WORKING AT THE MARGINS OF ABSTRACTION; UNDERSTANDING CHILD NEGLECT IN GENERAL PRACTICE, A MIXED METHODS STUDY

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Declaration of Authenticity and Author's Rights

‘This thesis is the result of the author’s original research. It has been composed by the author and has not been previously submitted for examination which has led to the award of a degree.’

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ABSTRACT

Child neglect as a form of child maltreatment has no standard definition nor is it associated with any particular research methodology. This study explores the impact of understanding child neglect in general practice with an initial study aim to address a research gap, that is, knowledge of a subject that is not formally taught and given scant attention in contemporary general practice. In doing so I looked beyond the boundaries of the profession and the immediate reception of constituted knowledge towards child neglect's social context and its historical aspects. Reading around the texts of child neglect, the research direction began to embrace the principles of a mixed methodology. This enabled an exploration of child neglect meaning from a number of perspectives in order to build a bigger picture of this complex abstract entity. Mixed methods research has been increasingly used in health but is infrequently employed in the context of general practice. A dialectic stance within mixed methods in this study was developed as the positivist findings of a structured questionnaire were integrated with strongly interpretive in depth interviews with GPs, focus group work and historical textual analysis inspired by a Habermasian framework. Habermas's treatise of communicative action and knowledge interests provide the philosophical background to justify the methodology employed within this thesis.

As a real world evaluation of an abstract concept this study addresses three research questions regarding mechanisms of knowledge acquisition, consensus and disagreement of child neglect in general practice and its situated meaning within its socio-historical context and relevance to contemporary general practice. All are considered within a mixed methodology that is generative of unique findings over and above single methods in a 'spiralling manner' (Greene, 2008) which would not have been possible with single methods alone. This creates new and synergistic understanding within the methodology through conceptualisation, data integration and research dialogue, but is dependent on simultaneous processes of 'methodological' and 'conceptual integration' (Day, Sammons & Gu, 2008).

Findings suggest that looking beyond the limits of normative assumptions of child neglect meaning is vital if we are to move forward in a holistic approach to ameliorate the effects of neglect and the practical requirements of accomplishing such a task. This is a suitable theoretical concern where child neglect appears to be discursively constructed today as stable ideological notions that are paralleled in historical texts of child neglect. This represents a process where neglected children have been regarded as a separate class who are consistently viewed through the lens of poverty and parental addictions. These continue to shape society's understanding of it today, because there remain unresolved tensions in the explanation of child neglect to establishing its multifaceted dimensions alongside a simultaneous reduction of meaning. Parton (2009) describes this dilemma as the 'social' being 'overshadowed' by the requirements of an increasingly technological 'informational' child protection system.

However, the research conclusions are drawn from a single study of one real-world evaluation of a complex phenomenon, but its findings of convergence and divergence within the discipline of mixed methods would suggest that more scholarship is required to explore the issues raised within this thesis.

CHAPTER ONE; INTRODUCTION

1.1 Setting the Scene

This study was sparked by my own reflections on working with vulnerable children and their families as a general practitioner (GP) in an inner city practice epidemiologically demarcated by high levels of deprivation and low socio-economic status that pose particular challenges to general practice (Deep End Report 12, 2010).

In my professional lifetime I have encountered many children over the years that I would regard as vulnerable and potentially neglected. On reaching adulthood many have become citizens realising their "economic potential", whereas others have not fared well in the domains of education, employment or health, frequently attending the surgery with on-going unresolved physical and psychological problems. Numerous clinical encounters that make it possible to observe child behaviour, parental and family functioning within a surgery setting and patients' homes in over seventeen years of practice have influenced the research questions that have shaped this thesis.

One of my first obstacles as a novice researcher was that to my mind the diverse fields of inquiry of child maltreatment make researching and writing about one of its constituent components, child neglect, a daunting project. As an object of study it does not have any single heritage of methodology. Whilst there is a substantial body of research describing child neglect within contemporary maltreatment research, if I were to concentrate my efforts on evaluating the epistemic position of GPs this would be a very limited thesis indeed.

One could begin the analysis at the level of the state, examining the legal and political apparatus dealing with child neglect and their impact on general practice. Equally a focus on working practices of GPs who are concerned about issues of child welfare would also be relevant, therefore it seems that an amalgam of theoretical perspectives may be appropriate. This naturally led me to speak to colleagues directly about their own work experiences and consequently, the research focuses on

discursive and narrative domains within sociolinguistics in professional talk as one analytic approach.

An exploration of the rhetorical devices which GPs employ to construct and negotiate their own understanding of child neglect partly answers questions of the extent of their knowledge and taken-for-granted assumptions and practices. Whatever source of information that is used to constitute meaning in their everyday activities, GPs present information (written or spoken) to colleagues and patients. Language and the use of language in its social context and in the construction of subjective meaning are fundamental to this process.

That said, without reference to a theory of communicative action at both levels of agency and structure the position of GPs and their contribution to this field is less well understood. Consequently throughout the progress of the research I have repeatedly returned to the diverse, wide-ranging corpus of Jürgen Habermas's work to clarify my own viewpoint in developing the study's theoretical perspectives. Habermas's oeuvre delves into many academic disciplines but at its core is his theory of communicative human rationality and a very practical approach to importing his theory of meaning into the complexity of social order.

His substantive philosophy of enlightenment, emancipation, ideology critique and a commitment to universalist ideals of inclusiveness and equality has helped me situate understanding of child neglect today in contemporary general practice within social and historical contexts. In addition his work supports theoretical contributions of a mixed methods research approach to child neglect meaning and proliferation of critical language awareness in the analysis.

In any research the nature and role of philosophical inquiry is important to make practical sense and to legitimise ways of thinking and doing research. This is of particular importance in a mixed methods analysis which remains a relatively new form of inquiry emerging from the debates of the paradigm wars, and departs from a research preoccupation with comparing validity of research methods and superiority between approaches to develop a 'third way' (Tashakkori & Teddlie, 1998, 2008: Teddlie & Tashakkori, 2009, 2010a).

Habermas (1987a, pp. 4-5) makes an appeal to philosophy to engage more practically in the development of scientific 'reliable' knowledge to negate the effects of 'a methodology emptied of philosophical thought…scientific knowledge cannot abstractly restore epistemology'. From this analytic standpoint I could not have reconstructed child neglect meaning in a broad sense from the project's statistical findings and required additional approaches to explore self-reflective knowledge accessed through language in use.

Social theoretical perspectives of child neglect, historical aspects and evolving legislation in over one hundred years of child welfare reform will be included in this eclectic mix of child neglect meaning filtered through the lens of contemporary general practice.

1.2 Study Background and Rationale for Researching Child Neglect – What's it Got To Do With General Practice?

Within overarching concerns of child welfare issues, child neglect is the most prevalent form of child maltreatment (Cawson, Wattam, Brooker & Kelly, 2000). For the purposes of this research child neglect is recognised as a fundamental failure of the relationship between caregiver (hereafter referred to the parent) and child.

The story of GPs' understanding of child neglect is in some ways an exploration of the microcosm of society's attitudes to a pervasive problem (albeit through the eyes of an elite professional group) which hampers child development and adaptive parenting.

Child neglect is not a topic for structured teaching in medicine at undergraduate or postgraduate level. Combined with a limited focus on child health within the contractual framework of general practice one could question whether the health and well-being of children should be uppermost in the minds at all of most practising GPs (Stephenson, 2010). The paucity of research examining GPs' attitudes and professional experience of child neglect raises more questions than it answers but of particular interest given the current situation, is how GPs acquire knowledge of this subject.

The research specifically explores GP beliefs and attitudes to their own professional involvement, within the context of child neglect, in making decisions about parenting behaviours and the status of the child. It is with the caveat that any evaluation of family dynamics cannot escape emotive and often judgmental aspects that challenge personal and professional attitudes at all levels of society. Whilst there is no single profession that deals with children that can declare they have a panoptic view of child neglect, I would argue that GPs have generalist skills and knowledge of families developed over many years and can at least claim to be a professional group who might have a panoramic view of it.

If one acknowledges that child protection and children's wellbeing is inextricably linked in the provision of an adequate child health service, the GP has access to extensive privileged information about families and almost universal contact with children and their families (Gunn, Lumley & Young, 1996). GPs should have a central role in the prevention of child neglect but unfortunately it is apparently understated or misunderstood (Wilson & Mullin, 2010). A lack of acknowledgment of child health and all other facets of family medicine that general practice embodies is emblematic of this dilemma. This is not the case for example, in adult chronic disease management regarded as integral to GP workload and supported within the terms of GPs' contractual obligations (Department of Health, 2003).

Questions of child neglect, its "diagnosis" and "treatment" are not answered within this framework therefore it may be most appropriate to orientate towards the broadest definition of neglect as 'unmet needs of the child regardless of parental intent' if the spectrum of neglect is to be captured (Dubowitz, Black, Starr & Zuravin, 1993, p.25). Whilst this seems a rather simplistic statement it nonetheless supports holistic working because there is an absence of a prescriptive approach on how 'unmet needs' should be interpreted and it lacks a punitive agenda. That said, this definition would not support a static framework of specific data fields incorporated into an IT system to calculate risk thresholds and trigger interventions. This is partly because there is no onus on general practice to collect consistent and comprehensive data about children in their practices that could contribute to 'analytic cube analysis'. Research has shown that this approach to data gathering from different domains to be

effective in monitoring child well–being and facilitate the integration of children's services (Lavenda et al., 2011).

Furthermore, decision making (based on risk) to treat patients that dominate other aspects of the biomedical model is misaligned to the abstract entity of child neglect, because any parent and child relationship is potentially at risk of becoming stressed to the point that the child has unmet needs. More fundamental concerns are who decides when a child's needs are not met and how that decision is enacted when examining a human behaviour devoid of its social context, a concern that is central to defining and measuring neglect.

Working at the margins of the private sphere of the family unit and the public sphere of health in a general medical setting presents unresolved challenges to the implementation of national policy that diffuses into the frontline working environment of general practice. That is not to say that GPs are ignored. They are acknowledged within a discursive framework which generally applies to any professional dealing with maltreated children. This purportedly shifts from a risk-orientated service to an approach that is concerned with partnership, discretion and is needs-led for all professionals dealing with vulnerable children (Department of Health, 2000).

However, the intent behind the language of child health policy documents does not appear to support an intrinsic and defined role for GPs. For example, 'Getting It Right For Every Child' (GIRFEC) a recent child protection policy document does not mention general practice at all (Scottish Government, 2008).

This does question how needs-led and partnership working can be comprehensively achieved if policy development becomes operational with minimal reference to the role of GPs (Scottish Government, 2011a). Viewing the challenges to understanding and defining child neglect from a Habermasian perspective goes some way to address such research concerns. Developing a comprehensive and inclusive child welfare framework, recognising the evolution of discursive representations of societal knowledge of neglect and the role of the physician enacting aspects of the

child welfare system, that are concordant with holistic working in contemporary general practice, all come to the fore.

From my own professional perspective I believe that child neglect is our most pressing child welfare concern. I have not encountered in my surgery large numbers of abused children but I have seen many more children who would be classified as vulnerable or 'in need' and more likely to be living in neglectful circumstances according to the legislation which underpins our child welfare system[1]. I would argue that my professional opinion is reflective of complex multiple and interacting factors which contribute to understanding of neglect as it presents in the consultation. This is influenced by societal factors that are distilled into the consultation dynamics. Nonetheless, it is often difficult to see how multiple influences often implicit within the clinical encounter can be reflected onto child protection policy in any meaningful way with matters of child neglect as they present in the consultation.

GPs might recognise the scenario of a single parent attending a methadone clinic who delays bringing his child for treatment because he could not afford the bus fare to the surgery. During the consultation apart from addressing the medical issues one may also question if this constitutes child (health) neglect. There is no protocol to determine the answer, and in most instances the GP would probably rely on her experience and advice from other colleagues to decide an appropriate plan of action to address their concerns when they deem appearances are 'not normal' (Lykke,

[1] The Children (Scotland) Act 1995 (Scottish Government, 1995) contains a statutory requirement of local authorities and their partners to produce a Childrens Services Plan. It emphasises the importance of the local authority working in close consultation with NHS Boards. Local authorities have a duty to make enquiries about the circumstances of children referred to them to determine if they are in need (Section 93 (4), a, i.ii.iii/iv).
1.being unable to maintain a reasonable standard of health
2.his/her development is likely to be impaired unless local authority services are provided.
3.he/she is disabled
4.he/she is affected adversely by the disability of any other person in the family
5.services maybe provided with a view to safeguarding or promoting a child's welfare for his or her family
6.services maybe provided with a view to safeguarding or promoting a child's welfare for any other member of his or her family.

Christensen & Reventlow, 2008). That decision often has to be reached within the limits of a ten-minute consultation within a busy surgery.

My concerns about the adverse outcomes of child neglect that I reflect upon in everyday work experience do not appear to be able to influence how resources could be allocated to actively support this work within my professional domain. This immutable fact has formed one of the questions of my research, that is, how is my little story as a GP working with vulnerable families, linked into the bigger story of child welfare?

Contemporary child neglect research shows this remains a difficult area of study particularly in general practice. There are apparently no adequate answers to the "how" and "what" of GP understanding of this subject, but for their immediate views, one turns to the talk of GPs. A detailed analysis of their language in Chapter 6, conveys many themes that have resonance with the limited corpus of research of GP participation in matters of child neglect often envisaged under the umbrella term 'child protection' (Birchall & Hallet, 1995; Bannon & Carter, 1991, 1998; Bannon, Carter, Barwell & Hicks, 1999; Gardner & Brandon, 2008; Horwath, 2007). Since GPs do not work within a vacuum, questions of how they can contribute to the child welfare agenda are relevant concerns.

1.3 Counting Child Neglect – It's Official

It is acknowledged that child neglect is often a recurrent behaviour that results in more families being re- referred into the child protection system than for any other maltreatment allegation (Levy, Markovic, Chaudhry, Ahart & Torres, 1995; Drake, Jonson-Reid, Way & Chung, 2003; Drake, Jonson-Reid & Sapokaite, 2006; Connell, Vanderploeg, Katz, Caron, Saunders & Tebes, 2009). That said, it is confounded by a logistic dilemma of how and when reported maltreatment can be confirmed or substantiated (Bell, 2010; Brayden et al., 1993; Polonko, 2006; Slep & Heyman, 2006) .

Substantiation when established, means that families can be subjected to the weight of the law—removal into care of the child, criminal charges against the parents—but

determining effectiveness of this process is measured from narrow statistics of children already referred into the child protection system (English, Graham, Litrownik, Everson & Bangdiwala, 2005; English et al., 2005; Kohl, Jonson-Reid & Drake, 2009). This challenges research conclusions because the mechanism that triggers a Criminal Prosecution Service (CPS) referral depends on the determinate of 'at risk' having concordance with clinical judgment (Cross & Casanueva, 2009; Lescheid et al., 2003). Gilbert and colleagues (2009a) give an overview of this dilemma where standard measurements are unable to incorporate the 'insidious nature' of neglect. Determinants of neglect fall short of thresholds of harm which affects how it is officially measured, with a 'ten-fold' difference in prevalence from the disparate sources used for data gathering. These can be constructed from victims' self-reports, parents reporting maltreating behaviours and figures from the child protection services or determined from a population based approach (Parrish, Young, Perham-Hester & Gessner, 2011).

Any country which gathers maltreatment data within a similar child protection system to the UK will have equivalent methodological challenges irrespective of the methodology. Data gathering seems challenged from all perspectives with conflicting evidence of child protection agencies awareness of child neglect when recording maltreatment (Ards & Harrell, 1993; Polonko, 2006).

CPS records appear to under-report neglect (Dubowitz, Pitts, Litrownik, Cox, Runyan & Black, 2005) whilst adult recall possibly over-inflates it (Hardt & Rutter, 2004; Scher, Forde, McQuaid & Stein, 2004; White, Widom & Chen, 2007), although other researchers would argue that retrospective accounts of neglect and abuse are trustworthy (Dube, Williamson, Thompson, Felitti & Anda, 2004; Bifulco, Bernazzani, Moran & Jacobs, 2005; Strauss, 2006; Shaffer, Huston & Egeland, 2008). This lack of certainty is compounded by researcher disagreement on whether neglect is a unitary concept, an overarching category compromised of a number of sub-categories, or a global concept where children who are neglected are considered to be subject to other forms of maltreatment (Scher, Forde, McQuaid & Stein, 2004; Scannapieco & Connell-Carrick, 2005; Mennen, Kim, Sang & Trickett, 2010). At this juncture, one begins to appreciate the complexity of 'measuring' neglect.

The reliance on evidentially led approaches contributes to the difficulties in measuring the true prevalence of neglect when recording standards are not sufficiently met (Drake, Jonson-Reid, Way & Chung, 2003). Descriptive adjectives of neglect for example, “serious”, “moderate”, “isolated” and “recurring” presuppose a common understanding of such terms in a process that is imbued with errors of reporting. Professionals appear to be influenced in their responses by memorable vivid data (Munro, 1999) in contrast with the innocuous language of child neglect, but a shared language of neglect is necessary if professionals are to support families and ameliorate the effects of every possible incident of neglectful behaviour. Within our current child protection system this is not possible.

It therefore remains dilemmatic that irrespective of the lens through which neglect is viewed, there is no consensus on which method most accurately reflects childhood experiences. Part of the solution to the methodological challenges in an effort to manage finite resources, is the contribution of actuarial risk assessment tools increasingly used in child protection services to categorise maltreatment types and instigate intervention. There is, however, a lack of research supporting the reliability and validity of many models of risk assessment to predict neglect occurrence when applied to vulnerable families (Conners, Whiteside-Mansell, Deere, Ledet & Edwards, 2006; Jagannathan & Camasso 1996; Leschied, Chiodo, Whitehead, Hurley & Marshall, 2003; Selbie, 2009) .

It is particularly problematic to screen families in primary care (Murry, Baker & Lewin, 2000), but until there is a an alternative model with better predictive values then risk assessment tools appear to be the preferred method. That said, research has suggested that practitioner clinical judgment and intuitive reasoning about family function can be as accurate as risk assessment models (Leschied et al., 2003). This is with the caveat that professionals are encouraged to be aware of the complexity required in their decision making, and the dangers of trying to simplify their approach (Munro, 1999).

The reliance of statistical methods to catalogue and reduce a human behaviour and essentially real life experience to individual factors may be less desirable in a neglect

context (Straus, Hamby, Finkelhor, Moore & Runyan, 1998; Turner & Wheaton, 1995). Can this challenge be turned around and regarded as an opportunity? Exploring the language of child neglect inculcates a myriad of subjective experiences and opinions to construct neglect in its broadest sense.

1.4 Building a Bigger Picture – A Mixed Methods Approach

> all relations are logical (in the broad sense of the word). But I hear voices in everything and dialogic relations among them…The problem of 'precision' and 'depth' (Bahktin, 1986, p. 169).

The goal of science is precision, the goal of humanities is depth but from Bahktin's perspective where would an abstract entity such as child neglect reside on a spectrum between these two goals?

The technical aspects of reduction of knowledge to objective fact is a subject that occupies researchers investigating scientific truths. It is not a denial of positivist thinking to conceptualise child neglect within mixed methods research (Bergman, 2010). Instead, it encourages an emancipative approach to the paradigm wars of the veracity of objective versus subjective knowledge that recognises the connections between different types of knowledge production. In Habermas's view (1987a, pp. 36-37) other types of knowledge work alongside scientific knowledge 'the conditions of the objectivity of possible natural-scientific knowledge are rooted in a deep – seated structure of human action...a cumulative learning process...under which new technical knowledge arises'.

The increased use of mixed methods research method has opened up the possibility of using this research design in a PhD thesis of child neglect within the context of general practice. Teddlie and Tashakkori (2010a, p.5) define this departure from the purist demands of either qualitative or quantitative approaches as 'methodological eclecticism'.

As a pragmatic approach[2] to a complex subject it combines the strengths of conventional research methods and endeavours to minimise weaknesses of both approaches acknowledging benefits when they are brought together (Connelly, 2009). In this context child neglect considered as a dialectic concept is appropriate because in the mix of methods a plurality of interests, voices and perspectives that shape neglect understanding can be represented in the analysis of findings.

Dimensions of a concept are developed from data findings of the quantitative aspect of study combined with qualitative data, specifically the functions of language in social contexts to enact relationships, represent experience and to organise discourse as meaningful text (Halliday & Matthiessen, 1999). This is made possible in the logic of inquiry of mixed methods, whether interpretation is inductive (discovery of patterns) or deductive (testing of theories and hypotheses). Onwuegbuzie and Johnson (2006, p.55) argue, 'inferences are made in research studies regardless of whether the associated interpretation is inductive or deductive…the concept of inference transcends quantitative and qualitative research'.

Bergman (2010, pp.172-173) speaks of concepts as being important to mixed methods 'they form the link between theory and empirical research' and in many levels of research 'translate' the research question into variables and 'create a bridge from the theoretical and conceptual to the measurement level'. Child neglect envisaged as a dialectic concept acts as a portal through which the findings of each aspect of the study can articulate with the other, to develop a comprehensive and

[2] Pragmatics, frequently associated with speech act theory, has philosophical roots in Ancient Greek thinking in Plato's Academy from the third to the early first century B.C. Authentic understanding and knowledge according to this approach is impossible due to epistemic limitations where plausible information and understanding must suffice and judgment must be suspended. Kant further expanded the thesis of pragmatism, his belief that humans are fundamentally limited in their ability to achieve understanding in totality. Instead, humans must function with understanding that is merely sufficient and prioritise the practical over the theoretical part of the human condition (Rescher, 2001). Within a study of language use, pragmatics bridges the gap between sentence meaning and the speaker's meaning by studying the interaction of linguistic properties and contextual factors particularly conversational implicature to outline an inferential view (Grice, 1975). This simultaneously decodes explicit content of an utterance and the implicit content within its situated context.

explanatory narrative of child neglect, that crosses structural boundaries and includes a temporal dimension.

This study therefore adopts a broader approach to look at and beyond the immediate environment of general practice to explore child neglect meaning at multiple levels where meaning emerges. In order to systematically detect within a mixed methods approach the values and ideologies of GPs as being representative of and connected to the varied discourses surrounding neglect, it explores the dialogic relations between aspects of human study. It is bounded by historical, social and political contexts that constitute a complex of experiences, evaluations, ideas and attitudes .

1.5 Where are The Limits of Knowledge?

> The pursuit of knowledge aims at discovering the truth of things. But if truth pivots on the idea that truths state how things actually stand, without any inherent reference to our beliefs, views and opinions-if, as mainstream tradition has it, truth is something altogether detached from human thought and ideas-then how can we possibly achieve knowledge about it? (Rescher, 2001, p. 5).

There is a persistent challenge to bridge the epistemological gap between theory and practice in the research domain of child neglect with conceptual difficulties in its definition and practical difficulties in its recognition and prevention. It is always a risk to attempt to categorise a complex concept into simple reductions of units of meaning and child neglect defies any such approach. Habermas's theories used as *bricoleur* ameliorate the consequences of reductionism to build a bigger picture, a jigsaw of understanding that enables certain epistemologies to be linked to certain methods.

The prominence of language in any study concerned with "understanding" and "explaining" in this context is unavoidable because it is the universal medium of communication. Habermas (1987b) progresses his treatise on speech validity claims to a theory of action and reason where action and language are intrinsically linked. In his view humans are linguistic and communicative beings whose actions are guided by mutual understanding that is reached through intersubjective agreement. Habermas (1987b, p. 313) argues that the pre-eminence of meaning within language

functions as ‘an internal connection between meaning and validity…for the entire spectrum of linguistic meaning...we understand its meaning when we know the conditions under which it can be accepted as valid’.

I would suggest that it is not possible to understand the processes and depth of knowledge acquisition of child neglect unless GPs can talk in detail about a subject that they probably have regarded as peripheral to their professional role but about which have developed tacit knowledge of it from their everyday contacts with children and families as the family doctor. One needs to embrace the ‘prime currency’ of discursive interaction in this research approach, according to Edwards and Potter (2001, p. 12) ‘(if) studying persons embedded in practices, including institutional settings, then discourse will be central to that study’.

The solution to the production of ‘reliable knowledge’ it seems is to complete the picture of ‘hermeneutic understanding’ where the relative contribution of individuated experience is acknowledged in the research process. Habermas (1987a, pp.162-163) elaborates,

> the problem of the relation of universal and particular does not arise owing to the inability of a concrete world of experience to meet the logic of general statements, but rather because of the inadequacy of this logic to life experience, even though the latter is always already articulated in ordinary language.

According to his theory ‘cognitive interests’ guide our knowledge quest through ‘knowledge-constitutive interests’. These are fundamental to universal and transcendental human knowledge and actions, and allow us to make sense of our everyday experiences. Nonetheless despite our best endeavours we can never grasp the totality of a knowledge of everything. The complexity of knowledge exists in ‘a web of myriad propositions’ that departs from the positivist position that emphasises absolute knowledge (Habermas,1987a). Habermas (1990, p.10) argues,

> we do not have unlimited freedom to convert the unproblematic background knowledge of our own culture into explicit knowledge…holistic and particularistic at the same time, it can never be grasped by an abstract, general analysis.

The process of physician knowledge acquisition stems from clinical cases encountered as students and postgraduates where advice from senior colleagues and other professional disciplines directs their approach to the patient's presenting complaint. Clinical knowledge is retained in a story telling format (Greenhalgh & Hurwitz, 1998; Hunter, 1991) storing concepts as referential templates that facilitate problem solving (Norman, 2005). Hunter (2006) regards this as a process of analogous, interpretive thinking 'practical reasoning...phronesis'[3] that is embedded in clinical judgment and constitutes intuitive working and informed decision making. It fuses observations in clinical settings with cognitive processing that is absolutely founded upon the case narrative as the 'epistemology of medicine' but is rarely referenced or acknowledged in teaching practices (Hunter, 2009).

Gabbay and le May (2004, pp.1016-1017) argue that GPs are very unlikely to construct their knowledge from research or other sources such as guidelines and instead rely on 'mindlines' collectively reinforced with internalised tacit guidelines centred on communication mechanisms that produce 'socially constituted knowledge'.

Others outline epistemic limits of knowledge acquisition as doctors develop mental models from the single case study 'illness scripts…episodic traces of previously analysed patients' (Schmidt & Rikers, 2007, p. 1135) where narrative competence is at the core of developing empathy and attributes of holistic healing (Charon, 2001, 2006; Egnew, 2009). Despite the importance of the single case study there is very little account of the process of knowledge acquisition from this and its contribution to a biomedical approach to evidence based medicine (Miles, Loughlin & Polychronis, 2007). It appears that at the outset the individual practitioner's

[3] The Aristotelian concept 'phronesis' is defined as 'a true and practical state involving reason, concerned with what is good and bad for a human being' (Crisp translation, 2000, 1140b5). It is understood as practical wisdom, requires experience and concerns itself with the complexity and variability of human behaviour. In medicine it is closely tied to clinical reasoning, how doctors ought to think and how they actually do think as they function to promote and restore health (Stempsey, 2009).Within the context of child neglect research the contribution of practical wisdom (and by inference the narrative) is given scant attention.

experiential knowledge is filtered out from the process of evidence gathering (Lockwood, 2004).

Freeman and Sweeney (2001, p. 1100-1102) echo this sentiment. They found that whilst some doctors implemented guidance which altered practice, a 'stronger theme' was the lack of implementation of guidance 'shaping the square peg of the evidence to fit the round hole of the patient's life' where evidence was not implemented in a 'linear way' but rooted in the experiences of the GP. Furthermore they argue that clinical evidence far from being 'an intellectually celibate commodity', has an 'emotional impact' on both doctor and patients where clinical evidence is only one aspect within the complexity of the consultation dynamics. They posit that following guidelines and implementing the evidence base bring their own dilemmatic problems to the consultation resulting in 'intellectual laziness' that strict adherence to guidelines fosters in medical thinking.

