadequate food, clothing, shelter and supervision, although a number of other conditions were discussed, such as medical and

educational neglect or parents' mental or physical incapacity or 'immoral' behaviour (primarily alcohol or drug abuse, criminal activity or sexual relations by the mothers). Swift (1995) and other researchers point out that 'parental neglect' is a category that is often linked to poverty and insufficient material conditions, and Coope and Theobald (2006) describe child neglect as a complex social phenomenon that combines insufficient parental care and an unresponsive or negative attitude towards the child compounded by governmental neglect and limited legislation.

In the 1970s, the concepts of *psychological* and *emotional neglect* and *abuse* (in different combinations) became more established based on arguments that early emotional care of the child affected later behaviour and psychological adjustment (Rose & Meezan, 1993). A pioneer of this idea was Bowlby who developed the psychoanalytical attachment theory in the 1950s, which has since been widely discussed. Basically, it is an idea that emphasizes the child's psychological well-being and development. Goldstein, Freud and Solnit (1973) defined neglect as deficient emotional attachment in the child-parent relation, based on the parent's failure to meet the child's need to feel cared for, nourished, comforted, loved and stimulated. A secure emotional parental attachment is described as important for the child's expectations in relationships and emotional and social development (Mennen & O'Keefe, 2005). Moreover, physical abuse involves elements of psychological and emotional abuse (Cawson et al., 2000), and later research suggests that the emotional consequences are often the most sustaining and damaging component after physical and sexual abuse (Rees, 2010). In Rees's (2010) review of studies on emotional abuse, she concludes that emotional abuse has lifelong implications for physical and mental health and is a major cause of mortality. Rees argues that there is a difficulty in that emotional abuse may be described but not 'defined' so that others can recognize it. In her paediatrician view, Rees (2010) states that emotional abuse has lagged behind physical abuse in paediatric training, practice and research, and she argues that there is a need to put greater clinical focus on the established body of social work and psychology literature.

There are many overlaps in researchers' definitions, with some including emotional or psychological aspects in their definitions of abuse and neglect, while

others clearly separate them. Tang (2008) stresses a broad definition: “child neglect is when a child’s basic physical and/or psychological needs are not met” (p. 359). She argues that a range of sub-types of neglect can be defined within this definition and that it is more consistent with research findings that show that the child’s more proximal contexts (i.e. parents and family) as well as distal contexts (i.e. neighbourhood, community, society and culture) contribute to child neglect (Tang, 2008). Tang describes the social contexts as ‘contributing’ to child neglect and does not acknowledge social contexts such as lack of material circumstances or adequate legal systems as in themselves ‘being’ a form of child neglect. In practice, this division between ‘contributing’ and ‘being’ may have profound consequences for the way different problems are or are not managed.

Child maltreatment is another concept widely used among researchers in recent decades. It is often used as an umbrella term for child abuse and neglect caused by parents or other caregivers (see, e.g., D’Cruz, 2004; Dubowitz et al., 1993; Rose & Meezan, 1993; Newton & Vandeven, 2008). D’Cruz (2004) shows that medical knowledge is taken for granted in child protection cases and is used to give legitimacy to the categorization of maltreatment, which excludes alternative meanings of child maltreatment. However, there are researchers who include a broader spectrum of risk situations in their definition of child maltreatment, such as discrimination and bullying at school (Cawson et al., 2000) or societal abuse such as child beggary, child labour, child marriage and child prostitution in Pierce and Bozalek’s (2004) South Africa study. The critics against this extended perspective argue that the various and imprecise definitions of child maltreatment mean that there is a lack of comparable operational definitions that limit researchers from drawing reliable conclusions of the prevalence of child maltreatment and its effect on children’s development (Hutchison, 1990; Manly, 2005).

Social work research has a history of using a broader and more holistic perspective, one that is reflected in the concept *children at risk of harm*. In the Swedish context, a common translation of *children at risk* is ‘barn som far illa’ (although a more accurate translation may be ‘barn som riskerar att fara illa’), which is sometimes seen as equivalent to child maltreatment due to the lack of a precise

Swedish translation (National Board of Health and Welfare, 2014a). The lack of a Swedish concept that offers the broader and more inclusive possibilities of the English term *child maltreatment* is perhaps a reason the term *barn som far illa* became established early in the 1970s (Swedish National Board of Health and Welfare, 1974), while the English term *children at risk of harm* was not internationally established until the 1990s. *Children at risk* is used in social work research and among researchers using a social constructionist approach. While many researchers attempt to define forms of child abuse and neglect, *children at risk of harm* is rather a perspective used in a more indefinite way, as can be seen in Gilbert, Parton and Skivene's (2011, p. 5) formulation "...children at risk of abuse, neglect, and other dangers that might inflict harm." Although Parton (2014) does not make such claims, as I understand him, he describes the meaning of *children at risk* when he criticizes the narrow definitions in terms of physical, emotional and sexual abuse and neglect, as usually perpetrated by caregivers – because this approach abandons the collective harm and exploitation that can be caused by institutions, harmful policies and laws, conflicts, failure of governance and social disruption (p. 188). Parton promotes an approach that is consistent with the view that violations of children's basic human rights constitute social harms, which he argues can involve physical, sexual, emotional, psychological as well as financial/economic harms. The child perspective is holistically formulated in this approach: it emphasizes the risks perceived as harms to the child, and not primarily *who is accountable* for causing the harm. It can be described as a harm-to-child perspective, rather than a caregiver perspective (Hutchison, 1990). From this harm-to-child perspective, risk is considered a mixture of structural and behavioural factors, and risk assessment attempts to emphasize how risk and resilience factors interact (Munro, 2010).

Of the social harms, poverty is outlined as a major and the most significant risk factor for many children worldwide, and girls are particularly vulnerable (Welbourne & Dixon, 2013). The conditions that constitute poverty are constructed differently in different contexts, and within the European Union it is basically defined as people falling below 60 per cent of the median income of a country (Eurostat, 2015). Poverty is described as being generally harmful to children and their development, and

Wintersberger, Alanen, Olk and Qvortrup (2007) argue that children are disproportionately more likely to experience poverty than any other generational group. However, the dominant framework for understanding children's experiences of poverty and its problems has become the family setting, and consequently there is a risk that the solution is assumed to lie within the family rather than in the poverty itself (Scraton, 1997). In other words, poverty is not assumed to 'be' child neglect, instead it is seen as 'contributing' to child neglect. Tang (2008) argues, for example, that poverty can be a useful factor for predicting neglect in combination with other risk factors within the family (such as a parent's health problems, a child with disabilities or a difficult temperament, and a family's social isolation). Understood in this way, the child 'protection' system is not expected to handle social problems such as poverty if the parents are not under suspicion for failing to meet the child's basic needs. The consequence of such understanding may be a form of blame culture against socially disadvantaged parents if poverty and social exclusion are not described and recognized as a potential risk of harm to children (Axford, 2010). Brooks-Gunn and Duncan (1997) argue, for example, that low income among families often has a considerable effect on children's and adolescents' well-being and achievement, but other forms of social exclusion such as low education, and non-participation in local communities, peer groups and leisure activities, and experiences of being seen as different from mainstream society have also shown to have an effect (Fangen, 2010; Koupil, 2012). Social conditions affect wellness during the course of life, and children whose parents live in social exclusion or below the poverty line for most of their childhood have shown to be at higher risk of developing illness (Brooks-Gunn & Duncan, 1997; Koupil, 2012). This means that children and youths who live in poverty and social exclusion also visit health care institutions more than others.

The thesis approach to children at risk

As shown above, there are various constructions of *children at risk of harm*. Some researchers struggle with better operational definitions to enhance comparability across studies, drawing conclusions across larger groups of children, which could lead to better social policy decisions (Manly, 2005), and others criticize narrow definitions

and argue that all violations of children's basic human rights constitute harm (Parton, 2014). Definitions may be important for specifying problems that need societal attention and, as Hutchison (1990) points out, they are important for social workers and others involved in coercive interventions. Despite such benefits of or needs for using operational definitions for particular purposes, social work attempts to promote all children's human rights and their right to be protected from risks of harm from a broad holistic perspective (International Federation of Social Workers, 2014). There is tension between striving for clear definitions and striving for a holistic perspective on risks, and this thesis reasons that social workers should not ignore some of children's needs because of narrow, sometimes institutionalized, definitions. It is of course not reasonable to expect individual professionals to solve the general problems of poverty and social exclusion, but they have a responsibility to act when meeting children at their workplaces suffering from such concerns (see, e.g., the professional principles stated by the International Federation of Social Workers, 2014). For example, as an HSW, I have taken action to reunite children with their parents who had lived in refugee camps abroad for years and advocated for rights to life-saving health care for children who had been told they did not have these rights because they were not Swedish citizens or were 'non-prioritized' because of their disability. In some cases, this contributed to a safer life for or the survival of a child, but for others I failed, sometimes with the most painful of consequences: the child's death. What we define as risks and the decision to act or not to act have profound consequences for children, and this is difficult work carried out every day by welfare professionals.

In social work and health care practice, defining whether a child may be at risk of harm is often a complicated task influenced by institutionalized definitions, the welfare system and which authority is considered responsible for a specific problem. Being aware of who is included and who is excluded in the construction of the term *children at risk* is important to understanding the power relations that surround children and to understanding what constitutes the produced knowledge and how the institutions do or do not exercise social control of the identified problems. This thesis uses, and reflects on, the institutionalized definitions and categorizations of children at risk but does not draw a sharp boundary around these. For example, the quantitative

study uses definitions such as child abuse and neglect, while the qualitative study asks the interviewees for their understandings of children they consider may be at risk. Having an open and extensive definition will hopefully allow issues of power and (in)visibility to be explored in relation to which children are assumed to be at risk in the Swedish context today. As one of the core components of social work is contributing to human and social rights in practice, we must not neglect the stories about children who fall outside the institutional definitions. This also makes it possible to explore the hospital personnel's work with children *they* consider may be at risk but who fall outside the institutionalized definitions.

RISKS IN CHILD WELFARE AND CHILD PROTECTION SYSTEMS

The way children at risk are described, perceived and managed is related to a broader question of the approach of societies to risks and the way societies organize risk management. The way societal systems are constructed and developed to deal with risks also depends on societal and political changes over time. In 1986, Beck argued that risk had been given a new role in society related to the shift from the industrial society to the advanced modernity during the 1900s, and he wrote: "In advanced modernity the social production of *wealth* is systematically accompanied by the social production of *risks*." (Beck, 1992: 19). Alongside the increasing attention on health risks in what Beck calls risk society, social welfare state norms were successively established to manage and minimize the risks. The increasing focus and knowledge production on children at risk of harm have therefore implicated increasing demands of political responsibilities and on political govern institutions to demonstrate their capacity to manage risk to ensure trust and legitimacy. At the same time, this has become more complex because a risk society involves judgments of experts constantly being questioned and evaluated, and Beck (1992) suggests that this is a form of circularity of knowledge and arguments that produces uncertainty in what he calls reflexive modernity. According to Power (2008), the uncertainty and discourses on risk have had a substantial impact on welfare organizations and transformed them into managers of uncertainty and risk.

It is possible to trace how the concepts of wealth, risk and uncertainty have formed high-income countries' approaches to children at risk. Ferguson (1997) argues that we may understand the ways in which child protection has changed better by taking into account the paradigm of the risk society in our analysis. By the mid-2000s, researchers agreed that there were two broad frameworks for comparing approaches and systems on an international level, namely the child protection approach and the more preventive family service-oriented child welfare approach (Parton, 2014). Although the two orientations may overlap, they point to some important characteristics.

The child protection approach is linked to neoliberal ideologies because of its association with the argument that the state should not interfere with family privacy except when legally required to do so (Fargion, 2014; Parton, 2014). It stresses that children should be protected from abuse from degenerative relatives, usually parents, and uses investigations in a legalistic way to focus on out-of-home placements, preferably compelled through court orders or other coercive powers of the state. This perspective is underpinned by a medico-scientific paradigm that involves the risk being detectable and diagnosed in an objective way and, consequently, 'abuse' and 'neglect' being prioritized issues. This means that possible injuries on the child's body attract much attention, for example through medical practitioners' use of skeletal surveys, cranial scans, anal dilatation, 'body atlases' and other standardized checklists or guidelines (D'Cruz, 2004). The effect on the organization of work is that child protection services are often separated from other supportive child and family services, and the assessment process is standardized with tools that restrict practitioners' discretionary power. The interventions are assumed to be protective and do not focus on preventive actions such as parental support (Fargion, 2014; Parton, 2014).

The child welfare approach involves a child protection approach but is linked to a socialistic ideology that uses a broader perspective on children's well-being, taking into account material and social conditions and needs. Child welfare systems in, for example, Scandinavian countries are thus characterized by early social investments in children. Maltreatment is often conceived as a problem of family conflict or parental dysfunction that arises from social and psychological difficulties, which need to be

responded to through the provision of help and support (Parton, 2014). Although the assessment is becoming more standardized, it still involves looking for resources and strengths in families, as well as potential problems (Spratt, 2003). Interventions can be both protective of children and supportive to meet the needs of families (Brunnberg & Pećnik, 2007).

Some researchers have claimed that countries that use child protection systems have gradually come closer to the child welfare approach in their attempt to work more preventively with children's general welfare, but Parton (2014) has noticed that such changes, back and forth, seem to relate to the ideologies of the governments as well as the countries' economic situation. It is also important to note that many of the world's countries do not have enough state resources to develop such systems, as large parts of their populations live in poverty or armed conflicts (Welbourne & Dixon, 2013). In countries where parents struggle to provide the basic needs and the physical survival of children, the two models of systems are problematic to use or achieve. As long as poverty is a major and/or the most significant risk for many children, low income countries may not have the conditions to form systems for protecting children from other harms (ibid.). Poverty is nevertheless a challenge for all countries, albeit to different extents, and Ferguson (1997) suggests that child care systems should be based on an understanding of different types of risks in a way that balances child welfare and protection.

The two orientations have effects on broadening or narrowing the risk definitions as well as on the assessment processes of children perceived to be at risk. Fargion (2014) argues that the child welfare approach emphasizes professional autonomy and early intervention based on individualized assessments, and she calls this approach 'reflective' and the child protection approach 'rational'. While the 'rational' approach is systematic and uses categories and standards to take control over and 'fix' risk situations and uncertainties, the 'reflective' approach more often accepts complexities and unpredictable elements, which makes room for taking power imbalances into account (ibid.). Houston and Griffiths (2000: 5) promote the latter perspective and reason that it may be more helpful to talk about 'understanding concerns' regarding children and their families than having an objective perspective on child risk

assessment, which they argue involves pseudo-scientific assessment of probabilities and abstract risk factors. Rather than striving for organizations preoccupied with bureaucracy, standardization and a hierarchical and responsive approach towards families, they promote a participative and democratic professional style that approaches risk in a more ethically sensitive and reflexive manner. When there is a need for guidelines, they then argue that those need to be flexible to help professionals respond to diverging meanings of risks (ibid.).

In addition to any shortcomings in child protection systems meeting the general welfare needs of children, Gilbert and colleagues (2009a: 176) argue that there may be shortcomings in child welfare systems to acknowledge harmful aspects of parents' behaviour and the need to prevent future harm. Although there is reason to recognize the broader picture of children's well-being and needs within the concept of being at risk, there is of course also reason to analytically separate children's need for protection from violence from other causes of harm.

Other voices are more critical of the idea that future harms can actually be assessed and prevented. Fahlgren (2009) points out that the attempt to predict the unpredictable and unknown future has become a core ethical dilemma in social work with children suspected of being at risk. Many researchers agree that uncertainty is not only here to stay but also something that may be positive and that should not be avoided. As Bauman writes:

“The uncertainty which haunts social work is nothing more nor nothing less than the uncertainty endemic to moral responsibility. It is there to stay forever; it may be neutralized only together with the ethical conscience”. (Bauman, 2000: 10)

How professionals relate to uncertainty in practice depends on a range of factors. White (2009) found that child health social workers were often sure about their views, related to not having time to notice uncertainty in their work, while other researchers (Spafford, Schryer, Campbell & Linigard, 2007) have found differences between social workers and medical and optometry students, and how they coped with uncertainty. The social work students embraced uncertainty as a vital part of their

work that could be managed with the help of supervision, while the medical students viewed uncertainty as something that should be avoided (ibid.). The medical students' avoidance of uncertainty mirrors the medico-scientific paradigm that D'Cruz (2004) argues is characteristic of the child protection approach.

The child protection approach is thus linked to a medico-scientific paradigm promoting more bureaucracy with checklists that are supposed to minimize uncertainty and contribute to actions (Lipshitz & Strauss, 1997). As seen above, this approach has been criticized, and some argue that it may be a threat to professionals' knowledge and discretion (Houston & Griffiths, 2000). A stricter way to organise risk management can minimize some of the uncertainty but does not remove the fact that professionals still need to assess and decide how to act in specific uncertain situations.

THE SWEDISH SYSTEM'S APPROACH TO CHILDREN AT RISK

Sweden is often characterized as a social welfare state with a preventive and family-oriented child welfare approach, although some researchers think it is more correct to describe the system as a mix between preventive welfare and protection functions (Gilbert, Parton & Skivenes, 2011; Wiklund, 2006; Östberg, 2014). The welfare approach involves tax-financed services for all people documented as living in the country. In spite of this, poverty among children in general has gradually increased since 2007 and is the highest among the Scandinavian countries (Fløtten & Skevik Grødem, 2014). Alongside the general social policy during the neoliberal government, 2006-2014, having failed to reduce child poverty, more expectations have been placed on social services' work with children at risk in terms of clearer routines and transparency in work, as well as a widening mission.

Legislation, risk definitions and investigation

Historically in Sweden, the 1902 legislation made it possible to place delinquent children in compulsory care, and when the Child Care Act (SFS 1924:361) was implemented in 1924, municipalities were given responsibility to judge if children were abused or neglected and instructed to implement new child care committees that

could decide to place such children in compulsory care. When the Child Care Act (SFS 1960:97) was updated in 1960, municipalities were given increased preventive responsibilities.

In 1979, corporal punishment was banned in Sweden and in 1982 the first Social Services Act (SFS 1980:620) was established – a framework law that outlines some basic values and principles for professional social workers. In 1990, Sweden ratified the United Nations Convention on the Rights of the Child (1989), which declares, for example, all children's right to a healthy childhood, to be looked after and to be protected from exploitation and all forms of violence. The Convention was partly incorporated into the Social Services Act, which states that all measures that concern children shall pay attention to what is best for the child. That same year, the Care of Young Persons Act (SFS 1990:52) was established, regulating the use of compulsive measures. The Social Services Act and the Care of Young Persons Act clearly state that what is best for the child shall be *determining* for all decisions about care and treatment for children. The government recently suggested that the Convention on the Rights of the Child should be law by 2018 (SOU 2016:19), which will probably involve further changes to several laws.

The present legislation on children at risk is also based on the principles in the Parental Code (SFS 1949:381), which outline that children up to eighteen years old have the right to be cared for and the right to a safe and good upbringing. There have been attempts over the years to incorporate the principles in the Convention on the Rights of the Child into the Parental Code, although criticism remains that formulations about what is best for the child are still too weak (Barnombudsmannen, 2005; Committee on the Rights of the Children, 2013). The Parental Code states that it is a parental responsibility to guarantee children their rights and that what is best for the child is the determinant in all decisions concerning custody, residence and contact. It further states that the child shall be treated with respect and not subjected to corporal punishment or any other offensive treatment. If parents fail to meet their child's needs and rights, society has a responsibility to support parenting with preventive measures to avoid more interfering actions and to protect the child in vulnerable situations when necessary (Government Bill 2012/13:10, 23–24). The preventive measures are not

restricted to cases in which parents fail to meet the child's needs and rights however. There has been growing focus on universal support of parenting in Sweden in the past decade. In 2009, the government formulated a nationwide strategy for parental support, arguing that all parents should have the right to public support to help them fulfil their parental responsibility. This strategy means that voluntary measures are addressed to all parents visiting child health care, aimed at promoting all children's health and development – and it focuses on protective factors rather than risk factors (Government Office, 2013).

The guiding principles for understanding the concept of *children at risk* can be summarized by the Child Protection Committee's reasoning that this concept includes the interaction between the risk and safe-keeping factors in the at-home situation and the child or the young person's own behaviour or social circumstances otherwise (SOU 2009:68, 230). The Government Bill (2012/13:10, 47) points out that it is not possible to give a complete definition of children at risk and that the child's health and development and the particular circumstances in the individual case determine the need for action. The National Board of Health and Welfare released the new guidelines in 2013, updated in 2014 with the latest legislative changes, which were addressed to health care personnel (National Board of Health and Welfare, 2014a). The guidelines provide a clearer description of what situations should be reported to social services and includes all types of abuse, neglect and exploitation that lead to actual or potential harm to a child's health or development. They exemplify that it may concern children and youth exposed to physical or psychological abuse, sexual abuse, violation, physical or psychological neglect, serious relational problems within the family, or witnessing or living in an environment in which violence or threats of violence are present. They also include descriptions on when children and youth are at risk because of their own behaviour, for example self-destructive behaviour, criminality or misuse of alcohol or drugs. Further examples are children exposed to threats, violence or other forms of abuse by peers or others, and children with severe problems in their school situation based on social difficulties (National Board of Health and Welfare, 2014a).

It is social services – or more specifically the child welfare services within social services – that receive reports and have jurisdiction to investigate children at risk. However, the work of child welfare services is a mix of preventive tasks, such as voluntary applications by parents or youth for support, and protective elements based on reports. Reports can be made anonymously by private individuals, but professionals who receive the information when on duty cannot be anonymous and are referred to here as ‘mandated reporters’. The expectation on professionals such as social workers and physicians to report child maltreatment can be traced back to the 1960s Child Care Act (SFS 1960:97), but the mandated reporting was clarified in the 1982 Social Services Act (SFS 1980:620), which stipulated that employees in institutions whose practice concerned children and youths were obliged to immediately make a report when they received information, meaning that the child welfare service needed to intervene for juveniles’ protection. In the updating of the Social Services Act (SFS 2001:453) 14 Ch. 1 §, it has been further specified that this obligation also includes, for example, adult health care, and that a report shall be made when employees *suspect* that a child may be at risk. This means that a report should be made even though there is no evidence of harm and that a report should be based on the mandated reporter’s own observations and worries about the child, including information that is unverified or hard to assess (Government Bill 2012/13:10). The National Board of Health and Welfare (2014a) has made further clarifications concerning who is obligated to make the report: no personnel with a suspicion can disclaim their responsibility to make a report by referring to someone else having committed to report. This means that subordinate personnel should not refer to a superior, though such situations have not been tried in court.

Mandated reporting involves information on a child actually *being* at risk as well as worries that a child *may be* at risk. It is not hospital professionals who investigate whether a child *is* at risk, however, that is the task of social services. If hospital professionals feel unsure about whether a particular situation or circumstance should be reported, they can consult social services without revealing the child’s identity. Reports should be written to avoid misunderstandings, but in cases in which social services receive vocal information, it is their responsibility to document such

information and verify with the person who made the vocal report that the information has been perceived correctly. The same day that the child welfare services receive a report they must assess if there is a need for immediate protection (National Board of Health and Welfare, 2015a). In that case, the Care of Young Persons Act (SFS 1990:52) must be applied, which states that the local social welfare committee must request that the County Administrative Court decide to place the child in temporary custody. Although the local social welfare committee consists of politically selected laypersons and not professional social workers, it has been shown that they usually follow the professional's proposal (Forkby, Höjer & Liljegren, 2014). If there is no need for immediate protection and no other extraordinary reasons, the child welfare services have at most 14 days to pre-assess if the report is serious enough to open an investigation, and it should not be opened if it is clear that the child welfare services should not or cannot take any measures. A pre-assessment should consider any previous reports and case history and can involve further contact with the reporter, the parents or the child, and a report meeting together with a mandated reporter and the family. If the child welfare services start an investigation, they must inform the parents about the identity of the mandated reporter and what the report concerns (National Board of Health and Welfare, 2015a).

An investigation means that the child welfare services collect more information from others, such as the reporter, professional experts and reference persons. Mandated reporters are obliged to provide child welfare services with all requested information that may be of importance to the investigation, independently of who the reporter is. Social services are not allowed to reveal any other information than whether an investigation has been or is already open, however, and if the parents and child confirm, the reporter can be informed that the investigation has been closed or a decision taken about measures. An investigation should continue for no longer than four months and be no more extensive than the circumstances motivate. The aim is to investigate the child's situation and needs, and how such needs can be met. In the decision-making, the child welfare services can decide to make a follow-up no later than two months after the investigation was closed, even if the parents or children do not give their consent. Children aged fifteen years or older have the right to plead their

own cases, receive information about decisions taken and make their own appeals against decisions (National Board of Health and Welfare, 2015a).

Characteristics of social services cases

Although most of the cases that the child welfare services handle are based on reports, they also handle voluntary applications by parents and youths for supporting services. As a consequence of the varied and sometimes poor municipal routines of keeping records of report data, there are no reliable nationwide data about the child welfare services' cases in Sweden (Wiklund, 2006); although there are studies on a municipal level showing that most cases are initiated by reports. For example, Almqvist and Åsbrink (2009) showed that 85 per cent of the cases in seven municipalities in Gävleborg County were initiated by reports and 11 per cent by applications, and Kaunitz, Andrée Löfholm and Sundell's (2004) study in Stockholm Municipality shows similarly that 86 per cent of the cases were initiated by reports and 14 per cent by applications. In Scania County's municipalities, 91 per cent of the cases were initiated by reports and 9 per cent by applications (Scania County Administrative Board, 1999), while Östberg's (2010) study in two municipalities showed that 63 per cent of the cases were initiated by reports and 37 per cent by parents' own applications for supporting family services.

The probability of a report or application leading to an investigation differs between municipalities. While some studies have shown that it is more common for applications than reports to lead to an investigation (Sundell, Vinnerljung, Andrée Löfholm & Humlesjö, 2004; Almqvist & Åsbrink, 2009), one shows the opposite result (Östberg, 2010). Wiklund (2006) who conducted the most extensive study of characteristics of incoming reports to Swedish child welfare services found that 36 per cent of all cases in 100 municipalities were not investigated, which he suggests it may be related to a number of factors: for example, vague legislative guidance on when cases should be investigated and a lack of risk assessment tools at the time the study was conducted. Wiklund (2006) also found that half of the reports did not lead to any measure, while Sundell, Vinnerljung, Andrée Löfholm and Humlesjö (2004) showed that 87 per cent of the reports that led to an investigation did not end up in any action

being taken and only a fifth of the incoming cases in Östberg's (2010) study led to a measure.

Wiklund (2006) shows that the number of reports made in Sweden is ranked in the middle in an international comparison but that Swedish child welfare services deal more often with cases that are regarded as lower priority from a child protection perspective. This is primarily related to the broad definition of risks and that youths' own risk behaviour is included in the Swedish legislation unlike, for example, the legislation in the United States or the United Kingdom.

In an international comparison, there are substantial differences from Anglo-Saxon countries concerning what issues are reported to social services in Sweden. Conditions related to the child with no reference to the caretaker, such as criminal activities or drug or alcohol use, are major motives for reports (Wiklund, 2006). Thereafter, most reports concern domestic violence and problems in adolescent-parent relations and school-related problems, and only a few reports concern children exposed to physical or sexual abuse, while some forms of neglect are slightly more common (see, e.g., Sundell et al., 2004; Wiklund, 2006; Cocozza, Gustafsson & Sydsjö, 2010). Moreover, the conditions reported are often vague and complex (Östberg, 2014), for example categorized as "other deficiencies in care" (Wiklund, 2006; 53). A nationwide study of primary nurses in Sweden shows that the most common categories when describing the reported children were social problems related to the families' work, housing or finances that affected the parents' energy and capacity (Lagerberg, 2004). These social problems are not always explicitly defined within the legislation that serves as a base for the mandated reporting; rather the government (Government Bill 2002/03:53) briefly discusses such social problems as a concern for the general welfare politics. However, it cannot be ignored that in everyday practice, the distinctions are not always clear between social problems, such as poverty, and the definitions of children at risk – which may involve consequences for families living in poverty. Franzén, Vinnerljung and Hjern (2008) showed that parents who received a financial allowance from sickness benefit or social services in Sweden more often had their children placed outside the home, and another study (Canvin et al., 2007) showed that poor parents in the United Kingdom avoided seeking

health care because of the risk of being misunderstood and reported to social services, and they avoided applying for financial aid from social services because of the risk of having their parental ability questioned.

Although there is a lack of nationwide data, the National Board of Health and Welfare (2012) argues that there seems to be underreporting from health care professionals, as only 10 per cent of the reports come from health care institutions. As a way to increase awareness about children who may be at risk, the National Board of Health and Welfare (2014a) released new guidelines in 2013, updated in 2014, with more detailed descriptions of what circumstances should be reported to social services. The same year, 24 changes were made to the Social Services Act (SFS 2001:453) and the Care of Young Persons Act (SFS 1990:52), and in the National Board of Health and Welfare's (2015b) follow-up, it conclude that reporting to social services had increased since 2013 – except from health care institutions.

HEALTH CARE PROFESSIONALS FACING CHILDREN AT RISK

Internationally, it is well documented that physicians and nurses feel unsure when identifying child maltreatment and face barriers in the work with child maltreatment. For example, Paavilainen and colleagues (2002) found that 71 per cent of a variety of professions at a Finnish hospital believed that the identification of maltreatment was difficult, and one-third believed that they would not be able to identify a maltreated child. Furthermore, physicians in Australia have mentioned difficulties in distinguishing accidents from non-accidents (Van Haeringen, Dadds & Armstrong, 1998), and psychosocial signals were less often noticed than other types of signals among paediatricians in Kuwait (Al-Moosa et al., 2003). Similarly, Shor (1998) found that Israeli paediatricians were less likely to assess psychological and emotional abuse and neglect as being as harmful as physical forms of abuse. It has also been shown that Taiwan nurses are unsure about the level of evidence required and harbour fear of making a report (Lee, Fraser & Chou, 2007).

Other studies show that time pressure and workload make health care personnel more unsure about when to identify child maltreatment (Markenson et al., 2002; Paavilainen et al., 2002) and that handling such cases is stressful for the personnel

(Johnson, 1999; Flaherty, Jones & Sege, 2004) and linked to emotions such as anxiety and uncertainty (Bannon, Carter & Ross, 1999; Lees, Meyer & Rafferty, 2011). Reasons given for not reporting have been shown to include fear of negative personal consequences (Marshall & Locke, 1997), feeling ambivalent and unsure (Tingberg, Bredlöv, & Ygge, 2008) and personnel trying to manage the problem themselves (Van Haringen, Dadds & Armstrong, 1998). Bannon, Carter and Ross (1999) found that general practitioners in the United Kingdom had received little training in child abuse issues compared with social workers and stressed the importance of a second opinion from someone perceived to be an expert, for example a paediatrician or social worker, due to the difficult process of identifying child abuse. Other practitioners asked for more inter-professional team work, attempting to understand each other's roles and closer work with social workers, who they perceived had the primary responsibility (Bannon, Carter & Ross, 1999).

Within the Swedish primary health care context, Lagerberg (2001) found that child health nurses' identification of child maltreatment was related to long-term experience in their district, personal interest in awareness of child maltreatment and having regular contact with social services. Talsma, Bengtsson Boström and Östberg's (2015) study of general practitioners in primary health care found that some of the stated reasons for not reporting were uncertainty about the suspicion, referral to other health care providers and planned short-term follow-up of the child – but the only significant factor for not reporting was that general practitioners educated abroad reported more rarely.

Among studies conducted within Swedish child hospitals, feeling uncertain about assessing the situation and a lack of education and training were found among physicians at one hospital (Borres & Hägg, 2007) and nurses at another hospital (Tingberg, Bredlöv & Ygge, 2008) to be barriers to reporting. The physicians also considered lack of time and being afraid of offending parents as barriers to reporting (Borres & Hägg, 2007), and the nurses stated that a lack of clear guidelines, routines and counselling were barriers (Tingberg, Bredlöv & Ygge, 2008).

In Sweden, and other countries with different legislation, the lack of trust in social services (or equivalent child protection services) has shown to be a barrier to health

care professionals' decision to report. Physicians in Australia (Van Heringen, Dadds & Armstrong, 1998) and the United States (Jones et al., 2008; Marshall & Locke, 1997) have been found to be hesitant to report child maltreatment because they do not believe that there will be any benefit to the child or family. Nayda (2002) showed that a group of South Australian nurses based their decisions on the benefits versus consequences of reporting, arguing that they often worried about the safety of the child after making a report to the child protection services. It has also been found that health care professionals are frustrated by the lack of response from social services in Sweden (Borres & Hägg, 2007; Tingberg, Bredlöv & Ygge, 2008) as well as in the United States (Eisbach & Driessnack, 2010; Flaherty et al., 2008; Jones et al., 2008), and other studies indicate that more dialogue with social services increases the feeling of certainness and the report rates (Lagerberg, 2001; Flaherty & Sege, 2005; Vulliamy & Sullivan, 2000). Talsma, Bengtsson Boström and Östberg (2015) showed that only 30 per cent of the physicians in Swedish primary health care trusted social services' methods of investigating and acting in cases of suspected child maltreatment, and Borres and Hägg (2007) found that as many as 60 per cent of paediatricians agreed that social services rarely took practical action. The extent to which a higher degree of collaboration between health care and social services would have an impact on the trust in social services remains an open question, but Wiklund (2007) confirms that such collaboration seldom exists.

What these studies do not answer, however, is how, for example, the reporting experiences differ between professions within Swedish children's hospitals and which factors are most important for different professions in not making reports. Furthermore, we do not know anything about HSWs or nurse assistants' assessment and reporting experiences. Nurse assistants spend a considerable amount of time with the children and their families within the wards, and HSWs often seem to be involved in cases of suspected child maltreatment, and they are sometimes regarded as experts (see, e.g., Bannon, Carter & Ross, 1999), which, in Sweden, is related to their shared educational background with professionals within social services. Although there are previous studies on factors influencing health care professionals' assessments and reports to social services, there is still a lack of in-depth understanding of the way

social norms and emotions are involved in professional discretion and assessment of children suspected of being at risk in the health care context.

3. THEORETICAL FRAME

The thesis focuses on the work enacted within the walls of children's hospitals: work performed by a variety of professional groups with different knowledge, status and roles. The professional relations are interesting for enhancing the understanding of how health care personnel organize their work with children who are or may be at risk. This chapter presents a theoretical frame that serves to improve the understanding of professionals who make assessments and decisions. It discusses the system of professions, and the HSWs' and their colleagues' positions within the health care context and two concepts of importance to the theoretical analysis, namely jurisdiction and professional discretion.

The factors influencing professional discretion are related to institutionalized norms, such as those imbedded in the legislation and those into which the professionals are socialized through their particular education, training and professional practice. This chapter thus describes how such norms influence discretion, but it also highlights how social norms based on gender, nationality/culture, class and (dis)ability are involved in risk assessment. Theorists further suggest that social norms and emotions are intrinsically linked. By discussing how professionals' emotions are stuck to certain groups of people and involved in classed hierarchical relations between professionals, the chapter attempts to widen the theoretical understanding of what influences and forms professional assessment and discretion.

THE SYSTEM OF PROFESSIONS AND JURISDICTIONAL WORK

This thesis involves experiences of four occupational groups – HSWs, physicians, nurses and nurse assistants – of assessing children who may be at risk. In the articles, they are all referred to as professions, although there are different opinions about the correctness of doing so. During the 1950s and 1960s, researchers tried hard to clarify

the differences between professions and other occupations, attempts that remain unsolved. Most researchers today consider the definitional precision of a profession as less important; rather professions and occupations are regarded as similar social forms that share many common characteristics (Evetts, 2013; Svensson & Evetts, 2003). One of the first researchers to take this standpoint was Hughes (1958), who argued that the differences between professions and other occupations were of degree rather than kind: both determine ways of thinking about the problems and the solutions to the problems that fall under their domain. This thesis uses the term *profession* in a pragmatic sense that agrees that the difference between professions and other occupations is about degree rather than kind, and the analysis focuses on aspects of the differences of degrees. For example, the differences in degrees between the education and responsibilities of the professions are discussed.

McClelland (1990) presented a way to discuss differences between professions using the concept of *professionalization* and argued that professionalization comes ‘from within’ (e.g. in medicine and law) and ‘from above’ (characterized as external forces to the occupation, e.g. engineering and social work). Evetts (2013) develops McClelland’s thoughts and argues that when professionalism comes primarily ‘from within’, the profession constructs its professional identity and has a position to bargain with states to secure and maintain its regulatory responsibilities. If successful, it can gain substantial benefits such as high salary, status and authority. Physicians are a successful example of this professionalization strategy, although their autonomy and self-regulated control over their work have decreased in recent decades (Bejerot, Aronsson, Hasselbladh & Bejerot, 2011). If professionalism is mainly constructed ‘from above’, professionals are more often under the control of organizational management, meaning less occupational control and autonomy and, as a consequence, less benefits in terms of salary, status and authority (Evetts, 2013).

One of Abbott’s (1988) core concepts in his theory about the system of professions is *jurisdiction*, which he considers to be the link between a professional and the professional’s work. He describes ‘the system of professions’ as each professional group striving to defend and expand its area of jurisdiction in competition with rival professions. Molander and Terum (2008) defines a profession’s jurisdiction

as a combination of autonomy and monopoly over certain work tasks, which can be legally formalized through, for example, legislation, public regulations or specified in workplace job descriptions. As mentioned, however, none of the health care professional groups has formal jurisdiction over children at risk, because the child welfare services own the jurisdiction over the investigation process – and the mandated reporting concerns all health care professionals. It is therefore particularly interesting to explore how the lack of formal and clear jurisdiction impacts health care professionals' work with children suspected of being at risk.

In the absence of formal jurisdiction, Abbott's (1988) theorization about informal jurisdiction becomes important to this thesis. He highlights that informal jurisdictional work can be achieved in public arenas but that it is also under constant and ongoing renegotiation between professions within workplaces. This may concern, for example, professions' negotiations about defining the problem, assessing, diagnosing, deciding and suggesting treatment based on the different professions' academic discipline and its knowledge base. Jurisdictional work is thus influenced by the negotiations and relations between professions, but it is also influenced by the intra-professional relations within a profession. Abbott uses the concept *internal differentiation* to outline how differentiation of workplaces may bring members of professions into closer interaction with members of related professions than their own, which may hypothetically be the case for those HSWs who lack colleagues from their own profession at their workplace. Internal differences may thus have profound consequences, such as embodying differences by intra-professional status, client, organization of work, and career pattern (ibid.). Furthermore, according to Sjöström (2014: 27), cultural differences among professional groups can entail differences in orientation that may influence the interaction between professions and professionals.

A professional group's jurisdictional work and intra-professional relations may therefore affect the profession's role at inter-disciplinary workplaces. Clear professional roles have also been said to be fundamental to effective inter-professional teams and ensure that problems concerning professional boundary infringements are avoided (Reeves, Levin, Espin & Swarenstein, 2010). Kvarnström (2007) points out the obstacles when team members do not acknowledge, understand or respect each

other's roles indicate that the professions' different statuses in the team may be significant to the utilization of knowledge contributions. Sufficient team communication and clear professional roles have shown to be helpful in assessment processes and in diagnosing child abuse and neglect (Shor, 2010; Haultain, 2011), and Rees (2010) points out, for example, that unclear roles and responsibilities can involve emotional abuse being misinterpreted as 'no abuse'.

Although there have been attempts to strengthen inter-professional team work to promote mutual respect for the expertise of the various professions the recent decades (World Health Organization, 1998), the hierarchies, and class and gender differences between hospital professions cannot be overlooked. As Larson (2005) points out, few professions have attained the dominance over other professions in a hierarchy of knowledge and organizational power that physicians have, which is related to the medical professions for centuries having been male-dominated and middle class (Davies, 1996). The hospital setting is characterized by physicians being leaders and having a long tradition of professionalization, jurisdiction, monopoly, higher education and knowledge production. During the nineteenth century, the average level of education, especially among women, has increased enormously in Sweden, and becoming a physician, nurse or HSW requires at least three to five years of university studies, although it is common to have further specialist or other education. Thus, nurses and HSWs have stabilized as women-dominated middle class professions, and there seems to be an ongoing gender shift within medicine resulting in 50 per cent of physicians and almost 70 per cent of paediatricians in Sweden being women in 2013 (Statistics Sweden, 2015a). Although it requires higher education to become a nurse or an HSW, and the nurses' professionalization efforts have resulted in more defined nursing and medical responsibilities and autonomy in Sweden, their claim for full jurisdiction has failed.

Abbott (1988) suggests that full jurisdiction is achieved by organized groups in public and legal arenas and that physicians successively maintain dominance over such jurisdiction at hospitals. He argues that this has resulted in the subordination of other professions, such as nursing and HSWs whose positions to various extents involve exclusion (i.e. they do not need to know why) and coercion (i.e. the physician

orders them to perform or not perform a task), even though such subordinated professions have received some symbols of authority. This form of subordinated division of hospital labour permits a delegation of routine work in which physicians split jurisdiction with other professions, practically or intellectually, for example, in that other professions can receive advisory control over certain aspects of the work (ibid.). Regarding children at risk, it can be presumed that physicians split their informal jurisdiction with other professions due to the legislation on all professionals' mandated reporting. One hypothesis is that HSWs, with their close professional relationship to the social workers within social services, have fairly strong informal jurisdiction and a strong advisory position regarding children at risk issues for both practical and intellectual reasons.

The subordination of professions and the delegation of work are not only based on practical or intellectual arguments; the status hierarchies are also rooted in other social structures. Davies (1996) argues that subordination is based in gender structures in which the physicians – historically and discursively a male-dominated profession – have been delegating what they have defined as less qualified work to other women-dominated professions. The context for jurisdictional work is therefore also gendered and classed. The nurses' professionalization efforts in Sweden have resulted in them having been delegated some medical care besides being responsible for the nursing care and that they are assisted by the subordinated nurse assistants who do less qualified nursing work. Nurse assistant is the only occupation of those studied in this thesis that does not require higher education – it basically requires studies at upper secondary school, although many who specialize in children's care have one year of additional university studies. This way the hierarchies between the hospital professions mirror the class and gender differences (cf. Davies, 1996; Larson, 1977) and, according to Larson (2005), are not only a question of professional jurisdictional struggles, as the hospital organizations are involved in a broader and complex political field in which they are politically governed and pressured to produce effective health care at the lowest possible costs.

HOSPITAL SOCIAL WORK: A SUB-PROFESSION IN A SUB-FIELD

The profession in focus in the thesis is HSW, but while the other professions included in the thesis work within their own primary field, HSW is a sub-profession (of social workers) in a sub-field of social work (the medical context; Sjöström, 2014). This means that it is a minority profession and often the one that characteristically contributes a more distinct social perspective within this medical context. This shapes certain conditions for the status of HSWs in the medical hierarchy, for their positions and professional strategies in health care settings and for their work with children suspected of being at risk.