One challenge of this study in medical thinking was that in order to trace GP stories of neglect, I needed to trawl through 'seen' cases which were not always immediately accessible under a cognitive template of child neglect. Teasing out aspects of child neglect understanding, emerged from discussing in very broad terms any contributory factor to family function that GPs thought were relevant in their assessment of parenting and child behaviours. The inquisitorial spotlight of the study therefore, falls on the small stories that GPs tell about their experiences of child neglect and theoretical connections into a larger story of child neglect that is retold at a societal level.

Chouliaraki and Fairclough (1999, p. 21) acknowledge the importance of social practices in the analysis of human action to explore identities and relations. They comment, "practices constitute a point of connection between abstract structures and their mechanisms, and concrete events–between 'society' and people living their lives". Resources such as expertise, knowledge and authority are given research attention as they contribute to professional discourses as representations of social practice. Van Dijk (1990, p. 166) argues that this is necessary 'to conceptualise common-sense notions of complex sociocultural or scientific phenomena'.

GPs employ a number of discursive strategies within this study to convey their attitudes and knowledge which require particular consideration. From this research standpoint in the qualitative aspects of the study I have endeavoured to develop a philosophical overview of language embedded in social and political processes that have contributed to pervasive ideologies of child neglect. These are theoretically made visible in the analysis of the immediate talk of GPs that Van Dijk (2009, p. 117) comments are representations of, 'abstract, socially shared knowledge of a group…a combination of micro(agency)-and macro (structure, system) and cognition –interaction aspects of society'.

Before embarking on my research my own experiential knowledge was typically atheoretical, pragmatic understanding, where what worked in practice for me as a GP became the standard for the norms and acceptability of my everyday working practices (Rescher, 2001). This resonates with adult learning theory where postgraduate learning stems from self-motivation and relevance to clinical practice (Coomarasamy & Khan, 2004) and is a process that is observational and language based. My own practices are therefore rooted in an amalgamation of experiential knowledge that is constructed from information encoded over many years, influenced by observations and discussion of patient management with colleagues and the patients themselves. Nonetheless, by far the most memorable and easily recalled information is created through patient contact.

From the limited corpus of literature, the mechanism for GP learning seems more local, that is knowledge developed in their immediate environment using language

based activities and expressed through ideological beliefs[4]. Irrespective of the single case shaping knowledge production the social context within a health setting is also crucial where the dynamic of the doctor-patient encounter becomes 'micropolitical' reflecting macropolitical influences including social class and 'politico-economic power' (Waitzkin & Britt, 1989).

To consider the multiple influences that are filtered into the doctor-patient interaction I have adopted Habermas's dialectical concerns of critical theory that incorporates three types of knowledge production. These are findings of positivistic science (where empirical child neglect research endeavours to determine causality), understanding the world in terms of the contribution of the past to the present and an explication of the knowledge of child neglect articulated in language.

Habermas is an advocate of both empirical-analytic science and historical-hermeneutic sciences within a framework of critical theory, and encourages reflection within knowledge production to escape its 'false consciousness'. Knowledge within the positivist tradition is limited, according to him, by its own assumption of 'absolute knowledge independent of the subjective conditions of possible knowledge' (Habermas, 1987a, p. 11). That said, he does not reject the contribution of technical rationality and sees positivist science existing alongside another invaluable strand of understanding in a restructured constitutive knowledge system, 'communicative rationality'.

Furthermore, pragmatism and hermeneutics are central to the 'beginning of a new paradigm' which function as an 'organon theory of knowledge' based on critical self-

[4] Van Dijk's (1998) view of ideology will be drawn on throughout the thesis as 'socially shared, general beliefs' (p. 32). He emphasises the multidisccplinary framework for his theory of ideology and comments ,

> if we ever want to explain that social practices or discourses are ideological ,or that ideologies are reproduced by them, we need to establish the theoretical relationships between the social and the personal ,the general and the particular, the group and its members ,and the abstract system and its specific instance or uses (Van Dijk, 1998, p. 33).

This underpins the study approach which focuses on ideology as reflective of the cultural and social conditions of knowledge of child neglect that link different aspects of the research project.

reflective knowledge (Habermas 1987a, pp. 10-11) and underpin a philosophical justification for the use of mixed methods. Habermas (1987a, p. 176) further explains,

> empiricalanalytic methods aim at disclosing and comprehending reality under the transcendental viewpoint of possible technical control, hermeneutic methods aim at maintaining the intersubjectivity of mutual understanding in ordinary-language communication and in action according to common norms.

1.6 The Key Issues

It is pertinent at this point to define the critical challenges in this dissertation by outlining the function of GPs in the role of identifying child neglect. In order to do this it is necessary to give an account of general practice and the child as patient in this professional setting.

1.6.1 What do GPs do?

A job description of general practice is perhaps more straightforward if it outlines what it is not. General practice is not regarded as a specialism within medicine, consequently GPs do not deal exclusively with health problems connected to one anatomical or physiological system in contrast to their hospital colleagues, for example, a renal physician or orthopaedic surgeon.

GPs work in the community usually as self-employed independent contractors who provide primary healthcare to a limited number of patients and do not take referrals from other medical professionals regarding matters of diagnosis and clinical management.

It is a cornerstone of the primary health care system that is universally accessed by patients of any age group, irrespective of a patient's perceived problem, which may not immediately be recognised as a medical problem. The presenting medical complaint determines the consultation outcome when patients are either managed by the GP or referred to specialist colleagues in secondary care, usually for further investigations, or to another primary care profession for example chiropody, physiotherapy. Any issue that patients perceive as being detrimental to their well-

being shapes the dynamic of the consultation (Popay, Kowarzik, Mallinson, Mackian & Barker, 2007a). Housing issues for example, may seem inappropriate for a medical consultation, but in the patient's mind if causing stress and depressive symptoms they can definitely be given a medical label.

Adult patients usually consult individually but they can be seen with their extended family with children, parents, grandparents together in a single consultation!

However this is my view from within general practice but a health economist will undoubtedly have a different perspective from a patient, a member of the primary care team or a health manager. For clarity this thesis will embody a description of general practice that has evolved historically and culturally from its origins within the formation of the National Health Service in 1948 (Digby, 1999).

The apparatus of modern general practice functions within a framework of chronic disease management. By apparatus I mean, the actors employed within the practice, that is, GPs, practice nurses and receptionists and the attached nursing staff (District Nurses, Health Visitors) who constitute the Primary Care Team. I also include the IT system that provides the infrastructure to record all information about the patient population in either distinct IT templates (for example for hypertension screening or asthma screening) or freehand text for individual consultations.

The numerous pressures on health funding demands that resources need to be invested in areas where there will be the greatest returns on health improvement. Informed by traditional positivist philosophy the notion of evidence based medicine (EBM) is central to the application of clinical knowledge (Biswas, Umakanth, Strumberg, Martin, Hande, & Nagra, 2007) or 'knowledge translation' (Goldman, Meuser, Lawrie, Rogers & Reeves, 2010) and improved inter disciplinary working. This approach demands objective evidence in the advancement of prevention and treatment of longterm conditions, for example, diabetes and ischemic heart disease. Workload and income are generated by detecting, monitoring and treating such conditions either in patients at risk of disease (primary prevention) or those already displaying symptoms (secondary prevention) .

A focus on the contribution of EBM underpins all aspects of general practice workload that is resourced and continually measured however, the corollary is that work that is not assessed or measured is excluded from the evidence base. Working within a target based culture, orientated to gathering evidence on the patient's health status using standard protocols for information gathering, specifically excludes the contribution of language to the consultation. It is, however, far from certain that the drive to embrace paperless documentation of patient contact and increased electronic record keeping equates to better medical care (Hahn et al., 2011). Furthermore, the translation of evidence into changing practice is better served if patient and practitoner perspectives are explored together, and when researchers can personally be involved in the transmission of new findings (Cohen et al., 2008).

A patient may present with an isolated physical or psychological complaint, but the consultation can become a triadic endeavour as the GP engages not only with the patient but in addition the IT system to record various measurements concerned with fulfilling the terms of the GMS contract (Department of Health, 2003). This is because certain diseases have taken priority in terms of prevention, to reduce the financial burden of adverse outcomes on overstretched health services. Consequently, there is a strong scientific focus on minimising the impact of such conditions on the individual patient and the wider community that filters down to general practice with an emphasis on completing IT templates which record numerous statistics, determine treatment targets and ultimately GP income.

The requirements of doctors to reproduce knowledge within such a rigid framework orientated to epidemiological outcome measurements, is paralleled by a call for more reflection within the medical profession on the unarticulated or unacknowledged extra-evidential considerations, that is the values and ideologies that underscore the evidence (Callahan, 1999). Shaw and Greenhalgh (2008) make the point that primary care is regarded as a 'population laboratory' within the traditional biomedical approach where there remain significant barriers to undertaking research that is appropriate to the context of primary care (Stange, 1996). Nonetheless, there are many socio-medical dynamics that are not readily amenable to quantitative research and as a consequence are omitted from the primary care research base (Miller et al.,

2005). Solberg and colleagues (2009) argue that there remain a number of 'chasms' between the multiplicity of shared knowledge requirements of those working in primary care and other professionals complicated by 'problematic concepts'. Within this debate the omission of dimensions of child neglect meaning from a restricted vision of child health in general practice would represent such a 'chasm'.

There lies the dilemma of general practice where its strength as a holistic inclusive universal service also makes it vulnerable to rationalisation. The continued atomisation of a service results in the qualitative aspects of its function, the "art" of general practice and interpretive inquiry that underpins the consultation becoming lost in the rush to categorise, bureaucratise and incentivise the doctor-patient relationship.

Despite the expansion of information technology, the clinical encounter remains a human endeavour centred on language use. Heath (1995, pp.3,19) eloquently describes this tension,

> The mysterious secrets of the trade or art of general practice seem to be poorly understood outside our discipline, and in the face of the current avalanche of change, there is an increasingly urgent need for us to explain ourselves…The general practitioner often seeing patients through twenty or thirty years of illness and disease, both major and minor, as well as a series of significant life events, is in a unique position to help the patient make some kind of sense of what is happening to them.

This is a plea that general practice retains the interpretive skills that are required to "hear" the patient's story and that it is recognised within a clinical context to ensure that it is logically part of measurable workload. Charon (2001, p.1897) emphasises the importance of narrative and story to the process of learning within a medical discipline to provide a greater depth of knowledge, develop physician reflexivity and empathy with the patient's suffering 'medicine practiced with narrative competence'. Thus, child neglect as an abstract entity cannot be reduced in meaning to one objective measurement. One must be concerned with the small stories that GPs tell, their situated ways of understanding and experiences that produce value-laden representations of reality and deserve analytic attention (Charon, 2006).

1.6.2 The Child, the GP and Information Sharing versus Data Protection

It is pertinent when exploring the situated identity of the child as a patient to consider the constructed definitions of "child" and explore the GP role of information sharing around child health matters that may be challenged by the complexities of neglect.

This thesis will refer to the definition of child within the Children (Scotland) Act 1995 as an individual who has not reached the age of majority, generally regarded as age eighteen. There are exceptions to this, for example, consideration of a child's ability to enter into legal transactions or give informed consent for medical procedures (Fabb & Guthrie, 1997, p. 80). A legal directive that acknowledges a child's physical and emotional development is extremely important in considering notions of childhood that relate to experiences and understanding of the social and physical world (Damon & Lerner, 2006).

GPs tend to see children in the surgery usually accompanied by their parents during scheduled appointments or opportunistically. The consultation outcome depends on the nature and complexity of the presenting problem which can encompass concerns of physical and psychological well-being. Child neglect within this context is usually assessed in relation to perceived problems of the parent such as addiction issues, mental health problems, economic stresses or less frequently by seeing the child independently (Hølge-Hazelton & Tulinius, 2009). This rests on the ability of the GP to assimilate a complex range of information. Lykke, Christensen and Reventlow (2011) advocate that it should be constructed within a reflexive dialogue with parents when there are concerns about child well-being.

That said, to engage in child neglect prevention through assessment of the child and parent provides an enduring challenge in terms of information gathering that other medical models do not require (Pheby, 1982; Lucassen, Parker & Wheeler, 2006). Consent to share sensitive information with other professionals may be dilemmatic whilst maintaining the GP role in advocacy on behalf of the child and parent. Incorporating a child-centered approach for children who have unmet needs and are more likely to be living in neglectful circumstances, impacts on complex issues of data protection because both parent and child are usually the patients of the same GP.

The entire process of knowing what information to share and with whom in any situation of child neglect, requires a measured judgment on the part of the GP. As a moral and ethical approach to a humanitarian challenge, resolving this challenge is not clear within the context of the Data Protection Act 1998 (UK Government, 1998) which states that personal data is processed fairly and lawfully. There is an inherent difficulty interpreting a complex decontextualised legal discourse which does not always reflect everyday dilemmas of working with vulnerable children and their families but is still expected to become inculcated and understood within a medical context.

The dynamics within the consultation are further complicated by children regarded as autonomous if they have Gillick competence in understanding issues of consent and confidentiality[5]. The notion of individual right to confidentiality is fundamental to the doctor –patient relationship and extends to children when they are deemed capable of giving effective consent for any medical procedure or treatment and where parental involvement may not be appropriate nor wanted by the child .

One could consider hypothetically a 14 year old coming to discuss issues of parental alcoholism and its impact on his life, or a 13 year old attending the surgery to discuss contraceptive requirements, neither child accompanied by an adult. These scenarios will be familiar to many practising GPs and may cause uneasiness because of the possibility of child welfare concerns, particularly in relation to either supervisory or emotional neglect.

To articulate the possibility of neglect in such circumstances to relevant child protection workers, or find an appropriate child led service to acknowledge and offer support to the child if required, challenges the professionalism of the GP because of sensitivity to issues of confidentiality for both parent and child and proportionality of response to the situation.

[5] Gillick v West Norfolk & Wisbech AHA & DHSS [1983] 3 WLR (QBD).

An awareness of the status of the child within children's rights needs to be exercised within the confines of the GP consultation, but again GPs cannot refer to explicit guidance concerning disclosure of information (without consent) if a child is believed to be at risk of serious harm or a child is in danger. The language of child protection is ambiguous on the interpretation of serious harm or danger within the context of neglect prevention (Scottish Government, 2004; RCPCH, 2004). The profession is more likely to understand concerns of confidentiality as it relates to the individual child's rights, within the context of provision of information to families with the accepted norm as parent as carer. Researchers have demonstrated that doctors appear to be more comfortable with a child's right to confidentiality as it relates to sexual health issues, but not issues of unmet needs, which tend not to be considered at the juncture of the parent-child relationship (Perez-Carceles, Pereniguez, Osuna & Luna, 2005).

The National Institute for Clinical Excellence (NICE, 2010, pp. 66-76) provides guidance to any healthcare professional concerned about child abuse and neglect which deserves to be noted because this can easily be accessed by GPs as a source of information. The definitional challenges and difficulties in determining thresholds of interventions are acknowledged whilst exemplars of neglect are produced for clarity. These include 'severe and persistent infections…inadequate clothing' with ingrained dirt, inadequate provision of food or poor nutrition and obesity, poor dental health and burns also cited as indicators of neglect. Given the categories of the maltreated child, there is surprisingly no consideration of the role of the state in neglect matters and material poverty is cited as a peripheral issue.

Irrespective of the source of information, guidance about the possibility of neglect tends to be built around notions of 'risk' or 'likely degree of risk' and endeavours to

reduce meaning of a complex abstract entity to concrete indicators within a structured protocol[6].

Is the dilemma of interpreting a complex situation any clearer when dealing with neglect, essentially an act of omission, with reference to such guidance? When should GPs decide and act on their professional judgment if a child is likely to be neglected or living 'in need' or equally at what point does parenting practice become inadequate and result in a child's needs not being met?

This is not easily answered. Unlike abuse when evidence is often observable (an unusually sited bruise or an unexplained fracture) the 'evidence' for neglect may only be apparent in a child or parent behaviour. This dualism between quantifiable (in abuse) and difficult-to-qualify (in neglect) constructs of maltreatment is fundamental to the challenges of identifying or indeed preventing neglect occurring.

1.7 The Research Questions

Drawing on the analytic approach and conceptual challenges embodied within this study already mentioned the research focuses on the following questions;

[6] The BMA (2009) guidance focuses on a structured approach but it is still difficult to see how this intuitively applies to a case by case basis in everyday working,

> Where doctors have concerns about a child who may be at risk of abuse or neglect, it is essential that these concerns are acted upon, in accordance with the guidance in this note, or other local and national protocols. The best interests of the child or children involved must guide decision-making at all times. Where suspicions of abuse or neglect have been raised, doctors must ensure that their concerns, and the actions they have either taken, or intend to take, including any discussion with colleagues or professionals in other agencies are clearly recorded in the child or children's medical record. Where doctors have raised concerns about a child with colleagues or with other agencies and no action is regarded as necessary, doctors must ensure that all individual concerns have been properly recognised and responded to. When working with children who may be at risk of neglect or abuse, doctors should judge each case on its merits, taking into consideration the likely degree of risk to the child or children involved. Disclosure of information between professionals from different agencies should always take place within an established system and be subject to a recognised protocol.

Question 1;

What do GPs know of child neglect?

Sub-questions;

A.How do they know what they know. What is the mechanism for acquisition and development of knowledge?

B.What factors do GPs attribute to the occurrence of child neglect?

Question 2;

Is there a consensus view from GPs on how they understand child neglect?

Sub-Questions;

A. Is there a group ideology with which GPs negotiate and construct meaning of child neglect?

B. Are there differences in how GPs perceive their role in child neglect prevention in the current structure of general practice ?

Question 3;

Are current child welfare concerns within the context of general practice better understood when situated within its historical context?

Sub-Questions;

A. What constructions of neglect are evident by examining the texts of child neglect within its socio-historical context?

B. Is this linked to general practice today?

1.8 Overview of the Data

A large data corpus was obtained for the purposes of this research within the setting of general practice. Quantitative data was obtained from survey questionnaire responses of a stratified random sample of GPs working in Greater Glasgow and Clyde Health Board. Qualitative data were retrieved from the spoken texts of 16 GP interviews and a focus group of GPs. Additional qualitative data was obtained from the examination of documentary material including the following- legislative documents, archived records of paediatric admissions to hospitals in Glasgow and London, parish council reports, a study of women jailed for neglect and medical reports to school boards on the physical condition of children.

The survey responses were analysed using SPSS as the preferred quantitative analytic software. The spoken data were transcribed in full initially but not all data obtained appear in the thesis. In the end it is a selection of complex material that is highlighted in order to demonstrate the clear themes that emerged in the entire corpus of data, including documentary text. The process of qualitative data analysis is discussed in Chapter 4.

1.9 Organisation of the Thesis

The outline of this dissertation is as follows. Chapter 2 is a critical review of the literature of child neglect within the rubric of child maltreatment research. The focus of this chapter is an examination of the multiple domains where child neglect meaning has emerged.

Chapter 3 is an overview of the theoretical influences that ultimately shape the methodology in order to address the research questions. Included, are theories of discourse analysis that constitutes the predominant analytic approach in this mixed methods study.

Chapter 4 considers the theoretical drivers of a mixed methods analysis and the task of data integration that is characteristic of mixed methods. Chapter 5 outlines the findings from the quantitative arm of the study and Chapters 6 and 7 describe the

qualitative data findings obtained from the analysis of GP interviews, a focus group and documentary material. I conclude in Chapter 8 the limitations of the study and implications for future work not only relevant to my own discipline but within a larger socio- political framework.

CHAPTER TWO; LITERATURE REVIEW

2.1 Introduction - Examining the Concept of Child Neglect

In Chapter 1, I outlined the rationale for choosing child neglect as my research subject and expected challenges. This chapter considers the literature that details the emergence of child neglect meaning from historical and socio-political perspectives to contemporary child maltreatment research. This anticipates in some sense the theoretical notions outlined in Chapter 3 that have shaped the methodology of this research project, because any explication of an abstract entity that emerges at the nexus of family function and the socio-political framework requires a broad approach. I include the findings from studies of child neglect from a number of research disciplines that are reflective of scientific approaches, and I also include a number of historians' thinking on the genealogy of child neglect meaning.

The nascent theories of child neglect broadly agree that there are many variables that directly or indirectly affect a child's developmental outcome. Child characteristics for example low birth weight and poor health (Sidebotham & Heron, 2003; Jaudes & Mackey-Bilaver, 2008), parental variables such as education status, parenting styles (Bifulco, Moran, Jacobs & Bunn, 2009; Egami, Ford, Greenfield & Crum, 1996; Gaudin, Polansky, Kilpatrick & Shilton, 1993, 1996; Maughan & Moore, 2010; Wilson, Rack, Shi & Norris, 2008) and neighbourhood disadvantage can all potentially contribute to the status of the neglected child. Consequently, any attempt to ameliorate the circumstances of the neglected child should acknowledge the importance of the ecological model of childhood development that was initially described in the humanities and social sciences (Belsky, 1993; Cicchetti & Lynch, 1993; Bronfenbrenner, 1979, 1993). Human development is highly complex and determined by a vast array of interactions between biological, environmental and psychological factors. As such it requires a whole picture approach to the needs of the developing child (Connell-Carrick & Scannapieco, 2006).

2.2 The Discursive Positioning of Child Neglect in a Historical Context – A Short History?

The contemporary debate concerned with protecting children from maltreatment within the family unit in part reflects the role of state in family matters with its roots in over one hundred years of social reform.This resides in tensions of preserving the family structure with a growing recognition of cumulative stresses on family function. That said, child neglect in Western culture is not a social phenomenon that is only defined historically by the events linked to the rapid industrialization and ensuing conditions that contributed to mass poverty amongst the working class of the Victorian era. There are descriptions of neglect from centuries before this period and indeed there seemed to be state sanctioned neglect of illegitimate babies in the seventeenth century with an act of Parliament to be passed in 1624 'to prevent the murthering of bastard children' (Hoffer & Hull, 1981, p. 124).

Other sources would suggest that neglect in this era was almost culturally acceptable. Heywood (2001, p. 62) comments, 'Infants under 2 years of age in particular were thought to suffer appalling neglect, with parents considering it unwise to invest much time or trouble in their offspring' leaving babies to stew in their own excrement for hours, the resort to 'mercenary' wet nurses and the 'large-scale abandonment' of children. Infants and toddlers remain most at risk of fatal supervisory neglect than any other maltreatment today (Berkowitz, 2001; Connell-Carrick & Scannapieco, 2006).

The English Poor Law of 1601 placed public responsibility for the poor in the hands of local towns people (Mcgowan, 1983, pp. 46-90), and until the early 20th century was the basis of child care legislation. It increased powers to Boards of Poor Law guardians to provide for destitute adults and their dependent children, and specifically included the right to assume the powers and duties of a parent having abandoned their children or deemed unfit (Hendrick, 2003). The concern for children during this time who experienced abuse or neglect arose from the philanthropic and child–saving motivations of private individuals and organisations, often focusing on poor children. The primacy of social class and poverty in all

aspects of state institutions tasked with preventing or ameliorating the condition of the neglected child, can be traced through a historical discourse where poor children have been almost legislated for in isolation (Behlmer, 1982; Hendrick, 1994, 2003; Murdoch, 2006).

In Britain the fragmented services required to meet the manifold needs of children evolved from the 1870s onwards throughout various acts and legislation to shape the services that we have today. It is not my intention to review all of these because of limitations of space, but for an overview of select social and health policies that progressed the causes of child welfare reform relevant to this era the reader is directed to Watkin's (1975) work.

There does seem to be agreement amongst scholars that the scale of industrial expansion in the early 20th century resulted in radical change to how children began to be viewed within society. A combination of interests from philanthropic individuals, welfare societies, expansion of mass education and progress in public health in the 19th century created increasing anxieties about Britain's position in the world. Fuelled by debates about the impact of the industrial urban environment upon British society, the concerns focused on a nation that was deficient in a healthy, morally robust workforce (Hendrick, 1994, 2003). Attention was directed towards the families of the lower classes with their apparently intractable social and moral decline and the poor state of their children expected to be the next generation of workers and citizens. Murdoch (2006, p. 143) describes the influences of patriotism and nationalist pride on the shifts in child welfare concern,

> Poor parents' direct contributions to the war effort as soldiers, as munitions workers, and as mothers of Britan's current and future soldiers began to outweigh reformers' concern about the morality and domesticity of poor families.

Far from being healthy and educated they lived in 'wretched subsistence' and despite compulsory education appeared 'untouched by the progress of the nation' (Smith, 1885, p.4). There were pervasive difficulties evident in children growing up in households with parental addiction problems who were poorly motivated and

neglected ‘a poor, miserable and degraded proletariat, living in close proximity to the wealthiest aristocracy the world has ever seen’ (Smith, 1885, p.3).

The scrutiny of the effect of poverty on children increased and neglect became more readily identified than abuse, with no ethical consideration given to the impact of articulating often brutal comments on the state of the neglected child. Hendrick (1994, p. 57) comments, ‘neglect was seen as more important because it signified the social failure of the poor...far more widespread than cruelty…a difficult notion to interpret, whereas neglect was far more amenable to a consensus view’.

This observation contrasts with current child maltreatment research where abuse is more readily identified than neglect (Gilbert et al., 2009a) because having no commonly agreed definition of neglect, a ‘consensus view’ is elusive. Furthermore the relationship between neglect and poverty has ironically, according to Wolock and Horowitz (1984), led to a progressive ‘deemphasis’ of its occurrence.

Direct state intervention in health steadily increased in the mid-nineteenth century through burgeoning legislation controlling public health, regulating health professionals and providing services to individuals according to needs. An increased range of services, expansion of the public sector and retention of important voluntary services all impacted on the provision of services for children, however the philosophical underpinnings in all aspects of child welfare had strong moral undertones. Cannan (1992, p. 53) asserts that, ‘The saving of the industrial child reflects a moral concern; the presence of women and children in industry was repeatedly linked to their depravity’. Hendrick (2003, p. 25) elaborates,

> Victorians campaigning for the welfare of children were driven by two sets of moral needs...their own personal and political anxieties, and also the perceived needs of selected children. For much of the century their motivation to improve the morality and personal responsibility of the poor and their children was religious.

This sets the scene for a research endeavour to uncover the interconnected strands of knowledge that reflect child neglect’s historical dimensions. Furthermore this forms one aspect of exploring theoretical connections between discursive representations of neglect meaning in a number of contexts that are predominantly articulated

through an adult discourse for differing ideological purpose. For example Murdoch (2006) challenges the notion that the poor law provision was not primarily for abandoned and neglected children but a support network for parents in times of crisis that were often precipitated by the hardships of poverty. She comments, 'many parents worked with welfare officials to watch over their children, believing that, despite their poverty, their parental right to do so was a fundamental right of citizenship' (Murdoch, 2006, p. 119).

2.3 Child Neglect A Modern Concept?

The aim of this section is to give an overview of child neglect from current child maltreatment literature. Cross-disciplinary research findings from the domains of health, psychology, sociology, psychiatry and the criminal justice system are referenced. It begins with a discussion of definitional challenges within a critical examination of research perspectives most relevant to this thesis.

2.3.1 The Defining Issues of Child Neglect – What exactly is it?

Child neglect can be understood within a number of contexts through interaction of factors based at individual, family and community level.Levine's (1980) caretaker-child strategy has influenced the direction of child neglect study understood as behavioural exchanges between child and caregiver, that ensure universal goals of child survival,self-sufficiency and enculturation. It is exemplified in the work of developmental psychologists exploring the influence of environment on parenting behaviours on child development (Belsky, 1993; Cicchetti & Lynch 1993; Lynch & Cicchetti, 1998, 2002). Their complex research models explore the multifaceted nature of child neglect incorporating transactional and ecological theories that provide a structured approach for understanding its antecedents and consequences (Belsky, 1993). Having no single risk factor or set of risk factors that "cause" neglect, scholars weight the interplay between the individual (parent and child) and the family and environmental context in which children are reared (Earls & Carlson, 2001). One approach is to understand the importance of 'latency, pathways and cumulative processes' that through complex interactions and daily experiences affect child into adult well-being (Maggi, Irwin, Siddiqi & Hertzman, 2010).

The family unit is the basic networking structure for children from early years into adolescence expected to maintain a child's subjective well-being (Denzin, 1982), but this is also the starting point when acknowledging failure in the parent-child relationship enmeshed within the broader framework of child welfare (Sidebotham & Heron, 2006; Wulczyn, 2009). Nonetheless, many children who live in neglectful family situations fail to access supportive services because omissions of care and subsequent neglect rarely 'result in harm that is (either) imminent (or) observable' (English, Graham, Litrownik, Everson & Bangdiwala, 2005, p.591).

In contemporary research aetiologies and consequences of child neglect are multiple and are interwoven into theoretical frameworks that have overlapping constructs and concepts (Belsky & Vondra, 1989; Dong et al., 2004; Garbarino & Sherman, 1980). Developing separate frameworks to address such concerns remains a challenge (Mennen, Kim, Sang & Trickett, 2010). Indeed, it is argued that it is only within the last three decades that child neglect has been recognised as conceptually different from child abuse and in need of empirical investigation in its own right (Wolock & Horowitz, 1984). Child neglect is essentially an act of omission (Cowen, 1999) and its detection challenges the notion of a predominantly evidentially led inquiry that is more commonly aligned with investigating child abuse.

Several authors regard neglect as a multidimensional phenomenon which exists on a continuum and varies by type, severity and chronicity (Ney, 1994; Claussen & Crittendon, 1991; English et al., 2005) and in terms of its measurements and effects (Slack, Holl, Altenbernd, McDaniel & Stevens, 2003). It can be insidious, with some children subjected to isolated incidents of neglect whilst others live in a continually neglectful environment (Manly et al., 1994, 2001). The variable occurrence of neglect confounds attempts to produce precise estimates in population studies that Widom (2004, p. 717) and colleagues eloquently sum up, 'Short of following an individual child throughout the course of his or her entire life, no one has been able to determine a way to make this assessment accurately'.

Sedlak and Broadhurst (1996) describe neglect categories as physical, emotional and educational, with seventeen subtypes. Similarly other scholars posit three types of

neglect as physical, mental health and cognitive (Slack, Holl, Altenbernd, McDaniel & Stevens, 2003) but the picture remains somewhat muddied by lack of unity on how neglect subtypes are defined.

Physical neglect further classified into health care, abandonment, supervisory neglect and nutritional neglect (Hegar & Yungman, 1989; Cowen, 1999) is thought to be the most serious and predictable (Jones & McCurdy, 1992). Healthcare neglect is typified by parents who seek medical attention when their child's need has escalated to a critical level, on an emergency basis and fail to comply with healthcare recommendations (Dubowitz, 1999, p. 109). The varied types of neglect are associated with differing intensity and adverse outcomes (Dubowitz, Pitts & Black, 2004; Knutson, Taber, Murray, Valles & Koeppl, 2010; Chapple & Vaske, 2010) for example, supervisory neglect has an association with childhood injuries (Landen, Bauer & Kohn, 2003; Schnitzer, Covington & Kruse, 2011) and obesity (Knutson, Taber, Murray, Valles & Koeppl, 2010).

Emotional neglect, it is argued, is the least immediately visible of all neglect subtypes. It is regarded as refusal or delay in psychological care and inadequate emotional support, attention or affection. Failure to address maladaptive behaviors and resultant emotional deprivation or a lack of a nurturing emotional environment (Glaser, 2002) characterises emotional neglect through distinct family behaviors for example maternal unavailability (Wark, Kruczek & Boley, 2003) .

Nonetheless, the question of what exactly is child neglect has not been answered and a precise answer remains elusive because child neglect as an interdisciplinary topic of research has no standard definition (Zaravin, 1999; Trickett, Mennen, Kim & Sang, 2009). Within a research context a number of contradictory positions confound a holistic inclusive approach to child neglect. Focusing on broad or narrow definitions that are dichotomised into substantiated or unsubstantiated reports of child neglect within child protection data (Hussey et al., 2005), to determine the point at which parenting becomes neglectful, is dilemmatic. Furthermore, Dubowitz, Pitts and Black (2004) argue that simply assessing 'general neglect' is less useful than investigating its subtypes, physical, psychological, and environmental neglect,

as separate constructs. This is because each subtype may be associated with different risk indicators and requires different research and intervention programs. In contrast, other researchers argue that the co-occurrence of different forms of maltreatment should be studied in any research of adverse outcomes of neglect or abuse to improve social and health outcomes (Dong et al., 2004a).

A lack of a meta-theoretical framework for studying an abstract entity magnifies the challenges of reduction versus expansion of knowledge in the science of child neglect and remains a matter of philosophical inquiry. In Habermasian terms this is reflected in the following extract,

> the distinctions between sensibility and understanding, intuition and concept, form and content-can be debunked, along with the distinctions between analytic and synthetic judgments, between priori and a posterior (Habermas, 1990, p. 10).

2.3.2 Consequences for Children

It is believed that neglect may have a more severe impact on a child's development than abuse (Hildyard & Wolfe, 2002; Egeland, Sroufe & Erickson, 1983) with distinct differences in functioning between children with a history of neglect alone and those with a history of concurrent neglect and abuse (Nolin & Ethier, 2007). This may be partly attributed to a recognised relationship between physical neglect and psychological maltreatment, particularly psychological neglect (Claussen & Crittendon, 1991), where the accumulative effect of such maltreatment types is thought to cause greater adjustment problems (Brown, Cohen, Johnson & Salzinger, 1998; Higgins & McCabe, 2001).

Interference with the parent's ability to nurture and form a positive reciprocal relationship with the child results in disorganised or insecure attachment and multiple child behavioural problems. In the context of acute and chronic neglect these are in part understood as negative behaviours and internalising problems (Bolger & Patterson, 2001; Dozier & Peloso, 2006) that culminate in poor social skills and self esteem, social withdrawal and increased anxiety (Caspi, 2000; De Bellis, Hooper, Spratt & Woolley, 2009; Peretti, Early & Chmura, 1998). These in turn adversely

affect daily living skills, particularly if they occur early in a child's development (English, Graham, Litrownik, Everson & Bangdiwala, 2005; English et al., 2005). Negative behaviours become apparent in the social and educational environment (Chapple & Vaske, 2010; De Bellis, Hooper, Spratt & Woolley, 2009; Egeland, Sroufe & Erickson, 1983; Eckenrode, Laird & Doris, 1993; Kendall-Tackett & Eckenrode, 1996; Mills et al., 2011) linking adverse life experiences of neglected children to pervasive patterns of maladaptive behaviors (Johnson-Reid et al., 2010).

Within this context it is not surprising that research of children who are neglected within their first six years of life and beyond concludes that they struggle in relationships with their peers and are less emotionally healthy (Bolger & Patterson, 2001; Shaffer, Yates & Egeland, 2009; Shipman, Edwards, Brown, Swisher & Jennings, 2005). It is axiomatic that if children have difficulty with relationships and communication, they display more social withdrawal with pervasive feelings of incompetence (Finzi, Cohen, Sapir & Weizman, 2000) that are rarely or adequately addressed within the provision of mental health support (Thompson, 2010).

It has been postulated for some time that neglect affects the domains of receptive and expressive language functions as a consequence of disrupted and insecure attachment usually mediated through maternal unavailability (Rodrigo et al., 2011). A positive reciprocal parent child relationship is very closely linked to language development (Fox, 1998) that if impaired, adversely affects children's social and communicative competence specifically in the domains of pragmatics and morphology. Researchers have noted higher rates of language delay in neglected preschool children (Allen & Oliver, 1982; Eigsti & Cicchetti, 2004) and it is recognised that language delay can be a very significant indicator of severe parental neglect (Hammond, Nebel-Gould & Brooks, 1989). The significance of secure attachment in children acquiring communicative competence as a process that begins in infancy, is emphasised by other researchers (Klann-Delius & Hofmeister, 1997; Rivero, 2010). Acquisition of communicative competence in pragmatics is particularly important as this relates to a child's ability to convey appropriate language within the context of a discussion. When deficient it can result in affected children experiencing difficulties in judging appropriate use of language and finding difficulty in gauging how others react to

them. Manso and Alonso (2009) expand this theory by arguing that pragmatics is crucial in children's development and their social interaction.

Other research proposes that neglect effects are more damaging than abuse because of the detrimental impact on brain plasticity (Curtis & Cicchetti, 2003; Cheatham, Larkina, Bauer, Toth & Cicchetti, 2010) that is important to the development of memory and recall (Farah et al., 2008). Neglected children fail to learn imitative behaviour because of maternal unavailability and insensitivity (Sylvestre & Merette, 2010) which in part contributes to an inability to develop social competency (Landry, Smith, Miller-Loncar & Swank, 1998). The physiological effect of increased levels of stress hormones that are found in neglected children (Fries, Shirtcliff & Pollak, 2008) influences brain affect pathways. The development of social perception, regulating body states, emotion, memory and creation of meaning are required skills for decision making and influenced by stress hormone levels. These attributes are crucial for maintaining social relationships (Posner, Rothbart & Gerardi-Caulton, 2001) and form the capacity for empathetic interpersonal communication (Decety, 2011; Harris 2003; Lamm & Singer, 2010).

Mapping the neurophysiological pathways of neglect influences on the developing brain (Lenzi et al., 2009) is an important development in contemporary maltreatment research, detailing the cognitive effects that underpin observed maladaptive behavior. These result in demonstrable changes similar to a brain injury (Killeen, 1999; Strathearn, Gray, O'Callaghan & Wood, 2001). Such conclusions are supported by advances in neurological radio- imaging techniques that have objectified a pathological dimension to the effects of neglect on brain structure, specifically corpus callosum size (Teicher, Dumont, Ito, Vaituzis, Giedd & Andersen, 2004). The pathology of child neglect may in part explain why neglected children display persistent abnormalities of brain function that manifest as the aforementioned cognitive, behavioural and emotional problems (De Bellis et al., 1999; DeBellis, 2001, 2005; Chugani et al., 2001; Maheu et al., 2010; Mueller et al., 2010). These are thought to perpetuate adverse health outcomes observed into adulthood that remain independent of social change (Dube et al., 2006) because the functions of motor performance, somatisation, language comprehension and short-term memory are key

to understanding the damaging cognitive sequelae in affected children (Nolin & Ethier, 2007).

As neuroscientific techniques advance and the negative impact that the social world can have on childhood outcomes becomes clearer, the interdependence of both in supporting optimum healthy brain development of children will, it is proposed, be better understood (Harris, 2003; Posner, Rothbart & Gerardi-Caulton, 2001). To reiterate, any conceivable factor that contributes to parental stress and can impact on a child's development with disastrous consequences are manifest as adverse outcomes of child development (Gilbert et al., 2009b; Spinhoven et al., 2010). Irrespective of the origins of language delay and childhood competence, however, early intervention by services is imperative to improve outcomes (Buschmann et al., 2008).

The consequences of neglect are not only observed on young children. Whilst there is a limited corpus of reliable data for older children who have been identified as neglected (Ards & Harrell, 1993; Wodarski, Kurtz, Gaudin & Howing, 1990), the most consistent outcome is also poor academic performance (Mills et al., 2011) that is related to patterns of negative behaviours and difficulty with social adjustment (Egeland, Sroufe & Erickson, 1983; Eckenrode, Laird & Doris, 1993; Kurtz, Gaudin, Wodarski & Howing, 1993). A history of neglect is specifically linked to depression and anxiety in older children (Brown, Cohen, Johnson & Smailes, 1999) and established early neglect in childhood is particularly relevant in considering later aggressive childhood behaviours (Kotch et al., 2008). The associated externalising and aggressive acting-out behaviours (Hecht & Hansen, 2001) are thought to contribute to youth offending rates and increase the likelihood of involvement in the criminal justice system (Chambers, Power, Louchs & Swanson, 2001; Stewart, Livingston & Dennison, 2008; Yun, Ball & Lim, 2011). It is notable that 40-60% of adolescents perpetrating violent offences are documented as having a history of neglect and abuse (Hussey, Chang & Kotch, 2006) where physical neglect has a specific association with violent behaviour in older youths (Chapple, Tyler & Bersani, 2005). It remains however a challenging area of study and whilst there appears to be a compelling link between child maltreatment and youth offending,

there remain inconclusive findings across studies (Maas, Herronkohl, & Sousa, 2008; Ireland & Thornberry, 2005; Thornberry, Ireland & Smith, 2001; Thornberry, Henry, Ireland & Smith, 2010).

Aside from complex adverse behavioural outcomes, neglect and other maltreatment types have physical health consequences apparent in negative health indicators by age twelve that influence the development of certain childhood diseases (Flaherty et al., 2009) and result in greater need for hospital treatment across many disease areas (Lanier, Jonson-Reid, Stahlschmidt, Drake & Constantino, 2010). The association with increased levels of adolescent alcohol misuse is particularly relevant today (Shin, Edwards & Heeren, 2009). This research is infrequent, however, and within the corpus of child neglect studies, it could be argued that the medicine of neglect is still "catching up" with other disciplines in describing its ontological perspective of it.

To conclude, it seems any approach under the umbrella of developmental traumatology cannot examine the psychobiological impact of adversity on childhood development and the effect of neglect in activating stress response systems in totality (Debellis, 2001, 2009), because child neglect exists within a tangled mass of interacting factors. These operate at levels of the family unit through to the macro-structure of government, that all play a part in exacerbating or ameliorating the effects of child neglect.

2.3.3 A Problem for Adults

Child neglect casts a long shadow into adulthood and it seems that it is not an experience that affected individuals can easily divest themselves of. A history of childhood neglect results in similar problems of attachment disorders in adults experienced as psychological and relationship difficulties (Gauthier, Stollak, Messe & Aronoff, 1996). Continued maltreatment in childhood is particularly harmful and contributes to victimisation in adulthood (Widom, Czaja & Dutton, 2008) with serious consequences (Ethier, Lemelin & Lacharite, 2004) as a result of increased violence and antisocial behavioural problems (Grogan-Kaylor & Otis, 2003; Widom & White, 1998).

There appears to be an association with risk-taking sexual behaviour and increasing exposure to HIV and other sexually transmitted diseases (Kang, Deren & Goldstein, 2002; Haydon, Hussey & Halpern, 2011; Wilson & Widom, 2011), involvement in prostitution (Wilson & Widom, 2010).

Neurobehavioural traits that are observed in adults who recall childhood neglect and who are homeless and socially excluded (Pluck, Lee, David, Macleod, Spence & Parks, 2011) reflect that a greater number have comorbid mental health problems (Bernet & Stein, 1999; Cohen, Brown & Smaile, 2001). These include depressive disorders, anxiety and somatic symptoms (Johnson, Cohen,Brown, Smailes & Bernstein, 1999; Johnson, Smailes, Cohen, Brown & Bernstein, 2000). Physical neglect particularly impacts on the degree of adult disability in schizophrenia (Gil, Gama, de Jesus, Lobato, Zimmer & Belmonte-de-Abreu, 2009) and emotional neglect appears to have a specific association with depression and social phobia (Spinhoven et al., 2010).

A history of childhood neglect is also implicated in addiction issues in adults (Corso, Edwards, Fang & Mercy, 2008; Felitti et al., 1998) who are more likely to develop alcohol and substance misuse (Dube, Felliti, Dong, Giles & Anda, 2003; Dube et al., 2006;Wilson&Widom,2009; Widom, White, Czaja & Marmorstein, 2007). This is thought to be mediated through dysregulation of stress responses and subsequent depression (DeBellis, 2002) where overall, childhood neglect appears to have a specific association in adulthood with alcohol misuse (Mullings, Hartley & Marquart, 2004; Widom et al., 2007).

Adults who recall childhood maltreatment including severe neglect are more likely to fall below the poverty line and drift into crime related activities. This results in 'substantial costs to society' because of lost productivity, reduced tax contribution and increased social spending (Zielinski, 2009). Lower education and employment status and earnings mediated by neglect effects may be more pronounced in women with a history of childhood maltreatment (Currie & Widom, 2010). Pervasive health problems, chronic pain, gastro-intestinal disorders and greater psychological disturbance are all documented as affecting this group (Arias, 2004).

Aside from its psychological impact and effect on adult economic productivity, adults who have been the victims of neglect have overall poorer physical health (Dube et al., 2003; Wickrama, Conger, Wallace & Elder, 2003) that may be clinically apparent for example, as increased rates of liver disease (Dong, Dube, Felitti, Giles & Anda, 2003). A history of adverse childhood experiences including neglect, may better predict adult ischaemic heart disease than traditional risk factors contained within a biomedical model (Dong et al., 2004b). Similarly other researchers have demonstrated a 'dose dependent' increase in inflammatory markers with a significant association with cardiovascular disease in adults who recall childhood neglect, where it is postulated that adult inflammatory markers independently mediate poor health outcomes (Danese, Pariante, Caspi, Taylor & Poulton, 2007; Danese et al., 2008). For adults, who as children, experienced particularly physical neglect and were raised in substance misusing families, there is an increased risk of premature death (Anda et al., 2009). Nonetheless, it remains a contested area of study with other research concluding that childhood maltreatment has no association with increasing adult mortality rates (White & Widom, 2003).

Despite these apparent contradictory findings, it is reasonable to conclude from current research evidence overall, that adults who recall childhood neglect in terms of their own personal well-being and with regards to their socioeconomic attainment, have decreased opportunity to attain better outcomes than those who do not.

2.3.4 Child Neglect as a Family Problem

> Convinced that the family, as the fundamental group of society and the natural environment for the growth and well-being of all its members and particularly children, should be afforded the necessary protection and assistance so that it can fully assume its responsibilities within the community (United Nations, 1989).

Child neglect contextualised at the immediate level of family function is possibly more important than any other situation because the most proximal influences in children's lives, that is, parental behaviour immediately impacts on child well-being (Ney, Fung & Wickett, 1992). 'Well-being' is an umbrella term that incorporates many facets of a child's individual and environmental characteristics (Camfield,

Streuli & Woodhead, 2009; Fattore, Mason & Watson, 2007) that in a discussion of child neglect, requires further layers of interpretation. During the GP consultation it becomes relevant when patients often bring the challenges of their everyday lives into the encounter irrespective of their physical complaints (Waitzkin & Britt, 1989; Waitzkin & Maguna, 1997). It is particularly salient in child neglect matters, where parents present with diverse problems including addiction issues, mental health problems, physical problems and social disadvantage that can adversely impact on their parenting abiliites.

Family members perpetrate neglect most often (Margolin, 1990; Sedlak & Broadhurst, 1996; Sedlak et al., 2010) and neglect when uncovered, tends to affect all children within the family unit (Hines, Kantor & Holt, 2006). This may seem an obvious statement but, it is very relevant to the difficulties in the prevention of neglect when child welfare legislation emphasises that children are best placed with their families.

Acknowledging that child neglect is a family problem in general practice is reflected in research findings where the family is the 'unit of analysis' of a child 'in need' (Hølge-Hazelton & Tulinius, 2009). Determinants of in need however are complex, inter-related and include any conceivable stress on parental functioning. It is suggested that multiple parental factors for example divorce, parental addictions should all be considered within the analysis of the dynamics of the family unit when exploring the adverse outcomes of childhood stresses (Felliti et al., 1998). Furthermore, any parental attribute should be considered alongside the broader socioeconomic environment, where parenting skills may be negatively affected by multiple stressors such as poverty and social isolation (Bifulco et al., 2002). Adverse economic circumstances can result in increased rates of parental stress and depression and less involved parenting which in turn adversely affects the child's psychosocial adjustment (Conger et al., 1992). Mechanisms that operate in an ecological/transactional framework include psychological, biological and environmental factors that interact throughout a variety of circumstances and developmental stages that result in neglectful parenting behaviours (Cicchetti &

Lynch, 1993; Lynch & Cicchetti, 1998). Given the wealth of empirical data, what does a neglectful family look like?

Neglectful and abusive families are routinely constructed from the child protection statistics and are disproportionately represented within the categories of poverty (Egami, Ford, Greenfield & Crum, 1996; Cort, Cerulli & He, 2010) and socioeconomically challenged communities (Coulton, Korbin, Su & Chow, 1995; Drake & Pandey, 1996). Whilst Dubowitz's assertion that neglecting families have numerous social and economic issues (2007) seems obvious, determining unmet needs within the context of the family unit makes this challenging and complex work for any professional, including GPs, who work at the margins of the private sphere of family life and the public sphere of state systems. GPs who are working in areas of deprivation for example, will be aware of the stresses that poverty brings to bear on the family dynamics in the unfolding consultation.

Neglectful parents are typically under 30 (Gaudin et al., 1996) and exhibit low rates of positive interaction with their children and family members. They are said to be socially isolated with fewer available support networks and often disengage from any support that is offered (Burgess & Conger, 1978) partly because of the perceived stigma associated with engaging with parental support (Pullman, VanHooser, Hoffman & Helfinger, 2010). Other researchers have noted that low parental education, limited parenting skills and high child care burden are also relevant concerns (Slack, Holl, McDaniel, Yoo & Bolger, 2004; Zaravin, 1991) .

Parental psychopathology, depression, anxiety, and antisocial personality traits have been shown to be directly related to child neglect occurrence (Leinonen, Solantus & Punamaki, 2003; Wilson, Rack, Shi, & Norris, 2008) mediated theoretically, by a limited ability to process or respond appropriately to their children's behaviour (Hildyard & Wolfe, 2007). Along with greater parental stress levels, anger, hyper-reactivity and parental low self-esteem, these should be given consideration in assessing situations of child neglect (Stith et al., 2009).

Intergenerational transfer of neglect is apparent as parents replicate their own childhood experiences of neglect and tend to become neglectful parents themselves

(Kim, 2009; Lounds, Borkowski & Whitman, 2006). Estimates of neglectful parents who were themselves maltreated vary between 25% and 35% (Kaufman & Zigler, 1987), with more recent studies estimating this figure to be much higher at 78% (Erikson & Egeland, 2002).

Research tends to focus on the role of mothers as the main carer (Dubowitz, Black, Kerr, Starr & Harrington, 2000; Bifulco et al., 2002; Lee, Bellamy & Guterman, 2009; Lounds, Borkowski & Whitman, 2006) who are described as more socially isolated from their communities with inadequate social supports (Polansky, Gaudin, Ammons & Davis, 1985; Gaudin, Polansky, Kilpatrick & Shilton, 1993; Casady & Lee, 2002), lower self-esteem and social adequacy (Christensen et al., 1994). Such attributes may exacerbate their social exclusion because they are regarded as 'deviant' by their community (Polansky et al., 1985).

The combination of problematic maternal behaviours for example impulsivity, low confidence (Polansky, Gaudin & Kilpatrick, 1992) combined with adverse living conditions, inadequate social support and mental health problems (Lewin & Abdrbo, 2009) are all thought as contributory factors to mothers neglecting or abusing their children. In particular, low maternal self-esteem appears to be most predictive of neglect (Downey & Coyne, 1990).

A specific consideration must be given to the strong association between parental substance misuse and child neglect (Dunn et al., 2002; Kirisci, Dunn, Mezzich, & Tarter, 2001) where the sequelae of parental drugs misuse is perhaps most visible in children who are living in impoverished communities. It may identify low-income families who are neglectful (Ondersma, 2002) and is implicated in increased child fatalities (Jaudes, & Ekwo, 1997). However, far from being a direct causative factor (Scannapieco & Connell-Carrick, 2007) it is postulated that it mediates the relationship between psychiatric disorders and neglect along more complex, indirect pathways (Johnson & Leff, 1999; Suchman & Luthar, 2000).

Nonetheless, despite the profile of the neglectful family, the challenges in the domain of health relate to inherent difficulties with 'diagnosing' neglect and its 'downstream' effects within a traditional biomedical model (Chaffin et al., 2006).

There is still much work to be done to unravel the 'mystery' of parental neglect and its negative impact on child development (Connell-Carrick & Scannapieco, 2006). It remains likely that at least within health, its mysterious effects will still be observed by GPs in their everyday working lives in both their child and adult patients in all levels of society when parenting becomes adversely affected (Patterson, Mockford, Barlow, Pyper & Stewart-Brown, 2002).

2.4 The Politicisation of Child Neglect

One cannot separate the entity of child neglect and its adverse health outcomes from the mechanics of child protection policy in the West, because systems that orientate to identifying and preventing child neglect within the context of family function are underpinned by our child welfare legislation. Kreiger (2008, p.223) argues, 'The understanding of the societal distributions of health thus cannot be divorced from considerations of political economy and political ecology' in the determination of causality. Furthermore, she comments that the paucity of conceptual understanding, professional and political accountability in biomedical research is 'unacceptable'.

The state has regarded child neglect throughout child welfare evolution as a troubling issue for society and has tended to identify child neglect through evidence gathering from the constituent parts of society deemed responsible for it. The state constitutes the child caregiver relationship through a paternalistic rights-based approach that appeals to a political and rhetorical pressure to empower children but is limited by structural constraints of poverty, discrimination and bureaucracy. These filter down from government institutions to professions who concern themselves with notions of children's rights and parental responsibilities in relation to the private sphere of the family function, and are evident in the competing discourses of child welfare and child protection (Parton, 1997; Smeyers, 2010).

The child welfare system in this country endorses an international agenda that balances the rights of the child with parental responsibilities, and is ultimately

orientated to keeping children and families together[7]. It has become inculcated into our own legislation, but it could be argued that its enactment remains an ideal. This is because the dimensions of child neglect are conceptually linked to all three categories of children's rights as manifestations of health and well-being, that is, their right to protection, participation and contribution to issues of childhood[8]. If neglect itself is inadequately conceptualised however, the operalisation of neglect meaning will itself be partial and deficient.

To address this, studying the social distribution and determinants of 'developmental health' particularly in the early years (Hertzman, 2010) is important. This is because many factors can adversely affect a broad range of physical and mental health outcomes (Berkman & Kawachi, 2000; Kawachi & Berkman, 2001; Leventhal & Brooks-Gunn, 2000, 2003) through socio-environmental factors such as indicators of child well-being, child maltreatment (Coulton, Korbin & Su, 1999; Coulton, Crampton, Irwin, Spilsbury & Korbin, 2007) and parenting practices (Kohen, Leventhal, Dahinten & McIntosh, 2008). Such determinants contribute to our understanding of where one might find neglect occurring at a community level. This is often scrutinised within state response to child poverty and its impact on child neglect that deserves attention because it seems particularly indefensible that we can

[7] 'Recalling that, in the Universal Declaration of Human Rights, the United Nations has proclaimed that childhood is entitled to special care and assistance' (United Nations, 2008).

[8] Much of our legal perspective and frameworks for delivering child health make reference to the UN (1989) Convention of the Rights of the Child (United Nations, 1989).This sets out minimal standards relating to children's civil, political, economic social and cultural rights broadly into three categories;

1) Provision – the right to maintain minimal standards of health ,physical care, family life education
2) Protection – from discrimination ,abuse ,neglect ,exploitation and substance abuse and
3) Participation – the right to a name and identity and to challenge decisions made on their behalf (listening to children's views). Although it is not an integral part of Scots Law this convention influences the judicial process and is referred to in matters relating to children and their welfare.

still discuss child poverty in the 21st century, on a scale that is apparent from current child poverty statistics[9].