The HSW was established at the beginning of the twentieth century when parallel movements advocated the need for a holistic and social perspective in health care that would address the poverty and social problems of patients (Olsson, 1999) and because different hospital personnel assembled around work duties that came to fall on HSWs (Abbott, 1988). As the social insurance and social welfare system developed in Sweden, the HSW changed from being primarily about discharge planning, mediation and coordination of resources to include investigation and motivation work, and giving of information and advice on how and where patients could claim their benefits and rights (Olsson, 1999). Besides the increased interest in psychology and psychoanalytic theories from the 1920s together with the increased autonomy, the HSW came to deal more in counselling and therapy. This bias towards individual therapeutic development (in which other professions are also involved) has partially alienated the HSW from other social work, weakening the profession (Olsson, 1999; Sjöström, 2014). However, Kullberg (2011) points out that social workers in health care more often than other social workers have further education and are seen, to a higher extent, as experts.

Unlike most other professional groups in the health care setting, HSWs (or social workers in general) are not included in the Patient Safety Act (SFS 2010:659), which regulates the licensing of health care professionals. The National Board of Health and Welfare (2014c) has recommended the establishment of a licensure for medical social workers (all social workers employed within health care institutions), and in March 2016, the Government ordered a proposal on how the examination for the licensure

should be constructed, but medical social workers are still not licensed with a protected professional title. The National Board of Health and Welfare's guidelines (2014b) stress the necessity to integrate psychosocial aspects into medical care for cancer patients – however, HSWs are not mentioned at all, instead 'contact nurses' are named for bearing this responsibility. Although the number of HSWs has increased to some extent since the 1990s (Sjöström, 2014), the privatization of health care has probably slowed down this development: only about 4 per cent of the approximately 5100 medical social workers in Sweden are employed within private health care (National Board of Health and Welfare, 2014c), which constitute about 15 per cent of specialized health care and 32 per cent of primary health care (Andersson, Janlöv & Rehnberg, 2014).

These are not the only barriers to HSW professionalization. As Abbott (1988) outlines, commonly shared definitions of work tasks, skills and classification systems are of vital importance for describing professions and their jurisdictional boundary work. Research on HSWs often points at the blurred and varied definitions of the profession's tasks and role however (Cowles & Lefcowitz, 1992; Davies & Connolly, 1995; Sjöström, 2014), sometimes expressed as challenges in articulating and conceptualizing some of the actions and applied knowledge of HSW practice (Skedsmo & Geirdal, 2011). In some countries, the HSW's tasks are described as primarily consisting of discharge management and mobilization of community services (Davies & Connolly, 1995; Wong, Chan & Tam, 2000; Holliman, Dziegielewsk & Datta, 2001; Olsson, 1999), and psychosocial assessment and treatment (Holliman, Dziegielewsk & Datta, 2001; Olsson, 1999), even though health care professions sometimes have different expectations of what the HSW's tasks are (Cowles & Lefcowitz, 1992; Wong, Chan & Tam, 2000). Cowles and Lefcowitz (1992), for instance, found that physicians and nurses expected the distinctive domain of the work of social workers to be limited to assisting patients and their families to obtain the community resources they needed for their social, environmental and emotional problems, while a majority of the social workers expected their unique role to include assessment and treatment of those problems.

In Sjöström's (2014: 136-137) comparison between Sweden and Germany, Sweden stood out as having difficulties agreeing on the commonly shared and collective profession-specific work tasks of the HSW, partly explained by it depending on the specific work field in question. Both countries "included social and psychosocial counselling, co-operation with other professionals both inside and outside health care, and co-ordination of services" (p. 135), but, over time, Sweden has gradually changed the definition away from structural social work and arguments that social factors and health have a mutual impact, to a more psychosocial approach with individual treatment as a characteristic element of HSW practice. The general increased standardization concerning work tasks can be seen in the Swedish HSW, like elsewhere, but the fact that the professional organization of HSWs, *Svensk Kuratorsförening*, has named them as recommendations or drafts, has, according to Sjöström (2014), reduced the pervasive power of the professional organization's efforts. Moreover, many Swedish hospitals lack HSW organizations, which mean that HSWs are often employed directly by the health care clinics. Consequently, their relation to other HSWs is hypothetically weaker than that between those who belong to HSW organizations, and there is a lack of an HSW leader promoting HSW issues. Mizrahi and Berger's (2001) study of HSW leaders within the United States stresses that HSWs need leaders who understand the complexities and challenges within the organization as well as in society and who have the commitment, competence and confidence to contribute to a change of direction for the profession. The way HSWs are organized has profound consequences for their professionalization and jurisdictional strategies.

Sjöström (2014) outlines two different jurisdictional strategies that professional subgroups such as HSWs can perform: the mimetic (in Sweden) and the aposematic (in Germany) strategy. The mimetic strategy is described as the subgroup trying to blend into its surroundings by pronouncing its differences from the original discipline and profession and becoming closer to the professions in the current organizational setting, for example by adopting this discipline's theories, narratives, organizational structures and logic. In the aposematic strategy, the subgroup instead pronounces its similarities to its original discipline and profession and attempts to distinguish itself

from the surrounding setting by using the primary discipline's knowledge base, theories and methods.

According to Sjöström (2014), the blending-in strategy promotes HSWs as part of multi-disciplinary work in a stronger manner, a development supported by the WHO (1998) in an attempt to encourage teamwork based on the mutual respect for expertise of the various professions. However, several studies (Frost, Robinson & Anning, 2005; Kadushin & Kulys, 1995; McMichael 2002; Werner & Carmel 2001) have shown that the experience of HSWs is of having a secondary role in health care settings and a lack of recognition and support from other professionals – leading to difficulties in collaboration. In some countries, for example Israel (Weiss, Spiro, Sherer & Korin-Langer, 2004), and hospitals, which is the case in Sweden, the subordination of HSWs has been handled by the establishment of HSW departments, which has developed professional autonomy and intra-professional support. In spite of the different obstacles to being a sub-profession, HSWs seem to promote and be quite motivated to take part in inter-professional collaboration compared with other hospital personnel (Abramson & Mizrahi, 1996; Harr, Fairchild & Souza, 2008).

There are no studies that explicitly analyse medical or HSWs' work with children at risk from the perspective of jurisdiction, but there are some that analyse their role and inter-professional work in these cases. For example, the interdisciplinary work between dieticians and social workers seemed to improve the responses of both professional groups when dealing with bio-psychosocial risk factors among children, although Shor (2010) also found that the social workers' role needed to be more clearly defined. D'Cruz (2004) shows in her in-depth analysis of a child maltreatment case that an HSW who relied on a medical practitioners' description of a child's bodily injuries ended up with alternative problem descriptions being actively excluded, an approach that limits involvement in family problems and possible preventive and supporting services.

Haultain (2011) showed that inter-professional work with maltreated children at a hospital in New Zealand was affected by personal qualities and the professionals' competence, and she argued that HSWs need to be visible, accessible and contribute actively in both practice and the policy arena. Another study (Connolly, 2012) in

Australia evaluated the experiences of implementing a model in which suspected at-risk children were referred to the HSW department within the hospital, which then took command of the work. I would argue that this model is an example of HSWs having obtained more formalized jurisdiction over child maltreatment tasks. In this model, the HSWs' role became clearly defined to ensure coordination between the teams and external agencies to offer families emotional and practical support to conduct psychosocial assessments and reporting. Connolly (2012) found that the HSWs' service to at-risk children was of high quality, and ensured continuity of child and family care, and efficiency improved when the duplication of tasks was reduced. However, the higher concentration of child maltreatment issues at the HSW department meant that some HSWs without the necessary skills or interest in this task decided to work elsewhere.

DISCRETION

The professional discretion to make assessments and decisions about a patient is often defined as what characterizes professionalism (Lipsky, 1980) and as lying at the very heart of professional work (Wallander & Molander, 2014; Freidson, 2001). This is based on the assumption that the knowledge of professionals should be used in their assessment and decision-making and that the system of professions may itself not even be necessary if there is no area of discretion in which they are supposed to use their knowledge. Discretionary power is given on the basis that professionals are trusted as being capable of making assessments and carefully weighted decisions. At the same time, professionals who have been delegated discretion have restrictions and are accountable for their assessments and decisions.

In 1977, Dworkin formulated what became an often used definition of discretion when he argued that “the concept of discretion is at home in only one context; when someone is in general charged with making decisions subject to standards set by a particular authority” (1977: 31-32). He visualized discretion as a doughnut that has an area left open by a surrounding belt of restrictions. The restrictions and standards given vary depending on what the specific authority has decided. Even though professional discretion is described as positive, restrictions are often seen as necessary

to manage extensive use or carelessness in work. Swedish professionals who choose not to make a report despite having information that a child may be at risk of harm can, for example, though it may be unusual, be prosecuted and convicted for misconduct (Supreme Court, 2014). However, Dworkin suggests that it is not only laws and policies that function as restrictions and argues that because laws are connected to moral principles, morals can be regarded as restrictions. Furthermore, the standards and restrictions set by authorities may be orders given by a leader within an organization and must therefore not be written rules or principles. From Dworkin's perspective, discretion involves navigating between conflicting rules and principles, but the fewer the restrictions, the wider (or stronger) the discretion (ibid.). However, the belt of restrictions is still what the specific authority has decided, in this case: when a professional suspect a child may be at risk, a report should be made. Theoretically, this means that the professional does not have the discretion to assess how to act, as long as there are no conflicting standards or rules given by authorities. Such conflicts could arise, for example, when a professional is told by someone in a leading position not to report a suspicion.

While Dworkin (1977) discusses discretion as something that is framed by standards and rules, Sosin (2010: 385) discusses discretion as being dependent on goals and argues that "...discretion arises from direct conflicts between goals, such as between equity and equality, treatment and control", although these are not the only goals for organizations and individual professionals in their work. Furthermore, Lipsky (1980) suggests that discretion depends on several inherent conditions of work that affect the goals, such as limited resources, large caseloads and lack of training, which impose on both organizations and personnel to prioritize and sort among work tasks and thus decisions on how to act. As professionals who work at what Lipsky calls 'the street level' of the welfare often lack resources, he argues that local routines are developed to manage workflow, helping the professionals to decide on whom and what problems they should focus.

“I argue that the decisions of street-level bureaucrats, the routines they establish, and the devices they invent to cope with uncertainties and work pressure, effectively become the public policies they carry out” (Lipsky, 1980: xii).

Even though there is legislation and policies, Lipsky (1980) stresses that it is the professional’s routines and simplifications that are the policies performed in practice. From this perspective, one way to manage the uncertainties of when to decide to report concerns about children who may be at risk is to develop certain routines for certain types of risk situations. Such routines could be seen during the data collections for this study, for instance when some physicians at a ward asked me if their daily routine-based reports about underage teenagers’ alcohol or substance use should be regarded as reports about children at risk in this study. By establishing a routine to report this particular problem, some of the physicians no longer automatically associate this particular problem with the other forms of suspected risks they are mandated to report. Reports of children at risk are often called ‘worry reports’ (‘*orosanmälan*’ in Swedish) and are often thought of as a difficult task, but an established routine seems to reduce the feeling of making a tough assessment and decision, and thus shrinking the discretionary space regarding particular situations.

Goal conflicts can also be about situations in which professionalism is in conflict with guidelines coming from above. For instance, Persson and Svensson (2012) showed that there were discrepancies between organizational ambition that pre-sentence reports (which determine if there are extenuating circumstances) written by probation officers should focus more on risk assessment of the offenders and the reports’ actual outcomes. The officers, who were mostly social workers, tended to focus on the offender’s needs and social situations more than the risk factors, regarding the risk of re-offending. The authors suggest that this may be understood as the report writers using their professional discretion based on a professional ideology that differed from the risk focus (*ibid.*). Thus professional norms may broaden the discretionary space, despite clear and narrower guidelines about how assessments should be made.

The fact that the obligation to report suspicions about at-risk children is considered a definite obligation and the fact that health care professionals often decide not to report despite having a suspicion show that the discretion is wide in practice. *What happens within this wide discretionary space is the very core of this thesis. What makes this discretionary space so wide and how can we understand the possible consequences for the children?*

Researchers discussing discretion often point out the risks with wide discretion as it may have serious consequences for patients. Sosin (2010) argues that these risks are often controlled from the top of the organizations with policies and standardizations, though this can promote unequal treatment. This thought is further developed by Molander and Grimen (2010) who observe that the extensive practice of discretion can lead both to unjustified unequal treatment (i.e. cases that are factually, morally or legally similar are treated differently) and to unjustified equal treatment (i.e. cases that are factually, morally or legally different are treated equally). They develop the reasoning that professional discretion is limited by norms or rules stipulated by an authority but at the same time have autonomy when they argue that the professionals, within this autonomy, in a cognitive way *reason* about what ought to be done. Several researchers suggest that the distinction between discretionary space and discretionary reasoning is crucial in discussions about how problems of discretion, such as unjustified un/equal treatment, should be handled (Molander & Grimen, 2010; Molander, Grimen & Eriksen, 2012; Wallander & Molander, 2014). Molander and Grimen (2010) suggest that this reasoning consists of a described *situation* in combination with a *norm* that results in a specific *action*. The authors argue that norms are what bridge the gap between a situation and an action and that without norms, people would not know what to do in different situations. A norm of action is usually not defined but stands for the way we are expected to act in a certain situation. However, they argue that there are also *deontic norms*, norms about what someone is obliged to do. For example, if a child is supposed to be at risk, hospital professionals are mandated by law to report it.

Wallander and Molander (2014) argue that studies on discretionary reasoning should not be narrowed to the action phase but also consider the earlier phases in

assessment processes. They present a combined conceptual and methodological frame (in the form of a factorial survey and the use of multilevel regression analysis) to study how cognitive activity is carried out by professionals who make judgments and decisions and argue that:

“While *norms of action* bridge the gap between descriptions of situations and conclusions about what to do, *rules of identification* bridge the gap between data and conclusions about what is the case (descriptions of situations).” (Wallander & Molander, 2014: 4, my italics).

To exemplify in the context of this thesis: when personnel gain *information* (or perceive sign/s) that a child may be at risk, there are *rules of identification* (e.g. institutionalized definitions of risks) that bridge the gap to the *conclusion* that there may be a problem or risk. Wallander and Molander (2014) state that this process of identification is a vital one that occurs before a professional considers norms of action about what to do. Thus, discretionary reasoning is described as forming a continuum. They further suggest that agreements and disagreements in discretionary reasoning may be better explained by including respondent and contextual variables as predictors in the model. They argue that this would make it possible to analyse how, for example, gender stereotypes influence discretion and reveal how implicit/tacit rules or social norms are involved in discretionary reasoning (ibid.).

As mentioned, this thesis focuses on exploring what happens within the discretionary space. The thesis involves discretionary reasoning, although it focuses less on reasoning as a continuum, starting from noticing signs and ending with an action as described by Wallander and Molander (2014) among others. I do not suggest that such a linear perception of continuum is irrelevant – it is a relevant understanding of practices, especially for constructing the frame within which assessment is supposed to be made in social services. The legislative and time limitations in social services require clear and fixed start and end points for several reasons. In this thesis, the continuum is considered as a process with fairly open start and end points. I do not only explore the detection of risks, there is a discursive exploration of how ideas of

risks are (re)constructed in HSWs' narratives, which involve discourses about risks that have been (re)constructed throughout the decades. Additionally, the thesis opens up the end point after a decision has been made: do the participants feel afterwards (when the data collection was made) that they should have made a report, even though they decided not to do so at the time?

Moreover, the thesis's approach to discretion as space means that discretion is more than cognitive reasoning (cf. Molander & Grimen, 2010; Wallander & Molander, 2014). What happens within the discretionary space depends on situational, social and emotional dimensions. Assessment is thus understood as a social process that involves the organizational context and conditions, the inter-professional relations and other social and emotional factors. Such factors are intertwined in cognitive reasoning, but the focus in this thesis is rather on enhancing the understanding of what such factors mean for professional discretion and what the consequences may be.

The social dimensions of interest include the way various norms are involved in discretion. As the observant reader may have noticed, several forms of norms have been mentioned, and I suggest that a conceptual distinction is necessary to avoid confusion. Some researchers on discretion point out the importance of social norms in discretion but use the concept of social norms in a blurred and unspecified way (e.g. Sosin, 2010). In attempting to make analytical meaningful and useful distinctions, I will refer to three different kinds of norms. Firstly, norms can take the form of professional norms based in educational and cultural differences between professional groups (see, e.g., Sjöström, 2014) in particular contexts. Here, such norms are called *institutionalized norms*. Secondly, there is what Molander and Grimen (2010) call *deontic norms*, what we are obliged to do; here primarily understood as the mandated reporting. Thirdly, there are *social norms* based on, for example, gender, ethnicity, (dis)ability and class, which are of particular interest to this thesis's approach to discretion. These conceptual distinctions do not disregard that all norms are basically social and that social norms may be institutionalized and legally sanctioned – it serves to unpack the blurriness often inherent in theories of discretion, as well as highlighting that social norms may have their own particular meaning in discretion. Some studies suggest very briefly that professional discretion is characterized by power relations

involving categorizations of clients and unequal treatment based on, for example, gender (Wallander, 2012) or disability (Molander, Grimen & Eriksen, 2012), phenomena which can be further explored methodologically (Wallander & Molander, 2014), but there is a lack of theoretically driven studies about *what social norms do in professional discretion*. Such an attempt could hopefully enhance our understanding of how certain social groups are categorized and assessed differently from others by professionals. Although there is a lack of research that explicitly links theories of professional discretion and theories of normativity, there is research on how social norms and categorizations are related to professional risk assessment.

NORMS AND NORMATIVITY IN RISK ASSESSMENT

The knowledge and norms that influence assessments not only come from authorities, professional disciplines and education but rather many things that we ‘know’ are grounded in (re)created discourses in the particular society in which we live. Which problems we worry about may be influenced by taken-for-granted assumptions rooted in social norms in a particular time and place (Loseke, 2003). This section focuses on social norms and normativity and the relation to the general concept of risk and thereafter discuss how this relation may influence the assessment of children at risk.

Norms, normativity and the ‘risky others’

Loseke (2003) argues that there is no automatic relationship between objective indicators and the social problems we worry about, which means that what evokes worry may be influenced by taken-for-granted assumptions of what is and is not normal. However, normal is often difficult to concretize because it is defined through that which deviates. The meaning of ‘normal’ tends to be associated with something ordinary as it constitutes the deviate, a deficiency or the undesired, and we tend to value the normal as an ideal or how something ought to be (Hacking, 1990). This way, the ordinary is made invisible and therefore perceived as neutral and not associated with the social problems and risks we worry about (Giritli Nygren, Fahlgren & Johansson, 2015). However, the ordinary or ‘normal’ position involves the power and

the privilege to define what deviates because a 'normal' and privileged position becomes the basis for measuring success and failure (Pease, 2006). This thought is valuable for understanding how social problems and risks are constructed in the daily work within welfare institutions where risks tend to be associated with underprivileged social groups.

To better understand how this is done, I use the reasoning that normativity involves a process of 'othering' (Dominelli, 2002). The processes of othering can be described as one of categorization and boundary drawing between 'us' and 'them' that is central to the norms that construct normality at a specific time or place (Svensson, 2007). Categories such as gender, nationality/culture, class and (dis)ability involve power relations and become the bearers of 'us' and 'them', where the privileged 'we' – the dominant group – has the power to define the deviant 'them' (Dominelli, 2002: 17). In such a way, the privileged 'we' constitutes a certain belonging that tends to shape a distance to the 'others' and constitutes 'them'. For example, Sawyer (2008) points out that, particularly in the Swedish context, belonging is often constructed in terms of national or geographic space and processes of racialization, terms that are distinct but often formulated together in a blurry way. This blurriness is embedded within terms that are used to define 'insiders' and 'outsiders', for example the negative loaded term 'foreigners' ('invandrare' in Swedish), which involves intersections of 'race', gender and class. Since the 1960s, the term 'different culture' has been widely used to explain 'foreigners' social problems in Sweden (Sandberg, 2010). The process of 'othering' thus often involves the 'other' being perceived as being a risk or blamed for causing risk, and different forms of risk management maintain boundaries between social groups (Olofsson et al., 2014).

Singling out already socially excluded or marginalized groups as 'risky others' is made possible by risk explanations grounded in moral discourses about social stereotypes and norms. Giritli Nygren, Öhman and Olofsson (2016) discuss how risks relate to social norms and argue that people who do not conform to contemporary normative notions become 'risk objects'. They point out that risk results from the interaction between various risk objects and society's expectations of how one should live one's life and with whom. While those who are considered non-risky are

constructed as normal, those who deviate from this norm become constructed as risky and immoral (Hunt, 2003).

The construction of risks is intertwined with that of differences, which are used in the struggle over values and morals (Montelius & Giritli Nygren, 2014, p. 440). Morals enable people who share the same common values to draw boundaries around what is right and wrong (see, e.g., Sayer, 2005), a basic foundation in risk construction. In this boundary drawing of right and wrong, risks and social problems are articulated as troublesome problems that require normalizing actions, often performed by social work.

Normativity and normalizing in social work practice

Social work cannot claim to rest on neutral professional values since it is governed by the state, legislations and political decisions. Thus, social workers assess, judge and deal with or 'fix' social problems on behalf of the public society and the morals and values inscribed in legislation and policies (Payne, 1999; Hamreby, 2004; Mattsson, 2005). Mattsson (2005) describes social work as a normalizing practice because it aims to uphold 'the normal' according to society's norms and values. As social work strives to deal with social problems it can also be said to strive for the normal. Normalizing social work with children can be basically be understood as the striving for children's equal opportunities and rights to a normal life and development, without being exposed to harm.