The failure of the parent-child relationship occurs more commonly as the level of economic poverty increases, represented by higher reported levels of physical and educational neglect in socioeconomically deprived households (Claussen & Crittenden, 1991; Freisthler, Merritt & Lascala, 2006). The occurrence of neglect rates are in the magnitude of 17% of the poorest households (Theodore, Chang & Runyan, 2007) and substantiated child neglect is forty-four times more likely to occur in low income families (Sedlak et al., 2010).

Adverse parenting practices are thought to be linked to neglect through a variety of issues conceptualised as limited social capital (Zolotor & Runyan, 2006) restricted access to health care, increased social stresses, inadequate housing (Ernst, Meyer & Depanfillis, 2004) homelessness and substance abuse. Poverty in some families, undoubtedly contributes to household dysfunction and interrupts the normal caregiver relationship (Sidebotham, Heron & Golding 2002; Sidebotham & Heron, 2006). Combined with limited parental education and employment it contributes to the chronicity of neglect (Nelson, Saunders & Landsman, 1993). That said, the pathways mediating the effects of poverty on neglect remain unclear and somewhat indirect (llham et al., 1998; Slack et al., 2004; Flouri, Tzavidis & Kallis, 2010). When uncovered, it is other factors that apparently make the effects of neglect visible (Dubowitz, Papas, Black & Starr, 2002). The association between poverty and children re-reported to the CPS, for example, becomes weaker over time in comparison with parental mental health issues (Johnson-Reid, Emery, Drake & Stahlschmidt, 2010).

[9] In Scotland the most recent child poverty statistics reveal 210000 of Scotland's one million children live in relative poverty with 100000 of them living in absolute poverty. The Scottish government has noted that there needs to be more progress to the levels of child poverty in Scotland which has seen little progress since 2004/5 (The Scottish Government, 2010).

On balance however, it seems difficult to ignore the relationship between poverty and its association with adverse educational (Leventhal, Fauth & Brooks-Gunn, 2005), physical and psychological outcomes for children. Timing and duration of 'deep and persistent' poverty is significant (Duncan, Brooks-Gunn & Klebanov, 1994; Duncan & Brooks-Gunn, 2000), particularly when child neglect has a similar litany of adverse outcomes with indirect links to the 'toxic effects' of poverty. Whilst poverty may not define neglect (Illham et al., 1998), it is the most consistent correlate identified with a unique impact on neglect occurrence (Lee & Goerge, 1999). Hertzman and Boyce (2010) argue that unfavourable social environments 'get under the skin' early in human development and maintain poor outcomes throughout life through direct and complex influences of adverse family and neighbourhood poverty (Nikulina, Widom & Czaja, 2010; Schuck & Widom , 2005).

Government recognises the link with poverty and had set a goal of halving child poverty by 2010 and eradicating it by 2020 through economic opportunity and reform of public services including health, to deliver high quality services to improve outcomes for poor children and help families in times of crisis. Unfortunately, it has failed to meet its first goal and that is of concern in today's economic climate where the relationship between poverty and child neglect can only magnify (Department of Work and Pensions, 2004).

It could be argued that child neglect at the macro level of state function is one dimension of a known socio-economic challenge because of its known association with poverty. Braveman and Gruskin (2003a, 2003b) comment on the sustained 'unjust social structures' that continue to exacerbate the social and economic consequences of ill-health (2003a) and make a plea that the institution of health recognises its role in ameliorating the effects of poverty on ill-health by advocating for social justice beyond the boundaries of the healthcare system (2003b).

This is an important consideration because there is a clear association between disadvantage with social class and adverse effects on child health in the first 10 years of life (Petrou, Kupek, Hockley & Goldacre, 2006). The marked health and mortality differentials across economic strata in Europe and America are in part due to health

selection and the inter-generational transfer of inequalities. This link is very strong with poor socioeconomic status and it is apparent that disadvantage in early life in whatever context that occurs, has adverse cognitive and physical effects on children and persist into adulthood (Palloni, 2001; Palloni, Milesi, White & Turner, 2009).

The natural conclusion from this standpoint is that the system is complicit because despite evidence that policy regimes can impact positively on child well-being (Engster & Stensota, 2011) child neglect continues to be sustained through the existence of unjust social structures. Nonetheless we must also be careful not to 'ghettoise' child neglect to the poorest communities (Slack et al., 2004; Sayer, 2005; Bell, 2010).

Whilst poverty brings its own unique challenges, child neglect requires attention of all strata of society with a preventive approach supported by a universal child health service that can encompass the notion of the 'well' child in its broadest social setting. Nonetheless, it is problematic to locate the dimensions of child neglect meaning in child welfare policy because it is conceptually difficult to delineate the parameters of an abstract concept. To address this and other challenges, Morrow and Mayall (2009) call for an expanded concept of child well-being in relation to child neglect and a greater critique of the language of well being and its social philosophical theoretical perspectives. They argue that it is now a term that is 'politically loaded and problematic' complicated by inadequate comparable data. Furthermore, Morrow and Mayall (2009) would advocate that there is a need to combine quantitative and qualitative data where child neglect should be conceptualised within a broad framework of child well-being incorporating socio-cultural and policy imperatives as explanatory factors in the analysis.

This would require a systematic approach where state institutions support the actions required to intervene as early as possible without waiting for evidence of the outcomes of neglect, if we are to address the distressing conclusion that physically or environmentally neglected children present 'the least positive and most negative affect' of all types of maltreated children (Egeland, Sroufe & Erickson, 1983, p. 469).

2.5 The British Picture

British research of retrospective accounts of neglect from face-to-face interviews with young adults aged between 18-24 years has documented self-reported neglect rates of 37% (May-Chalal & Cawson, 2005). One study of adults aged 18-33 years in a UK wide survey uncovered rates of serious physical neglect of 6% (Brooker, Cawson, Kelly & Wattam, 2001). This however, needs to be interpreted with caution because of the limits to the veracity of adult recall within any maltreatment study (Bernet & Stein, 1999; Hardt & Rutter, 2004; Scher, Forde, McQuaid & Stein, 2004; Baker, 2009). Nonetheless, adult retrospective accounts are given their place within the maltreatment literature because despite inherent bias they provide a meaningful dimension to maltreatment understanding (Dube et al., 2004; Kendall-Tackett & Becker-Blease, 2004; Widom et al., 2004). It is further strengthened as a research approach if reports can be validated by a reliable and robust measurement tool (Bifulco, Bernazzani, Moran & Jacobs, 2005).

Neglect is now the most frequently used category on child protection registers in England, accounting for 43% of registrations in 2005/06 (Department for Education and Skills, 2006). From Scottish data in 2009/2010, 26% of all child protection referrals resulted in registration on the child protection register with 44% of those under the category of 'physical neglect' (Scottish Government, 2010). Within these data parental addiction problems have significant implications for neglect rates because the number of reported and substantiated cases does not reflect the enormity of this challenge, and is compounded by a lack of large-scale, systematic research into the association between use of different types of substances and child maltreatment (Cleaver, Unell & Aldgate; 1999).

That said, neglect is the most commonly experienced form of maltreatment that children may experience who are living with parental substance misusers (Kroll & Taylor, 2003). Consequently there is a particular need for doctors to be mindful of this association (Wells, 2009). Estimates of children living with parental drug users who are subject to serious neglect range from 30% to 73% (Jaudes, Ekwo & Van Voorhis, 1995). In Scotland, the numbers of children affected could be as high as

59000, but the true extent of neglect that these children experience remains unknown (Scottish Executive, 2004).

The discrepancy in child neglect rates between official statistics and other methods of recording (Shaffer, Huston & Egeland, 2008; Mumpower, 2010), are similar to research of adults who recall childhood maltreatment, with neglect commonly reported with physical abuse in one third of the population (Scher, Forde, McQuaid & Stein, 2004) .

If we regard child well-being as a measure of how good it is to be a child in this country then we continue to perpetuate this rather fragmented and stuttering approach to ameliorate the difficult situations that children experience in the UK including those who live in neglectful circumstances. Across several domains including health and education, the UK has scored particularly poorly despite its national wealth in comparison with other countries (Bradshaw, 2007; Bradshaw & Richardson, 2009). Unicef (2007) has declared that children in the UK fare particularly badly in a league table of rich nations in aspects of emotional well-being and 'happiness' but this remains an incomplete measurement tool as it relates to child neglect.

2.6 It's A Costly Business

Courtney (1999) has suggested that all the factors that contribute to the human suffering of child maltreatment are impossible to attribute a financial cost to in part because of difficulties with definitions. Other researchers have attempted to quantify neglect's economic costs to society with specific reference to the burden of decreased human capital through childhood vulnerability that is 'biologically unecessary' (Kershaw, Warburton, Anderson, Hertzman, Irwin & Forer, 2010). Examples of this are time lost at work through illness and injury, absent school attendance in the short and long term, indirect costs of special education, adult mental health and other healthcare services and the costs to the judicial system (Currie & Widom, 2010).

American studies estimate that the economic burden of child maltreatment has risen from 56 billion dollars in 1993 to 80 billion dollars in 2007. However these data are

incomplete, compounded by other methodological issues such as quantifying reduced life expectancy (Corso & Fertig, 2010) and other intangible costs for example, mental anguish and social stigma. Many issues that are pertinent to assessing qualitative aspects of the consequences of neglect (Corso et al., 2008) are challenging to attribute to financial costs.

Estimating the cost of child maltreatment in the UK is equally dilemmatic. Research has suggested a figure of £735 million but it is unlikely that there is any credible estimate with regard to neglect alone (NICE, 2009).

2.7 Views From Outside And In – What GPs And Other Professionals Think Is Going On

There are a number of striking similarities in studies that examine barriers to doctor participation in child welfare issues in this country and other health systems. Research has highlighted a number of impediments to professional involvement, for example, a lack of cooperation between services, failure to implement recommendations (particularly related to adolescent mental health issues), funding issues and a shortage of suitably trained professionals (Bannon & Carter, 1991, 1998; Bannon, Carter, Barwell & Hicks, 1999: Birchall & Hallett, 1995; Horwath, 2007). Waterhouse and McGhee (2009) highlight a general sense of anxiety about the consequences of failure in child protection procedures from the level of government that cascades down to frontline professionals in any discipline, but particularly Social Work, that deals with vulnerable children. At the level of the individual this anxiety is manifest as fear of making a mistake and being ridiculed (Rowse, 2009), with the additional challenge of psychologically coping as a professional with the emotional demands of screening for child neglect (Waibel-Duncan, 2006).

With specific reference to GPs, Gardner and Brandon (2008, p.183) comment it is ‘well-nigh impossible’ to persuade general practitioners to engage actively with child protection training and inter-agency work.

There are many factors involved, but specific to doctors, are issues of confidence in the child protection system, the dynamics of the doctor patient relationship, concerns

that the benefit of reporting children does not outweigh the harm caused and definitions of risk thresholds (Bannon & Carter, 1998; Bannon, Carter, Barwell & Hicks, 1999; Afza, Wardle & Light, 2007).

Other researchers (Gunn, Hickson & Cooper, 2005) comment that the difficulties encountered are because many of the concerns of child neglect are abstract concepts socially constructed and reliant on professional experience. Gunn, Hickson and Cooper (2005, p.98) argue that 'the pre-eminence' of child protection services as a 'common pathway' for assessing the scale of unmet need may not be the most appropriate approach to matters of child neglect. Indeed, Gregoire and Agnello (2011, p.1240) have recently argued that child protection has become a 'a form of madness' because of an almost delusional belief in society that increasing bureaucratic approaches will solve the intractable problems of child welfare in this country.

This appears to be in contrast to Gilbert's (2009b) view where it is suggested that the development of guidelines based on 'systematic reviews of the research evidence' will improve recognition and response to such concerns. From research on postgraduate learning acquisition it is difficult to see how this would be realised given the mechanism of professional learning outlined in Chapter 1, but more pertinent to issues of child neglect, how will this be achieved when the evidence base excludes many accounts of child neglect experiences?

Horwath's (2007, p. 125) research exploring barriers to multi-professional involvement in child neglect issues concludes that, 'assessment practice is as much a practice-moral activity as a technical rational one'. In her study, GPs expressed the view that they learn by their practical experience but it is limited with regards to neglect. . This has important implications for maintaining a well developed child health service that embodies a holistic approach to child maltreatment when working with vulnerable families. Unfortunately it has become increasingly subsumed by importance attached to chronic disease management of adults and decreased opportunistic and scheduled appointments with children and families.

Horwath (2007, p. 129) concludes that referral of children into the CPS from concerned professionals, 'will only occur if there is a recognition at all levels within organisations that professionals are not automatons but human beings whose practice will always be affected by a range of different influences'.

Nonetheless, GPs do have an intuitive grasp of identifying children 'in need' which they invoke in clinical contacts with vulnerable families (Lykke, Christensen & Reventlow, 2008, 2011). The family is the unit of analysis in which GPs incorporate parental factors such as mental health problems and addictions to identify a child who may need support from them, through the 'indirect consultation'. This knowledge is articulated in everyday language by GPs from experience gained in clinical encounters that is often understood within the context of observed parental behaviours and not from technical frames of reference (Hølge-Hazelton & Tulinius, 2009).

2.8 The Solutions

It would be very disheartening if the literature was limited to pessimistic theories of the genealogy and consequences of child neglect without a balancing discussion of the prevention or amelioration of its adverse effects. Positive interventions tend to focus on the circumstances of the initial onset of child maltreatment (Allin, Wathen & MacMillan, 2005; Daniel, Taylor & Scott, 2010) with the purpose of crucially supporting the family unit particularly in early years development. Orientating services towards family support must nonetheless, be explicit and widely disseminated through political and economic institutions (McNeill, 2010), if purposeful interventions are to take into account the multiplicity of neglect and target the various factors that contribute to it (Sidebotham & Golding, 2001) .

Brofenbrenner (1993) suggests that one approach is child development envisaged in a series of nested social situations in a hierarchy from immediate family and community environment, through to indirect effects of cultural traditions to address the multiple influences on neglect occurrence. The development of parenting skills and improvement of family living conditions in terms of income, employment, education, housing or child care (Prilleltensky, 2001) is concordant with ecological–

developmental theory that identifies protective factors that contribute to childhood resilience (Freisthler, Merritt & Lascala, 2006; Garmezy, 1991, 1993; Leventhal & Brooks-Gunn, 2000; Luthar, 2007; Luthar & Zigler, 1991; Nikulina, Widom & Czaja, 2010; Nikulina, Widom & Czaja, 2010; Rutter, 1987, 2006, 2007; Ungar, 2011; Zolotor & Runyan, 2006). Many government initiatives try to promote resilience by tackling issues of economic hardship but it remains an emergent area of research (Zielenski & Bradshaw, 2006). This section will discuss a number of possible solutions to child neglect posited by current research.

2.8.1 Listening To the Voice of the Child

> States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child ,the views of the child being given due weight in accordance with the age and maturity of the child (United Nations, 1989, Article 12).

Children's rights today are embedded in an international treaty signed up to by a number of countries including the UK, that transcends the single state and its obligations to all children to provide fundamental rights of 'participation, provision and protection' (United Nations, 1989). It remains a challenge in this country to recognise these rights when they remain 'imperfect obligations' towards children (O'Neill 1996, p. 32). This is arguably an effect of practice and procedures that exist without a comprehensive consensual communicative basis binding society members together.

There has been a limited focus on the participation of children in the development and application of child welfare policy, despite adopting the right of children to be listened to into our legal framework. Archard and Skivenes (2009) argue that seeking the views of the child is a necessity if 'legitimate and rational' decisions about a child's welfare are to be made. Fairclough (1992, p.66) argues '(the) discursive constitution of society does not emanate from a free play of ideas in people's heads but from a social practice which is firmly rooted in and orientated to real, material social structures'. If we concur with this assertion that the family unit exists as a social structure that is discursively influenced by the internal dynamics of the family unit and the external dynamics of the institutional practices, it is pertinent to ask

where in this rather complex matrix of discursive processes is the voice of the neglected child heard?

Researchers have commented that children tend to be the least involved in any research with a focus on child neglect as this does not fit with an adultist view of children being competent interviewees (Chan, Lam & Shae, 2011; Futh, O'Connor, Matias, Green & Scott, 2008). As a social grouping children have not participated, in their own language, in such a research agenda until recently (Helwig & Turiel, 2002). Several authors (Curtis, Liabo, Roberts & Barker, 2004; Irwin, Johnson, Henderson, Dahinten & Hertzman, 2007; Mayall, 1994) explore the possibility that even very young children are capable of taking part in discussions about their views on school, home and health services, and other work suggests that within health it is possible to incorporate the views of children directly albeit with adult mediation in eliciting their views (Clavering & McLaughlin, 2010). Alderson (2000) argues that we should allow children to give their own views about childhood in research as they are the primary source of knowledge about their own experiences. Acknowledging their views as such can formulate 'child impact' statements that can profoundly influence child centred policy in a progressive agenda (Foley, 2001, p. 61).

From a perspective of developing a child-centred approach in research it is acknowledged that children are capable of representing their own views that allows researchers to "hear" children's accounts of their own circumstances and the challenges that they face (Chan, Lam & Shae, 2011; Fraser, 2004; Futh, O'Connor, Matias, Green & Scott, 2008; Mayall, 1994; Morrow, 2001; Prilleltensky, 2010). This moves away from paternalistic child rescue to a collaborative approach with children and parents and recognises the rights of the child as active participants. As discussed, parental substance misuse has a particular association with child neglect (Ondersma, 2002). From the limited corpus of research one group of children, in their own words, described the challenges that they faced in these circumstances. Examples of these include children becoming a carer for their parents or younger siblings, anxieties over becoming separated from the family unit, school problems and being directly exposed to drug using activities from an early age (Aberlour, 2002). Other

researchers describe these challenges to child well-being within the context of the 'parentified child' (Bekir, McLellan, Childress & Gariti, 1993)

Centring the child in this debate is inherently part of the solution to the challenges of child welfare issues that departs from a narrow definitional agenda (Fattore, mason & Watson, 2007) and specifically emphasises that health engages with child maltreatment policies to improve its role in recognising and preventing child maltreatment (Reading et al., 2009).

Irrespective of how this approach to child welfare could be achieved it is acknowledged that some children either because of their own characteristics or personal circumstances have difficulty in having their voice heard in the first instance (Mcleod, 2007). Referred to as 'hard to reach' children, they are frequently in greatest need of services but become marginalised in the process of service provision for example, pupils excluded from school with behavioural problems, those with limited literacy skills or living in sustained adverse conditions (Rees, Gorin, Jobe, Stein, Medforth & Goswami, 2010)[10].

The marginalisation of the neglected child is further hampered by the significant language delay and specific difficulty in pragmatics of communication (Manso & Alonso, 2009) that complicates any participation in research where children who experience sustained neglect are least able to make their views known.

If we are to uphold children's rights to participate in having their views acknowledged in issues of child welfare and respect their individuality (Archard & Skivenes, 2009) then health professionals should inquire more frequently about children's personal circumstances and support the role of health in the exercise of children's rights (Waterston & Goldhagen, 2007). Their participation in this agenda is an important concept in the development of their citizenship (Earls & Carlson,

[10] This recent study of older childrens' experiences of maltreatment revealed interesting findings about their views of child welfare professionals and highlights the disparity in referral rates for age groups when child neglect tends to become minimised as a child protection issue in older children.

2001; McLeod, 2000; Smith, 2010; Morrow, 2001), with the caveat that children's knowledge of their rights and understanding of the concept of rights is articulated from a viewpoint that is naturally dependent on age, emotional and intellectual development (Helwig & Jasiobedzka, 2001; Helwig & Turiel, 2002; Hurley & Underwood, 2002;) .

Despite the challenges, there is some evidence of good professional practice for children of all ages participating in issues of child protection and child welfare (D'Cruz & Stagnetti 2008) but within the context of general practice, orientating toward a child centred approach is complicated by the consultation dynamic that is a triadic event between doctor, parent and child (Cahill & Papageorgiou 2007a). Children rarely participate during the 'proximal consultation' (Cahill & Papageorgiou, 2007b) where the child in need is determined from parental factors (Hølge-Hazelton & Tulinius 2009). This omission is particularly relevant in the debate to the challenges of defining neglect from the child's perspective (D'Cruz & Stagnetti, 2008).

2.8.2 Promoting Childhood Resilience

> In the context of exposure to significant adversity, resilience is both the capacity of individuals to navigate their way to the psychological, social, cultural, and physical resources that sustain their well-being, and their capacity individually and collectively to negotiate for these resources to be provided and experienced in culturally meaningful ways (Ungar, 2008, p. 225).

There appear to be a number of protective factors that reduce the likelihood of poor developmental and psychosocial outcomes in neglected children (Hoge, Austin & Pollack, 2007; Masten & Coatsworth, 1998; Masten, Burt, Roisman, Obradovic, Long & Tellegen, 2004; Masten & Obradovic, 2006; Masten, 2007; Runyan et al., 1998). Consequently, there is growing interest in the notion of resilience in maltreated children as an important focus for improving outcomes for children because lasting behavioural, functional or mental health problems are far from certain in children who are neglected (Haskett, Nears, Ward & Mcpherson, 2006). Similarly, for adults who recall childhood maltreatment, many do not universally

display adjustment problems that are often associated with it (McGloin & Widom, 2001).

An ecological model is important to the study of resilience because environmental factors can promote or interfere with its occurrence (DuMont, Widom & Czaja, 2007). For example, the successfully functioning 'efficacious' community (Drake & Pandey, 1997; Evans et al., 2011; Flouri, Tzavidis & Kallis, 2010) may increase the possibility of better outcomes in challenging environments (Landau, 2010; Roditti, 2005; Runyan et al., 1998) through negating the impact of loneliness and social isolation on neglectful parenting behaviours (Gaudin, Polansky, Kilpatrick & Shilton, 1993). The subjective well-being of children is related to family function where there is a clear relation between children's behaviour and parental stress.

Childhood outcomes deteriorate as the number of proximal factors multiply independent of socially adverse conditions. This finding is important when considering child neglect because differences in parental coping and interpersonal skills act independently of social class in influencing child outcomes (Landry et al., 2002; Luthar & Latendresse, 2005; Flouri et al., 2010). Research in Glasgow mapping out emotional disturbance and conduct disorder in school entry children has uncovered rates roughly 50% higher in areas of high deprivation categories but concludes that 'some of the most deprived areas appear to have excellent childhood mental health' (Wilson, 2011, p.7).

Positive social networks can compensate for immediate family stresses and improve outcomes of children living in adverse circumstances (Dowdell, 2005; Roditti, 2005) and children universally attach a great deal of importance to supportive relationships with family and friends. Access to healthcare, an empathetic doctor and an expectation that they will be listened to respectfully by adults responding accordingly to their requirements in the contexts of education and health, are aspects of what children consider a 'good life' (Andresen & Fegter, 2011).

In summary, there appear to be a number of factors which promote increased resilience in neglected children. Parental warmth and affection, family, positive peer support and inter-personal relationships, bond to community, church and school, easy

temperament, high level of self-esteem, internal locus of control and self-efficacy are all cited (Collishaw et al., 2007; Hoge, Austin & Pollack, 2007; Rutter, 2007). Other researchers place additional emphasis on the presence of adaptive resources, for example coping, autonomy and planning skills (Masten et al., 2004) that influence a child's ability to overcome adversity and persists as a protective trait that develops and sustains adulthood (Obradovic, Burt & Masten, 2006).

Promoting childhood resilience as a 'a broad systems construct' (Masten, 2007) requires a balanced, comprehensive approach. To address the challenges of child neglect prevention at multiple levels within an ecological context (Rutter, 2006; Ungar, 2010, 2011) depends in part on collaboration across agencies (Luthar & Brown, 2007). This requires improved funding and planning of services and retaining experienced staff who understand the concept of resilience to empower vulnerable children and their families to access support (Daniel, 2006).

If strategic policy is directed towards and inculcated within universally accessible child services, the adverse effects of neglect that affect childhood outcomes can be improved (Farah et al., 2006; Hertzman et al., 2010a). Resilience in children is consequently strengthened along with social competence and adaptive functioning skills.

2.8.3 A Focus on the Family Unit

Approaches to family therapy to reduce maltreatment occurrence is broadly within the context of universal and targeted services such as parenting support programmes (Law, Plunkett, Taylor & Gunning, 2009; Lowell, Carter, Godoy, Paulicin & Briggs-Gowan, 2011; Prinz, 2009; Swenson, Schaeffer, Henggeler, Faldowski & Mayhew, 2010; Tarabulsy et al., 2008). A universal approach providing early child development programs addressing emotional, social, physical and cognitive needs benefits all children and disadvantaged the most (Williams & Wynder, 1993; Hertzman et al., 2010b). One particular American study, the Nurse-Family Partnership, was pivotal in understanding the longterm benefits of highly skilled professionals supporting families more likely to maltreat their children. Comparing a control study group who received minimal intervention and services the research has

consistently demonstrated improved developmental outcomes for children, reductions in maltreatment rates, better employment and health prospects for mothers beyond their involvement in the programme (Kitzman et al., 2010; Olds, Henderson, Chamberlin & Tatelbaum, 1986; Olds & Kitzman, 1990; Olds et al., 1997; Olds et al., 2007; Olds et al.,2010; Zielenski, Eckenrode & Olds, 2009). It achieves this by promoting appropriate interaction between parent and child (Donelan-McCall, Eckenrode & Olds, 2009) and acknowledging that neglectful parents tend to have established difficulties, they display less empathetic concern for their children, misinterpret behavioural signals and overestimate their child's capabilities relative to their developmental age (DePaul & Guibert, 2008).

That said, not all interventions in parenting are orientated to the same outcomes including neglect prevention, and despite repeated contact between professionals and vulnerable families it remains unclear which approach best prevents adverse outcomes for children (Barlow, Johnston, Kendrick, Polnay & Stewart-Brown, 2006; Barlow, Smailagic, Ferriter, Bennett & Jones, 2010; Conley and Duerr, 2010; Hiscock, Bayer, Price, Ukoumunne, Rogers & Wake, 2008; Olds & Kitzman, 1990; Scott et al., 2010; Spijkers, Jansen, de Meer & Reijneveld, 2010; Walker & Kirby, 2010; Woodman et al., 2011). Furthermore, improving parenting practices through state intervention appears to be better received if it is within the context of voluntary and not compulsory parenting programmes (Holt, 2010) where parents feel accepted without censure and their own needs are recognised within the programmes (Kane, Wood & Barlow, 2007).

2.8.4 The Role of the Doctor

GPs should understand the protective and detrimental influences that impact on child well-being, and the role of health to develop a collaborative systems approach to support childhood resilience and reduce the adverse effects of child neglect. Having no single solution within any one professional approach to neglect prevention, GPs remain relevant because they contribute to the process of ongoing family assessment and support (Levine, 2006; Scribano, 2010). Patients who have a history of childhood neglect frequently use health services (Rees, 2010; Yanos, Czaja &

Widom, 2010) thus, general practice's role in this context is predominantly at a low-level of assessment and support of families. This facilitates vulnerable families' entry into parenting programs and complements other aspects of maltreatment prevention within the child welfare system (Klevens & Whitaker, 2007).

Working at the margins of family life and the system of health, GPs are well placed to understand the specific challenges that adversely affect family function and result in the vulnerable family and the vulnerable child (Hertzman & Bertrand, 2007).

The gaze of the GP needs to be steadfastly fixed on the vulnerable family when they 'see' neglect in a number of contextual situations for example during a house visit or neglectful parenting interactions in a consultation. GPs essentially must comprehend any presentation of neglect as and when they come into contact with vulnerable families, that can be translated into supportive action, through increased engagement with the family or liaising with other professionals.