However, there are different perspectives on what normalization means. Wolfensberger (1972) argues from a functionalist perspective that normalization means that people living under disadvantaged conditions should have the opportunity to experience mainstream society's patterns in their daily lives. This perspective is based on the presumptions that people who are defined as deviant from the 'normal' should be normalized into the dominant mainstream society. Chappell (1992) raises criticism against this view, for example by pointing out that it upholds power imbalances, as professionals are in power to categorize people, judging whether their conditions motivate services and interventions – and control to what services those people should have a right. Chappell argues that this perspective on normalization

maintains power imbalances in that it does not change the very foundation of power structures and unequal material conditions. The unequal material conditions as well as the categorization of people as deviant are socially constructed by mainstream society; they are not located in the individual (*ibid.*). Thus, while normalization, on the one hand, means the striving for equal rights and opportunity to a ‘normal life’, on the other hand, it means a (re)construction of people as deviant. This ambivalent two-sidedness of normality and normalization constructs tension that seems to be imbued with social work practice.

The idea of the HSW as a normalizing practice, in terms of promoting a normal life under nonstandard circumstances that can be a consequence of living with illness or disabilities, is certainly not new (see, e.g., Berkman et al., 1990). However, there is a lack of previous studies about normativity in HSWs’ work with children suspected of being at risk. The following examples of normativity and normalization in social work with children at risk are therefore drawn from the Swedish child welfare system, which has a long history of being a normalizing practice, influenced by social norms based on class, gender, ethnicity and (dis)ability (Hamreby, 2004; Lundström & Sallnäs, 2003).

What actions are used in attempting to normalize the life of children at risk partly depends on what or who is perceived as causing harm to the child. Taking poverty and the class perspective as an example, it was discussed in the subsection ‘The rise and development of risk definitions within research’ that child poverty is often understood within the family setting, and that risks as well as solutions are assumed to lie within the family rather than the poverty itself (Scatron, 1997). In a similar way, Lundström and Sallnäs (2003) outline that the problems of working class families have been considered as a lack of moral rather than material resources, especially in the early 1900s. This meant that a great majority of those in contact with child welfare or placed in institutions or foster homes were working class children, a tendency that has remained throughout the decades even though there have been political efforts to improve the socio-economic conditions among working class families.

Additionally, there is a range of studies showing how gender norms have influenced Swedish child welfare professionals’ assessment during the 1900s. For

example, Hamreby (2004) shows that girls have often been considered as sexually immoral and promiscuous within child welfare, while the worries about boys have concerned their criminal and aggressive behaviour. These children were working class children who were perceived by the middle and upper classes as immoral and a threat to society's order. In the beginning of the 1900s, the normalizing of these children consisted of subjecting them to fostering intervention and, if considered necessary, separating them from their immoral parents.

Gender norms also characterize how good and inadequate parenthoods have been described within welfare institutions. In the 1950s, the ideal parenthood became more clearly pictured as based in the heterosexual nuclear family in official documents in Sweden (Hallberg et al., 2005). Even though the fathers' role has been strengthened through gender equality reforms, and parenting has been formulated as an individual responsibility since the 1970s (Bangura Arvidsson, 2011; Hallberg et al., 2005), the idea of mothers as the main caregivers has remained a normative foundation imbedded in professional assessment. The heterosexual nuclear family ideal, expressed as the child's need for both a mother and a father who can complement each other's parenting, has resulted in single mothers having been regarded as a risk group and being overrepresented in child welfare due to economic constraints, and their parenting has also been problemized (Bangura Arvidsson, 2011; Johansson, 2006). Some studies show that it is the mother's conditions and the ideas about normal parental behaviour that orient assessments rather than the possible risks to the child (Parton, Thorpe & Wattam, 1997; Egelund, 1997), and other studies show that it is the mother's parental capability that is investigated by social services, while the father is almost absent in the investigations (Andersson, 2010; Höjer, 2009; Franséhn, 2003; Johansson, 2003). As mothers are perceived as the main responsible parent, social workers' risk investigations tend to focus on them. The flipside is that fathers' parenting is made invisible even in cases when they cause danger to the child. While a good mother expects to take full parental responsibility, a father can give away as well as be taken away more easily from his parental responsibilities (Bangura Arvidsson, 2011). The heterosexual nuclear family norm has been shown to rest on a biological discourse in which a father can be described as a bad or even dangerous parent, at the same time he

is described as an important and ‘good dad’ based on being a man with biological ties to the child (Eriksson, 2003; Johansson, 2006).

What is constructed as ‘good parenting’ in a society is also influenced by norms based on nationality and culture. There may be various ideas about what good parenting and child rearing mean in different countries and cultures (Reisig & Miller, 2009; Östberg, 2010) and which social workers may experience in their work – but studies also show that social workers in Sweden tend to overemphasize culturalized explanations in risk assessments of immigrant or ethnic minority families, rather than emphasizing the individual or socio-economic explanations used for families of the majority population¹ (Pringle, 2010; Soydan, 1995; Williams & Soydan, 2005; Östberg, 2010). Soydan (1995) describes this as an ethnocentric approach among social workers: immigrant families are assessed from the perspective that the dominant culture in Sweden – which is the social workers’ context – is the best one. Östberg (2010) argues that when social problems are culturalized, the social worker tends to focus even more on the parent, meaning that normalizing actions focus on the parents, for example by informing and educating the parents about what is considered acceptable forms of child rearing in Sweden (Östberg, 2010).

Most studies that analyse normativity in Swedish social workers’ risk assessments focus on gender, class and/or racialization/culturalization. There are very few in-depth analyses of what ‘normal’ and ‘ordinary’ mean in Swedish social workers’ assessments of families, but one example is Sawyer’s (2012) intersectional analysis of constructions of normality within a family assessment home. Sawyer found that the term ‘orderly life’ alluded to economic sufficiency, limited social welfare service contact and colour blindness and was linked to a nuclear heterosexual organization of family life. Normal parenthood is thus constructed around ideas that are linked to norms about gender, sexuality, class, (dis)ability and nationality (and/or culture or ‘race’), which implies that ‘risk parenting’ tends to be associated with those who do

¹ Although the last decade’s research outlines an overrepresentation of children who are, or whose parents are, born abroad within child welfare institutions (Andersson Vogel, 2012; Vinnerljung, 2001), it has been shown that this overrepresentation disappears when taking socio-economic factors into account (Vinnerljung, Franzén, Gustafsson & Johansson, 2008).

not conform to contemporary normative notions. Sawyer (2012) also found that normativity was closely linked to emotions in risk assessment and shows that risk assessment is emotion work.

THE SOCIALITY OF EMOTIONS

So far I have discussed how normativity is involved in risk assessment and professional discretion, and in this final theoretical section, I will argue that social norms are linked to emotions, which are also vital in discretion. The early social scientists' research on emotion focused primarily on cognition², but in the 1960s Goffman (1959; 1967) stressed a social perspective, arguing that emotions are a natural part of human relations in organizations because people are trying to avoid shame and embarrassment to maintain respect from others. It was not until the 1970s that sociality of emotions became established when Hochschild (1975) developed Goffman's theory and introduced the concepts *emotion work* and *emotion management*, a theory she developed in a more systematic way a few years later in her work *Managed heart* (Hochschild, 1983). She claimed that emotions are produced and formed socially within certain cultural frames that shape emotion rules about right and wrong emotional expressions in a given situation. In this way emotions have a basic function as they orient people in social contexts.

Emotions and feelings

Emotion researchers use a range of different descriptions about what emotions and feelings are or should be understood as, and there is no common inter-disciplinary definition. The word *emotion* is based on the Latin word *e movere*, which means 'to put in motion', usually associated with physical movement (Wettergren, Starrin & Lindgren, 2008: 23). Much of the attention has focused on the psychological and biological perspective to show how emotions are linked to bodily changes (Lupton, 1998). The growing field of studies on the sociality of emotions has focused less on

² As can be seen in the section 'Discretion', studies on discretionary reasoning still emphasise assessment and decision-making as a primarily cognitive activity.

where the emotions are located. Instead, Ahmed (2008), for example, put emphasis on *what emotions do*, in terms of how they move and are productive in social life, instead of studying emotions as things that people have. This perspective refuses the opposition between the biological and social perspectives and means that emotions may involve bodily effects such as blushing or an increased heartbeat. These experiences of embodiment are always in the process of being constructed through and mediated by cultural and social circumstances (Lupton, 1998). Munt (2008) also points out that the body itself can be the source of shame, such as in chronic illness or disorders, because of what the dominant ideas of health and well-being dictate through the idealization of norms. She further means that shame tends to leave a residue to which other emotions are easily attached, as hate, contempt, humiliation, rage, mortification and disgust.

It is common that researchers study specific and previously chosen emotions, such as shame or hate, and argue, often from a bio-psychological perspective, that it is necessary to clarify if an emotion actually can or should be defined as an emotion. Thus, the thesis also uses the term *feeling*, which is considered a broader concept, for instance by Wettergren, Starrin and Lindgren (2008: 23) who claim that while all emotions are feelings, all feelings are not emotions. To exemplify, some emotions and feelings, such as worry or ambivalence, were defined before the thesis studies were conducted, but the qualitative analysis also showed how informants describe ‘feelings of’, for example, distance or withness (see also subsection ‘The stickiness of normativity’). Feelings of distance or withness cannot be defined as emotions, instead they are considered as feelings. Moreover, the informants did not necessarily articulate that they *felt*, for example, distance, some of these findings resulted from the analysis searching for feelings that were embedded in informants’ formulations. This analytical approach is based on the argument that people may be unaware of their feelings, unconscious feelings that are foundational for the social processes in which they are involved (see, e.g., Sheff, 1988; Turner & Stets, 2006).

Emotions as (ir)rational motivation to act

The conventional approach since the Enlightenment holds that emotion and reason are binary (Barbalet, 2004; Munt, 2008), and emotions have been described as irrelevant or an obstacle to good judgement (Ahmed, 2008) or even as a dangerous element in public society that should be left at home (Parsons, 1964). In the last decades, this binary relation between emotion and reason has been questioned and increasingly considered as interdependent rather than binary, and emotions as being involved in rational decision-making. It is argued that rationality and emotion are an important mechanism behind motivation, and that rationality is closely linked to people striving for positive emotional payoff (Collins, 1993; Illouz & Finkelmann, 2009).

However, Barbalet (2004) problematizes that the rationality of emotions only serves goals of self-interest and argues instead that there may be goals of conflict or goals about socially moral behaviours that are sometimes ruled out in legislation with expectations of commitment. The emotions themselves are neither rational nor irrational. Whether they become (ir)rational depends on whether they contribute to achieving a particular goal or cause harm or damage from a particular perspective. Taking mandatory reporting as an example of such a goal, Barbalet's (2004) reasoning can be understood as the specific emotions activated when facing children who may be at risk and can be considered as rational or irrational depending on whether they serve to realize the goal of mandated reporting. Feeling sadness for a maltreated child from this perspective is rational if the act resulting from it serves to establish the goal that the child gets support or protection. Feeling frustrated about the lack of feedback from social services can (no matter how understandable) be considered as irrational if it means that no report is made.

Mandated reporting is a goal that requires commitment from health care professionals. Barbalet (2004) argues that all goals have inherent emotions imbedded in them that contribute to people feeling committed to fulfilling the goal. Hochschild (1983) uses similar reasoning when she describes her concept of feeling rules at workplaces. Feeling rules can be understood as the emotion work required to establish an institutional norm or obligation. In this thesis, feeling worry about children who may be at risk is considered to be imbedded in the mandated reporting, and thus

considered to be a feeling rule. Professionals must feel some kind of worry for the child who they consider may be at risk of harm, otherwise they would not consider making a report.

However, there may be conflicting goals when a worker who feels worry about a child at the same time lacks feelings of trust in social services intervening if a report is made. The conflicting goals become even stronger if the worker feels anxious that making a report may destroy the relationship with the parents. When there are conflicting goals and ambivalences, legislative clarifications can attempt to solve them by, for example, stating that reporting is not only desirable but also that breaking mandated reporting is regarded as a misconduct for which personnel can be prosecuted and convicted (see, e.g., Supreme Court, 2014). This may be understood as an attempt to force a goal of commitment to be a question of self-interest: A professional who wants to avoid feelings of shame probably also avoids being categorized as a wrongdoer and lawbreaker. As Munt (2008) points out, societies require a degree of remorse and shame from wrongdoers.

What is considered as rational is constructed in a particular context. Illouz and Finkelman (2009) describe rationality as a cultural construct, a historically bound cultural practice that is a powerful component of action. They point out that rationality is not necessarily a conscious weighing of pros and cons but rather can take non-conscious forms where reasoning takes shorter and faster routes. When people draw snap judgements about others, problems or situations, non-conscious thoughts are activated involving past experiences, memories and the emotional meanings imbedded within those (Ahmed, 2008; Illouz & Finkelman, 2009; Sawyer & Fahlgren, 2016). The conscious and non-conscious process of judging and weighing pros and cons is often emotionally ambivalent. Smelser (1998) suggests that such ambivalence is rational in the sense that it is logical and may even conduce to further reasoning in decision-making.

Ambivalence is tightly related to the uncertainty of what a decision may lead to in the unknown future (Barbalet, 2004; Fahlgren, 2009). You can never be sure that a report will result in social services taking appropriate decisions and that everything will be fine for the child. A way to overcome this uncertainty of the future is to make

it feel rational to report anyway, creating a feeling of certainty (Barbalet, 2004), for instance with the support of a feeling rule (Hochschild, 1983) that contributes to the particular goal. At the same time, the goal of mandated reporting requires feelings of commitment, and the realizing of this goal requires personnel to feel some form of trust in the child welfare system and social services. Barbalet (2004) argues that trust can overcome the uncertainty of the future, precisely because it is an emotion – you can never know the facts of the future. Trustful relationships are thus a vital foundation of a system that feels rational by those who take part in it – and it is highly valued by welfare professionals, as well as the patients and clients who are dependent on the professionals. Trust is, perhaps, even more important in unequal relations.

Emotions and normativity in boundary drawings at the workplace

Emotions not only have a function to set moral boundaries for what is the right or wrong thing to do, they are also involved in status and power relations at workplaces. Turner and Stets (2006) suggest that the emotions workers feel depend on their expectations of their particular position, and they argue that gender, ethnicity and age are factors that structure people in different status hierarchies in organizations. This goes back to different emotions such as confidence, resentment, shame and fear being distributed differentially, not only within workplace hierarchies but also across social groups that possess varying levels of power and status (Barbalet, 2004).

Hochschild (1983) became a pioneer of the perspective that emotions are involved in – reconstructing or challenging – the boundary drawing of normativity at workplaces. She argues that emotion work is based on social norms such as gender and class, and the way emotions are experienced, performed and managed by workers depends on the institutional setting. She points out that different professions' emotion work relates to their class differences. For example, she argues that people who belong to the middle class have had more training in managing their feelings than people in the working class, which is related to middle class occupations more often being involved in emotional labour. Working class occupations, on the other hand, are less dominated by feeling rules, even though they have the least chance of setting such rules due to the authorities having a certain mandate over feeling rules (ibid.). Using

Hochschild's perspective: physicians, nurses and HSWs would thus have had most training in managing their feelings and be most likely to follow feeling rules that worries about children should be reported, while the working class nurse assistants would hypothetically be less restricted by this feeling rule.

Although Fineman (2003) does not articulate the class differences between professions, he notices that, for example, physicians and social workers who often perform emotion work in terms of professionally dealing with other people's emotions often strive not to express their own feelings. There are several studies supporting this idea, arguing that middle class professionals who perform a great deal of emotion work are supposed to act neutral themselves. For example, social workers are expected to put their own feelings aside (Taylor & Devine, 1994) and react in an 'appropriate' way in accordance with professional emotional rules disguised as ethical codes and professional techniques (Zembylas, 2002), which entail socialization while emotional behaviour involves neutrality and universalism (Olesen & Bone, 2009). Following Spafford, Schryer, Campbell and Linigard's (2007) study, there seems to be a difference between social work and medical students coping with emotions such as uncertainty, with the medical students believing such emotions should be avoided and the social work student believing they should be managed. It thus seems that as the promotion of neutrality and emotional distance increases in the hierarchies, the class levels and the male-dominated professions (see also Davies, 1996).

Whereas working class occupations involve less emotion work, it is suggested that their emotion work is formed from their particular position (Hochschild, 1983; Fineman, 2003). According to Fineman (2003), personnel experience stress when they consider a work task to be beyond their capacities, which can be related to lack of education, training and experience of the task, and Neckel (1996) considers inferiority an emotional dimension of social inequality. Neckel suggests that inferiority involves power but that it is not necessarily the same as feeling powerless. Rather it is about an asymmetrical social relationship that can take the form of struggle and competition in working life. Similarly to Fineman (2003), Neckel (1996) suggests that inferiority is common when people are or feel excluded, do not have access to information, or feel incompetent and recognize what others are capable of. Neckel argues that in such

situations inferiority means that these people or professional groups avoid competition and strive only for what they are already entitled to do. By limiting the ambition and competition, the feeling of inferiority can be reduced.

As mentioned earlier, inter-professional team work has been strengthened in the last decades to promote mutual respect for the expertise of different professions (World Health Organization, 1998) and to make different professions work closer together. According to Lindgren and Olsson (2008), this has resulted in the hierarchies having become less strict, and in their interviews with health care personnel, they found effects on the personnel's emotion work. The authors argue that the former strong intra-professional emotional support was loosened, especially at bigger hospitals where a large number of professionals replace each other in the teams in such a way that they no longer have the chance to build lasting inter-professional emotional support. Rather than obtaining intra-professional emotional support, Lindgren and Olsson (2008) argue that nowadays, professionals have to engage in the emotional management of frustrated teams, which I showed earlier involves negotiation of roles and tasks.

The stickiness of normativity

Within emotion sociology, there is a common understanding that emotions emerge in social interactions and are the very source of our actions. As described above, emotions function as motivations to act, and this also accounts for the way people act towards certain groups of people. Emotions have binding or separating functions in that emotions bind people together or separate them from each other (Kemper, 1984). Ahmed (2008) has developed an idea of how this binding and separating of emotions can be understood together with normativity and argues that it is through the way we respond emotionally to others that boundaries are made and that the 'I' and the 'we' are shaped. She explores what emotions do in contact with others and argues that people (or signs, categories, objects or bodies) become 'sticky' as sites of personal and social tension. Ahmed (2008) describes *stickiness* as a relationship that can be understood as feelings of 'witness' that bind people together and feelings of 'otherness' that block people from each other. Through such emotions, people act in

ways that bring them together or push them away from each other in symbolic but also material ways. Sawyer and Fahlgren (2016) describe this process as the fear of being associated with, or even becoming, ‘the other’ as shaping the boundaries between ‘I’ and ‘them’. In this way, the process of othering described by Dominelli (2002) can be understood as intertwined with the process of stickiness.

Stickiness can thus basically be described as feelings causing different attitudes and orientations for actions. Brennan (2004) explains this as a consequence of emotional transmission involving judgment and discernment – elements that are vital dimensions in professional assessment. As outlined earlier, emotions function as orientations in judging and decision-making, and the point made here is that emotions also function as orientations for the way certain people are judged based on how they are categorized or conform to normative notions (Giritli Nygren, Öhman & Olofsson, 2016). Ahmed (2008) describes stickiness as an outcome of the surfacing of histories of associations between categories, people and signs. Professionals may stick emotions such as worry to children or parents in a conscious way, but emotional encounters are also mediated by unconscious memories and associations. Which histories of associations are activated depends on the particular situation. In the case of professionals’ worries about children, children at risk is a category that is associated with a range of signs such as ‘foreigners’ or ‘mental diseases’ that are associated with ‘risk families’. When hospital professionals attribute such signs of ‘risk’ to parents, the parents may become sticky ‘risk objects’, which allows the professionals to take action.

To summarize this chapter, professional discretion is suggested to involve emotions that are linked to different kinds of norms that orient personnel how to judge and act. The different kinds of norms discussed are social norms, legal norms and profession-specific institutionalized norms. I also suggest that the analyses of professional assessment should take into account the different statuses of professionals in the hospital context and explore how the lack of clear and full jurisdiction impacts their assessment and reporting. The way the theories have been used and operationalized in the studies is discussed in the following chapters.

4. RESEARCH DESIGN AND METHODOLOGIES

This thesis includes two different studies published (or accepted for publication) as four separate articles in peer-reviewed international journals. The two studies are based on two data collections with different methodologies: qualitative semi-structured interviews and a quantitative questionnaire. Considering the lack of knowledge about hospital social work with children suspected of being at risk in Sweden, there is particular focus on obtaining more knowledge about HSWs' work by explorative semi-structured interviews. A questionnaire was then used to obtain a broader picture of physicians, nurses, nurse assistants and HSWs' experiences of working with children at risk. The data were analysed with different methods of analysis and from different theoretical perspectives.

In the following, some general issues with the research design and the two chosen methodologies are discussed. A short description of the participants, data sampling and methods of analysis are presented, with more detailed specifics in the articles. Here, the focus is rather on discussing the trustworthiness of the studies and the ethical considerations taken during the research process.

WHY THESE METHODS?

The two different methodologies were pragmatically chosen to best answer the aim and research questions of the thesis. Different methodologies are able to answer different questions, and a combination of methodologies can allow diversity of findings and thus serve to produce stronger inferences (Denzin, 2010). The research questions are of different character, some aim to capture complex issues such as how emotions are imbedded in assessment, while others aim to find prevalence about, for instance, the reporting experiences among a large number of participants and among different professional groups. Prevalence studies require many participants to answer

the same questions and for the answers to be easy to categorize to enable comparisons. I therefore chose to use a quantitative questionnaire that primarily consisted of pre-defined alternatives for answers, although some were open ended. It was important that all the selected professions – physicians, nurses, nurse assistants and HSWs – could understand and answer the questions from their respective point of view.