Maintaining their gaze on the child 'in need' is at the heart of medical ethics and morality which challenges any doctor to negotiate the system of modern medicine and retain the interest of the patient as her primary concern. Sieghart (1982) argues doctors can become conflicted by differences of state and patient interests, but urges them to retain their altruistic goals and perhaps look beyond the immediacy of their own working practices toward international norms and legal standards, to negate the constraints in exercising their ethical beliefs (Sieghart,1985). This is even more pertinent today with the diminution of the role of the GP in child health when there is simultaneously an accumulating evidence base of the 'transmission of neglect' (Debellis, 2001, 2005, 2009; Pagani, 2007; Polonko, 2006) mediated through impaired cognitive development.

As the neuroscience of child development begins to explain at a cellular level the observed effects of child neglect on child behaviour and subsequent adult psychopathology, it requires a progressive approach to connect the science of the individual mind and the consequences of social behaviour (Posner, Rothbart & Gerardi-Caulton, 2001). Adding into the equation the 'toxic effects' of poverty on child health (McNeill, 2010) and family function that contribute to child neglect

occurrence (Coulton et al., 2007; Drake & Pandey, 1996; Korbin, Coulton, Lindstrom-Ufuti & Spilsbury, 2000; Larson, Russ, Crall & Halfon, 2008; Nikulina et al., 2010), challenges the state to provide a way out for families living in perpetually low socioeconomic environments and to acknowledge the influence of policy on health inequalities (Beckfield & Krieger, 2009).

Identifying and preventing neglect should, in the context of general practice, be re-calibrated from its evidentially –led trajectory within the framework of child protection and embrace the holistic role of the GP in child welfare concerns. One function is sign-posting parents into supportive services to improve their parenting capacity and by association children whose needs are unmet (Wilson & Mullin, 2010)

Dubowitz (2002) argues that the role of the physician in neglect prevention is important. He highlights the relationship between the family and physician that is built up often over many years from numerous consultations. He further highlights the importance of the knowledge of family dynamics and adaptive family behaviours that can only be realised because of such a long term therapeutic relationship. It would seem counter-intuitive to suggest that there should be no role for GPs in this debate, but at present there is very little evidence to suggest otherwise.

The lack of involvement of GPs in maltreatment prevention is in someway reflected in the findings of various significant child protection inquiries (O'Neill, 2003; Laming, 2003; Herbison, 2006; Care Quality Commission, 2009). Communication deficiencies within GP systems are often cited, but unless there are system changes that explicitly support the GP role in neglect prevention alongside development of a common understanding of neglect, it is difficult to see how the genealogy of "pathologies" of communication will be tackled.

2.8.5 Improving Child Neglect Recognition in the System

> In child protection, thresholds are often associated with the measurement of risk…about predicting the consequences of maltreatment for a child's long-term well-being and judging the benefits of offering a service against the costs of taking no action…But they are often confused with the setting of

> priorities which can help to decide why one child with one level of risk is offered help, yet another with the same level of risk but a different type of problem is not…Somewhere in the dynamic between the actions of an individual practitioner and the expectations of those that plan services for children in need, the professional influence is brought to bear (Little, 1997, pp.28-32).

Theoretical frameworks that locate child neglect within the problem family promote an ontological approach that idealises parenting practices and regards child neglect as a consequence of a deviant form of parenting that violates acceptable parenting practices. The inherent difficulties in determining the multiple dimensions of neglect in this approach are apparent in the enactment of welfare policy. Smith and Fong (2004, pp.107-108) argue that policy is 'a reflection of societal and cultural values' and that the most appropriate system approach would be to 'eliminate poverty' more than any other intervention to produce 'broad and sweeping' social reforms.

The tensions of substantiated versus unsubstantiated neglect continues to challenge the determination of its existence within the CPS (Fakunmoju, 2009). Having no discernible difference in outcomes for children referred into the CPS whether neglect is substantiated or not (Hussey et al., 2005) culminates in missed opportunities to improve adverse outcomes for children (Campbell, Cook, Lafleur & Keenan, 2010). This is partly attributed to the notion of thresholds which underpin the level of risk at which children access services. Thresholds remain conceptually problematic because of a lack of clarity within statute when state systems orientate towards evidence of neglect that do not necessarily encompass acts of omission or absent parental behaviours. It is further confounded by reduction of neglect meaning when it is operationalised and classified to neatly fit categories within risk measurement tools linked to issues of coding within IT systems (Runyan, Dunne & Zolotor, 2009).

A reliance on accepted indicators of neglect as evidence of the scale of the problem undoubtedly misrepresents populations who are maltreated (Schnitzer, Covington, Wirtz, Verhoek-Oftedahl & Palusci, 2008), because the process of determining the circumstances of neglect as already outlined needs to consider the multiple and conceptually challenging factors involved. Orientating towards the practice of safeguarding children that is a broader interpretive concept than child protection,

may be more productive because it encompasses physical problems within a psychosocial framework. It is a useful starting point for doctors working closely with families in the community (Hall & Williams, 2008) to develop competency in assessing vulnerability in families by focusing on definitions of well-being that are broadly understood as issues of need, rights, poverty, quality of life and social exclusion (Axford, 2008).

As the child welfare system becomes increasingly complex with competing voices of authority, it must be remembered that meaningful support for neglected children requires a collaborative endeavour with children, parents and professionals within a communicative framework that underpins common understanding of neglect. This is particularly relevant to establishing collaborative, interagency approaches to improve child welfare (Horwath, & Morrison, 2007). Sameroff (2010) argues that a unified theory of child development that dialectically integrates nature and nurture is fundamental to improve aspects of recognition and prevention of child maltreatment. Furthermore he comments that 'neither provide ultimate truths and neither can be an end in itself' but function as 'an integrated way to look at and for things' (Sameroff, 2010, p. 20).

2.9 Conclusion

The truth of child neglect is not only evident in scientific measurement, it has a truth and a reality embedded in its social and emotional contexts. To explore a human behaviour within these parameters requires a philosophical overview that can reconcile the two intellectual projects of scientific positivism and appropriation of hermeneutics. Habermas's (1999a, p.21) treatise on intersubjective understanding provides the mechanism of communicable knowledge within universal pragmatics 'to identify and reconstruct universal conditions of possible mutual understanding (Verstandigung)' in the exploration of a multiplicity of truths that relate to the same issue.

So what are the accepted truths of child neglect and their relevance to general practice, when child welfare services appear to focus on indicators that restrict the meaning of child well-being in relation to child neglect (Fattore ,Mason & Watson,

2007)? In reality, child neglect is not only an isolated individual experience with individual consequences. It exists within a broader societal context, where realities of neglect reflect the complexity of the subject and the contributing factors which are multiple and interrelated within the various strata of social life. It is therefore unavoidable when exploring the meaning of child neglect located in a contextually sensitive medium to completely separate out the political, historical and social dimensions that have shaped neglect meaning.

The legal framework has been established through over 100 years of child welfare reform and shapes the politics of child neglect but according to Habermas (1996, p.30) 'the legitimacy of statues' is only achieved if they have been created through 'rational legislative process…from pragmatic, ethical, and moral points of view'. It is therefore pertinent to ask within this research focus if laws relevant to child neglect issues do represent the unrestrained discourses of 'communicatively engaged citizens...the socially integrative force of...free and equal citizens' (Habermas, 1996, p. 32).

I have a stated interest in how child neglect is understood in my own profession but reading the literature the voice of the GP remains inaudible. Of course one could question within the complexity of neglect research if such an omission makes any tangible difference to child neglect understanding. However, I would argue that an overarching understanding of neglect cannot be achieved without uniting its disparate perspectives, including those of GPs working with vulnerable children and families.

Many of the qualitative aspects of neglect's adverse effects are never 'measured' within a health context because of its complexity as an abstract concept. The psychopathology of child neglect outcomes, the reduced social capital of neglectful families and on a more optimistic note the resilient children, who despite their adverse and stressful childhood experiences, develop into well-adjusted adults who do not follow the oft cited route to replicating their own parents behaviour, are constituents of that understanding that are often imagined quantitatively but should also be equally thought of as qualitative insights.

CHAPTER THREE; PHILOSOPHICAL AND THEORETICAL UNDERPINNINGS OF THE RESEARCH

3.1 Introduction

The first two chapters outlined the definitional and measurement challenges of child neglect from a number of perspectives. Within each unique research setting it is incumbent on the researcher to adapt analytic approaches to best fit the researcher's specific project. As a result, the structure of this analytic framework demands certain theoretical approaches developed from research questions that are relevant to the context of my own everyday work experiences.

I have observed child neglect more frequently than child abuse within my patient population, where identifying a child in need becomes a dual process of recognising a parent in need. In my experience some families struggle more in the same environmental conditions than others, and if you are a child living in adverse circumstances who has not reached thresholds of state intervention, you are "on your own". From this perspective I not only wanted to investigate the concept of child neglect from a GP perspective but explore its meaning beyond the boundaries of my own profession, because child neglect it seems, has endless permutations.

This chapter discusses the philosophical and theoretical underpinnings of the research and I intend to achieve this by reviewing the broader conceptual issues of quantitative and qualitative approaches. The scientific inquiry of this study and preferences stated within the research process, could only be fully explored within an accepted philosophical overview of how different aspects of knowledge can be connected with each other. I develop this overarching framework using Habermas's treatise of types of knowledge production and communicative action to achieve this end.

3.2 Counting a Concept-Theoretical Approaches

Within medical research, evidence that is constituted from statistical analysis is acceptable to validate professional practice but a purely quantitative approach in this

study context is confounded by the epistemic limits of our ability to define, understand and explain neglect. Child neglect resists any research attempt to have it fit neatly into one research model because precise measurements or standardised instrumentation of parental behaviours are problematic with respect to child neglect (De Bellis, 2001).

From my own research standpoint, the reliance on quantitative approaches alone to explore essentially a human behaviour would be deficient. It would omit the methodological and conceptual value that analysis of the language surrounding this complex entity contributes to developing new insights (Kreiger & Smith, 2000; Lancaster et al., 2010). Whilst the contribution of positivistic research to health in particular is widely promoted, the epistemological assumptions that typify this approach, for example categorisation, have caused concern because of insufficient attention paid to an individual's lived in experiences (Kreiger, 1999; Bryman, 2001).

It is impossible to quantify precisely how many children are subject to neglect when disparate sources for data are employed within different research methods to determine adverse outcomes (Slack et al., 2003). It is theoretically impossible to locate child neglect within 'pure' science or 'pure' knowledge when there is no common agreement of what it actually means. In Habermasian terms it is unhelpful to understand child neglect cleansed of subjectivity or value beliefs and opinions. Habermas (1988, p. 265) argues that these are inherent requirements of conceptualising and enacting meaning 'the persuasiveness which a value claims with respect to action' that cannot be separated from the 'sewage of emotionality…stamped solely with the stigma of irrationality' and are therefore inherent requirements of understanding the whole constructed concept.

Methodological challenges in this research field are inevitable when analysing data from small, non-randomly selected sample sizes with unknown generalisability,

variable model specification and a lack of statistical control[11]. This is perhaps not surprising given the multiple aetiologies of neglect, its contested meaning at an individual level and the ethical impossibility of randomising children and families to supportive services in this country where access to child health provision is universal and regarded as a right. What can be broadly concluded from the data is that the true incidence is unknown but underestimated (Swahn et al., 2006) where psychological abuse and neglect are the most under-reported maltreatment types (McKenzie, Scott, Waller & Campbell, 2011). Neglect occurs more frequently than official figures suggest with neglected children more likely to be subjected to other forms of maltreatment particularly physical and emotional abuse (May-Chalal & Cawson,2005; Trickett, Mennen, Kim & Sang, 2009; Gilbert et al., 2009a; Mennen, Kim, Sang & Trickett, 2010; Sedlak et al., 2010). It is therefore my intention within the quantitative aspect, to explore objective dimensions of child neglect meaning as a first analytic step in shaping the contours of child neglect meaning.

The next section will explore theories of the other side to quantifying child neglect, that is qualifying child neglect.

3.3 Language Counts-Discursively Constructing Child Neglect

3.3.1 Introduction

> language enters life through concrete utterances (which manifest language) and life enters language through concrete utterances as well (Bahktin, 1986, p. 63).

The dominant analysis of data in this thesis resides in qualitative methods, specifically theoretical approaches to language, using the tools of discourse analysis

[11] Olds' work discussed in Chapter 2 is an exception to this where parent and child outcomes were measured from randomised groups assigned to intensive intervention or minimum support.

and critical linguistics to better qualify the meaning attached to child neglect from a number of data fields of spoken and written text[12].

Language is a social resource and stands in a dialectic relation to society (Fairclough, 1992) containing referential and representational expressions of meaning. This study explores thought contained within spoken and written text, but requires the traditions of critical linguistics to provide the analytic framework to look at the meaning contained within and beyond the boundaries of the text. Orientating towards integration of language and practice, in the context of linguistic analysis of experience allows theoretical connections between the individual with society, the system and lifeworld, the particular with the universal. Habermas comments (1984, p. 43),

> we also speak of the rationality of a conduct of life, and in the sociocultural conditions for such a conduct of life there is reflected perhaps the rationality of a lifeworld shared not only by individuals but by collectives as well.

A research focus on language contained within narratives considers it representative of an objective event and proposes that meaning and reality is constructed during the making and telling of personal narratives. Bruner (1991, p. 15) argues that narratives function to structure perceptual experience and organise memory and 'segment and purpose-build the very events of life'. In this research narrative is one aspect employed in a mixed methods study to validate what is apparent in the spoken texts that epistemically connect subjective experience and objective fact (Rescher, 2001). Brown and Yule (1983, p.65) outline the 'principle of analogy' adopted by speakers

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[12] Habermas provides little guidance in the technical aspects of of language analysis but a constant reflection of the research findings onto his theoretical approach to communicative rationality provides a framework to the analysis . Habermas progresses his thinking on speech validity claims to a theory of action and reason where action and language are intrinsically linked, because humans are linguistic and communicative beings whose actions are guided by mutual understanding and intersubjective agreement. Habermas (1987b, pp. 314-315) comments,

> rationality can be worked out...with the help of a pragmatic logic of argumentation...it integrates the moral-practical as well as the aesthetic-expressive domains...recalls older ideas of logos...the connotations of a noncoercively unifying, consensus-building force of discourse...Communicative reason is expressed in a decentered understanding of the world.

and hearers in contextual interpretation of discourse 'interpreted in the light of past experience of similar discourse, by analogy with previous similar texts'. The importance of past experience in the analysis of meaning in language is echoed by Atkinson's (1995, p. 137) study of physician discourse in 'the deployment of personal narratives and reminiscences'.

Neglect understood as a dialectic concept bridges many contextually sensitive situations that are cultural, political, social and ethical. A common bond between each domain is that language is foundational to communicative action orientated towards mutual understanding between all the actors who are involved in matters of child neglect. Habermas (2001, p. 85) explains,

> facticity…implicit in symbolic objects such as sentences, actions, gestures, traditions, institutions, worldviews…gain permanency only through the medium of acknowledged interpretations.

He argues that this process is a necessary step to in the maintenance of a durable and useful truth-conditional theory of meaning in any exploration of knowledge, "implicit knowledge...mastered only intuitively and requires the reflexive work of rational reconstruction in order to be transformed from a 'know-how' into a 'know-that' " (Habermas, 1999a, p. 238). He does not specifically refer to a basis of communicative rationality within the field of medicine but regards it as existing within a 'cultural system' (Habermas, 1984). Within this system, the language of participating GPs is not necessarily an expression of expert knowledge but an individual expression of opinion, reflective of cultural attitudes and beliefs, 'institutionally stabilised and professionally organised'. They become legitimised and given authority by their existence as 'higher validity claims' (Habermas, 1984, p. 40). In an analysis that connects the discursive practices of agency and structure language serves as a 'heuristically productive starting point for systematising validity claims' because according to Habermas's (1984, p.40) theory, 'no validity claim appears at the level of cultural objectivations that would not also be contained in communicative utterances'.

A Habermasian paradigm of linguistic philosophy contains an interpretive scheme that acknowledges the analysis of language is situated within a 'relation of part and

whole' where the interpreter 'must learn to speak the language he interprets' (Habermas, 1987a, p.172). Everyday language has a preset communicative structure that conveys through grammar, internal relations of language, 'a habitual social context of life'. This cannot be 'wholly grasped in general categories' but requires hermeneutic understanding that through linguistic analysis 'reveals the empirical content of indirectly communicated life experience' (Habermas, 1987a, p.172). This is an important research concern that endeavours to connect discursive practices of state institutions, individual understanding of child neglect, objective and subjective knowledge across a temporal dimension. These all converge as aspects of knowledge that connect with child neglect imagined as a dialectic concept.

Habermas moves beyond a narrow understanding of language as being descriptive and assertoric within a formal semantic approach, by taking the smallest meaningful units to investigate linguistic expressions and by considering other ways of using language.

The analyst can utilise Habermasian principles of universal pragmatics 'to represent something in the world using a sentence, to express the speaker's intentions, and to establish legitimate interpersonal relations' (Habermas, 1999a p. 54). When it has a specific contextual function integrated with 'rationalisation of the lifeworld'[13], there exists a philosophical framework to locate the challenges of child neglect in relation to individuals and society, the everyday and taken for granted beliefs that objectify neglect and the endeavour to "solve" it.

3.3.2 Child Neglect at the Nexus of System and Lifeworld

A strategy- orientated society using different mechanisms to mediate power at the levels of agency and structure, exercising instrumental rationality (achieving results)

[13] Habermas (1984) develops this theory of evolution in society where he proposes that critically reviewing and exploring everyday beliefs that are taken for granted are necessary for any aspect of social life including science and technology (pp. 143-271). Outhwaite (2009, pp. 66-79) provides an explication that the reader is directed to which clarifies in some depth the strands of Habermas' thinking which at times seems rather complicated and difficult to grasp.

and communicative rationality (achieving understanding) represents a dichotomy of technical interest versus a practical emancipatory interest. What society does about child neglect versus what society understands of child neglect maintains an inherent tension that can be used positively or negatively by the political system. General practice is one professional domain where, in the context of child neglect, paying attention to children's lived in experiences would embrace Habermas's theory of communicative action (1984). This has already been noted in Chapter 2 as challenges to the recognition of children as autonomous patients.

The distinctions between communicative and strategic action, lifeworld and system allow theoretical connections to be made between the multiple social structures concerned with child neglect issues. Of equal importance is the practical value of Habermas's treatise on communicative action that has a unifying theme centered on unconstrained dialogue. This restricts power under the conditions of understanding and consensus with both processes contributing to an analysis of language and social action. This stated commitment to universalist ideals of inclusiveness and equality idealises the process where moral-practical insights have developed and potentially altered system approaches throughout the progression of child welfare concerns. The contribution of communicative action to historical child welfare concerns is outlined in the analysis of archival text in Chapter 8.

From a Habermasian perspective then, communicative action is the guiding interest to reach understanding and agreement among participants. Free unimpeded linguistic interaction, undistorted by power, is central to democratic participatory processes revealing the truth through unforced consensus. In the study context my suggestion is that Habermas's idea of communicative rationality may also serve as a starting point for thinking about the particular domains of objectivity and of truth from the standpoint of any professional "seeing" neglect and for any child who experiences neglect. It also provides a communicative space for participatory research that moves towards emancipation and mediates Habermas's critique of positivism and the need for objective science. In this study it is tied very closely to the purpose of a methodology that enables the mixing of different perspectives in order to achieve deeper understanding.

The intertextuality of chains of texts connecting to, shaping other texts and mixing genres informs a broad analytic, eclectic approach in the analysis of language in this research.

3.4 What is a Text?

A brief mention may be given to the scholarly debates on what constitutes a text that is a topic which occupies both linguists and discourse analysts[14]. An explication of the practical dimensions of textual analysis is outlined by Fairclough (2010, p. 240),

> Texts are seen as 'work', as part of productive activity and as part of the process of producing social life...analysed both **paradigmatically** and **syntagmatically**. The paradigmatic aspect of language...concerns the range of alternative possibilities available, and the choices that are made amongst them in particular texts. The syntagmatic aspect of language concerns the organisation or chaining of words together in structures (e.g. phrases or sentences).

From this standpoint it is important to note the context of the emergence of the text and the limits and boundaries used to delineate the external relations influencing the production of text. A critical analysis acknowledges theoretical complexities and ambiguities imported into meaning embedded within the disciplines where meaning emerges. In this analytic tradition, the examination of multiple written and spoken texts reveal salient political and ideological features that reflect the histories of the participants and institutions in the production of texts (Jaworski & Coupland, 1999, p. 474).

[14] According to Titscher and Jenner (2000, p. 22) a text must satisfy the following criteria of cohesion (the components of textual surface) where grammatical rules are obeyed through recurrence, anaphora and cataphora, ellipsis (shared world knowledge). Coherence, intentionality (attitude and purpose of text production), acceptability can be the basis of communicative issues. Informativity (quantity of new or expected information in a text) , cultural and situational appropriateness that form the concept of discourse or text in context and intertextuality where a text relates to preceding or simultaneous discourse with formal criteria link texts to each other. Cohesion and coherence are text internal the other criteria are text external.

3.5 Theories of Applied Linguistics

3.5.1 Introduction

> All knowledge is constituted in semiotic systems, with language as the most central; and all such representations of knowledge are constructed from language in the first place…*experience is the reality that we construe for ourselves by means of language* (Halliday & Matthiessen, 1999, p. 3).

It can be perplexing as a researcher from a non-linguistic background to grasp the array of terms within the theoretical and methodological traditions of the broad fields of socio- linguistics and applied linguistics under the categories of conversation and discourse analysis. At this juncture it is pertinent to provide an outline of the three different analytic approaches that are employed throughout the qualitative approach to the study, namely Conversation analysis (CA), Discourse Analysis (DA) and Critical Discourse Analysis (CDA) and their relation to each other.

Both CA and DA are concerned with how language is used. Their shared assumptions and approaches are broadly similar, namely language is a central and constitutive feature of social life. That said, there are significant differences that inform the methodological approaches and impact on the analysis which centres on the balance between privileging talk and action[15].

DA is a broad area of language study with different epistemological roots, a form of semiotics which includes body language and visual images. This thesis will focus on the discourse of language in written and spoken text. It broadly follows two assumptions that the spoken text is primarily to maintain human relationships 'primary interactional use' and the written text to transfer information 'primary transactional use' (Brown & Yule, 1983, p. 13).

[15] For an useful exploration of this subject see Woofitt (2005) and Ten Have (2007) who outline a detailed account of CA methodology both emphasising the technical contribution of CA in any CDA approach to spoken data as the 'first step' in the analysis.

Despite the scholarly attention given to discourse analysis[16] there is no simple definition that is consistent across the disciplines that undertake discourse study. Gee (1999, p. 5) comments,

> There are many approaches to discourse analysis, none of them...uniquely 'right'. Different approaches fit different issues and questions...different approaches sometimes reach similar conclusions through using different tools and terminologies connected to different 'micro-communities' of researchers .

In DA, the action orientation of language is at a level of the wider interpersonal or social functions served by talk to examine how people construct attitudes, memories where speech events are very context –specific and speakers accomplish numerous social actions through different forms of talk (Potter & Wetherell, 1987). Regarded as language as social practice it is underpinned by a social constructionist orientation to knowledge, in which multiple versions of the world are legitimate. It stands apart from CA because its analytic focus is the connection between language and power to reveal discursive aspects of societal disparities and inequalities, a departure from the technical aspects of language analysis.

CA was developed from the work of Harvey Sacks investigating the corpus of telephone calls to the Los Angeles Suicide Prevention Centre. His subsequent work extended to mundane conversations and along with his colleagues Emmanuel Schegloff and Gail Jefferson (Sacks, Jefferson & Schegloff, 1992) developed a model of language and communication where 'language in interaction had a social organisation with formal properties which were independent of whatever information might be in transit between the brains of the participants' (Woofitt, 2005 p.8.). In this

[16] The reader is directed to texts that have informed the analytic approach to the research. Burman and Parker (1993) outline the role of discourse analysis in psychology and the exploration of the socio-cognitive approach. Brown and Yule (1983) reference a diverse variety of discourse types in their explication of DA studies whereas Wetherall, Taylor and Yates (2001;i) provide a useful explication of the approach to research analysis 'a set of methods and theories for investigating language in use and language in it social contexts'. Jaworski and Coupland (1999) provide a comprehensive collection of texts to outline the methodology of language analysis within the wider contexts of social and political themes. Gee(1999, p. 27) outlines an approach to DA where he focuses on language use as one part of a discourse that requires recognition of its other constituent parts interactions, beliefs, symbols to build notions of identity and activity within the Discourse(delineated by the author with a capital 'D') .

model language is not a neutral medium of communication, as it performs activities in the interactions between speakers. Connections between utterances have sequences between and connections to prior utterances. Wooffitt (2005, p.35) summarises this approach under five themes,

> turn-taking focused on the structure of turn design...normative conventions which underpin turn-transfer...action sequences are fundamental units of interaction...CA examines how speakers' conduct displays a sensitivity of the normative expectations associated with sequential organisations...people's own interpretation of on-going interaction as revealed in turn-by-turn unfolding of conversation.

The broad traditions of medical sociology incorporate medical discourse and professional socialisation in spoken data. Demonstrating experience and knowledge acquisition in accounts of personal narrative and individual reminiscence, requires an additional focus on Hallidayan principles of language theory to progress the analysis beyond the immediate interpretation of text. Situational and cultural contexts are expressed through the different strata of language within the metafunctions of language namely ideational, interpersonal and textual (Halliday & Mathiessen, 2004). Both interpersonal and ideational metafunctions are particularly relevant to the research because interpersonal metafunction represents the author's attitude towards subject matter, and ideational metafunction represents language resources used for organising experience as meaning and experiential knowledge (Eggins, 2004).

3.5.2 Critical Discourse Analysis and Social Change

A very significant component of textual analysis used within this thesis is CDA because as an analytic approach, it promotes a transdisciplinary exploration of the pluralistic discourses of neglect meaning that are examined within this work. During its development as a research instrument the analytic tools of CDA have become more diverse in order to deal with 'real-world language –related data' (Coffin, Lillis & O'Halloran, 2010, p. 95). Its focus on a semiotic approach has emerged from critical linguistics, 'critical...because it is rooted in a radical critique of social relations' (Choularaiki & Fairclough, 1999, p.38). Current thinkers in CDA include Fairclough (1989, 1992, 1995, 2003, 2010) who has retained a strong sociological

focus and Wodak (1989) whose social critical discourse analytic practice has been influenced by Hallidayan (1989, 1994) systemic functional linguistics (SFL). SFL contributes to the critical program as a deconstructive approach to language in use by examining the choices that language users make in conveying opinion and attitudes referencing 'the social context for the linguistic development of the individual' (Martin & Rose, 2002, pp. 266-7).

Fairclough's work contributes to the analysis of this research because of his socially determinist position that provides a basis for the study of texts in (relative) isolation as simultaneously reflecting local, institutional and societal domains. Furthermore a dialectic approach further situates the research topic within the background of the historical context leading up to the present day because it acknowledges ideological and political effects are a function of past history. This analytic framework underpins theoretical links between language and social change as discourse and social structure enter into a dynamic relationship. Fairclough argues (2010, p. 233) discourses can be 'operationalised' within a tripartite approach 'they may be enacted as new ways of (inter)acting, they may be inculcated as new ways of being(identities), and they may be physically materialised, e.g. as new ways of organising space'.