There are several methodological options for research questions that aim to capture complexities and give a deeper understanding of an issue. Some of the questions here were to explore how emotions and normativity influence the assessment process of children suspected of being at risk and to explore the HSWs' contribution and position in the inter-professional hospital setting. Such in-depth understanding requires qualitative methodologies. Considering that there is also an inter-professional perspective, mixed focus groups or mixed interviews could have been appropriate, although the focus on HSWs' experiences motivates interviews with HSWs. The focus on emotions and normativity also motivates in-depth interviews rather than focus groups, because interviews allow participants to describe fully experienced cases and the feelings embedded in these particular assessment processes without being affected or interrupted by others. Of course interviews with HSWs could be combined with mixed focus groups or observations at workplaces – but in this thesis there has been a demarcation and emphasis on HSWs due to the lack of previous research and the fact that, as an HSW practitioner and researcher, I feel a responsibility to contribute to the HSW research field. Although there are methodological limitations, the interviews resulted in more data than the space this thesis allows me to present.

The first aim was to start with the quantitative questionnaire study to find out more about the broad picture of the different professions' experiences and the conditions within the hospitals. However, when constructing the questionnaire I felt unsure about whether the right questions were being asked and if I needed more insights from the practitioners' experiences to address the best questions possible in the questionnaire. I therefore decided to start with qualitative interviews with HSWs. During the work with the interview study, the questionnaire questions became more precise.

SAMPLING, PARTICIPANTS AND METHODS OF ANALYSIS

This section presents an overall description of the data sampling, participants and methods of analysis. The emphasis is on the two separate studies: the qualitative interview study (presented in Articles I and II) and the quantitative questionnaire study (presented in Articles III and IV), although the methods of analysis are discussed for each separate article.

The qualitative interview study

In the first study conducted, the interview questions were open ended on themes about the HSWs' role in their teams, case descriptions, if and how emotions are involved in the assessments and if some groups of families are paid more attention to because of their social positioning based on gender, nationality, class or (dis)ability³. Fourteen interviews were conducted with HSWs in eight Swedish hospitals in inpatient wards: nine were executed at three university children's hospitals and five at the paediatric departments within five regional hospitals spread throughout Sweden. The aim was to get a geographic spread and distribution among gender and ethnic background in selected hospitals when possible. Only three respondents differed from the description 'white non-immigrant women', as a result of the fact that most regional hospitals only have one or a few HSWs employed, usually white non-immigrant women. The interviews took, on average, one hour to complete. They were carried out in the participants' own offices at their workplaces, tape-recorded and transcribed verbatim.

The analysis in the first article searched for specific content related to HSWs' contributions to the assessment processes and how they construct their own professional role and draw boundaries to other professionals regarding at-risk children – and content analysis (Gillham, 2005) was therefore used together with a theoretical frame on professionalism. The second article analysed how emotions are linked to normativity in HSWs' narratives about the parents, and the method of analysis was inspired by a critical discourse analysis approach, which explores the use of social categories and the power relations between them (Fairclough, 2013). During the

³ The interview guide is found in Appendix I.

interviews, the informants were asked to describe situations of worries about children who may be at risk that they had been affected more by emotionally than usual and also whether they believed some social groups were over-represented. During the interviews it became clear that the situations by which they had been affected more emotionally were also the cases in which issues of social norms and stereotypes became visible. The analysis therefore became close to the narratives in the sense that the theoretical frame about normativity, emotions and stickiness was developed in interplay with the empirical analysis (Starrin, Larsson, Dahlgren & Styrborn, 1991) that searched for the way emotions were linked to normative discourses that appeared to relate primarily to gender, nation/culture, class and (dis)ability.

The quantitative questionnaire study

The main purpose of the quantitative study was to explore what experiences the different professions have of handling suspicions about children at risk and exploring a range of factors that may be barriers to assessment and to taking action. The questionnaire used was constructed by me with inspiration from previous research and the results of the interview study. This means that I initially conducted a literature review of which factors previous studies have found to have affected health care professionals' assessment and decision-making about child maltreatment. No previous questionnaires were found that covered the aim and research questions of this thesis. The questions are therefore a mixture of particular questions addressed in previous studies (e.g. obtained education in child maltreatment and legislation, feeling insecure when identifying child maltreatment, time pressure, afraid of threats and lack of feedback from social services) but translated into Swedish and sometimes reformulated to fit all the professions included in the thesis. However, some of the questions asked in this thesis had not been studied previously, for instance questions about access to different kinds of organizational support or who they believed should be responsible for making reports. It turned out that I needed greater insight from the practice to be sure I asked the right questions. The initial plan was to conduct the questionnaire study before the interview study described above, but as I needed greater insight I decided to start with the interview study. After the interviews had been

completed, the construction of the questionnaire became easier, and this also meant that some questions in the draft for the questionnaire were revised and others that arose from the interviews were added; for example which profession the respondents chose to consult when they had a suspicion. I will return to the issue of the questionnaire's validity and trustworthiness in the next section.

The questionnaire included 22 questions asking for the respondent's gender, age, profession, work experience, education and experiences of reporting and not reporting children they believed may be at risk⁴. It also asked about available organizational support, who they chose to consult and who they believed were responsible for making reports. The respondents were also asked to grade the extent to which eleven emotional and circumstantial factors may have influenced them not to make a report. Another set of questions concerned the extent to which the respondents had experience of reporting a range of fourteen possible risk situations – these questions were not analysed in this thesis however. Some of the questions included open-ended response options.

The four largest university hospitals were strategically chosen for the data sampling, as it can be argued that they actively promote evidence-based practice to a greater extent than regional hospitals and may have more developed organizational support for work with children at risk. The hospitals included were Astrid Lindgren Children's Hospital in Stockholm (the two major hospitals located in Solna and Huddinge), Academic Children's Hospital in Uppsala, Queen Silvia's Hospital in Gothenburg and the children's departments at Scania's University Hospital (located in Lund and Malmö). Considering that HSW is a minor profession, a positive outcome of choosing respondents from the major hospitals was that it was possible to gather a large number of responses. The professional groups selected for this study were physicians, HSWs, nurses and nurse assistants. The latter group was chosen because the members spend comparatively more time than the others with the children and their families in the wards. Only personnel working in inpatient wards were selected –

⁴ The questionnaire is found in Appendix II.

although some also worked with outpatients – and they worked in a range of different wards.

After contact with several professional organizations and trade unions, it was clear that it was not possible for them to assist with contact information for their members, and it was therefore not possible to conduct a total population study. Neither was it possible to obtain contact information from all departments to enable the questionnaire to be sent to the selected personnel. As a consequence, the respondents do not represent the total population of professionals within the departments; they should instead be considered a subset of those actively working at the time the study took place.

After obtaining approval from the directors of the children's hospitals to carry out the study at the hospital, contact was made with about 100 directors of different departments, and sometimes a contact person for a team of physicians or HSWs. Some did not respond, and in one case the director did not feel it was possible to carry out the study at that particular department due to the work pressure being too stressful for the team, which had many newly employed members. In sum, 23 visits were made to different departmental or team meetings between April and June 2013. Physicians and HSWs mostly had their workplace/team meetings with their respective professions, whereas nurses and nurse assistants had joint meetings. The study was presented and the questionnaire distributed, filled in and collected at the meetings. Due to time constraints at some meetings, these groups were provided with addressed envelopes to send in the questionnaire later. One reminder was sent to the departments that had received addressed envelopes. In total, 365 questionnaires were distributed and 295 (80.8 per cent) were completed correctly and returned. In all, 72 physicians, 119 nurses, 70 nurse assistants and 34 HSWs responded to the questionnaire. The fairly high response rate should be regarded as a result of attending the workplaces and the direct contact with those who were chosen for inclusion in this study.

The assembled data were analysed through the statistical program SPSS 22.0. The third article aimed to describe frequencies and compare differences between the four hospitals and professional groups regarding the organizational and professional conditions at the hospitals. Bivariate analysis was used to achieve this. The fourth

article similarly shows frequencies and comparisons between the professional groups, reporting experiences using bivariate analysis. A ranking scale was compiled from the result of the respondents grading the extent to which a range of emotional and circumstantial factors had influenced them in deciding not to report. Moreover, binary logistic regressions were performed to analyse which factors had most adjusted impact on the main variables' reporting rate and on decisions not to make reports.

TRUSTWORTHINESS AND GENERALIZATION

The question of what constitutes valid knowledge involves the bigger philosophic question of what is truth. From a social constructionist perspective, truth, facts and knowledge are considered to be constructed through correspondence (see, e.g., Hacking, 1995, 1999). Knowledge is not about what is real: it is the communication that forms the context within which knowledge is understood. What people believe is true and valid knowledge has to do with whether they believe these facts are probable and the arguments trustworthy (Kvale, 1995). It is from this perspective that I am going to discuss the trustworthiness of the research process.

Kvale (1995) describes validity as a form of scientific handicraft that puts the focus on the quality of research by checking, questioning and theorizing the explored phenomena. He argues that "In a craftsmanship approach to validation, the emphasis is moved from inspection at the end of the production line, to quality controls throughout the stages of knowledge production." (p. 27). Methodologically, there have been repeated controls. For instance, since the questionnaire was constructed by me, its validity and reliability had to be confirmed before it was used. Besides being informed by the interview study, it was also discussed with other researchers within the field and pre-tested by two representatives of each selected profession, though not at the same children's hospitals. The representatives were asked to fill in the questionnaire and leave comments concerning whether they thought the questions were relevant and understandable and whether they could suggest any additional questions or other changes from their respective practical experience. Before the questionnaire was finally used for the data collection, one question was added and minor language clarifications were made to enable *all* the professions to understand and answer them.

The coded questionnaires and the data registered in the SPSS program were double-checked by me. To further ensure reliability, the analysis was performed several times, and a statistical specialist was consulted to make sure there were no mistakes in the analysis.

Lupovici (2009) stresses the importance of *contextual validity*, i.e. demonstrating the influences of constitutive factors that create the context and revealing the contextual process in which the research was constituted. This has been done to different extents in the articles depending on their research questions and the space given. This overall summary aims to give a broader contextualization about, for instance, the historical development of child welfare and child protection, Swedish legislation and the professions involved, and the actual context they take part in today. A contextual description can of course never be fully accomplished from all possible perspectives. The focus has been to reveal those constitutive factors that I see as having most effect on the research questions, the chosen methodologies and, not least, to picture the context from which the results should be analysed and understood.

The *internal validity* concerns the question of whether the study result corresponds to the respondents' narratives and the collected data. It is a challenge to shed light on all the different perspectives that I have received through the sampling, and the ambition has been to present nuanced and differentiated perspectives. The varied analyses of methods have been helpful to capture different aspects and levels of analysis. Such mixed research design can be argued to enhance complementary strength because it allows for greater diversity of findings (Denzin, 2010) as it says something about the overall patterns and provides a deeper understanding of the explored issue. This complementary strength has its limitations however: only the HSWs' assessment is explored with different methodologies – the thesis does not offer a qualitative deeper understanding of the other professions' assessments. The HSWs also stand out when it comes to the question of *generalization*. The quantitative results cannot be generalized for the whole population of physicians, nurses and nurse assistants within the departments, as the whole population was not included⁵. Instead,

⁵ Total number of staff in the selected professional groups at each hospital (in- and outpatient care): Astrid Lindgren Children's Hospital 2133 (including administrative personnel), Academic

they should be considered a subset of those actively working at the time at which the study took place. As all the HSWs at the selected hospital were invited to participate, and their response rate were 77.3 per cent, their answers can be generalized for HSWs at the four largest child university hospitals in Sweden.

Results from interviews can seldom be generalized for a whole population in a universalized sense and nor can the result from this qualitative study. Halkier (2011) suggests another approach to generalization for qualitative research, namely *analytical generalization*, which addresses the patterns of findings that enhance the understandings of how and why a process or action occurs. Halkier argues that one of several ways to draw analytical generalizations is by positioning, which can be described as the analytical inferences and generalizations made on the basis of the patterns of expressions and actions in the collected data, where the contents of the expressions and actions are constituted by relations, negotiations, processes or discourses. These kinds of analytical generalizations are made in the qualitative analyses in this thesis, for example in the first article, which outlines that HSWs take three different positions at their workplaces based on the analysis of their professional relations, negotiations and the profession-specific norms guiding them in the assessment process. Halkier (2011) argues that positioning as a form of generalizing enables conclusions about patterns in informants' daily relations and, at the same time, expresses the instabilities and complexities. Importantly, such generalization should always be understood as bound to the situation and context.

Other researchers argue that qualitative research should be scrutinized from its trustworthiness and validity rather than its generalizability. The process of *communicative validity*, which can be described as the collective process in which knowledge claims are tested and interrogated in a critical dialogue (Kvale, 1995; Aguinaldo, 2004), has been important to this thesis. Communicative validity is not about finding consensus on the true knowledge at stake but rather about discussing the knowledge claims from adverse perspectives where arguments and theories are

Children's Hospital 601 (including administrative personnel), Queen Silvia Children's Hospital 1157, and the children's department at the Scania University Hospital 598. These numbers should be regarded as rough estimates because of the different administrative systems within the hospitals.

implemented or rejected. During the research process, a number of theories and a variety of approaches have been discussed but rejected in favour of the chosen ones. These discussions have primarily taken place within the scientific community, such as with journal reviewers, reviewers at the university, supervisors and other research colleagues, and at seminar discussions and, in some cases, with practitioners. They have all contributed critical and valuable knowledge, insights and arguments that have strengthened trustworthiness.

A social constructionist perspective on validity further argues that research should generate new alternatives for thoughts and actions (Kvale, 1995; Aguinaldo, 2004) by, for instance, critically reflecting on how definitions and concepts maintain unequal social relations (Aguinaldo, 2004). Kvale (1995) calls this *pragmatic validity* that goes beyond the mere communicative aspects. Rather than being solely descriptive and predictive, research can be transforming in that the level of understanding is enhanced in such a way that participants and their organizations are able to take action. What the desired result and actions may be on the basis of this thesis is the primary discussion in the last chapter, but according to Kvale (1995) this is always a matter of values and ethics. This brings us to the wider theme of ethical considerations in the next section.

ETHICAL CONSIDERATIONS

The overall aim of the thesis is to explore what influences hospital personnel's assessment of children who are or may be at risk, an aim that has an underlying assumption that children have the right to a childhood free from violence and other harms. Advocating for children's rights and social justice is a professional code of ethics in social work (International Federation of Social Workers, 2014). As Nipperess and Briskman (2009) argue, children's rights often lag in social work practice but need to be at the forefront. This is especially important when working with children in underprivileged groups. Children who regularly attend hospitals are often disabled or have a serious disease and are therefore particularly vulnerable. An ethical tension that arises here is the children's rights to gain support and the consideration that parents should not be inaccurately mistaken for harming their child or being unjustifiably scrutinized because of already being underprivileged. At the same time, a child may be

put at risk by the parents, and the parents may be stressed as a consequence of being stigmatized or marginalized because they do not conform to contemporary normative notions. This ethical tension has been reflected on throughout the research project.

In their literature review, Peled and Leichtentritt (2002) found that ethical considerations are rarely discussed in social work studies published in journal articles. This is also true for several of the articles in this thesis. One reason is the limited space in journals and another is that the journal editors and reviewers may not consider this as the most important aspect (Peled & Leichtentritt, 2002). I will therefore now take the opportunity in this section to discuss how the ethical considerations have been taken.

Like many qualitative researchers, I find it valuable to connect ethics and reflexivity. McGraw, Zvonkovic and Walker (2000) explain reflexivity as “a process whereby researchers place themselves and their practices under scrutiny, acknowledging the ethical dilemmas that permeate the research process and impinge on the creation of knowledge” (p. 68). Guillemin and Gillam (2004) argue that reflexivity is particularly important in the day-to-day ethical issues that arise in the research process. They distinguish ethics in practice (day-to-day ethical issues) from procedural ethics (planning and the research ethics committee’s application) and highlight that reflexivity is needed, particularly for critical ethical moments in research, for instance to ensure that interaction with participants is performed in a humane and non-explorative way to avoid, for example, social and emotional harm to the participants.

Ethical considerations before and during the data sampling

In the preparation of the data sampling, the ethical issues concerned particularly the participants’ integrity and what questions should be addressed to them. Their integrity must be ensured and subjected to the Swedish Act of Ethics (SFS 2003:460) and the Act of Protection of Sensitive Personal Data (SFS 1998:204). The way this is done differs between the chosen methodologies used, and they were reviewed, communicated and approved by the Mid Sweden University Ethical Committee in 2010 and 2013. Ethical considerations were taken when, for instance, constructing the

questionnaire, where questions about the respondent's personal life or identity were avoided, and the questionnaire contained no other personal data than gender identity, profession and hospital. One question concerned which country or continent their main education took place in/on in an attempt to capture potentially varied geographical experiences. The number of respondents who had had their main education abroad was very low and, for that reason, is not used as a variable in the analysis.

The data sampling was enabled at the director's invitation to join a work meeting where I presented the study and the personnel had time dedicated to fill in the questionnaire. I encouraged the director to hand out the cover letter with information about the study and for participation to be completely voluntary before I attended the meeting, and the same cover letter was attached to the questionnaire they received at the meeting. Some personnel said that they did not have the time to fill in the questionnaire, and they were given an addressed envelope and information that they could send in their anonymously filled-in questionnaire if they wished. Taking part in the meetings and the dialogues that arose was often interesting and gave me new situated knowledge and reflections. Several participants also expressed that they had gained an opportunity to discuss and reflect on their work with children who may be at risk.

In the qualitative interviews, I sometimes interviewed the only child HSW at small hospitals, which made it impossible to disclose at which hospital the study took place or the gender of the interviewee as the number of men is limited within this sub-profession. I made sure that the interviewees' colleagues or directors at the small hospitals did not know if they participated in the study by contacting the interviewees directly. At the large hospitals I needed the director's support to obtain information about which HSWs worked with children and at inpatient wards. I interviewed several of them, which minimized the risk of the individuals being identified in the results. I contacted all the interviewees by phone, emailed them information about the study and offered them time to contemplate whether they wanted to participate on a voluntary basis. One had had previous negative experience of taking part in an interview study and expressed some concern about how the current study would be used. That gave me the opportunity to explain the research process in more detail and answer the person's

questions. In general, I believe it was helpful that I was clear about having worked as an HSW myself, an experience that also facilitated interviewing and possibly imbued and positioned me as a person who had been an ‘insider’.

In the narratives, the interviewees were asked to describe situations in which they had had a worry about a child. Some reflected on how detailed their descriptions would be as they are bound by professional secrecy according to the Official Secrets Act (SFS 2009:400). In situations in which they expressed that they had perhaps given more information than they should have (e.g. a child’s country of birth, present housing area or first names), I clarified during and after the interviews that any descriptions that could somehow make it possible for anyone to identify families, respondents, their colleagues or places would be edited when transcribing the interviews. This meant that some descriptions could not be presented, even though they concerned urgent, described issues about oppression and social injustice.

All the situations and narratives involve different emotions and reasons. During the interviews, I asked the participants to describe a situation that had affected them more emotionally than usual, a question that might have involved potential emotional pain for some participants. HSWs deal with highly emotional situations involving violence, severe diseases and deaths in their everyday work, and they are usually supervised. It is therefore conceivable that the interview question in most cases did not raise more feelings than usual, but I followed up by asking if they had received any emotional support, a question that made it more natural to discuss the potential need for it after the interview. For example, one interviewee silently and sorrowfully started to cry while talking about a child but turned the narrative onto easier issues, which I perceived that the person wanted at the time. I found it appropriate that the interviewee controlled the direction of the narrative, though I brought up the question about the opportunities to receive emotional support later in the interview.

As a researcher, I was also asked whether the topic was emotionally difficult – and the research process does of course involve dimensions of emotion work. Some descriptions were indeed painful, and the months of listening to and slowly transcribing them were sometimes emotionally exhausting. However, compared with my own experiences of working as an HSW, taking a researcher’s position involves a

form of distance from the practice, which is far less exhausting than doing the actual work with children at risk. During the months of travelling between hospitals in Sweden (when I was often perceived as a pharmaceutical salesperson clutching my suitcase beside me), I wrote daily notes about things like how waiting or meeting rooms were perceived as welcoming and safe from a child's perspective and reflections on the meetings and narratives and the emotions they evoked. Writing the notes helped me reflect on why I had the feelings I had and was also as a way of documenting and reflecting on a range of ethical perspectives grounded in the narratives or meetings during the data collection.

Ethical considerations when analysing and presenting results

As mentioned, there were several ethical reasons the interviewees could not be presented with signs of their geographical belonging or identities and they were therefore coded from R1 up to R14 in the transcriptions and quotes. The interviewees are also presented without signs based on categories such as age, gender, nationality/culture, class and (dis)ability with the result that their voice is presented as ostensibly 'neutral' in such a way that they are not positioned in these power relations, in contrast to the parents they are describing. This means that the focus is on their voices and the discourses and not the power positions from which the different narratives are (re)constructed.

Some differences between ethical considerations in qualitative and quantitative research have been shown above, though in some aspects they are alike. For example, there is always a risk of oversimplification. Peled and Leichtentritt (2002) argue that an ethical aspect of qualitative research is to ensure that alternative voices are heard in the text, which can be seen in the qualitative articles of this thesis. I would argue that this ethical principle can also be considered when analysing quantitative data. The risk of oversimplification is even more apparent in quantitative studies in which already constructed fixed categories are used and the results reviewed by referees, often from a positivistic tradition, promoting 'strong results'. Thus, one aim was to conduct a complementary statistical analysis that reveals different viewpoints and alternative answers to a question. Sometimes, these results show different alternative analyses

(i.e. the different ways emotions influence assessment), which can hardly be simplified, and in other cases the statistical strength is quite steady (i.e. differences between professions), which outlines clearer tendencies of how the work with children who may be at risk of harm are constructed within children's hospitals in contemporary Sweden.

5. SUMMARY OF THE ARTICLES

I. Hospital social workers' assessment processes for children at risk – positions in and contributions to inter-professional teams

The first article is based on interviews with fourteen HSWs and explores how they describe assessment processes for children at risk at their inter-professional workplaces. The article examines how the HSWs contribute to the assessment processes of their inter-professional teams and how they construct their own professional role and draw boundaries to other professionals regarding at-risk children.

When the interviewees described cases they have handled, a broad picture emerged of at-risk children, revealing physical, psychological and sexual child abuse; physical, psychological and emotional neglect; and children exposed to parents' drug abuse, psychological illness or watching the father abuse the mother. Some cases concerned how a lack of legal rights and a responsible authority may also be a risk factor for children. While some HSWs described their role as handling the cases physicians did not, 'things that anybody could report', others talked about their profession as the one with the main responsibility for assessing unclear and more complex cases.

The analysis showed that HSWs took three different positions in their teams – active, reflective or passive – which led to different actions in the assessment processes. The three possible positions were analysed as related to three institutionalized norms of action – juridical, therapeutic and medical – norms that build on the different professional knowledge systems. The juridical norm is essentially based on mandated reporting according to the Social Services Act (SFS 2001:453), a deontic norm that personnel in health care are obliged to follow. This involves active positioning and, for example, making contributions such as performing minor psychosocial investigations and doing coordinating work, as in the historically

more traditional HSW model. The therapeutic norm can be understood as guiding those who primarily used counselling or motivation work to get parents to seek support voluntarily. Here, reflective work linked to therapeutic professionalism efforts was emphasized. Finally, the medical norm guided those who argued for the need for substantial medical facts like documented injuries that would be most likely to lead to legal consequences. This means following the physician's judgment, which was related to a weaker relationship to other social workers and weaker jurisdictional competition.

The outlined norms and the positions taken involve consequences for the children and their families and also pose questions for the future professionalization efforts of HSWs.

II. Emotions and normativity in assessment for children at risk

The second article is based on interviews with fourteen HSWs and explores how emotions are linked to normativity in HSWs' assessment of parents in their narratives about children who may be at risk and focuses particularly on how emotions become stuck to different categories of parents in assessments.

Emotions were found to be part of the assessment of different categories of parents in various ways and that strongly expressed emotions were often directly linked to normativity in a 'sticky' way. Feelings of affection, shame and cruelty were involved in the assessment of parents with a medical diagnosis, while feelings of blame and worry were stuck to different gender stereotypes, depending on whether neglect or abuse was in focus. The assessment of parents of different national or cultural backgrounds more often involved feelings of blame and distance, while feelings of witness, being fooled, fear, ambivalence and difficulty characterized the assessment of the 'normal' family.

Despite the tendency among the informants to neutralize their feelings, the feeling of worry could be understood as an acceptable or even necessary feeling for the informants to express in their work with children who may be at risk and thus be described as a 'feeling rule' at the workplace. However, the naming of the feeling of worry was also related to other feelings that were linked to historically (re)created

discourses about normality: emotions such as difficulty, shame, fear, ambivalence, closeness, affection, cruelty, blame and feelings of distance or withness or being fooled. Where there was no feeling of blame towards the parents, such as those with medical diagnoses, this produced feelings such as affection, shame and cruelty, contradictory feelings that were understood to both bind and block the relationship between HSWs and the parents. In this way, the lack of a feeling of blame seems to produce contradictory ‘illogical’ emotions, as it allows feelings of affection and withness. The feeling of withness was linked to signs of normality, yet if there was an injured child, the absence of other associated ‘warning signs’ evoked feelings of fear, ambivalence and difficulty in assessment, as the ‘logic of normativity’ does not work in such cases.

When the feeling of blame was present, the ‘logic of normativity’ went to work and produced ‘logical emotions’ such as worry, and the orientations of actions such as questioning the parents or reporting them followed logically in the assessment process. Similarly, ‘warning signs’ followed the ‘logic of normativity’ and produced the logical emotion of worry. The histories of association between warning signs and the feelings that are stuck to these signs raise the question of if and how the emotions themselves can be said to be integrated into discriminative structures. However, when informants reflected critically on warning signs and normativity in assessment processes, there were more ambivalent feelings about the logic of normativity and less feeling of blame. In this way, critical reflexivity can disturb the logic of normativity and its associated emotions.

III. Assessing children at risk:

Organizational and professional conditions within children’s hospitals

The third article is based on the questionnaire study directed at 295 physicians, nurses, nurse assistants and HSWs at the four largest children’s hospitals in Sweden. The article explores the self-reported organizational and professional conditions within the hospitals concerning the work with children suspected of being at risk of harm.

The findings show that the hospitals offered different kinds of organizational support – such as a child protection team, child advocacy centres, specialists, guidelines and routines – of which the professional groups had varied knowledge. Nurses, especially nurse assistants, had a lower awareness of such organizational support and had obtained less knowledge about child maltreatment than physicians and HSWs, which suggests that, especially, the former professional groups need more education and the opportunity to become more involved in the assessment and reporting processes. The study also asked the respondents about their use of another form of support, namely supervision or mentors, and it was found that almost all HSWs regularly used supervision, while it was uncommon that the other professionals used such support.

The knowledge obtained about the Social Services Act and what it implies for the respondents in their work with children at risk also differed between the professional groups. All the HSWs stated that they had obtained sufficient knowledge, but only 38 per cent of the nurse assistants had. When the respondents were asked about who they believed should have the responsibility to make report, it was shown that 32 per cent of the nurse assistants and 13 per cent of the nurses believed that physicians should have the responsibility, yet only 10 per cent of physicians agreed with this. However, most respondents, especially among the physicians and HSWs, agreed that the person who has a suspicion should make a report, which is also what the Social Services Act stipulates.

The analysis argues that if multidisciplinary structures and organizational support are not promoted or known about in the hospitals, risk management may, in practice, be flawed. Work with children at risk may be perceived as ‘dirty work’ among some professionals, explained as work that no single profession has jurisdiction to perform. Thus, it is a task that is everyone’s but no one’s responsibility – which can lead to strategies of avoidance among professionals.

IV. Why Don't They Report?

Hospital Personnel Working with Children at Risk

The fourth article is based on the questionnaire study directed at 295 physicians, nurses, nurse assistants and HSWs and explores the personnel's reporting experiences and their decisions not to report, and analyses possible reasons they are not reporting.

The results show that more than half of the respondents had never made a report and that 80 per cent were low reporters. There were major differences between the professional groups however: for nurses and nurse assistants the odds to be low reporters were high compared with those of physicians and HSWs, and HSWs made reports most often. The regressions also showed that respondents who had been in the profession for more than five years and had access to guidelines and routines had significantly lower odds of being low reporters but higher odds of deciding not to report. While high reporters characteristically had access to guidelines and routines, it did not mean that they always decided to report. An analysis may be that guidelines and routines increase the reporting rate to some extent but that other factors may have a more profound impact on professionals' decisions not to report their suspicions.

Emotions had hardly any relation to the actual reporting rates when regressions were made but were involved in the decisions not to report. Feelings of stress were particularly significant for deciding not to report in regression, although a ranking scale showed that feeling insecure about assessing the situation as abuse or neglect, and ambivalence about how to act were the most common feelings among the respondents. Stress was more common among nurses and nurse assistants, and an analysis may be that stress can occur when professionals experience that the type of work is beyond their capacities and what they have been trained for.

Importantly, the ranking scale showed that different emotions had different effects on the different professional groups. Nurses, nurse assistants and physicians were all highly influenced by feeling insecure about assessing a situation as abuse or neglect, and ambivalent about how to act and the circumstances such as when the parent or youth explained an injury. Beside these, the nurse assistants, the group most influenced by feelings, more often felt insecure about cultural differences in

upbringing and more often lacked trust in interventions by social services. HSWs stood out as being less strongly affected by the emotions explored in this study, although a third had felt ambivalent about how to act in a suspected risk situation. These results are suggested to have implications for the way training should be designed for different professions.

6. OVERALL ANALYSIS AND DISCUSSION

The overall aim was to explore factors that influence professional discretion in the assessment by Swedish child hospital personnel of children who are or may be at risk of harm. Enhancing the understanding of what happens within the discretionary space has been a major focus, and the findings show that the discretionary space is wide in practice and that the assessment process of children at risk is multifaceted and complex. It is primarily the HSWs' discretion that has been emphasized, but the quantitative study that includes their colleagues, physicians, nurses and nurse assistants has made it possible to analyse the ways in which inter-professional relations affect discretion in the hospital context.

As the findings show, the hospital personnel's assessment of children suspected of being at risk is influenced by a range of factors. The hospital setting, with hierarchies and imbedded class differences between physicians, nurses and nurse assistants affect, to a large extent, how the other explored factors influence the personnel's assessment. For instance, the nurses and, especially, nurse assistants had lower awareness of organizational support and had obtained less knowledge about child maltreatment and the Social Services Act than the physicians and the HSWs (Article III), which may explain why nurse assistants, in particular, had lower trust in intervention by social services (Article IV). The differences in status within hospital settings were shown to shape a certain hospital culture, i.e. that the professionals did not act as the Social Services Act stipulates: that the one who has a suspicion shall report (Article III). Instead, it outlined that physicians and HSWs made the reports, while nurses and nurse assistants almost never made reports (Article IV), and one out of three nurse assistants and 13 per cent of the nurses believed that physicians should have the responsibility to make reports (Article III).

Thus, the deontic norm, the obligation to report, seems to have little influence on nurses and nurse assistants. The interview study also found that profession-specific

institutionalized norms (Article I) influenced the HSWs taking different positions in their teams, which led to different actions in the assessment processes. The interviews also showed that emotions are linked to social norms in HSWs' assessment of parents, resulting in their worries being stuck to parents with disabilities or mental illness, and those described as having a working class background or a cultural or national background other than Swedish (Article II). While emotions were found to be part of the HSWs' assessment of parents, they were also shown to have different influence on the hospital personnel's decisions not to report, with interesting differences between the professionals (Article IV).

This final chapter deepens the theoretical analysis of these overall findings and discusses the theoretical and practical implications. It starts with an analysis of the effect of emotions on professional discretion in the case of assessing children who are suspected of being at risk, and the theoretical implications of theories of discretion. The consequences of the lack of jurisdiction for children at risk is deliberated on followed by a discussion of the HSWs' position and contribution and the possible implications for HSW professionalization in the future. Further discussion about the practical implications of the findings focus on the Swedish child welfare approach and the legislation on mandatory reporting. It is suggested that changes are needed to make the legislation work, but what possible changes could they be? In the final part, I return to the children by discussing possible consequences of wide professional discretion from the children's perspective.

DISCRETION AND THE IMPACT OF EMOTIONS

As Beck and other researchers stress, uncertainty characterizes the risk society of our time. It is therefore particularly interesting that the most common feelings among the respondents were of insecurity in assessing the situation as abuse or neglect and ambivalence about how to act (Article IV). These feelings are strongly related to uncertainty and confirm that uncertainty is often present in risk assessment.

It seems that the different feelings explored in the thesis have relevance in different phases of the assessment process. For example, feeling insecure about how to assess if a child may be at risk of harm is something that arises, particularly at the

beginning of the process, yet it can be a feeling that remains and may thus influence the entire process. As the third article shows, a majority of the respondents believe that they have not obtained sufficient education about child maltreatment, which suggests that there are substantial uncertainties inherent in the discretionary reasoning.

Other feelings, such as ambivalence and fear, are more explicitly located later in the assessment process. Ambivalence often occurs in decision-making about how to act (after the identification of a presumed risk) and can be caused by conflicting goals (Barbalet, 2004). On the one hand, there is a goal inherent in the deontic norm and the attached feeling rule that all worries about harm shall be reported to social services. On the other hand, there may be a range of possible factors and feelings that signal that a report should not be made. These can be goals of self-interest to believe in other actions than reporting or, for instance, the uncertainty about what a report would lead to in the unknown future (see also Barbalet, 2004; Fahlgren, 2009). Similarly, feeling afraid belongs more clearly to thoughts about the future, closely related to the decision-making about how to act. The results show, for example, that of the reasons given for deciding not to report, about every fourth nurse and nurse assistant stated that they have felt afraid for their own security, and close to 40 per cent of the physicians stated that they have felt afraid to disturb the relationship with the parent if they make a report (Article IV). Fear could of course also concern what happens with the child if they decide not to make a report, although such a question is not asked in this thesis.

Although emotions can arise or become more intense in certain phases in what Wallander and Molander (2014) call the continuum of discretionary reasoning, it also seems like the emotional dimensions of discretion have no certain fixed start and end points. Uncertainty and insecurity seem to frame the very thought of handling children suspected of being at risk, and the emotional dimensions of assessment can continue for a long time in changing forms, sometimes many years and involve the professional stepping in and out of the various parts of the assessment process. This may concern, in particular, cases when personnel care for children with long-term disease or disabilities over many years. Furthermore, for the individual professional, this may be an emotional process that continues for years after contact with the family has been

closed. This can, for example, be the case when personnel reflect on how it turned out for the child following a decision on whether to make a report, and if there was something else that should have been done instead of, or besides, that decision.

Some of the factors that have been identified as barriers to acknowledging and supporting children seem easier to learn to handle than others. Assessing a situation as one of a child at risk, which many participants have shown that they feel insecure about (Article IV), is of course not always easy bearing in mind the different definitions, but it is still possible to change with, for example, sufficient education and increased awareness – which would decrease feelings of uncertainty and incompetence. The fact that some participants were afraid of threats or of disturbing the relationship with the parents or a youth by making a report (Article IV), on the other hand, may be more difficult to find an easy ‘solution’ to. Such feelings may be processed and managed with experienced professionals attempting to find the best possible and ethical way to treat the family. While different factors can be said to be more or less involved in different phases in processes, supportive factors may also be suitable before, during or perhaps after a case is active.

The differences between the professions show that HSWs are comparatively less influenced by emotions in their decisions to report (Article IV), which is interesting to relate to Spafford, Schryer, Campbell and Linigard’s (2007) findings that social work students embraced uncertainty while medical students tried to avoid it. One question this raises is whether the HSWs’ embracing approach to feelings in itself contributes to them not considering such emotions to the same extent as barriers to assessment. The interviews with the HSWs clearly show that various emotions are present in their assessment (Article I and II), but the quantitative study found that emotions do not usually stand in the way of making decisions (Article IV).

The fourth article showed that feelings such as insecurity about assessing the situation and ambivalence about how to act had a particular impact on the nurse’s and nurse assistant’s decisions not to make reports. Furthermore, feeling too stressed to manage a report gave notably high odds for such a decision, even though it was not the most common feeling. This study cannot answer the question of whether nurses and nurse assistants actually have an overload of work, but there are several findings that

seem to be related to each other. Nurses, and particularly nurse assistants, rarely had experience of reporting, and the third article shows that the nurse assistants, in particular, had obtained comparably little knowledge about child maltreatment and what the Social Services Act implied for their work. Fineman (2003) explains that stress can occur when personnel experience that the type of work is beyond the personnel's capacities, which can be related to a lack of education, training and experience of the task. It is therefore reasonable to suggest that the nurses and nurse assistants who lack experience, education and training in this field feel uncertainty and stress. Moreover, Neckel (1996) points out that when people are excluded, do not receive information or knowledge or simply feel incompetent, they often feel inferior, which can lead to further withdrawal.

The findings also point to nearly a third to half of the physicians, nurses and nurse assistants lacking trust in interventions by social services, while only one in ten HSWs did so (Article IV). The first article found that the higher degree of trust by HSWs was related to more frequent experiences of working at social services, and this was further related to their positions in the work with children at risk. Those with a high level of confidence in social services took an active position, while those with low confidence took a passive position. The overall findings show that more knowledge about social services and their work tends to take away the distrustful and uncertain feelings towards social services and their measures. The higher the trust in social services, the more committed the professionals are to act, according to the deontic norm and the feeling rule that all worries should be reported.

TOWARDS A WIDER UNDERSTANDING OF DISCRETION

According to Dworkin (1977), the discretionary space is surrounded by a belt of restrictions and standards, pictured as a ring-shaped doughnut. He does not give a precise description of what this belt in the doughnut consists but argues that it depends on what the specific authority has decided. In this thesis, one basic ingredient in this belt of restrictions is the obligation to make reports. The findings also point out that there are profession-specific institutionalized norms for HSWs (Article I) and a hospital culture that means that professions of lower status in the hierarchy tend to

pass over the responsibility to physicians (Article III), two examples that can be said to form institutional, but informal, standards for discretion and assessment. However, the result also shows that there are social norms and emotions involved in discretion that are not dependent on the authorities' decisions, factors that often make professionals reject the obligation to report (Articles I, II and IV). Moreover, current authorities do not dictate that worries should be stuck to certain groups of parents, meaning that professionals do not report fathers for suspected neglect, or that a family with an 'ordinary surface' is not reported despite signs of physical injuries (Article II). It could be argued, however, that such normativity is a residue from historical normative discourses in Swedish welfare institutions, which are still circulating in assessments of children suspected of being at risk. If we return to Dworkin's picture of discretion as a doughnut that has a belt of restrictions consisting of institutional standards, rules and restrictions given by authorities, this thesis shows that there are not only articulated conflicting standards or rules given by authorities, there are more factors with vital influence on discretion, for example emotions and normative discourses. Such factors do not necessarily lie within the institutional belt of restrictions, but they may provide motivation to act and they tend to loosen the belt of restrictions and widen the discretionary space.

In the first article, Molander and Grimen's (2010) model of discretion was used. Although it functioned well as a base for the analysis, it became clear that the model in its 'clarity' did not capture the spectrum of factors involved in assessment. Although Molander and Grimen discuss how norms such as deontic ones result in a specific action, they do not consider that there are social norms and emotions that circulate, give associations and affect actions. My second article provides a deeper understanding of how normativity and emotions are related to the ways worries tend to be stuck to certain groups of parents based on discourses in which risk in general is associated with underprivileged groups, and discourses about physical abuse are associated particularly with men, while discourses about neglect are associated particularly with women. Similarly to the results of earlier research (see, e.g., Bangura Arvidsson, 2011; Franséhn, 2003; Johansson, 2003), the idea of good parenting was intertwined with the idea of the mother as the main responsible caregiver and thus the

worries were stuck to mothers when insufficient care and neglect of a child were in focus. The idea of the good parent was closely linked to the surface of the ‘ordinary’ family. There was broad understanding among the informants that it felt harder to assess highly educated, middle-class parents with a depicted orderly life because such signs were not associated with risk parenting, rather, signs of normality evoked feelings of witness, as some of the informants described these parents as being “just like me”. As normality was characterized by the *absence* of ‘warning signs’, worries about risk were simply not stuck to families with an ‘ordinary surface’. These findings show that the discretionary space is stretched by social norms and emotions, and suggest that theories about discretion need to be widened. Discretion apparently involves more dimensions, such as the emotional and normative, than the traditional theories embrace.

Even though Molander and Grimen’s (2010) model of discretion could not explain how emotions were involved in discretion in the first article, it was useful when analysing which institutional norms of action guide the HSWs in their work with children at risk. Three institutionalized norms – juridical, therapeutic and medical, building on different knowledge systems – were analysed to relate to the three positions taken by HSWs as team members – active, reflective and passive – which led to different kinds of actions. The juridical, therapeutic and medical norms can also be understood as sub-profession-specific discourses that dominate HSWs’ work with children suspected of being at risk. These institutionalized norms were shown to widen or shrink the discretionary space in different ways. The juridical norm emphasizes the legislation and shrinks the discretionary space, while the therapeutic norm widens the discretion considerably as the HSWs trust their own ability to make assessments. The medical norm, on the other hand, can either widen or shrink HSWs’ assessment: it widened the discretion in terms of the HSWs disregarding the legislation if the physician claimed that a report should not be made, for instance due to a lack of medical evidence (two competing rules for action), while it shrunk the HSWs’ discretion in terms of disregarding their own professions knowledge base.

In the theoretical frame, I described how worry functions as a feeling rule necessary for health care personnel’s motivation to act and make reports. Trust and

certainty have also been described as important foundations for the risk society and the system of risk management. This thesis has found that emotions are vital for the professional's motives to work and act in line with the belt of restrictions and its goal that they should report worries. However, it is not just 'professionals' in a universal sense that make reports – it is different professions that have different positions in the hospital hierarchy. This shapes different emotions, orientations and motives to act. The professions had obtained various extents of education about children at risk and information about organizational support (Article III), which involved them activating a variety of emotions that supported or were in conflict with the logic of the (feeling) rule that they should report their worries about children. I suggest that the result showing that nurses, and particularly nurse assistants, do not report should be understood not only as a matter of them having obtained less education and information about organizational support but that this exclusion is related to status and the imbedded class differences that involve certain emotion work. It could thus be argued that Hochschild (1983) is right: it seems like professions of lower status are not governed by feeling rules to the same extent as other professions. Moreover, this seems to be linked to there being a form of inferiority inherent in their work (Neckel, 1996). Discretion can therefore not be understood separated from its context, the gendered and classed position of the professional and the social relations in which the professional is involved. Previous research has suggested that the system of profession and professionalization is a question of gender and class – but there is a peculiar silence so far about how such social structures impact their discretion.