Fairclough (1999, p.233) further comments that CDA 'oscillates' between structures of social practices and 'strategies of social agents...to achieve outcomes or objectives within existing structures and practices'. An exploration of language and society from these three perspectives, social, cognitive and historical all have something to say about how child neglect can be understood in contemporary general practice. For example, exploring organisational structure provides the researcher with insights into the political and social background of the Health Service and the constituent parts of general practice. This in turn provides an explanatory framework of diverse pressures on discourse participants from institutional domains. The operationalisation of child neglect could for example be contained within a new protocol in the management of child protection that could have reference to general practice but no explicit role for GPs within the text. In this context, DA would explore the socio-cultural aspects of

texts but would require the analytic tools of CDA to progress the analysis by providing a critical dimension in its theoretical explication of textual meaning.

3.5.3 A Discursive Historical Approach

> We must discover how human studies are related to the fact of humanity...chemical effects of gunpowder...are as much a part of the course of modern war as the moral qualities of the soldiers who stand in its smoke (Dilthey, 1976, p. 172).

Exploring the language of child neglect from a critical historical perspective enables the study of the relationship of different kinds of texts to the progress of child welfare issues. In a Habermasian framework selected texts can be held up as examples of where at certain points the capacity of human rationality[17] has overcome existing obstacles in the pursuit of a comprehensive child welfare policy. Nonetheless it is possible to argue the contra lateral position, that the irrationality of human capacity has simultaneously restricted the development of such an approach to child neglect.

Language and its meaning are often taken for granted as common sense and a reflection of the natural state of the world. One aspect of the qualitative approach within this thesis explores the discursive constructions of child neglect informed by legislation that focused on the delinquent and impoverished child. Far from suggesting however in the analysis that there is a direct link between language use and effects on social practice, the relation between language and society is understood to be indirectly mediated. Nonetheless, within the tradition of critical linguistics the theoretical connections between discourse and society allow the analysis to move from semantic macrostructures to local meanings of words that are not fixed but dependent on the contexts of their production, 'optimally appropriate

[17] 'Rationality' refers in the first instance to the disposition of speaking and acting subjects to acquire and use fallible knowledge…as soon as we conceive of knowledge as communicatively mediated, rationality is assessed in terms of the capacity of responsible participants in interaction to orient themselves in relation to validity claims geared to intersubjective recognition...it brings along with it the connotations of a noncoercively unifying, consensus-building force of a discourse...in a decentred understanding of the world (Habermas 2007b, 1987, p. 314) .

in the social situation…the basis for an empirical pragmatics of discourse, accounting for the way discourse adapts its structures to communicative actions' (Van Dijk, 2009, p. 7).

The starting point of child welfare reform is traced from the 19th century specifically looking at definitional and social constructs of child neglect, where culturally and coherent aspects of the texts make their history appear authoritative and factual. In researching child neglect from this period onwards, one begins to see how this may be accomplished within a pattern of language that rises above historical contingencies across its temporal dimension. In contemporary debate, despite a sophisticated final analysis of neglect, I believe the prevailing ideological core remains stable. The repeated focus on poverty and parental addictions represent socially-culturally shared beliefs accepted as general properties of neglect.

Drawing on Reisigl and Wodak's (2001) outline of the discourse-historical approach of CDA, I explore the notions of context, structure and agency as very important considerations underpinned by critique, ideology and power. The discursive strategies provide tools for exploring membership categorisation, the positive or negative qualification of social actors and stereotypical traits, claims of truth and normative rightness and aspects of the speaker or writer's point of view (Reisigl & Wodak, 2001, p. 94). As such, it draws on and integrates three aspects of critical theory,

> *discourse-immanent critique* discovering inconsistencies, self-contradictions, paradoxes…in text-internal structures, *socio-diagnostic critique* …demystifying the…persuasive or 'manipulative' character of discursive practices, *prospective critique*…the improvement of communication (Reisigl & Wodak, 2001, p. 88).

All contribute to the analysis of historical aspects of child neglect meaning making and appear to uncover connections to the contemporary language of child neglect, albeit in more dilute forms.

The researcher can integrate in this approach to the data 'past experiences, present events and future visions' which not only recognise the relationship between texts but also a restatement 'recontextualisation' of accepted knowledge to support

interdisciplinary research (Wodak & Meyer, 2001, p. 11). Wodak and Meyer (2001, pp.4-5) advocate that CDA has an eclectic array of interests,

> studying social phenomena which are necessarily complex and thus require a multi-disciplinary and multi-methodical approach…discourse means anything from a historical monument, a lieu de memoire, a policy, a political strategy, narratives in a restricted or broad sense of the term, text, talk, a speech, topic-related conversations, to language per se.

A particular focus on the language of politics where context is understood as historical is an important characteristic of CDA when integrating large amounts of data from archival sources. In the process of examining discrete pieces of language within their wider political and social contexts the researcher can "read off" social structures and power relations from the text. This maintains an inherently etic standpoint of CDA (Reisgl & Wodak, 2001) and enables the embedded stance within the text to be 'demystified'(Wodak & Meyer, 2001). By transcending the 'pure linguistic dimension' I endeavour to integrate knowledge represented in varied data sources including historical aspects and explore 'ways in which particular genres of discourse are subject to diachronic change, that is, the intertextuality and interdiscursivity' (Weiss & Wodak, 2003, p. 22).

The operation and resistance of power contributes to an exploration of social continuity or social change (Fairclough, 1989, 1992). It has research parsimony with CDA in producing the simplest explication of dominant discursive processes that shape understanding of child neglect 'to shed light on the discursive aspects of social disparities and inequalities' (Wodak & Meyer, 2001, p. 32). When a historical discourse analytic approach meets the basic tenets of CDA outlined by Fairclough and Wodak's (1997) eight–point programme it fulfils its democratic purpose to uncover power relations through a critical awareness of language[18].

[18] 1) CDA addresses social problems 2) Power relations are discursive 3) Discourse constitutes society and culture 4) Discourse does ideological work 5) Discourse is historical 6) The link between text and a society is mediated 7) Discourse analysis is interpretative and explanatory 8) Discourse is a form of social action (Fairclough & Wodak 1997, pp. 271-280) .

CDA then, mediates between the social and the linguistic. More importantly for this thesis, from a hybridity of texts the notion of interdiscursivity can explore social structuring of semiotic hybridity and transdiciplinary working. The logic of one discipline can be put to work in another (Chouliaraki & Fairclough, 1999). As findings from each strand of the study are integrated they contribute to an expansive approach within mixed methods and synergistic understanding of child neglect as a dialectic concept.

Adapting Wodak's discourse –historical CDA approach to archival textual analysis, enables this perspective of child neglect to be appropriated into the research focus. The epistemic aim is to accurately represent how language departs from being only a descriptive account of child neglect to a representation of social practices that have often viewed and enacted child neglect through the lens of the impoverished "dirty child".

In this respect the function of CDA becomes a positive approach to the analysis of discourse and exploration of the "givens" of child neglect, where Habermas's conceptual framework of ethical and explicit standards of the validity of communication truth, clarity, sincerity and legitimacy are fundamental. They provide a philosophical overview to locating distorted communication within his theorising of strategic and communicative practices that connect validity claims to different aspects of the world and functions of language (Habermas, 1984) but simultaneously can undo distortions of communication and contribute in a positive way to the human condition[19].

[19] Habermas provides little guidance in the techniques of language analysis but a constant reflection of the research findings onto his theoretical approach to communicative rationality provides a philosophical framework to the study. Habermas progresses his thinking on speech validity claims to a theory of action and reason where action and language are intrinsically linked. Humans are linguistic and communicative beings whose actions are guided by mutual understanding and intersubjective agreement (1987b, p. 314) .

3.5.4 Travelling Along a Continuum – Critical Linguistics In The Company of SFL

> The world, in many senses, is characterised by perverse sets of practices unopposedly supported by obscure structures of legitimation, signification, and domination. By looking at wider contexts in terms of the instantiation of sets of rules and language resources, language investigation within SFL or CDA may have a bigger impact on the way human agents understand and act upon the different dimensions of such structures (Meurier, 2004, p. 95).

The theoretical connections between SFL and CDA will be expanded in this section and at this juncture it is important to explain the common interest of both, that is, the link between language and society. Young and Harrison (2004, p.1) note several commonalities that include cultural and historical aspects of meaning 'a view of language as a social construct…the ways in which language has fashioned society…(a) dialectical view of language in which particular discursive events influence the contexts in which they occur'. SFL is of particular interest to CDA because it enables emphasis on functional aspects of language and less on the syntactic aspects. The categories of SFL of use to CDA are concerned with how experience is represented in language, ideational 'real world meaning', organisation of text as a piece of writing, (textual meaning) and the role between the writer's attitude towards the subject matter and the reader (interpersonal meaning). Language use is key when exploring identities and relations in CDA 'an open dynamic system' in relationship to its social environment 'the social is built into the grammatical tissue of language' (Chouliaraki & Fairclough, 1999, p. 139).

The analytic tools of SFL move the researcher beyond a simple running commentary of the text to connect with the methodology of CDA to unpick power relations within a text (Eggins, 2004, p. 11). In the spoken data they provide an explanatory framework of expressions of attitudes and judgments contained within the grammatical area of modality, 'a semantic space between yes and no, a cline running between positive and negative poles', (Martin & Rose 2003, p. 48) dichotomised into modalisation and modulation .

Modalisation expresses the probability of something happening or the expression of the likelihood or the frequency of something happening. Modulation represents an important function of speech in the analysis of language of how speakers express

their judgments or attitudes within the notions of their obligation or inclination towards proposals presented in the talk (Halliday & Mathiessen, 2004, p. 147) .

3.6 Ideology and Identity

The link between the social and the personal is 'crucial' in a theory of ideology as it relates to discourses of child neglect. Van Dijk comments (1998, pp.32-33),

> if we ever want to explain that social practices or discourses are ideological…we need to establish the theoretical relationships between the social and the personal, the general and the particular, the group and its members, and the abstract system and its specific instances or uses.

Where language is used as a means to encode particular positions and values these are made explicit ideologically as language actively constructs the world and makes visible actions or events evident from the text (Eggins, 2004). Furthermore, ideology contributes to an important aspect of the study of discourse within the tradition of CDA in the pursuit and maintenance of power. Combining Fairclough's (1989, 1992, 2003, 2010) orientation towards the social dimension of discourse, Van Dijk's (1998, 2009) explication of ideology and attention to the changes of language within its historical dimension provide useful insights to relations between changes in social and cultural practices.

Van Dijk's theory of ideology underpins the notion of shared group knowledge which will be shown to be evident in the spoken texts of GPs and archival data. Van Dijk (1998, p. 37) elaborates,

> general, cultural knowledge is the basis of all group-specific beliefs, including ideologies. Such cultural knowledge or cultural common ground, may be defined as the (fuzzy) set of those beliefs that are shared by (virtually) all competent members of a culture, and that are held to be true by those members by similarly shared criteria of truth...the repertory of 'common knowledge' of a culture.

In this study GPs use 'fashions of speaking' to convey their practical knowledge of an aspect of their medical practice. These represent a constellation of linguistic patterns that are critical to the formation of an ideology (Hasan, 1996) that simultaneously give insight to everyday practice. Within the spoken text GPs, locate

their own experiences of child neglect within a discursive framework that conveys acquisition of knowledge and shared perspectives, originating from their professional training but simultaneously influenced by other cultural dimensions.

From the GP interviews there are relatively stable definitions of neglect but differing accounts of ideological function. Nonetheless these are connected to concrete events, situations, processes, interaction with other groups namely patients and other professionals. All are audible in the analysis of ideology and shared common beliefs.

One challenge of ideological theory is linking personal belief to shared social representation. To construct a shared ideology of child neglect there must be common understanding of any situation that stresses the parent –child relationship. Observations and experiences are incorporated into cognitive processes which register at a level of explanation, where individual meaning collectively constitutes common patterns in the spoken data which is essentially 'shared knowledge'.

In this study ideology is an important bridge between the quantitative and qualitative findings. In the spoken and written data ideological constructs convey a shared understanding and acceptance of neglect definitions. These can also be provisionally imagined from the relationships between variables that form objective dimensions of neglect meaning from the statistical analysis (Chapter 6).

3.7 Metaphors We Work By

3.7.1 Introduction

At this point it is relevant to give a brief definition of metaphor simply defined as describing something in terms of another thing, a psychological process of 'understanding one kind of thing in terms of another' (Lakoff & Johnson, 1980, p. 116).

A linguistic description of metaphor can be understood in terms of the source and target domains. The target domain is the thing being described, while the source domain provides analogous meaning that together constitute a conceptual metaphor. The conceptual domain 'is any coherent organisation of experience' where metaphor

is often employed because an abstract concept is better understood if expressed within a more concrete concept (Kövecses & Csábi, 2002, p. 4). Whilst there may be disagreement in how two concepts interact, the boundaries between them are regarded by all theorists as important to create mappings between the source and target domain to transfer knowledge, inference and structure. To develop cognitive understanding of such concepts the function of metaphor is complex but fundamental to successful daily communication (Runnblad & Annaz, 2010) and particularly important in shaping social attitudes and understanding abstract concepts (Landau, Meier & Keefer, 2010).

3.7.2 Metaphor Theory and Identity

Metaphor is pervasive in all contexts of language use including medical thinking (Coulehan, 2003), that is acknowledged as 'deeply metaphoric' (Rosenman, 2008). In the initial hearing of the study's spoken texts expressions of metaphor can be identified without a great deal of effort.

The origins of metaphorical thinking can be traced back to Aristotle who was concerned with questions of whether metaphors expressed absolute and objective truths or informal reasoning through clarity of speech. Aristotle (1991, p.235) proposed that, 'words mean something...Exotic words are unfamiliar and pertinent ones we know, and so it is metaphor that particularly has this effect...produces understanding and recognition through generic similarity'. Lakoff and Johnson (1980) in their seminal study Metaphors We Live By did not subscribe to this view. They hold the view that there is no absolute truth and that understanding of our world is based on interaction with both our physical environment and with members of our society, that is represented by cultural differences of understanding. Adopting their approach acknowledges metaphor is not just merely descriptive. It is a significant property of language and mind linked to cognitive structures and facilitates understanding that is fundamental to explaining our conceptual system.

This departs from the poetic and rhetorical function of metaphor to emphasise the cognitive force of metaphor and its contribution to understanding experience,

> It is reasonable enough to assume that words alone don't change reality. But changes in our conceptual system do change what is real for us and affect how we perceive the world and act upon those perceptions (Lakoff & Johnson, 1980, pp. 145-146).

It deserves detailed consideration in this research where an exploration of abstract concepts 'understanding' and 'neglect' is applied to dynamic systems of language. The most frequent ontological metaphoric expressions noted in this study are orientational, spatial and structural metaphors that represent aspects of thinking and acting, as experiences become conceptualised in language but expressed thorough metaphor because experience itself is abstract (Lakoff & Johnson, 1980).

Gibbs (1994, p. 125) referring to Ortony's work outlines three theoretical functions of metaphor use. These are inexpressibility hypothesis to 'express ideas that would be extremely difficult to convey with literal language', compactness hypothesis where metaphor provides 'a particularly compact means of communication' and vividness hypothesis to convey 'richer, more detailed, more vivid images of our subjective experience' than literal language.

Lakoff and Johnson (1980) comment that highlighting and suppressing features is an important function of metaphor as a concept acquires 'the status of truth' and new meaning that becomes widely accepted. They argue that 'metaphors can sanction actions, justify inferences and help set goals' (Lakoff & Johnson, 1980, p. 114). The construction of ideology is centred around this process and in this context, conceptual understanding through metaphor use is appropriate to examine through the lens of CDA. The interactional properties of metaphor with environment and sense of being is concordant with Fairclough's (1992) view of the 'social' of discourse.

Metaphorical expressions provide a bridge between constitutive elements of conceptual areas. Kövecses (2002, pp. 239-245) draws distinctions between three levels of metaphor that he describes as supraindividual 'decontextualised linguistic examples', individual level 'metaphors that exist in the heads of individual speakers' and subindividual 'universal sensorimotor experiences that underlie and motivate

conceptual metaphors'. The data analysis in Chapter 7 focuses particularly on the individual and subindividual level of metaphor production.

The individual level explores the limits of speakers' conceptual system dependent on the context of a particular communicative system, and their own personal life stories which influence the use of particular metaphors and the blending of source and domain properties. I have argued that GPs belong to the same linguistic community therefore one could theoretically expect evidence of metaphorical expressions that constitute the same conceptual metaphors because GPs share common professional experiences.

The subindividual level is conceptual metaphor motivated by universal sensorimotor experiences related to the human physiology (metaphors of thought for example) or cultural experiences (sports metaphor for example), and are category based correlations.

Metaphor is evident in all aspects of the qualitative data as the concept of child neglect becomes realised through linguistic means. With the potential to form stable constructs of neglect over time, they become accepted ways of speaking that model social practice 'through inculcation' (Goatly, 2007 p. 29). Semino (2008, p. 33) comments on the 'commonsense' or 'natural' view of things that conventional metaphor is inherently part of within a particular social group 'shared set of beliefs, or ideology' which become dominant within their linguistic repertoires.

3.7.3 Metaphors in Medicine

Metaphors in medical talk are normally studied within texts relating to illness description (Arroliga, Newman, Longworth & Stoller, 2002; Reisfield & Wilson, 2004; Segal, 2007; Switzer, Wittink, Karsch & Barg, 2006). Aita and colleagues (2003) explore metaphor use in clarifying tacit knowledge, values and variation in practice behaviour within the context of cancer prevention in primary care. According to Lakoff and Johnson (1980) the 'war' against cancer is a conventional metaphor and in relation to conceptual metaphor theory represents a process that is

grounded in experience, culturally, socially conditioned and simultaneously integral to medical understanding[20].

There is a body of research evaluating the role of metaphor use in communication in clinical settings (Casarett et al., 2010; Cocksedge & May, 2005; Plotnikoff, 2004; Skelton, Wearn & Hobbs, 2002). Described as discursive strategies that are specifically employed to objectify patients and reduce subjective experience 'de-personalisation' (Anspach, 1988), they also function in maintaining an effective doctor-patient relationship in complex patients with unexplained medical symptoms (Olde Hartman et al., 2011).

Metaphor expressions are employed by patients and GPs for different purposes (Skelton, Wearn & Hobbs, 2002). GPs tend to re-contextualise patients narratives for the purpose of solving clinical problems, facilitate patient understanding or to listen and reflect on patient concerns that are not necessarily rooted in a bio-medical paradigm. Research distinguishes between metaphors used by each group separately or as shared metaphorical concepts. Doctors tend to use metaphors of machinery conceptually grounded in the objectification of the body and illness, 'fixing' something that is not working. They talk of themselves as problem solvers and 'controllers' of illness where metaphorical expressions allude to knowledge and power in obvious ways (Skelton, Wearn & Hobbs, 2002).

3.7.4 Metaphor-A Bridge Within Applied Linguistics

Metaphors that 'offer new conceptualisations of reality' (Semino, 2008, p. 31) are embedded in the ideational function of language in constructing reality.

[20] For a comprehensive account of medical metaphors the reader is directed to Metaphors in Medical Texts (Van Rijn-Van Tongeren, 1997). The conceptual metaphor 'cancer is war' is commonly cited, metaphors are used to structure concepts embedded in numerous medical texts and help explain medical theories and new concepts to both professionals and lay persons. Semino (2008, pp. 175-190) similarly writes of the metaphor of illness, conceptual metaphors relate to cancer as 'war' and illness as 'journeys'.

A research challenge was to identify and explore metaphor expressions that explained understanding, learning and knowledge acquisition and justify this approach in the analytic process.

Research by cognitive scientists suggests that organisation of concepts is knowledge-based and driven by theories about the world. One important contribution of metaphor theory to conceptual organisation is comparison and categorisation (Lakoff, 1987) to make sense of a complex abstract phenomena and to locate its meaning within language that reflecs itst social dynamics (Gibbs, 2008, p. 79). One important aspect of CDA highlights how metaphors are ideologically significant and can contribute to the evaluation of the situations being described. The metaphorical expressions in this research, that emerge as common themes within an investigation of cultural attitudes and beliefs contribute to ideological practices which are 'dominant ways of talking about a particular aspect of reality' (Semino, 2008, p. 33). Other ways of thinking and talking become excluded (O'Brien, 2003) in the process of such beliefs becoming accepted and unchallenged as common sense knowledge.

The specific contribution of metaphor in this research, is that it dialectically links the different research paradigms within the thesis. Whilst the analysis is constrained within the parameters of the research aims, the entities of neglect and understanding that are explored remain dynamic activities, that are never fully complete or closed off, because the language of neglect is not fixed and determinate. That said, it could be argued that if neglect is inherent in human behaviour, then despite the fluidity of language describing its meaning, the origins of the failure of the parent-child relationship that ultimately leads to child neglect remains an undisputed and fixed entity. The language surrounding neglect from this perspective becomes ideological, being encoded in metaphoric expression.

With this in mind, the thesis unpicks the role of metaphor in the social and institutional aspects of neglect meaning not as individualistic internalised meaning alone, but shared social cognition 'commonsense' elements that contribute to

understanding of a central concept. A number of conceptual metaphors[21] contribute to this process identified by metaphorical expressions used to augment the findings of ideological stance embedded in the data (Chapters 7, 8).

3.8 Transitivity-Taking a Stance in Discourse

> It is next to impossible to get a clear fix on our own ignorance, because in order to know that there is a certain knowable fact that we do not know,we would have to know this fact itself, which (by hypothesis) we do not...For the realm of ignorance is just as vast, complex, and many faceted as that of knowledge itself (Rescher, 2001, p. 65).

If child neglect is regarded as an abstract concept, and understanding of it constructed from everyday experiences, then the situations that give meaning to neglect are unpredictable and contingent.

Wherever there is a child with needs then there is the possibility of neglect. The influences of environment, social class and material poverty examined within interactional and ecological models, influence cognitive processes that reduce and restrict neglect within the boundaries of language in order to convey readily grasped versions of it. The interviews in this thesis are considered as representations of such influences and a "window" into the minds of GPs.

The system of transitivity is one analytic tool of SFL 'how speakers encode in language their mental picture of reality and how they account for their experience of the world around them...the transmission of ideas...part of the ideational function of language' (Simpson, 1993, p. 88). An exploration of experience contained within language is a necessary requirement of this approach if an exploration of child neglect meaning is almost exclusively represented by GP's personal narratives of engaging with vulnerable families in the consultation. Configurations of language

[21] Kovecses (2002, pp. 4-5) elaborates 'metaphor is defined as understanding one conceptual domain in terms of another conceptual domain…A conceptual metaphor consists of two conceptual domains, in which one domain is understood in terms of another…any coherent organisation of experience…The particular pairings of source and target domains give rise to metaphorical linguistic expressions…derived from the connecting of two conceptual domains'.

that represent their experience in a particular way require the functions of modality and modulisation in that analysis where the grammar within the clause, the choice of language used, constitutes the system of transitivity (Eggins, 2004, pp. 213-253).

Lakoff (1972, p. 462) has pointed out that natural language sentences contain elements of truth or falseness contained in another linguistic device- hedges that he defines as 'words or phrases whose job is to make things more or less fuzzy'. Other writers comment on the relevance of hedging in discursive interaction between physicians used as linguistic 'shields' employing modal verbs to deal with uncertainty, 'approximators' used to modify medical terms and allow less precision in descriptions (Prince, Frader, Bosk & Dipietro, 1982).

It appears that the linguistic challenge of constructing knowledge of neglect as an abstract entity requires flexible imprecise meanings although the cultural processes that are fundamental to creating experience, for example the consultation, child protection courses, interaction with other professionals, can be described in precise concrete terms.

3.9 The Talk of Doctors

There are a number of scholars who emphasise the importance of narrative and language skills to reproduce medical work. This lends credence to a theory of discursive production of knowledge and action[22] combining personal narrative and objectified description. The medical narrative discussed in Chapter 1 is an important facet of doctors' acquisition of knowledge that emphasises the interpretive nature of Medicine (Bruner, 1991; Montgomery, 1991; Launer, 2002). Attention to narrative contributes to a greater depth of knowledge of understanding and experience (Charon, 2001, 2006; DasGupta, Meyer, Calero-Breckheimer, Costley & Guillen,

[22] Mol (2002) adopts an ethnographic approach to explore knowledge practices of doctors centred on language use, Greenhalgh and Hurwitz (1998) explore the role of narrative underlying and informing doctors' diagnostic skills. Launer (2002, p. 22) outlines the contribution of narrative to family therapy in primary care summarised in the following concepts 'conversations, curiosity, circularity, contexts, co-creation and caution'.

2006; Greenhalgh & Hurwitz, 1998) and strengthens appropriate clinical responses to a patient's presenting problem (Boyd, 1996; Connelly, 2005). Narrative competence is vital in increasingly technological medicine to defend the role of physician as holistic practitioner (Egnew, 2009; Pilnick, Hindmarsh & Gill, 2009). Furthermore, interpretive reasoning 'phronesis' is a fundamental requirement to the processes informing sound clinical judgment (Hunter, 2009).

The analysis of medical discourse has generally focused on the fine grained talk of the asymmetry of the doctor patient encounter (Ten Have, 1991) rather than the intercollegial talk of doctors. Several authors focus on hierarchical discourses of gender and power relations within the consultation with negative consequences for doctor and patient (Bell, Kravitz, Thom, Krupat & Azarzi, 2002; Kravitz et al., 2002; Mishler, 1984; Stivers, 2005). Atkinson (1995, p.53) departs from this analytic focus to explore discursive interaction between doctors in the construction of knowledge. In doing so he acknowledges the ethnomethodological dimension of such exchanges. His research is worth noting because of his particular comments on hospital specialists 'practical phenomenologists' who work within different clinical specialties but achieve intersubjective understanding through semiotic processes 'socially-that is, culturally and linguistically-organised' (Atkinson, 1995, p. 79). Language use is fundamental to this because it mediates as 'a shared frame of reference, and a shared language of special descriptions' and functions as a 'diagnostic tool' (Atkinson, 1995, p. 79). The process of acquiring 'craft knowledge' through indeterminate means 'tacit –equally indeterminate…rarely, if ever, subject to codification, prescription or explicit instruction' (Atkinson,1995, p. 90) is exemplified in this study's findings.

Bakhtin (1981, p.290) argues that thought is an internal dialogue drawn from the internalisation of public debate, all language use is ideological and all texts are in dialogue with others in any complexly represented discursive space,

> In any given moment of verbal-ideological life, each generation at each social level has its own language; moreover, every age group has as a matter of fact its own language, its own vocabulary, its own particular accentual system that, in their turn vary depending on social level, academic institution...and other stratifying factors .

Drawing partly on his theory of genre, the analysis of the interviews explores the possibility that representations of GP knowledge exist in a dynamic relationship with the social world as they enact and shape their social identities in the context of understanding child neglect.

A sociolinguistic approach then provides a paradigm for studying GP interviews where speech is acknowledged as not only an expression of thought but an interactive discursive accomplishment. As a 'mediation between the social and the linguistic' (Chouliaraki & Fairclough, 1999 p. 16), speech incorporates linguistic devices that are used to negotiate social relationships, identity and subjectivity .

Added to this is my own role in the data analysis, from the perspective of someone not trained in linguistics but belonging to a profession whose work is founded on the principles of communicative rationality. The analysis of the talk of doctors is justified because GPs belong to a specific social group and linguistic community (Helman, 2007) where narrative analysis in this context relates to clinical reasoning. The interview transcripts serve as a window into GPs' individual experiences (Hunter, 1991) to acknowledge and reference the impact of their social and historical world on explored values, beliefs and customs. Atkinson (1995, p. 147) elaborates,

> If we trace some of the frameworks of spoken knowledge production, then we can see how medical opinion can also become increasingly apodictic as one moves from journal science to the primarily personal warrants of experience. Apodictic knowledge is quintessentially transmitted through maxims and the lessons of anecdote and recollection.