It would be unfair to claim that theorists of discretion do not acknowledge emotions and normativity at all. Cognitive aspects are considered a foundation of discretionary reasoning and the risk of un/equal treatment is a common theme. Some researchers mention very briefly, for instance, uncertainty, stress, gender stereotypes, blaming poor people, institutional racism and how social workers prefer some clients above others in assessment (see, e.g., Lipsky, 1980; Wallander & Molander, 2014). However, they do not complete any theoretical reasoning of what emotion and normativity mean for discretion. To understand *what normativity and emotions do in assessment and how they impact discretion*, I had to turn to the field of research on

normativity and sociality of emotion. Conventional approaches that emotions should not be involved in reasoning and decision-making have been heavily criticized within the sociology of emotions, and I believe it is time to scrutinize theories of discretion for the very same reason. Discretionary reasoning is always a matter of emotions. Emotions are imbedded in inter-professional relations and professional decision-making and are stuck to certain social groups of people in assessment. This suggests that there is a gap in studies of professional discretion that needs to be filled with further theoretically driven studies that may enhance our understanding of – or to some extent even reformulate – how discretion can be described, understood and explored.

WORK WITH NO JURISDICTION: EVERYONE AND NO ONE IS RESPONSIBLE

The lack of jurisdiction over children at risk within health care is a repeated concern in the thesis. The Swedish model stating that, by law, all professionals have a personal responsibility to make reports about children suspected of being at risk has, put bluntly, not worked, considering that nurses, and particularly nurse assistants, almost never report, and many state that they have never had a suspicion that they afterwards felt they should have reported. As discussed in the third article, there seems to be a work culture within hospitals that professions of lower status in the hierarchy tend to pass over the responsibility to report to physicians. Regardless of whether this hospital culture seems functional in practice, all professionals who, in different ways, work closely with children should have the basic skills to identify those children who may be in need of support or protection. This work culture is also put into a juridical dilemma, the updated legislation of later years clarifies that it is actually not legal to pass over the responsibility to someone else: reporting is an individual responsibility. This, in combination with the jurisdiction of social services, can be one explanation for the absence of jurisdictional work and making claims (Abbott, 1988) concerning children at risk within health care. Although most of the HSWs were committed to the work with children at risk and some educated members of other professions in this

field, they did not express claims that the HSW profession should take a lead in such matters. Interestingly, some HSWs were shown to try to expand and defend their area of jurisdiction in their contacts with the primary profession in social services as specialized on premature, disabled or seriously ill children and claim they had expert knowledge about these children's particular needs (Article I). The HSWs' jurisdictional work was thus found to be intra-professional rather than inter-professional (cf. Abbott, 1988).

Abbott (1988) calls attention to the fact that even if physicians successively maintain dominance over jurisdiction in hospitals, they can split jurisdiction with other professions, practically or intellectually, in, for example, that other professions can receive advisory control over certain aspects of the work. The findings in this thesis can be understood as even though no single profession has jurisdiction over children at risk within the hospitals, there is, generally speaking, a split in jurisdiction between physicians and HSWs in practice. Physicians' relatively strong jurisdiction is based on their general status as the owner of jurisdiction within hospitals and their capability to identify certain physical and medical forms of abuse and neglect, and HSWs' relatively strong jurisdiction is based on their comparably high degree of education within this field and their shared education with, and fairly strong professional relation to, the social workers within social services. The practically split jurisdiction between physicians and HSWs forms a jurisdictional pattern despite the absence of jurisdictional claims.

The physicians' jurisdiction was primarily supported by some of the nursing professionals, and this could be seen in that 32 per cent of the nurse assistants and 13 per cent of the nurses believed that physicians should have the responsibility to make reports (Article III). This tendency can be analysed as a consequence of these professions having obtained less education and information on organizational support and being less involved in children-at-risk issues, which leads to inferiority. One complementary analysis could be that particular wards had a routine, meaning that subordinated professions were told that it is the physician who should make the report – but considering the finding that almost half of the nurse assistants did not know if there were any routines or guidelines (Article III), this makes it a limited explanation.

It is fairly clear, however, that even though most professionals certainly believe it is important to identify and report children who may be at risk of harm, the different professions have different motivations to act and to being committed to this work.

The alternative to the lack of jurisdiction within health care, and the outlined pattern of informal split jurisdiction, would be legislation that supports a model where one profession is chiefly responsible for the work with children at risk. However, if one profession should claim to fill the jurisdictional vacancy and be given the major jurisdiction within health care settings, for example HSWs as in Connolly's (2012) study, this would not automatically *increase* the number of reports as long as HSWs do not meet all families⁶. Even if one profession were to have the jurisdiction, make the reports and do the related work on a more routine basis, this profession would still be dependent on other professions identifying and referring cases to them. As this study has shown, however, the nurse assistants in particular do not seem to identify children at risk very often, based on the findings that they almost never make reports and less often than the other professionals feel afterwards that they should have made a report – and the most common reason given for not making reports was insecurity about assessing the situation as abuse or neglect.

There are some practical implications of the findings, especially important if the non-jurisdictional model should be maintained and the ambition is to make it work adequately. If the aim is to identify more children suspected of being at risk of harm and increase the reporting from health care institutions, all health care professionals working closely with children and their families need more awareness, knowledge and equivalent opportunities to be involved in the issue. This means education in the Social Services Act (SFS 1980:620) and other relevant legislation and training in how to identify when a child should be reported to social services and/or is in need of other forms of action. Moreover, all professional groups should have information about organizational support and of being involved in discussions about children at risk. The analyses made in this thesis suggest that more education, training and involvement in

⁶ While all patients meet physicians, nurses and nurse assistants at the wards this is not always the case regarding HSWs. On some wards it is routine for HSWs to meet all the patients, while on other wards they only meet the patients and relatives who make contact themselves or who have been referred by other personnel.

the assessment process can reduce stress, uncertainty and possible inferiority among occupations that are now not actively committed to assessing and reporting children suspected of being at risk of harm.

POSITION, CONTRIBUTION AND PROFESSIONALIZATION OF HOSPITAL SOCIAL WORK

The findings suggest that HSWs do have an important role in the work with children at risk. As outlined in the theoretical section, HSWs in Sweden have emphasized therapeutic skills in their development, and this was partly found in the first article. It was clear, however, that the major group of HSWs took an active position in the assessment processes, although the second major group preferred a more reflective approach to families in cases when there was no concern about the child needing more immediate protection. It is interesting to compare this with Fargion (2014) who argued that the child welfare approach is more reflective and emphasizes professional autonomy and that the child protection approach is more ‘rational’, systematic and standardized. My findings suggests that even though the Swedish child welfare system can be characterized as more reflective, it is also possible to link the HSWs’ active position in the hospital setting (Article I) to a more rational approach. However, in this study, rationality should not be understood in precisely the same way as that in which Fargion (2014) emphasizes it. Here it should be understood as being based on the norm related to mandatory reporting, a legal ‘deontic’ norm. This legal norm attempts to reduce the uncertainties that health care professionals may feel about assessing and reporting because it highlights that health care professionals are actually not expected to be sure about the child being at risk – it is the task of social services to investigate if that is the case. In the hospital setting, the rationality is not primarily related to ‘effective tools for risk assessment’, it is more strongly related to reporting being more routinized.

The findings that some HSWs are taking a reflective position and prefer to handle the situation themselves before considering making a report is a tendency that is in line with the development of Swedish HSWs towards the therapeutic approach

observed by Sjöström (2014) and Olsson (1999). In the context of children at risk, it seems that even though most HSWs do emphasize the knowledge based on their primary profession of social work and the Social Services Act, there are those who emphasize the more therapeutic approach and trust their own abilities to support the families themselves to make a change. Perhaps this is seen as an act less fraught with conflict than routinely made reports, yet it is not in accordance with the interpretation of the law. Even when sufficient treatment is given and another institution has already made a report to social services, a report should be made by an HSW who is concerned about a child (JO 2005: 299). The reflective approach that emphasizes professional autonomy is therefore limited by the legislation and, apparently, there is an imbedded conflict between the legislation and the HSW professionalization towards a therapeutic approach.

It is of course positive that HSWs obtain therapeutic knowledge. Such skills can be valuable for the patients' wellness, motivation for change and for maintaining a good relationship with the family also after a report is made. It is important, however, that a therapeutic approach does not decrease the social work approach in terms of social rights. Within the medical context, HSWs are the professional group with particular knowledge about, for example, the social welfare structures, national civil and social laws, and social services functions and work. This makes them capable of contributing to assessment processes identifying children who may be at risk from a broad perspective and of clarifying whether social services are the authority that should be helpful in specific situations or if there is another authority that should be contacted. There are cases of institutional discrimination, for example when a lack of legal rights, a responsible authority or other problems at an institutional level may in itself be a risk factor for children. These are situations when HSWs need to function as an advocate for the child and its family and convince an authority to act beyond its own directives or, as pictured in the first article, act far beyond their own regular work. The more social inequalities and exclusion there are among health care-seeking children and parents, the more important such actions. Furthermore, the particular knowledge HSWs develop about the social and psychosocial needs of premature,

disabled or seriously ill children can be important to investigation and decision-making by social services (Article I).

This thesis also contributes new knowledge about HSWs' work with the comparisons made between HSWs and other professions. These comparisons outline that HSWs stand out in different aspects, findings that interviews with HSWs cannot contribute. For example, it was found that HSWs had obtained a comparatively large amount of knowledge (Article III), made most reports per individual (Article IV) and were less affected by emotions such as stress, anxiety and insecurity in their decisions not to report, compared with the other professions (Article IV). In the interviews, some HSWs also talked about their profession as the one with the main responsibility for assessing unclear or more complex cases (Article I) that could be described as more uncertain. This suggests that HSWs in general are skilled at dealing with the emotional dimensions of discretion, partly because they are emotionally trained to work with uncertainty and partly because, in practice, they are delegated the most uncertain cases and situations. If this is the case, HSWs may have a profound role in risk assessment within health care institutions and, with their knowledge and experiences, they can be supportive of other professions, even though the HSWs are not the ones making the report.

This study highlights that HSWs' definitions of which children are at risk are broader than the institutional definitions. There are several examples in the first article of the Swedish welfare system not including all residents and failing to meet the needs of families living under a variety of nonstandard circumstances, which in themselves can pose a risk to children. In such ways, the institutionalized definitions and categorizations work as an excluding practice. There are also several examples of the HSWs taking action in cases of such institutional discrimination – and this demands practical social work beyond therapeutic skills. It is this practical social work and the social perspectives on assessing and handling problems that HSWs have a kind of jurisdiction over in practice, while there are many health care professions that compete over therapeutic work. This needs to be considered in future professionalization efforts. Perhaps more dramatically expressed in words: this is a matter of the profession's survival, the possibilities for maintaining social and holistic perspectives

within health care and the patients' possibilities to receive support with social problems.

The findings further address the relationship between weak boundary work, weak mutual support, a lack of intra-professional unity and an HSW organization at the hospital, and tendencies for HSWs to become passive and not contributing their professional knowledge and relying on the physician's judgement (Article I). HSW organizations at hospitals are important for identifying common problems, formulating strategies and making changes. They are also vital for maintaining and developing specific sub-professional knowledge, building mutual support and increasing the professional self-confidence necessary not to let inferiority contribute to withdrawal (Neckel, 1996). While there is international literature on the importance of HSW organizations with HSW leaders who understand the surrounding complexities and challenges and have the competence and confidence to contribute to the directions of changes needed (see, e.g., Mizrahi & Berger, 2001), this is an underexplored issue within the Swedish context that needs further attention.

WHERE ARE WE HEADING?

Some argue that the child welfare and child protection systems seem to be moving closer together, meaning that the child protection systems embrace supporting aspects, and child welfare systems like the one in Sweden embrace the New Public Management approach with efficiency, checklists and risk assessment tools. In Sweden, there seem to be two parallel movements, both based on arguments about the best for the child: on the one hand there is increasing universal parental support addressed to all parents (Government Office, 2013) and on the other increasing focus on how institutions and professionals manage to take their responsibility to report their suspicions of harm to social services (see, e.g., National Board of Health and Welfare, 2014a; 2012). In recent years, new national guidelines addressed to health care professionals have been implemented, the laws clarified and sharpened, and the Supreme Court has stated that professionals who fail to make immediate reports can be convicted. The increasing focus on risk assessment and professionals' accountability to report in Sweden indicate a movement towards a 'guilt culture',

which Fineman (2003) has described as more characteristic of child protection approaches such as that in the United States.

It is argued that child protection systems are linked to the neoliberal ideology because they are associated with the reasoning that the state should not interfere with family privacy except when legally required (Fargion, 2014; Parton, 2014). Such a system attempts to reduce public services and promote the individuals' own responsibility – an ideology in which blaming of individuals' presumed shortcomings can grow, that is to say the blaming of inadequate or violent parents and immoral teenagers. It goes hand in hand that reduced public services require narrower definitions of children at risk, and children who are at risk of harm because of institutional and structural reasons will not be included in such definitions. Consequently, in practice, these children will be the 'problem' of individual professionals to handle. In the first article, some HSWs described the great amount of time and work they devoted to diseased children with particular needs whose parents were living under nonstandard circumstances, such as in poverty and illness for which they were not able to seek help due to their lack of a residence permit. It is conceivable that there will be more such examples in the future if poverty among children increases and the number of people without residence permits continues to grow. During 2015, there were more people than usual seeking asylum in Sweden, resulting in, for example, Karolinska University Hospital employing several specific 'asylum HSWs'. The same year, the government as well as several political parties suggested that it should be harder to be granted a permanent residence permit and family reunion in Sweden, which – if decided – would result in an increasing number of children and parents living in insecurity and separated from each other, and an increasing number of children being excluded from basic rights, support and protection. The United Nations, NGOs and a number of professional associations have raised criticism against such suggestions, arguing that it is a serious violation of the Convention on the Rights of the Child (1989), a convention the government has suggested will be transformed into law in Sweden in 2018 (SOU 2016:19).

If Sweden is heading for a child protection approach at the same time as institutional exclusion and discrimination increase, this will have effects on children

and their parents as well as welfare professionals. As shown in the first article, when patients struggle with problems without a responsible authority (or even caused by the system), HSWs are needed to mitigate the consequences.

So far, however, the Swedish institutionalized definitions of children at risk are fairly broad. The risk definitions involved in the mandated reporting have been clarified in the national guidelines (National Board of Health and Welfare, 2014a) presented earlier, and poverty and structural harms are not included in these. However, the guidelines also describe a range of risk factors that they suggest health care personnel should know about in an attempt to prevent and identify when children may be at risk. They point out that such risk factors may not cause a problem: they may be factors that researchers have found to increase the risk of negative development of the child, an approach comparable with Tang's (2008) reasoning that social contexts may contribute to child neglect. Possible risk factors for children described by the National Board of Health and Welfare (2014a) include criminality, partner violence, alcohol and substance abuse, and lack of sufficient housing, schools or health care. It is worth noting, however, that they also describe certain characteristics of parents as possible risk factors for children and single out parents who are young, single, unemployed, recipients of social allowances, on sick leave or mentally ill, or who have a low level of education, intellectual impairments or a foreign background. These seem to be stereotyped descriptions based on a general overrepresentation of these social groups within child welfare.

In my second article, several HSWs, in a similar manner and more or less critically, talk about such descriptions and signs as 'risk parents', 'risk factors', 'warning signs', 'stereotypes' or 'things to be observant about' or 'vigilant about' when assessing parenting. I use the umbrella term 'warning signs' to describe these signs and argue that they can be analysed as 'sticky signs' (Ahmed, 2008) because they function as surfaced signs of warning that are linked to the informants feeling that something is not 'normal' in the family. The only dimension that distinguishes the warning signs described by the HSWs from those in the national guidelines is gender. The HSWs clearly outline gender stereotypes in terms of neglect being associated with mothering and abuse with fathering. If the National Board of Health and Welfare

would pursue its logic of referring to research about groups that are related to risk factors for children, they would pinpoint men as a consequence of the fact that fathers are overrepresented as perpetrators in the statistics of physically or sexually abused children (see, e.g., Cavanagh, Dobash & Dobash, 2007; Janson, Jernebro & Långberg, 2011) but they do not, except for mentioning men's violence against women. This begs the question: Why?

A possible explanation may be that it is conceived to be inappropriate or controversial to add the gender variable in this context of being a 'risk factor'. They do not mention that nearly 80 per cent of single parents in Sweden are women (Statistics Sweden, 2015b), nor do they mention that men are overrepresented as sexual abusers (Shannon & Törnqvist, 2011) and physical abusers (moreover, men born in Sweden are overrepresented for pushing, roughly grabbing and shaking their children compared with men born outside Sweden; Janson, Jernebro & Långberg, 2011). What is clear in this thesis is that gender stereotypes work as active 'warning signs' in assessment (Article II) in line with research statistics – but my suggestion is not that we should add gender to the national guidelines' risk factors, rather we need to be more careful with such descriptions of what constitute risk factors. As several HSWs reasoned, the normative logic of 'warning signs' does not automatically mean that the child is exposed to risk, but such recreation of warning signs may lead to discrimination against the groups with which they are associated (Article II). To single out families with a foreign background as a risk factor for children, which is done in the national guidelines as well as among HSWs in this thesis, is related to blaming and discrimination. It is worth bearing in mind that the overrepresentation of immigrant children in child welfare institutions disappears when taking socio-economic factors into account (Vinnerljung et al., 2008). Blaming of poor families also occurs, and the way poverty is tackled as a risk factor should be a vital question if we should continue to walk the road to a child protection system. The increased parental support may strengthen parenting and the family's social network, but it is not a solution to the poverty that can cause harm to children.

Risk definitions as such are not a bad thing; they may be necessary to ensure that children are receiving support or protection – but as Parton (2014) writes, we need to

reflect carefully about the character of the problem that we try to define and what changes we hope to see by using a particular definition. Definitions are never free from values. If the development towards a child protection system involves heading closer to a guilt culture, this may increase the lack of trust in, and fear of, social services, and decrease the possibilities of working with a reflective approach that takes into account understanding concerns regarding children and their families (Houston & Griffiths, 2000). Moreover, the obligation to report *all* concerns about children who may be at risk does not fully harmonize with what Houston and Griffiths (2000) describe as being a participative and democratic professional style that approaches risk in a more ethically sensitive and reflexive manner. Although the present legislation does not promote flexible actions, this thesis shows that the practice still does. Furthermore, as long as definitions of risks are flexible in practice, i.e. beyond the intentions of the legislation (Article I), there will always be situations of risk that social services cannot manage. Professionals are aware of this, so the question of what should be reported and when can probably not be completely solved – it is always the situation in focus that must be assessed. Some of the national guidelines' clarifications of what potential harmful situations and actions should be reported to social services can hypothetically reduce some uncertainties – if the guidelines reach out to all affected professionals. The quantitative study's findings are based on data that were collected only a few months after the national guidelines were released. The respondents were not asked about these particular guidelines, and the findings show no signs that they would have been informed by them (Article III), but perhaps they will be implemented among professionals and shown to have an influence in the future.

The third article found that hospitals differed in the type and level of organizational support offered to personnel, such as access to child protection teams, children's advocacy centres, other specialists, guidelines and routines, supervision in groups or mentors. Importantly, the professional groups showed different levels of knowledge and awareness about such support, with nurses and nurse assistants showing a lower level of awareness than physicians and HSWs. This highlights the different conditions for the different occupations, which can be added to the similar differences in obtained education. The hospital hierarchy and the different statuses of

the professionals therefore seem not only to lead to differences in knowledge contributions to workplaces (Kvarnström, 2007) but also to the information and knowledge obtained following this hierarchy, i.e. the lower the status, the less information will reach the person. Health care institutions, and all health care education, therefore need to meet the challenge to make sure that health care professionals obtain information about organizational support and sufficient knowledge about the legislation and how to identify children who may be at risk of harm. This is vital not only for the children who need support or protection but also for the personnel who otherwise may be prosecuted and convicted for misconduct (see, e.g., Supreme Court, 2014).

While spreading information about the structures supporting the work with children at risk is unlikely to involve much work for organizations, offering supervision and mentoring to all health care professions may require further resources. The findings show that only HSWs regularly use supervision, while at most one-fifth of the other professional groups use it (Article III). Although the regressions that were made did not show supervision to be of major importance to reporting rates or decisions not to report, there is a trend suggesting that supervision together with other supportive structures can be helpful (Article IV). In addition, the non-jurisdictional model together with the increasing development of inter-professional teams may involve less intra-professional support as well as less intra-professional emotional support, according to Lindgren and Olsson (2008), which raises the question of supervision and mentors as two forms of support that could meet those needs. Working with children at risk is often emotionally strenuous, and to raise such questions at lunches and coffee breaks at work may be hard, as at least some personnel consider these breaks as time for recovery.

THE CHILD PERSPECTIVE

This thesis has been preoccupied with the HSWs and their colleagues' assessment and work with children and their families. The children's own perspective has not been explored here, although the child perspective is at the very foundation of the thesis. Children's right to a healthy childhood, to being looked after and to being protected

from exploitation and all forms of violence is based on the United Nation's Convention on the Rights of the Child (1989), a convention that in many ways serves as a base for the child welfare system and child health care.

The way health care professionals use their discretionary space when worrying about a child being at risk of harm has profound consequences for the children. The main result of the thesis is that HSWs and their colleagues have, or at least act as if they have, wide discretion in spite of being mandated reporters. The first article discussed the tendency for the extensive practice of discretion to lead to both unjustified unequal and unjustified equal treatment. One analysis showed that there was a connection between the juridical norm and equal treatment, and between the medical norm and unequal treatment. It was found that the juridical norm might have meant that reports were made about children who were not actually maltreated, which can expose families to troublesome questioning and investigation. Even though some HSWs argued that no harm is caused by such reports if social services conclude that there is no harm to the child, some parents and children may experience harm and have their trust in child health care damaged. These are perhaps, in part, unavoidable costs of a robust system with committed parties, but it is nonetheless something that must be handled in the best possible ways to ensure the system itself does not cause unnecessary harm to the children it is supposed to support.

While the juridical norm was linked to equal treatment, the medical norm was instead linked to unequal treatment because it implied that at-risk children were not paid sufficient attention and being reported by some HSWs (Article I). There were some examples when HSWs' non-actions were guided by, for instance, a physicians' argument that it could not be proved that the severe anal injuries were caused by parents' sexual abuse. This suggests that the different statuses can lead to HSWs not trusting their own professional judgements and not valuing them as being as important as those of the physicians (Article I). HSWs not valuing their own knowledge and judgement can be understood as a form of outcome that Neckel (1996) calls inferiority, in the worst case resulting in children not being protected from violence and harms. This is perhaps one of the most serious outcomes of the hospital hierarchy and the dominating medical norm, and an example of when health care professional's

prestige or fear of making wrong judgements may have serious consequences for a child and contribute to the violation of the child and the child's rights.

The first article also outlines a third group of HSWs who were guided by a reflective approach in assessment relating to the therapeutic norm. This group tended to reflect on various ways to act and offer support or treatment, and they valued their own capacities to do so. This reflective approach harmonizes with Houston and Griffith's (2000) description of a participative and democratic professional style that approaches risk in a more ethically sensitive and reflexive manner and takes into account understanding concerns regarding children and their families (Houston & Griffiths, 2000). This approach promotes the preventive features within the child welfare approach and shapes the very discretionary space needed for critical reflexivity about the way in which emotions and normativity may affect their assessment (Article II). I suggest that the analysis in the second article may be an attempt to reveal, although not completely solve, the risks of wide discretion, namely unjustified unequal treatment or unjustified equal treatment of children and their parents. The second article shows that critical reflexivity is important for unpacking judgements that (re)produce discrimination over unprivileged groups, meaning that unprivileged parents and their children are treated with more suspicion or just not taken as seriously. The analysis further suggests that critical reflexivity may disturb the silence of normality that may involve children from privileged groups not being given enough attention because the 'normal' family lacks the 'warning signs' that tend to produce feelings of worry.

The reflective approach requires HSWs to have adequate knowledge and skills to make fair assessments and to judge what and when actions should be taken. However, this approach does not fully harmonize with mandated reporting because mandated reporting relates to a child protection approach that demands reporting above reflexive and preventive work in health care institutions. The mandated reporting thus leaves us with the unsolved dilemma of unjustified unequal treatment and unjustified equal treatment of children. There is limited room for an ethically sensitive approach within existing legislation, with inherent risks that the system itself may involve distrustful relationships and possible harms to the children it is supposed to support. The guilt

culture imbedded in a child protection approach is unavoidably offending or stigmatizing for some children and their families.

Health care professionals thus not only need education about the legislation and how to identify children at risk, they also need training in how to critically reflect on ‘warning signs’ that involve categories that are, to some extent, discriminative. This involves there being a need for training in the child perspective and children’s various rights, including freedom from discrimination and the right to express own views and be heard in all matters that affect the child, with respect to the age and maturity of the child.

The Convention on the Rights of the Child (1989) has gradually been strengthened over the years in legislation and within the welfare institutions’ work routines – but at the same time there are conflicting and worrying tendencies about the remaining child poverty and institutional discrimination. The norms imbedded in children’s rights and human rights serve as an important base for advocating respect for each child’s rights and equality, but structural factors causing harms can still be overseen if problems are narrowly constructed as family problems. As discussed earlier, there is tension imbedded in normalization as it strives for equal rights and opportunity to a ‘normal’ life, while at the same time there is criticism against it as it reconstructs people as ‘deviant’ and fails to challenge the very foundation of the power structures and unequal material conditions (Chappell, 1992). Although this criticism is important, it is reasonable to uphold the principles of all human’s equal worth and rights as they map out that we must not arbitrarily discriminate against some children. The tension imbedded in normalizing work, of which children at risk assessments are part, can at least partly, as some of the HSWs showed, be handled by critically reflecting on the particular conditions in individual cases and what we are actually worried about. Are the things we worry about a matter of problematic parenting or are they based on structural factors or normative assumptions? These are questions that should be asked continuously by professionals to promote reflexive and ethically sensitive professional work that sets the child’s perspective, the strengthening of parenting, as well as structural factors on the frontline. Risk assessment should consider both individual and

structural factors and respond to those: advocating may be needed both in individual cases and at societal level.

The HSWs in this thesis describe some structural harms for already vulnerable children, for which they can only try to relieve the consequences. Hospital professionals face many children living with disabilities or long-term illness, groups of children who more often than others already live with limited socio-economic resources, despite the extra costs of their specific needs. Some of these children need protective interventions related to insufficient or harmful caregiving, while others need protection or support, with a social system that in itself can cause them harm. Moreover, some children are suffering the consequences of their parents living as refugees without a residence permit, a situation that can involve a range of juridical, socio-economic and practical problems which themselves becomes a risk for the child's development, health and life. Children not only need safety for themselves but also for their families.

If Sweden aims to realize the commitment of all children's right to a secure and good childhood and actively works against discrimination of some groups of children, there is plenty of work to do. What HSWs and their colleagues can do has been outlined above, but the legislative and policy changes needed to secure the equity of all children, and not only of some, require political actions. The welfare system must be inclusive and strive to remove institutional barriers and other structural factors that may cause harm to children.

The suggested transformation of the Convention on the Rights of the Child (1989) to Swedish law will hopefully strengthen the children's perspective at the legislative policy as well as professional practice levels. The above discussion about the national guidelines addressed to health care professionals (National Board of Health and Welfare, 2014a) indicates, for example, that the guidelines need some careful revisions that take into account all relevant articles in the Convention. Such revisions could include descriptions of structural harms without singling out some social groups of parents as risk factors. Sometimes it is structural factors that cause harm and not necessarily the parents – an important distinction from a children's perspective. What is best for the child may sometimes be to address insufficient parenting and at other

times to address the structural circumstances. How problems or situations are described and understood by professionals may have consequences for the children and the kind of treatment they receive.

SVENSK SAMMANFATTNING

Barn som far illa? Sjukhuskuratorers och deras kollegors erfarenheter av bedömning och anmälan

Avhandlingen undersöker läkares, sjuksköterskors och undersköterskors och särskilt sjukhuskuratorers erfarenheter av att arbeta med barn som far och misstänks fara illa. Tyngdpunkten ligger på att undersöka hur en rad olika faktorer påverkar dessa professionella gruppers bedömningar och anmälningar till socialtjänsten. I Sverige har all personal som möter barn i tjänsten skyldighet att göra en anmälan till socialtjänsten vid misstanke om att ett barn far eller misstänks fara illa (SFS 2001:453). Tidigare studier har visat att personal inom hälso- och sjukvården gör färre anmälningar jämfört med personal inom andra institutioner. Detta trots att barn med sjukdomar och funktionshinder har visat sig vara särskilt utsatta för olika former av våld, och att dessa grupper av barn mer frekvent än andra barn besöker sjukvården.

Syfte och frågeställningar

Det övergripande syftet är att undersöka en rad faktorer påverkan på barnsjukhuspersonals professionella diskretion i deras bedömningar av barn som far eller misstänks fara illa. De olika faktorer som undersöks är bland annat emotioner, sociala normer, professionella relationer, erhållen utbildning och erfarenhet samt kännedom om organisatoriskt stöd. Sjukhuskuratorer står i fokus, men även läkares, sjuksköterskors och undersköterskors uppfattningar om, och erfarenheter av, bedömning och anmälan undersöks och analyseras i två av avhandlingens fyra artiklar. I den sammanfattande kappan kontextualiseras resultaten genom att diskutera dem i

relation till det svenska barnavårdssystemet, och en övergripande analys av de professionellas diskretion, bedömningar och erfarenheter görs, och teoretiska och praktiska implikationer diskuteras.

Teoretiskt ramverk

Till stöd för analyserna har avhandlingen ett teoretiskt ramverk bestående av teoretiska begrepp från professionsstudier, emotionssociologi och normativitetstudier. Det är särskilt två begrepp från professionsstudier som står i fokus; professionell diskretion samt jurisdiktion. Genom att visa på hur emotioner och normativitet inverkar i professionella bedömningar och ligger till grund för handling förs en diskussion om hur detta påverkar professionell diskretion.

Metoder, data och analysmetoder

Avhandlingen består av två delstudier. Den första är en kvalitativ intervjustudie med 14 kuratorer på åtta olika barn- och ungdomssjukhus (eller kliniker) på såväl universitetssjukhus som regionala sjukhus i Sverige. Den andra delstudien är en kvantitativ enkätstudie med 295 deltagande läkare, sjuksköterskor, undersköterskor och kuratorer på de fyra största barnsjukhusen, med en svarsfrekvens på 80,8 procent.

Intervjustudien analyseras i två artiklar, där artikel I använder sig av innehållsanalys och artikel II har en diskursanalytisk ansats. Enkätstudien analyseras även den i två artiklar, där artikel III har en beskrivande och jämförande ansats, medan artikel IV utöver en beskrivande och jämförande ansats också använder sig av rankning samt logistiska regressioner.

Resultat

Artikel I undersöker kuratorers position och bidrag i sina interprofessionella team, och visar att kuratorerna tog tre alternativa huvudsakliga positioner – aktiv, reflekterande eller passiv – i sina interprofessionella team, vilka ledde till olika handlingar i bedömningsprocessen. De tre positionerna var relaterade till tre institutionaliserade normer för handling – juridisk, terapeutisk och medicinsk – normer

som vilar på olika professionella kunskapssystem. Den juridiska normen baseras på anmälnings-skyldigheten och relaterade till en aktiv position där kuratorerna exempelvis bidrog med psykosociala utredningar och att samordna arbetet. Den terapeutiska normen var vägledande för de som primärt använde sig av rådgivande eller motiverande samtal i syfte att få föräldrar att själva söka hjälp. Den medicinska normen var vägledande för kuratorer som argumenterade för behovet av dokumenterade medicinska fakta som kan användas som bevis på att övergrepp skett och som skulle kunna leda till rättsliga konsekvenser. Den medicinska normen innebar en mer passiv position då kuratorn följde läkarens bedömning vilket visade sig vara relaterat till en svagare relation till andra kuratorer och socialarbetare samt uteblivna jurisdiktionsanspråk. Artikeln diskuterar vilka konsekvenser de olika institutionaliserade normerna och positionerna får för barn och deras familjer, och väcker frågor om framtida professionaliserings-anspråk för kuratorsprofessionen.

Artikel II undersöker hur emotioner relaterar till normativitet i kuratorers bedömningar av föräldrar i deras berättelser om barn som misstänks fara illa. Analysen visar att emotioner på olika sätt var en del av bedömningar av olika grupper av föräldrar, och att mer kraftigt uttryckta känslor ofta relaterade till normativitet på ett ”klibbigt” sätt. Känslor av ömhet, skam och grymhet aktiverades i bedömningar av föräldrar med medicinska diagnoser, medan känslor av oro och skuldbeläggande klibbades fast vid könsstereotyper beroende på om omsorgssvikt (mödrar) eller fysiskt våld (fäder) stod i fokus. Känslor av skuldbeläggande och distans tenderade att klibba fast vid föräldrar som beskrevs ha en annan kulturell eller nationell bakgrund än svensk, medan känslor av samhörighet, rädsla, svårighet och att bli lurad tillsammans formade ambivalenta känslor i bedömningen av den ”normala” familjen.

Avsaknaden av skuldbeläggande producerade känslor av ömhet, skam och grymhet – motstridiga ”ologiska känslor” som kunde fungera bindande i relationen mellan kuratorn och föräldrar då det öppnade upp för känslor av tillhörighet. När skuldbeläggande var närvarande aktiverades ”logiska känslor” som oro vilket möjliggjorde ”normativitetens logik” och att handlingar orienterades mot att exempelvis ifrågasätta föräldrar eller anmäla dem till socialtjänsten. Kuratorerna talade också om ”varningssignaler” som på liknande sätt passar in i normativitetens

logik, vilket betyder att signaler om ”avvikelser” i form av funktionshinder, arbetarklass, eller annan kulturell eller nationell bakgrund än svensk tenderade att producera känslor av oro. Känslor är på så sätt involverade i diskriminerande strukturer, men när kuratorerna reflekterade kritiskt över ”varningssignaler” och normativitet i sina bedömningar, så minskade känslor av skuldbeläggande vilket aktiverade ambivalenta känslor. På så sätt stör reflexivitet normativitetens logik i bedömningar.

Artikel III undersöker de organisatoriska och professionella villkoren för läkare, sjuksköterskors, undersköterskors och kuratorers arbete med barn som misstänks fara illa på de fyra största barnsjukhusen. Enkätsvaren visar att alla dessa sjukhus erbjöd olika former av organisatoriskt stöd, så som barnskyddsteam, barnahus, specialistkonsulter, grupphandledning, mentorer, och riktlinjer och rutiner, men att de olika professionerna hade varierad kännedom om, och tillgång, till dessa. Sjuksköterskor och undersköterskor hade lägre kännedom om sådant stöd, och medan i princip alla kuratorer regelbundet gick i grupphandledning, var det ovanligt bland de övriga professionerna att gå i grupphandledning eller att använda sig av en mentor. Artikeln visar även att särskilt sjuksköterskor och undersköterskor hade mindre kunskaper på området barn som far illa jämfört med läkare och kuratorer. Exempelvis svarade samtliga kuratorer att de hade tillräcklig kunskap om vad Socialtjänstlagen innebär för dem i arbetet, medan enbart 38 procent av undersköterskorna svarade att de hade det.

Liknande mönster återgavs på frågan om vem respondenterna ansåg skulle ha ansvar för att göra anmälningar: 32 procent av undersköterskorna och 13 procent av sjuksköterskorna ansåg att läkaren ska ha detta ansvar, vilket bara 10 procent av läkarna själva höll med om. Men de flesta, särskilt bland kuratorerna, ansåg i enlighet med lagens intention att det är den som har en misstanke om att ett barn far illa som ska göra anmälan. Artikeln argumenterar att om personalen inte har erhållit tillräcklig kunskap och inte känner till det organisatoriska stödet, så riskerar det praktiska arbetet med barn som far illa att brista. En konsekvens av att barn som far illa är allas, och ingen enskild professions, ansvar kan bli att detta arbete betraktas som ett ”slaskarbete” och leda till undvikande strategier bland hälso- och sjukvårdens professioner.

Artikel IV undersöker de olika professionernas erfarenheter av att anmäla till socialtjänsten, och analyserar en rad olika faktorer påverkan på anmälningsgrad samt beslut att inte anmäla trots att de haft en oro för ett barn. Mer än hälften hade aldrig gjort en anmälan, och nära sex av tio hade vid enstaka tillfällen valt att inte göra en anmälan trots misstanke. Men svaren skilde sig mycket mellan professionerna. Sjuksköterskors och undersköterskors odds för att vara låganmälare var mycket hög jämfört med läkare och kuratorer. Respondenter som hade arbetat mer än fem år i yrket och hade tillgång till riktlinjer och rutiner hade istället lägre odds för att vara låganmälare, men högre odds för att ha beslutat att inte göra en anmälan. Tillgång till riktlinjer och rutiner verkar alltså i viss mån öka anmälningsgraden, medan andra faktorer tycks påverka deras beslut att inte göra anmälan.

Emotioner hade ingen påtaglig relation till den faktiska anmälningsgraden i regressionsanalys, men känslor av stress visade sig ha hög signifikans för beslut att inte anmäla. Detta trots att stress placerades lägst i en räkninganalys av respondenternas svar på i vilken grad en rad olika känslor och omständigheter påverkat deras beslut att inte anmäla. Rankningen visade istället att osäkerhet i att bedöma en aktuell situation som misshandel eller omsorgssvikt, och ambivalens kring vilken åtgärd som var bäst för tillfället hade störst inverkan. Rankningen visade också att de olika känslorna präglades starkt av professionstillhörighet: sjuksköterskor, undersköterskor och läkare hade påverkats mycket av osäkerhet i att bedöma en situation som misshandel eller omsorgssvikt, ofta känt ambivalens kring hur de skulle agera, och påverkats av om föräldern eller den unga själva förklarat en skada. Undersköterskorna, den grupp som påverkas mest av emotioner, var även oftare påverkade av osäkerhet kring kulturella skillnader i barnuppfostran och bristande förtroende för att socialtjänsten ingriper tillräckligt. Kuratorer stod ut som minst påverkade av emotioner även om en tredjedel av dem känt sig ambivalenta i hur de skulle agera vid oro för ett barn.

Övergripande analys och diskussion

Resultaten visar att hälso- och sjukvårdspersonal har, eller åtminstone agerar som att de har, en vid diskretion i sina bedömningar av barn som far eller misstänks fara illa

och att en majoritet vid enstaka tillfällen valt att inte göra en anmälan även om de haft en misstanke. Detta trots att all personal som arbetar med barn är skyldiga att omedelbart göra en anmälan till socialtjänsten vid en misstanke, utan krav på bevis att det förhåller sig så.

Hur ska vi teoretiskt förstå den vida diskretionen i bedömningarna? Avhandlingens analyser pekar på att professionell diskretion bör förstås i sin kontext och genom att ta hänsyn till den status den professionella har i organisationens hierarkier, och hur det i sin tur samvarierar med andra faktorer. Lägre status innebar exempelvis att ha tillägnat sig mindre utbildning på området barn som far illa och ha mindre kännedom om organisatoriskt stöd. Professionella med lägre status påverkades också mer av emotioner i sina beslut att inte anmäla. Det kan delvis förstås som att stress och osäkerhet ökar när arbetsuppgifter upplevs ligga bortom personalens kapacitet, som en konsekvens av att de tillägnat sig mindre kunskaper och erfarenheter. Att inte ha tillgång till information och kunskaper kan även innebära känslor av underlägsenhet, vilket kan resultera i att personal undviker dessa arbetsuppgifter. De emotioner och sociala normer som präglar professionella hierarkier påverkar i förlängningen alltså bedömningar av patienter.

Emotioner och normativitet var också på olika sätt sammanlänkade i kuratorernas bedömningar av föräldrar. Oro och andra ”logiska känslor” aktiverades av olika former av ”varningssignaler” som var baserade i diskurser där risker associeras till stereotyper och oprivilegierade grupper, medan ambivalenta känslor väcktes när det fanns tecken på skador hos barn från ”normala” familjer. Avhandlingen argumenterar att traditionella teorier om professionell diskretion saknar en fördjupad teoretisk diskussion om vad emotioner och normativitet gör i bedömningar, och hur det påverkar professionell diskretion.

Resultaten får också praktiska implikationer. Det är tydligt att lagen om alla professionellas anmälningsskyldighet inte fungerar som det är tänkt eftersom det i praktiken i princip bara är läkare och kuratorer som gör anmälningar av de professioner som studerats här. Sjukhushierarkin tycks forma en sjukhuskultur som inte följer socialtjänstlagens intentioner. Detta förstås delvis som beroende på bristen på formell jurisdiktion inom hälso- och sjukvården: barn som far eller misstänks fara

illa är allas, men ingen särskild professions, ansvar. I praktiken har därför jurisdiktionen huvudsakligen kommit att delas på informellt sätt mellan läkare och kuratorer. En slutsats är att om lagen ska ha förutsättningar att fungera, så behöver alla professioner som möter barn eller föräldrar få grundläggande utbildning om barn som far illa och anmälningsplikten, involveras i bedömningar, och få information om det organisatoriska stöd som sjukhusen erbjuder personal. Detta är viktigt såväl för drabbade barn som för personalen själv som annars riskerar att åtalas och dömas för tjänstefel.

Resultaten får också praktiska implikationer för kuratorer i Sverige. Även om en större del av de intervjuade kuratorerna tog en aktiv position i arbetet med barn som far eller misstänks fara illa, så fanns det de som tog en mer reflekterande eller en mer passiv position. Den passiva positionen kan innebära en försvagning av professionen och kuratorers bidrag på arbetsplatser, och att barn som far illa inte blir uppmärksammade och får stöd och skydd. Den reflekterande positionen kan istället innebära ökade förutsättningar för ett mer ödmjukt förhållningssätt till en familjs sociala villkor och ge utrymme för den reflexivitet som är nödvändig för att bryta ”normativitetens logik” och diskriminerande strukturer i bedömningar. Hänsynstagande till familjers sociala villkor återfinns i det svenska barnavårdssystemet, men hälso- och sjukvårdspersonals skyldighet att omedelbart anmäla en misstanke till socialtjänsten är en princip som ger tämligen lite utrymme för ett reflexivt förhållningssätt inom sjukvården.

De senaste årens skärpningar av lagstiftningen på området och att högsta domstolen dömt till tjänstefel i ett fall där anmälan inte omedelbart gjordes, väcker frågor om att Sverige är på väg mot den ”skuldkultur” som är mer karaktäriserande för Anglosaxiska länders barnskyddssystem. Även om det skulle kunna innebära ett starkare skydd av de mest utsatta barnen, så finns en risk att en utveckling mot ökat fokus på riskgrupper av barn och straffbeläggande av professionella i sig själv kan skada förtroenderelationer mellan patienter och professionella och att systemet orsakar mer skada än nytta i de fall familjer skulle behöva stöd snarare än bli misstänkliggjorda. Barn far inte alltid illa på grund av bristande föräldraskap, de kan också fara illa på grund av strukturella faktorer, såsom social exkludering eller institutionell

diskriminering, vilket kan fodra andra åtgärder än de barnvårdens instanser kan erbjuda – en viktig distinktion från barnperspektiv. Hur risker beskrivs och förstås av professionella får konsekvenser för barnen och för de sätt som risker hanteras.

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