GPs work within areas of clinical uncertainty where the inherent fallibility of medicine is contained within the limits of their knowledge. This necessitates a pragmatic view of knowledge that becomes established and interrelated not only to

define clinical matters but abstract entities with neglect falling into that category[23]. Dixon (1983) would argue that this endeavour is better served within a linguistic framework.

The research focus on language 'talk in-interaction' explores the social structure which frames GP understanding of child neglect which are 'rationality of various routes to belief' (Rescher, 2001, p. 43). Child neglect meaning is articulated by individuals who work within very specific boundaries of their profession, trained to a similar standard, observing a multitude of human behaviours and making decisions based on personal observation 'the systemic course of experience' (Rescher, 2001, p. 43).

To reiterate, the focus on language and language in use not only explores constructed meaning of child neglect in GPs' own words but the wider processes that allow that meaning to come about.

3.10 The Talk of the Institution, Talk Within its Context

If we understand that social actors produce representations of their own practice and representations of other practices 'recontextualisation' (Bernstein, 1990, 1996) it becomes relevant to consider the institutional constraints on the production of discursive accounts of neglect within a health setting but also the influence of discourse on institutional practices (Arminen, 2000).

[23] The contribution of pragmatics within discourse analytic approaches is problematic when discourse analysis is more often associated with conversation analysis and pragmatics with speech act theory. Discourse analysis is regarded as 'text-centered, more static, more interested in product' whereas pragmatics is 'user-centred, more dynamic, more interested in the process of text production' however Brinton (2001, p.139) argues that it is 'difficult to distinguish the two with any conviction'.I distinguished loosely between both in this study. Discourse analysis applied to all textual analysis with pragmatics applied to initial exploration of expressive functions within the text for example opinion, common knowledge, ideological function as the analysis moved from a pragmatic to dialectic paradigm using increasingly sensitive analysis of language function.

The importance of context as realising institutional practice can also be stretched out to the divergent views that shape the epistemic community. Van Dijk (2009, pp. 70-71) explains,

> People participate in social situations not only as individuals, with their own personal experiences, but also as social actors and as members of social group…we find an ongoing process of Self and Other perception, categorisation and judgment of all participants which influences interaction in general and discourse in particular.

Categorisation is a primary resource available to individuals to signal their differences or similarities and language use as one aspect of semiotics is part of that process.

Linguistic analysis of utterances within their contextual setting reflects the work of Halliday (1989, 1994) and contemporary discourse and critical discourse analysts (Fairclough, 1989, 1992, 2003; Wodak & Meyer, 2001; Wodak & Chillton, 2005) who regard production of knowledge as a reflection of social norms and presuppositions. Habermas (1984, p.140) provides a philosophical overview with his theory of meaning at the level of pragmatics appropriate to a reconstructive approach,

> social-scientific paradigms are internally connected with the social contexts in which they emerge and become influential. In them is reflected the world- and self-understanding of various collectives…they serve the interpretation of social-interest situations, horizons of aspiration and expectation.

Amongst the many scholars of linguistics, there are a number of established writers who apply theories and methods of research in communication and culture specifically to medical discourse and have assisted in the progression of my own research (Atkinson, 1995; Chenail, 1990; Greenhalgh & Hurwitz, 1998; Heritage & Maynard,2006; Mishler, 1984; Mol, 2002).Their work explores ethnomethodological dimensions of medical discourse that is not restricted to one theoretical perspective, and engages with an explanatory strategy that knowledge (theoretical, practical and critical) emerges within different frameworks and serves varied human interests .

3.11 Limitations of Discursive Approaches

It is incumbent on the researcher when making claims of the data findings in an analysis that favours critical linguistics to be aware of its limitations. The inevitable criticisms refer to atheoretical approaches to the principles underlying critical analysis and an apparent lack of integration of discursive, social and cognitive dimensions (Van Dijk, 2008) that can lead to methodological "badness".

GP views provide a unique lens with which to view neglect because it is not an acknowledged medical problem and is regarded as a social issue by many. It appears to be constructed within their own belief systems that broadly represent individual observation and knowledge gathered from sources out with the scientific domain of child health.

In this respect the integration of the social and cognitive influences is already present in the whole spoken text, and it becomes the researcher's role to identify which aspects of text represent such processes in a broad inquiry into an abstract entity 'child neglect'. Within their medical world it is apparent that many outside influences permeate GPs' own knowledge activated through the discourses of power. Thus, fragmentation of services, exclusion from political processes, restriction of their own working practices all represent dimensions of imbalanced power relations. Nonetheless during this research undertaking, it is important to highlight the persuasive nature of texts which may encourage the reader to be co-opted by the researcher into a particular stance on the data conclusions. An analytic approach that gathers data across a variety of discourses and identifies their common themes may ameliorate this unwanted effect.

The criticisms of CDA and SFL that are integrated within one study arise primarily from the limits of textual analysis which emphasise divergent aspects of language analysis within emic (SFL) and etic processes (CDA).

Having investigated the analytic tools of SFL, a more sensitive reading of the data seems appropriate to the research aims. Intuitive textual hybridity and integration of data does not seem an impossibility when perhaps selecting aspects of SFL and CDA

to better understand and account for the language user's voice in the text. I was looking for potential explanations for the changes and stability to the language of child neglect and a better grasp of SFL, albeit within my own limits of knowledge of linguistics, allowed this. The connection of findings from different genres of text became theoretically possible as I explored different social membership and relations in a variety of situational contexts.

Whilst the connections between SFL and CDA augment the analysis, the limitations of SFL and its absence of grounding in context specific concerns of discourse production are commented on by Chouliaraki and Fairclough (1999, p.143). They note 'the apparatus of SFL…pushes the analyst to the side of the system'. I possibly sidestepped that whole debate as I could understand aspects of the text in a pragmatic sense which I reflected onto my own lifeworld experiences from my initial reading of the texts. In this respect I was never really removed from the analytic process. I was simultaneously examining the use of modalised verbs for example and reflecting on its relevance to what I had initially understood from the data. My initial impression of what GP colleagues were saying, heard in the nuance of conversation, were borne out in this finer grained analysis but at the time of the interviews or focus group, I was neither coding metaphor expressions nor modalised verbs in my head.

Fairclough (2010, pp. 230-239) argues that both CDA and SFL together function as a semiotic 'point of entry' for dialectic relations between social practices and events that require a necessarily transdisciplinary approach between different theories and disciplines. Thereafter progressing from the traditions of SFL to CDA seemed the natural direction to take the analysis and to move beyond knowledge reduced to personal belief. This addresses one criticism of qualitative research (Hammersly, 2008) and is not an irrelevant aspect of the study conclusions because, the importance of personal knowledge contributing to mental models of shared cultural knowledge that represents societal beliefs and practices is emphasised throughout the analysis.

CDA allows me to make explicit the relations between discourse and knowledge as acquired and shared during personal interaction with other people and organisations,

groups and institutions. The research challenge is to create a contextually sensitive reading of texts and a scale of analysis necessary to draw generalised conclusions about the instantiation of power relations, whilst remaining mindful of inherent tensions between the micro and macro analysis of texts. This thesis attempts to establish clear relationships between language and context by combining a selection of analytic tools of SFL with the traditions of CDA that does two things with textual analysis.

Firstly, SFL ameliorates the effect of artificially separating a whole text or communicative event from its human context because the influence of opinion and attitudes are made explicit (Jones, 2007). This was a necessary analytic step to explain how GPs position themselves in relation to the research subject or to explore the historical comments about the neglected child.

Secondly, CDA challenges the world has a stable intrinsic order divided into natural categories that language passively draws its meaning from. The immediate language contained within the discourses of child neglect have overtly sociological and political influences that shape individual understanding of child neglect albeit by a circuitous route.

I would argue that the limits of human cognition render it impossible to comprehend the entirety of semiotic practices that encompass meaning of child neglect. CDA allows the analyst to make some sense of the genealogy of child neglect and its meaning in the individual and collective consciousness of society, but as already discussed any research is a compromise, a reduction of data and the requirements of CDA do not escape this. That said, the analytic approach is concordant with Jørgensen and Phillips (2002, p.178) recommendations that the researcher adopt a 'modified ideology critique', and urge analytic caution as 'people's worldviews are not always in line with reality'. They further comment that the value of examining worldviews softens the 'hierarchy between the researcher's knowledge and other people's knowledge; access to truth is no longer viewed as a scientific privilege' (Jørgensen & Phillips 2002, p.178). The constructed meaning in taken-for-granted everyday practices that has informed much of the analysis of the spoken data in this

study looks very closely at individual utterances alongside changes to the language of child neglect and child welfare practices. This requires the analytic framework of CDA for that specific exploration.

In a given situation, most meanings are relatively stable and individual subjects have only limited possibilities for manipulating them but 'Changes in meaning ascriptions are collective social processes...many of our understandings of the world are naturalised...we view them not as understandings of the world but as the world (Jørgensen & Phillips, 2002, p. 178).

I would further argue that this is a two-way process where reality is not always aligned with individuals' worldviews because the emancipatory potential of communicative action is lacking (Habermas, 1987). Current child maltreatment literature (Chapter 2) offers very little enlightenment for GPs who observe child neglect but feel rather disempowered to do anything about it.

In this respect opinion does matter but there is no linear relationship between theory and practice particularly when practice is being constructed mostly within the domain of personal experience. Nonetheless when given adequate research attention it can convey a deeper understanding through a dynamic of dialecticism. This refutes a belief that qualitative methods are the lowest level of evidence and not to be used in informing practice (Sackett, 1993). To address this dilemma I therefore move towards a framework of mixed methods and away from any paradigmatic tensions that would restrict my research approach to exploring dimensions of a complex abstract entity.

3.12 Chapter Summary

This chapter has explored the theoretical influences of the quantitative and qualitative aspects of the research process that have become inculcated into the overarching analytic framework of mixed methods outlined in the next chapter. I have employed qualitative approaches as the predominant analytic approach because the theoretical influences employed in the analysis apply to not only the voice of the contemporary general practitioner but also the voices of the social, legal and political

systems. These stretch out beyond their historical context and uncover otherwise hidden processes that go some way to explain convergence and divergence within these study data.

This casts a very wide net around social organisations and institutions to explore different perspectives and identify some of the mechanisms that have underpinned for example policy shifts, certain categories of child neglect becoming obsolete and others becoming dominant.

A dialectical-relational approach which regards language as one element of social processes constituted by other semiotic elements "dialectically related to others …in the sense of being different but not 'discrete', ie. not fully separate" (Fairclough, 2010,p. 163) draws on Fairclough's integrated framework of culture, politics and economy. This functions to facilitate the goal of transdiciplinary research that examines the relationship between institutions and organisations as they reproduce ideological processes where actions, interpersonal relations and material infrastructure 'internalise' each other .

The circumstantial shifts in the language of neglect are examined within a critical analysis of select texts of statute and other sources reflecting wider societal concerns of child neglect. This research approach integrates sociological, historical and political aspects of child neglect 'the totality of society in its historical specificity' (Wodak & Meyer, 2001, p. 6) that through the synergism of mixed methods, theoretically maintains a connection with contemporary general practice.

CHAPTER FOUR; A MIXED METHODS APPROACH TO UNDERSTANDING CHILD NEGLECT IN GENERAL PRACTICE

4.1 Introduction

> Merely fact-minded sciences make merely fact-minded people. In our vital need-so we are told –this science has nothing to say to us. It excludes in principle precisely…the most burning questions of the meaning or meaningless of the whole human existence (Husserl 1970, pp. 5-6).

This chapter explores how the multifaceted and complex abstract entity of child neglect has shaped the methodological demands of this research endeavour, leading to the adoption of a mixed methods approach. Any research inquiry of a complex dynamic of family function is better served to my mind by a model that reflects its multiple dimensions. The child health experiences and interactions that connect GPs to a larger framework of child welfare justifies a research process that can engage with the real world and policy related issues that influence its constructed meaning. An initial commitment to a pragmatic approach overcomes concerns of eclecticism within the study where the different perspectives of neglect are regarded as contributing to, not impeding the research questions.The research aim is to avoid descending into a myriad of small ideas and conclusions that exist in isolation, disarticulated from the whole concept of child neglect meaning. Wolfe (2010) describes this dilemma as 'Enlightened Eclecticism or Hazardous Hotchpotch'. The study endeavours to fuse and erase artificial boundaries that cognitively separate quantifying and qualifying an entity to explore its situated meaning

Mixed methods are used more frequently in social sciences research to overcome 'the methodological divide' of traditional research approaches (Dunning, Williams, Aboyni & Crooks, 2008) and to develop comprehensive and explanatory models of data assessment and interpretation. The emergence of mixed methods as an alternative to the qualitative-quantitative divide provides an explanatory framework that connects many of the concerns of research rigour common to qualitative and quantitative approaches. Richards (2005, p.36) proposes that, 'qualitative and quantitative data do not inhabit different worlds. They are different ways of recording

observations of the same world'. Thus, the contribution of mixed methods has progressed to the point where it is 'increasingly articulated, attached to research practice, and recognised as the third major research approach or *research paradigm*' (Johnson, Onwuegbuzie & Turner, 2007, p. 112). To summarise,research efforts are located on a continuum from exclusively qualitative to exclusively quantitative, reflecting that many studies contain elements of both (Creswell, 2007; Creswell Plano Clark, 2006; Tashakkori & Teddlie,1998; Teddlie & Tashakkori, 2009, 2010a, 2010b).

There are a number of authors who provide a concise discussion of practical steps worth taking to ensure the unique potential gain of mixed methods for acquiring knowledge about the world.

Greene, Caracelli and Graham (1989) highlight five major aspects of mixed methods that may enhance the evaluation of the study. Their pivotal study is worth citing specifically as a "how to" of mixed methods research from recommendations drawn from fifty-seven empirical mixed methods studies. The authors outline a typology of five mixed methods designs described as triangulation, complementarity, development, initiation and expansion[24] to provide evidence of established studies of mixed methods and frames of reference for different research projects. Greene's (2008) explication of a mixed methodology crossing four domains in a generic framework is a useful of how to bridge the 'entrenched divides' and develop the response to the research questions. These are, according to Greene, the domains of philosophical assumptions (questions of ontology and epistemology), inquiry logics 'justifications for a given methodological logic and its constituent parts', guidelines for practice "the 'how-to' of social inquiry" and lastly socio-political comments

[24] Data integration is key in mixed methods research (Greene, Caracelli & Graham, 1989). Triangulation (testing the consistency of findings obtained through different instruments) complementarity (which clarifies and illustrates results from one method with the use of another method), development (where results from one method shape subsequent methods or steps in the research process), initiation (which stimulates new research questions or challenges from results obtained through one method) and expansion(which provides richness and detail to the study exploring specific features of each method) are the basic tenets of data integration.

'whose interests are being served, what broad purpose is being fulfilled by the study' (Greene, 2008, pp. 8-9).

More recently, Tashakkori and Teddlie (2010, p.273) have noted nine core characteristics of a mixed methods approach which serves as a reference point when undertaking such research (Table 1).

1	Methodological eclecticism
2	Paradigm pluralism
3	Emphasis on diversity at all levels of the research enterprise
4	Emphasis on continua rather than a set of dichotomies
5	Iterative, cyclical approach to research
6	Focus on the research question (or research problem) in determining the methods used within any given study
7	Set of basic ''signature'' research designs and analytical processes
8	Tendency toward balance and compromise that is implicit within the 'third methodological community'
9	Reliance on visual representations (e.g., figures, diagrams) and a common notational system

Table 1: Contemporary 'Core' Characteristics of Mixed Methods Research

4.2 The Need for Mixed Methods Research in Health

> Good general medical practice should be based on evidence whenever appropriate and possible, but what form of evidence can do justice to the multifaceted world I encounter as a general practitioner/family physician?...I need to generate evidence about hidden and interconnected things in patients' lives, such as loss of purpose or relationship difficulties. Finally, I need to bring together a diversity of objective and subjective evidence to develop with a patient a unique plan that will improve more than one thing at the same time (Thomas, 2006, p. 450).

The evolution of mixed methods has taken place in a variety of academic study with scholars encouraging the recognition of the epistemological and methodological differences that exist within this field of research (Alise & Teddlie, 2010; Creswell & Tashakkori, 2007; Denscombe, 2008). Mixed method studies within health,however, seem to be infrequent (McKibbon & Gadd, 2004). Quantitative approaches are most often cited in part influenced by perceived methodological weaknesses inherent in qualitative methods (Dixon-Woods, Fitzpatrick & Roberts, 2001; Murphy & Dingwall, 2001) and a lack of faith in the research process (Dixon-Woods, Fitzpatrick & Roberts, 2001).Qualitative methods within health usually precede large randomised trials in order to inform them, initiated before the quantitative arm of a study is underway (Allen, Tsao, Hayes & Zeltzer, 2011; Farquhar et al., 2011; Thomas et al., 2011). The quantitative arm of the study in mixed methods research is used primarily for evidentiary power to bolster debate on generality of findings, whereas quotes from the qualitative aspects of the study privilege individuality but contribute to 'diversity within generality' (Richardson, 1990). It is suggested that combining qualitative and quantitative approaches provide more robust ethical and conceptual dimensions to the research process (Taljaard et al., 2009), whilst other researchers argue that exploring qualitative concepts such as trust, research vulnerability within the research project is vital for clinical 'equipoise' (Binik et al., 2011)

Much of the debate about the justification of mixed methods rests on issues of validating a unified framework (Dellinger & Leech, 2007; Pluye, Gagnon, Griffiths & Johnson-Lafleur, 2009). In keeping with concerns of any research approach it is argued that validity in mixed methods is crucial. There remain unanswered questions however, about how this is applied when there is no consensus on what criteria are necessary to evaluate mixed methods research (O'Cathain, Murphy & Nicholl, 2008).

It is acknowledged nonetheless, that qualitative methods within mixed methods research provide an important contribution to an evaluation of a complex phenomena (Glogowska, 2011). For example, cancer care is one aspect of health that scholars argue is better served by mixed methods research with a greater lean toward

qualitative data gathering (Boyd et al., 2010; Farquhar,Ewing & Booth, 2011; Menon et al., 2008; Tan, O'Connor, Miles, Klein & Schattner, 2009). Furthermore, it is argued that acceptability of interventions in primary care are better served by a mixed methods approach (Lancaster et al., 2010).

As a generalist interested in a social aspect of life albeit reflected onto a medical setting, bridging the 'entrenched divides' made sense if my research focus was to explore multiple realities of child neglect. Greene (2008) argues that aspects of a human behaviour are better conceptually explored within dimensions linked to wider social systems. Adopting this perspective also progresses the interpretive sense of neglect as a localised phenomena 'the dynamic interplay between theory and practice…thinking / knowing … acting / doing' (Greene, 2008, p. 8).

The theoretical approaches within mixed methods research offer a comprehensive research paradigm than can provide a more detailed and comprehensive understanding of the phenomenon under study, and explain anomalies in the inquiry process (Morse, 2010). This appeals to the study aims that move from the general to the particular, the macro to the micro context of a subject of social inquiry that has important implications for child health. Research questions and purposes, sampling logics, analysis of options, criteria for quality and 'defensible' forms of writing and reporting are all encapsulated within the methodology of the research.

The core of this debate is that irrespective of the research aims any research that is concerned with human behaviour is situated in a highly complex often unpredictable research environment (Smith, 1994). The health implications, therefore, of child neglect are best suited to a research approach that can explore the diverse values and life experiences in general practice that, over time, crystallise professional understanding of child neglect within the broader framework of child health.

4.2.1 Reliability and Validity

I want to explore two concepts of research rigour at this point in the study which deserve specific attention. Reliability and validity are important to research aims in

maintaining exacting standards and should be acknowledged in any research process. Tracy (1995, p. 209) comments,

> reliability and validity, as traditionally conceived…presume there is an objective world to be known...that differences are a result of measurement error (lack of reliability) and that when differences exist, there is one accurate representation of what is (validity).

Validity and reliability were introduced as concepts from quantitative research and applied incongruously to qualitative approaches. As a result, alternative terms have been proposed for qualitative research such as transferability that equates to external validity, and dependability that equates to reliability (Dörnyei, 2007, p. 48-77). There is broad agreement that the biggest threat to qualitative research is concerned with its subjectivity and specifically its commitment to the canons of well designed research which makes conclusions of a text's credibility, transferability, dependability and conformability (Lincoln & Guba, 1985). This debate needs to address concerns, however, of proponents of quantitative research who argue that an absence of standard procedures for prior hypotheses testing and explicit controls for validity threats reduce the legitimacy of qualitative results. Advocates of qualitative research would argue these processes are not relevant, with other procedures available to qualitative researchers. Guba and Lincoln (1989) propose that validity is a positivist assumption and within qualitative research should be replaced by 'authenticity'. Validity has a particular relevance to mixed methods but is not easily conceptualised.

Creswell and Plano Clark (2007, p. 190) question,

> What does mixed methods validity look like from a pragmatic viewpoint? How does this viewpoint differ from post-positivist, constructivist and emancipatory perspectives? What special validity issues are raised by specific types of design?

The debates surrounding the technical processes associated with ensuring any research is well-designed, robust, transparent and ethical are extensive but they are noted and reflected upon by the researcher within the limits of this research. I agree with Hammersley's (2008) comments that all researchers assessing the contribution of their work maintain reflective practice, locate themselves within the process and

the influences they bring to bear. Hammersley argues that these concerns relate to implicit judgments about the data requirements that also extend to inferences made from findings framed within the methodological principles and are 'true of quantitative as of qualitative researchers' (2008, p. 160).

4.3 Working with Competing Paradigms of Mixed Methods

The methodology of mixed methods embodies two competing paradigms of either a pragmatic or dialectic stance with pragmatism as the dominant approach.

Pragmatism embodies practical consequences and the effects of concepts and behaviours as vital components of meaning and truth but at a level of pragmatic understanding. Greene and Hall (2010, p. 132) elaborate,

> Pragmatic inquirers may select any method based on its appropriateness to the situation at hand...the results of pragmatic inquiry are viewed as assertions that become warranted in terms of their transferability in different situations...an active and iterative process of establishing warranted assertions as they are applied in new experiences.

The dialectic stance developed by Greene and Caracelli (1997) consciously chooses and engages with differing paradigms in the conduct of mixed methods research and governs the choice of methods. It is simultaneously guided by a pragmatic requirement as a basis for integration of data where issues of convergence and divergence of data promote the value of multiple methods to address specific research concerns, a 'respectful conversation among different ways of seeing and knowing' (Greene, 2007, p. 79). Onwuegbuzie and Johnson (2006) argue that dialecticism is integral to mixed methods as a constant movement between quantitative and qualitative aspects to progress cross paradigmatic understanding which they have termed 'commensurability validity'.

During the study's development the dialectic and pragmatic approaches to evaluation seemed more difficult to completely separate. They became complementary rather than competing with each other as the study progressed using findings from both research approaches within an overarching framework of mixed methods to identify convergent and divergent findings (Caracelli & Greene, 1993) .

4.4 Neglect as a Dialectic Concept Within Mixed Methods

Greene and Hall (2010, p.124) develop the research stance of dialecticism further and comment that it represents 'a meaningful engagement with difference...intended to be fundamentally generative of insight and understanding...of conceptual and practical consequence'.

Bergman (2010, pp. 171-172) writes of concepts as 'abstractum, or a mental representation'. He comments that they function 'between theory and empirical research…the building blocks of theory'. Concepts according to him 'translate components of a research question…into variables…transformed into measurable entities usually via logical argumentation and authority claims'.

Concepts therefore, pervade the entire research process at all levels from the initial research question, data collection instruments, researchers' stance to research theory but are rarely the objects of inquiry themselves (Bergman,2010).

It is worth at this point therefore, considering neglect as a dialectic concept in this study as a portal through which different research aspects of this study converge on to make sense of the findings. Child neglect can be realised within an analysis of language using qualitative research approaches or equally, by examining objective dimensions of meaning of child neglect by employing quantitative analytic techniques. Both culminate in facets of legitimate knowledge production that relate to how child neglect is understood. It is important to recognise this philosophical underpinning of the research approach to avoid misunderstanding epistemological differences (Robins et al., 2008), where the different worldviews of child neglect are considered to be representative aspects of the same phenomenon.

I began the research with no overarching hypothesis to test that would prove causality in the mechanisms that construct understanding of a complex subject and allow me to reject or accept the research findings. I intuitively believed that within this research approach the analysis would be constrained if data findings were considered only within a statistical analysis. The conceptual and methodological framework of a quantitative approach does not account for the personal narratives

and other discursive aspects that can broaden and enrich the concept of child neglect. Nor does it recognise the subjective views and the experiences of actors and their situated meanings in everyday working practice. In this context, the analytic decisions within the study tend to reflect a posteriori thinking and the dominance of qualitative methods. A posteriori thinking is a quest to understand in this research, for example, what GPs mean by their use of language and what experiences are contained within the language. Nonetheless, because of the addition of quantitative data, research decisions were in part analysed from an a priori perspective. For example, it is assumed that the term neglect in the structured survey refers to a pre-established knowledge base that does not require subjective accounts or experiences to define it (Onwuegbuzie & Combs, 2010, p. 417).

4.5 The Turn to Mixed Methods in General Practice; An Artful Science

4.5.1 Synergy In Mixed Methods - Piecing The Jigsaw Together

> If you want to know why a square peg doesn't fit into a round hole, you had better not describe the peg in terms of its constituent elementary particles (Putman, as cited in Rorty, 1982, p. 201).

Within a mixed methods framework the dialectic approach developed by Greene and Caracelli (1997) juxtapositions without controversy, distinct and defined methods consisting of phenomenology, ethnography and post-positivism. In this context the mixed methodology decreases the distance between the diverse methods incorporated into this thesis. In order to attain conceptual and methodological integration I had to analyse language use at an increasingly sensitive level and integrate these findings with a reconstructed concept from factor analysis in the quantitative approach. It is the acceptance of these theoretical approaches to the datasets that enables me to 'mix' all aspects of knowledge that the data represent within a mental model of neglect as a dialectic concept. It is also how I conceptualise within the research, a typology of synergy that underpins this mixed methods study

The characteristics that exemplify this project as a synergistic approach (Natasi, Hitchcock & Brown, 2010, p.321). has four principles that underpin the mixed methods framework of the study. Firstly synergy in mixed methods combines

qualitative and quantitative findings and acknowledges that this provides greater research insight than each component alone. Secondly a 'position of equal value' regards qualitative and quantitative approaches as equivalent within the research, independent of this study's increasing focus on qualitative methods. Thirdly a dialectic perspective which actively seeks multiple perspectives is stated throughout the study and lastly, the emphasis of a reflective stance of the researcher within the interpretation of the data is necessary to counterbalance 'opposing qualitative – quantitative views'. Dialecticism's contribution is vital to the analysis because each method leaves unanswered questions and as the findings become integrated lead to unanticipated conceptualisation where, 'Ideas become accepted in some domains, and over time they become challenged and replaced'(Johnson, 2008, p. 203).

It is a prerequisite when exploring the direct and indirect contributory influences on neglect understanding, to be able to demonstrate a research approach that can illuminate the connections between the varied realities contained within these varied datasets. Integrated within a typology of synergism, with the caveat that integration highlights not only convergent but divergent findings this approach, enables the complexity of connecting different aspects of knowledge of the same conceptual entity (Day, Sammons & Gu, 2008).

This ensures that the conclusions are greater than the individual findings of the separate research strands alone. It is an enduring aspect of dialecticism that could be argued is fundamental in any research project but within a stated typology of synergy it serves to bridge the subjectivity- objectivity divide of knowledge production.

4.5.2 Integrating Concept Dimensions - The Challenges And Realities

Authors of mixed methods note that one of the most fundamental challenges is to 'genuinely integrate' data findings (Bryman, 2007). Conceptual integration is a prerequisite of methodological integration (Day, Sammons & Gu, 2008) that rejects the ' disciplinarisation of mixed-methods' where different fields of inquiry do not communicate with or inform each other (Tashakkori & Creswell, 2008). Progressing towards meaningful integration of data (O'Cathain, Murphy & Nicholl, 2010) overcomes the degrees of separation of quantitative and qualitative approaches that

become ‘poles on a multidimensional continuum’ (Bazely, 2007). To achieve this requires a ‘mental model’ of the research topic (Philips, 1996). Neglect understood as a dialectic concept or a portal through which all aspects of the research findings are filtered, is the point at which all findings are integrated with each other. Greene and Hall (2010, p. 125) comment that ‘the actual dialectic mixing of consequence lies in the construction or composition of inferences, drawn from purposeful conversations among and integration of different threads of data patterns’. Consequently, the researcher can subsequently ‘maintain an open and flexible frame of mind…remaining as free as possible of paradigmatic dogmas’ (Dornyei, 2007, p. 307).

Nonetheless it is not possible to escape ‘paradigmatic dogmas’ underpinning the research when the study design, issues of inference and the logistics of undertaking mixed methods research all need to be considered (Tashakkori & Teddlie, 1998, 2010). This impacts on the writing up and conclusions within a mixed methods study described as concerns of representation, legitimation and integration (Onwuegbuzie & Leech, 2006). Within the initial analytic process it is a natural requirement of cognition to conceptualise and understand data by categorisation. Data categorisation in quantitative analysis is the first step in coding data, that enables the researcher to undertake statistical analytic procedures by examining individual variables and exploring relationships between them. Data reduction in qualitative analysis can better contribute to the analysis if categories and themes are constantly re-read within the context of the whole corpus of data. This attempts to bring full circle the process of understanding and explanation which ultimately reveals the complexity of meaning ‘the wood and the trees’ (Blignault & Ritchie, 2009).

From my own research standpoint in both research approaches I did not progress by artificially codifying my thought processes. It was continuous reflection punctuated with moments of realisation where ultimately the analysis and data collection became ‘inextricably linked’ (Bryman & Burgess, 1994, p. 219). In this respect, the research analysis informed the research approach as the challenges evolved from the theoretical to the practical, and my own learning journey continued. Nonetheless, there is no neat fit between sociological and linguistic categories or definitive answer

to questions of differences and similarities of what an independent observer would conclude from the same data presented in this research project (Hammersly, 2008). My own view is to acknowledge such challenges at the outset, because the research subject as a complex human behaviour is better understood if the analysis can incorporate subjective thought and individual opinion from the various social strata where meaning emerges.

Knowing what standards to use requires a judgment about reality and the choice of research questions. This is inevitably value laden where the practical aspects of research methods, research design and questions of power are influenced by 'key and omnipresent sociological and political factors operating at every level of society' (Johnson, 2008, p. 203). All come into the mix of an explication of child neglect meaning in this study where I have endeavoured to address each of these 'areas of contention' within my description of the research process (Johnson, 2008).

Barriers to data integration should be acknowledged and appear under three common themes. These are, the intrinsic properties of quantitative and qualitative methods themselves, advocating for one approach over the other and the researcher skills and preferences (Bryman, 2007; Johnson, 2008). I would disagree however that researcher preference is a barrier. To my mind the rationale behind the choice and breadth of data collection are all important constituents of the explication of the research, and an interesting aspect of the research process itself. Furthermore, whilst I acknowledge that any research approach has its limitations and constraints, blending findings from one research approach with another in part addresses issues of overlapping facets of a complex phenomenon. I regarded all data findings as uncontested representations of knowledge (but not undisputed realities), however, the inherent challenge of a mixed methods approach is to describe the theoretical framework that allows me to connect each aspect of the study findings within the limitations of the study context. The interactive combination of data with concurrent analysis and interpretation of findings promote holism where 'no single belief or proposition will necessarily save or destroy a theoretical or philosophical system' (Johnson, 2008, p. 205).

The initial pragmatic approach to the analysis of the spoken data appeared relatively straightforward however there was then a gap of several months whilst I continued to write up the analysis of the quantitative section. When I returned to the qualitative data to undertake a more sensitive analysis I was initially overwhelmed by the task of selecting material. For the purposes of the research I required a narrower focus in my endeavour to integrate data not only from spoken text but also the historical data and findings from the quantitative arm of the study. This was not arbitrary because the measurement and evaluation of child neglect are interconnected processes that include aspects of how it is perceived at societal and professional levels. There were also subsidiary reasons for approaching the analysis in this way.

I wanted the study to have something original to say about GP acquisition of knowledge of child neglect. In all aspects of the study I wanted to avoid oversimplification of the complex dimensions of the research subject within a research approach that was empirically grounded and conceptually coherent. I regarded the steps in the analysis as stages that generate heuristic devices and informed creative thinking about the meaning contained within language in the qualitative approaches, and, how this theoretically connected to the findings that best explained the reduction of quantitative data. In the spoken data ,for example, an initial textual analysis revealed common themes whose constructed meaning progressed using the analytic tools of SFL and CDA. The historical textual analysis gave some clue of the genealogy of current understanding of child neglect and how stability in meaning is maintained despite the contingency of language use. The descriptive statistics best explained the make-up of the GP population and contributory factors to their knowledge base, whereas inferential statistics and factor analysis gave an explanation of the boundaries of objectified knowledge dimensions.

I have in this context, deliberately sought out possible mechanisms to inculcate sociological and political influences into accepted meaning of child neglect and reflect these onto the data findings. Advice that I found useful throughout the project was to maintain a research discipline of constantly revisiting the research questions, keeping a consistent focus to the work and imagining the concept because as scholars comment, ‘research questions set boundaries to a research project, clarify its specific

directions, and keep a study from becoming too large' (Plano Clark & Badiee, 2010, p. 277).

A constant reflection on the convergent and divergent data findings simultaneously challenged and confirmed some of my own assumptions that I held at the beginning of the research. In this respect the study maintained an interative cycle of exploring existing and emergent conceptual understanding of child neglect. Ultimately the researcher should bear in mind throughout the project that to overcome the challenges to mixed methods respecting the theoretical drive, maintaining parsimony and finally recognising when the study is finished are all key objectives (Morse, 2010, p. 341).

4.6 Research Design

4.6.1 Introduction

The research was conducted using traditional research methods. It employed four single method sub studies to answer the research questions based on a variety of data gathering namely, a survey questionnaire, in depth interviews, a focus group and historical documents. The use of qualitative methods became more dominant because the project at its core, essentially focuses on how GPs negotiate and enact their professional identity collectively and individually regarding child neglect issues in everyday talk. In this context the quantitative findings were supplementary to the focus of inquiry and research agenda.

The philosophical tenets of mixed methods that allow both to be possible within the one study resulted in an eclectic mixed methods approach that created a number of datasets. There is a constant movement backwards and forwards between datasets in this project made possible because of the availability of the audio recordings of the interviews and focus group work, the NVIVO coding framework, SPSS output tables and the original SPSS dataset. The archival documents as primary sources of information are ultimately recontextualised through the researcher perspective but nonetheless are referenced and retrievable for independent evaluation. The research processes contribute to the research rigour 'the inclusion of value claims, or value

laden claims, within science' (Nelson, 1996, p. 65) because the process of data gathering, its stated aims and overarching theoretical framework are documented and more importantly the process of analysis and findings can be tracked and located within the study datasets.

The quantitative and qualitative data were gathered sequentially with the questionnaire undertaken in the first phase, followed by interviews and a focus group and lastly the historical data collection. As a lone researcher this seemed a more organised approach to data collection to keep things in order. However strict ordering of analytic stages was not enforced as the study progressed. I began to the blur the boundaries of individual data findings as I revisited themes from each to develop an overview of multiple dimensions of the concept of child neglect. Dornyei (2007, p.168) explains, 'mixed methods research offers researchers the advantage of being able to choose from the full repertoire of methodological options, producing as a result many different kinds of creative mixes'.

The practicalities of gathering data is as important as understanding the research questions, sampling goals, the unit of analysis and data selection. In this study for example all data from the postal questionnaires were processed whereas selective aspects of the spoken and written texts are transcribed in a reduction and recontextualisation of text. This aspect of data handling is not a concern of quantitative analysis but pervasive in qualitative research and represents my own beliefs that I bring to the analysis of the texts outlined in Chapters 6 and 7.

Analysis of historical documentary evidence as the last phase of the qualitative data gathering explores within the tradition of CDA contextually situated meaning that is relevant to state institutions for example health domains, legislation, the courts to construct ideological positioning of child neglect. This contributes to a picture of child neglect that looks beyond the immediacy of the contemporary language of GPs. It adopts both an insider's and an outsider's perspective to 'unpick the relations which constitute social practices '(Chouliaraki & Fairclough, 1999, p. 27), where multiple sources of data connect as pieces of a bigger jigsaw of understanding of the research subject.

4.6.2 Ethical Approval and Approaching the Participants

Ethical approval for the study was obtained from both NHS Greater Glasgow & Clyde Community and Mental Health Partnership and Strathclyde University Ethics Committee. Both have similar ethical requirements and the research framework was in accordance with the Scottish Executive Health Department's own guidance (2006b).

Many of the ethical issues that emerged from the research process are common to both modes of inquiry and encompass challenges of confidentiality, respondent and researcher anonymity, to respondent consent of sharing the research findings with a wider audience. Any research endeavour involving human subjects, including this project, throws up questions for example of data ownership that are not provided succinctly in definitions of sensitive data (Parry & Mauthner, 2004). During the research process I had to rely on my own ethical parameters to address some of the issues as they arose but this was not insurmountable during the research.

The relationship between procedural ethics (approval from ethics committee) and ethics in practice (everyday ethical issues in undertaking research) is bridged by researcher reflexivity and critical interpretation. According to Guilleman and Gillam (2004), reflexivity is a requirement at all stages of a process as data is interpreted, analysed and presented because all research involving humans 'starts from a position of ethical tension'. Forbat and Henderson (2005), suggest that sharing transcripts with interview participants contributes to reflexivity and whilst I did this with individual and focus group participants I received very little comment back on the content.

All participants are anonymous, identified by their interviewee number with the participant characteristics noted in Appendix A.

4.6.3 Survey design

The initial research method was quantitative, the data instrument a self-administered questionnaire testing associations between a number of variables GP gender, years of working, levels of practice deprivation and beliefs about child neglect (Appendix A).

Using a survey as the primary research instrument often yields the lowest results but for time and budget constraints was the most practical choice for this research. The main benefits of a survey is flexibility in dealing with different types of data and generating accurate incidence information for the given population of interest. If well designed it aims to minimise random error in responses and provide a strong response rate (Fowler, 1995, 2002; Sapsford, 2007). The survey content reflected findings from contemporary neglect literature outlined in Chapter 2, but the choice of questions was also influenced by my own observations in practice.

The items in the questionnaire were divided into four main categories;

- demographic information
- training qualifications
- aspects of the child welfare structure
- factors associated with neglect.

The closed question responses were incorporated into a database in SPSS 15.0 consisting of 52 categorical variables assigned coding values. Each GP in the random sample was assigned a number and represented a case in the database that appeared in numerical order in the rows of the database. The case number assigned to each GP can be cross checked with my own paper copy of the returned questionnaires that were kept together in a separate folder. Each categorical variable in the survey was given a value for example, 1 for ‘Male’, 2 for ‘Female’ and a value assigned for missing data.

The ordinal variables that represented survey items used a Likert scale as a bipolar scaling method measuring either a positive or negative response to a question. These data are treated as ordinal but it cannot be assumed that respondents perceive the

distance between responses as equidistant (Coolidge, 2006). They were analysed using the non-parametric Mann-Whitney test (Field, 2004, p. 522).

Responses from the survey questions 1 to 5 and question 11 relate to practice demographics, gender and age. In the initial step, frequencies and percentages for respondents' answers were calculated using descriptive statistics and generated SPSS output tables relevant to age groups, areas of deprivation category and practice training status (Table 9 - Table 14).

Questions were specifically aimed at GP experiences that respondents could relate to in their everyday working environment for, GPs would implicitly understand questions about the CHCP or the GMS contract.

Survey item seven, was an open-ended question and space was provided in question ten for comments to encourage the respondents to express their thoughts and feelings on how they felt their knowledge of child neglect was influenced. It is an important consideration of the survey to include both closed-ended and open-ended questions to explore consistency in patterns of the data findings (Patton, 1990).

The order of questions was important as some of the concepts were related. One question in item eight explores GP attitudes to screening and is conceptually related to GPs having more resources for screening but separated by other items to alleviate consistency bias (Weisberg, Krosnick & Bowen, 1996).

A complex phenomenon is not likely to be defined by a few variables nor is it likely that GP understanding of child neglect can be adequately be explained by statistical modelling alone. Anett (2002) argues that all empirical measurements of psychometric properties are 'unavoidably subjective' and intersubjective with understanding key to 'scientific probity'.

The categories are related to each research question and are intrinsically linked to both the qualitative and quantitative aspects of the research. The categories of training qualifications and demographics relate to Research Question 1. Aspects of child welfare and factors associated with neglect relate to Research Question 2

whereas the open questions in the survey in addition to interview and focus group data are conceptually linked to both. Research Question 3 is concerned with historical and political aspects of child neglect meaning within the child welfare agenda that is explored in the data findings of the historical documents (Chapter 8).

These survey data findings are presented in Chapter 5 and work in a logical sequence of descriptive and inferential statistics of demographic data proceeding to factor analysis as the most appropriate research approach.

4.6.4 Inferential Statistics

Independent sample *t*-tests are used to compare relationships between categorical variables gender, age groups and level of deprivation of practice area. Within the GP population the data is assumed to be sampled from normally distributed populations with the same variance in terms of age, years' experience in general practice. Kinnear and Gray (2006, p. 198) recommend this 'provided the data show no obvious contraindications…marked skewness or great disparity of variance'. However, because I could not be sure about the demographics of non-responders I continued the analysis with the non-parametric Mann-Whitney and made few assumptions about the dataset.

The difference between two sets of scores big enough to reach statistical significance was computed for each variable by an independent samples *t*-test to determine the *p*-probability. For comparison an accepted alpha of 0.05 was used for each variable to reject or accept the null hypothesis. Following on from this, factor analysis examined the correlations between variables in datasets regarded as a way of summarising or reducing data to a few underlying dimensions (Hinton, 2004). As the researcher has no definite prior beliefs about how many factors will explain the data, it was important within the quantitative aspect of the research to progress to exploratory factor analysis.

4.6.5 Exploratory Factor Analysis.

'Understanding neglect' cannot be measured directly and in this research context it may be a very indirect process of assessing parental and child behaviours. The challenge for the measuring instrument is complex because the researcher is dealing with something that is not always immediately real in the sense of being manifest, but rather with something which is latent and often not directly observable (Tinsley & Tinsley, 1987). Dörnyei (2007, p. 233) defines factor analysis as a process of reduction 'a few variables that will still contain most of the information found in the original variables'.

Exploratory factor analysis can be used to develop new constructs and expand theoretical approaches. Both are requirements suited to the aims of mixed methods where factor analysis is an established method used for validity confirmation of psychometric measurement tools in research of childhood and parental behaviours (Price, Spence, Sheffield & Donovan, 2002; Sanne, Torsheim, Heiervang & Stormark, 2009; Teverovsky, Bickel & Feldman, 2009; Ungar & Liebenberg, 2011; Wren et al., 2007). Two studies (Maughan & Moore, 2010; Dubowitz et al., 2011) have explored neglect dimensions from the neglected child's perspective using factor anlaysis. 'Parental Separations', 'Chaotic Households', 'Marital Harmony' and 'Father Involvement and Parental Supervision' were identified as a four factor solution in Maughan and Moore's (2010) study, whereas Dubowitz et al (2011) identified a three factor solution, 'Provision of Physical Needs', 'Emotional Support' and 'Parental Monitoring'.

A factor analysis always begins with the calculation of the observed variable within a correlation matrix proceeding to factor extraction and rotation and at this juncture the factors are interpreted (Table 20).

The correlation between each pair of variables within an R-matrix measures the strength of the relationship between two variables or effect size using Pearson's correlation coefficient R (Table 19). Proceeding to exploratory factor analysis reduces the data set from a group of interrelated variables into a smaller set of factors or cluster of variables. This achieves research parsimony by explaining the maximum

amount of common variance using the smallest number of explanatory concepts (Tinsley & Tinsley, 1987, p.414). Where there are clusters of sizeable correlations this would suggest that the measurements are representative of the same intellectual but hidden dimension (Kinnear & Gray, 2006, p. 501).

Any statistical model is a representation of a phenomenon where complex statistical processes test whether the model is a plausible account of the real world. In this study, factor analysis describes a linear relationship that links the observed variable to the factor and is a process of simplification of the complex relationships that are manifest in child neglect dimensions.

4.6.6 Pilot Testing

A draft version of the survey was piloted in June of 2007 to all GPs working in my own place of work in Govan Health Centre who were also asked to provide commentary on the survey design. This culminated in a return rate of 47% (n=8). Using their feedback a few survey items were revised to clarify the wording but otherwise the survey questions remained unaltered. The pilot phase allowed invaluable peer review of the format of the questionnaire and ease of completion, a process which contributes to issues of interpretive validity.

4.6.7 Participants and Research Site-Quantitative Sampling

Issues of sampling have ultimately different purposes in both methods that require consideration. In quantitative analysis robust sampling procedures and sample size are fundamental considerations to ensure internal validity (Carneiro, 2003) and draw conclusions from the data that are generalised to an entire population. Individual idiosyncrasies are not of particular interest.

In this research GPs working in Greater Glasgow and Clyde Health Board were selected by stratified random sampling using gender as the strata parameter from a database of all 860 GPs working in this health board.

The questionnaires were sent out in batches of fifty, to 219 GPs over the period March to May 2008. I included a covering letter with the survey outlining the

purpose of the research and the details of the ethics approval (Appendix A) and a first class stamp-addressed envelope to encourage return of the questionnaire (David & Sutton, 2004, p. 177; Edwards et al., 2002).

4.6.8 Qualitative Approaches and Issues of Sampling

Interviews provide a research approach that details participants' life experiences. Reissman comments (1993, p.2) 'The purpose is to see how respondents in interviews impose order on the flow of experience to make sense of events and actions in their lives'. Whilst the interview was semi-structured and had a certain order of questions (Appendix A) there was still enough flexibility in the order of questions where at times the interview could take an unexpected turn. I felt this encouraged the development of 'anecdotal' responses because whilst I was exploring specific aspects of working with vulnerable families I was also keen that the participants could tell their own story in their own way.

The qualitative approach is not necessarily concerned with how representative the sample population is because there is an assumption of 'ecological validity' to provide insights into the phenomena under study. This is obtained in cooperation with participants where 'volunteer characteristics and experimenter effects are rendered visible and accountable' (Bannister, Burman, Parker, Taylor & Tindall, 1994, p. 11).

Advice on sampling parameters is more straightforward for quantitative research than qualitative research. One concern of this study's qualitative approach was how many interviews were appropriate? Until there is 'data saturation' seems to be the standard answer but I required an approximation to the number of interviews that might be regarded as appropriate. An invaluable article on sampling designs suggests between fifteen and twenty interviews to avoid a crisis in representation when using small sample sizes in qualitative research (Onwuegbuzie & Collins, 2007).

The process of selecting participants for interviews and the focus group was flexible and evolved during the research process. GPs were selected using convenience

sampling which is regarded as the least satisfactory sampling procedure. The researcher engages with the most conveniently available people to become participants within the requirements of designated criteria (David & Sutton, 2004, p. 151) but the findings of the research cannot be generalised to the population beyond the research participants[25]. That said, a research focus on language analysis of individual case studies meant that for ease of access for this project it was a suitable sampling technique.

I interviewed a number of GPs whom I knew personally. Convenience in this research relates to practical issues: mostly time limits of the research, accessibility to study participants and their availability because most were interviewed in between surgery times.

4.6.9 Recruiting Participants

Recruiting GPs to participate in any interactive research process is not easy because GPs do not have protected study time that would minimise the impact on their clinical commitments. In addition, I think there is also a deeper issue about perceived relevance or usefulness any research has to them individually in an everyday working sense.

I did not specifically recruit on the basis of age or gender but reflecting the demographics of mostly local colleagues, the sample included a range of ages and years of experience with most GPs having worked more than fifteen years in practice and with more males (*n*= 11) interviewed than females (*n*=5). Whilst the issue of gender is not the predominate focus in the analysis of the spoken data it is noted as a possible influence on the beliefs, expectation and values that GPs ascribe to neglect meaning.

[25] For an overview of non-probability sampling techniques the reader is directed to Gilbert (2001) and David and Sutton (2004).

I contacted GPs directly that I knew either as working colleagues or through socially tenuous connections by e-mail and phone. In addition I interviewed three GPs (GPs 4, 6 and 10, Appendix A) who contacted me by e-mail after answering the questionnaire.

The focus group was recruited in a similar manner and because of ease of access the focus group was very 'location centric' in contrast to the individual interview participants who worked in other locations outside my own working environment. Discussion was lengthy therefore I provided lunch to encourage attendance but even then one colleague who assured me that he could participate failed to do so because he was caught up in another meeting. Such are the challenges and vagaries of undertaking research.

4.6.10 Process of Interview

The majority of individual GP interviews took place in their surgeries (Appendix A) but a number were interviewed in their homes (GPs 7, 13, 14, 15) or other workplace settings (GPs 6, 8). The focus group took place in a local community facility in the presence of my supervisor.

The actual process of formally interviewing GP colleagues with a tape recorder present and asking a set of pre-determined questions as opposed to the usual 'coffee morning' chat seemed initially quite an alien undertaking. However within the ensuing discussions there was no discernible power dynamic I think, because I was interviewing my peers and work colleagues. There was humorous discussion throughout the interviews and focus group but I think the most relaxed interviews were with the GPs that I knew well from working within my place of work. The GPs that I did not know before the interview process seemed less relaxed and indeed one GP admitted that she was quite nervous about the interview and needed some reassurance.

Neither interviewing at the GP's home nor the surgery appeared to alter the dynamics of the interview. As far as I was aware, it was the topic and their own particular stance towards it that influenced the interaction with interviews varying in lengths

between 8 minutes 17 seconds and 36 minutes and 42 seconds. If a GP felt very unsure of their own practice, uncomfortable or ambivalent about the research area, it became evident from the ensuing dialogue and length of discussion.

4.6.11 Focus Group

Focus group research first gained prominence in health pioneered in AIDS work by action participation researchers (Puchta & Potter, 2004; Wilkinson, 2004) and its role in general practice research was first promoted almost two decades ago (Barbour, 1995). It has been used in research of GPs' attitudes towards child health matters (Jarrett, Dadich, Robards & Bennett, 2011; Lykke, Christensen & Reventlow, 2008, 2011) but its use in this field is infrequent.

As a research method it has a different feel from the interview process because a number of speakers are co-constructing meaning in relation to the research questions (often simultaneously) as the researcher role changes from interviewer to moderator. It is the function of the moderator to ask the group and not individuals, facilitate discussion and encourage participation in informal group discussion. Ultimately this results in less control over the flow of speech (Reventlow & Tulnius, 2005; Wilkinson, 2004) where the broad questions considered within this data relate to how GPs position themselves within the context of the research topic, through interaction with each other.

One of the key requirements of focus group work is informality that was exemplified in the rather noisy and sometimes incoherent data. The discussion was recorded on the same digital recorder used for the interviews and although the recording was overall very clear, it was more difficult to transcribe at certain points because of the frequent overlap of speech between participants as they debated the issues under question.

Puchta and Potter (2004, p. 12) outline a guide for conducting such research with the analytic focus on largely speech intonation and hesitations. Within this research the analysis departs from an emphasis on speech adjacency pairs more typically aligned with aspects of CA because the research focus is the close examination of themes and

rhetorical strategies that are common to both sites of spoken data obtained from the interviews and focus group work.

4.6.12 Historical Data

The aim of the archival data analysis is the reconstruction of child neglect from a selection of historical (but not all possible) sources that were not necessarily sympathetic to the plight of the neglected child in this country. The extracts are organised principally in chronological order and are held up as exemplars that encapsulate child neglect meaning. They are connected to certain eras of reform represented within a broad range of data sources but because of time and word limits it is inevitably a restricted analysis. Thus, the material cited was not obtained through a systematic search of archival sources. Instead it seemed more in keeping with a snowballing technique, where on finding one document of interest it would point me in the direction of another. I gathered my material from a number of sources, initially making enquiries to the BMA and RCGP libraries and then the National Archives on medical interests in child neglect matters. I often relied on the goodwill of librarians who undertook data searches and provided references for relevant material.

In addition, I collated historical documentary evidence from a number of other sources. I researched archival material held in The Glasgow Room in the Mitchell Library, the medical record archives of Yorkhill Hospital in Glasgow and an online search of medical records of children admitted to Great Ormond St Hospital. These data incorporate texts outlining aspects of child neglect meaning from a number of institutional settings ranging from the criminal justice system to minutes of committee meetings of local government departments. These are primary sources of data that reflect the social concerns of the day that are not read 'flatly' but acknowledged as textual representations of a multi-dimensional world.

Whilst contemporary research would suggest that the interest of the medical profession in maltreatment of children by their parents was the re-discovery of child abuse the 'Battered Baby Syndrome' (Kempe, Silverman, Steele, Droegmueller & Silver, 1962) neglect and abuse of children was documented by doctors many years previously in health records, academic journals and official government reports.

Ambroise Tardieu, a French physician in 1860, published detailed cases of multiple maltreatment types, co-occurrence of neglect and abuse, fatal and non-fatal effects of child neglect and the medical 'findings' of neglect (Roche, Fortin, Labbe, Brown & Chadwick, 2005).

Nontheless, a comprehensive exploration of medicine's contribution to child neglect matters within the context of this research is not possible, because the historical data is one aspect of the research approach and has to allow room for the other datasets that contribute to the whole study. To maintain a proportionate contribution of the historical documents to the study aims I employ the analytic traditions of CDA discussed in Chapter 3. This approach allows the researcher to highlight the voice of the physician over a substantial period of child welfare reform and theoretically explore the mechanisms underlying their contribution to a societal discourse of child neglect[26].

Within the context of this research, to locate the individual physician's voice in a historical context one begins a search in archival hospital records. This was challenging as child neglect was usually defined in relation to other clinical problems as a 'cause for admission' to hospital for example, malnourishment or a burn injury. It was further complicated by the lack of standard history taking and partial records of the admission history. In addition, it is not possible to access medical records less than 100 years old because of data protection and sensitivity issues. It also has to be remembered that only impoverished children were admitted to hospital during the period of early child welfare reform as the wealthy classes could afford to be treated at home. The descriptions of neglected children are inevitably written from this perspective.

The historical texts represent beliefs used ideologically to legitimise opinion and reinforce collective action. Whilst they denote socially accepted opinion on child neglect meaning, they are simultaneously infused with the voice of the individual

[26] The reader is directed to Chapter 3 for an explication of a historical discourse analytic framework.

who was often challenging such beliefs that Lee (2009, p. 39) comments function as, "a particular kind of abstraction (is) 'wedged' into space between the system and the utterance". Aspects of language that reflect such influences are highlighted in the process of dominant discourses becoming assimilated and established, often within competing interests connected to child welfare concerns.

4.7 Transcribing

4.7.1 Spoken Data

An analysis that is anchored to a transcript of spoken language takes its point of departure from multimodal analysis of physical alignments, gaze or gestures (O'Halloran, 2004). This aspect of the qualitative approach is concerned with language in use recontextualised as written transcriptions where the sixteen GP interviews and focus group audio recordings provide a necessary and constant source of reference. This is required because the volume of data means that my own initial impressions and recollections would be ephemeral and inadequate for the purposes of analysis. A digital audio recorder allowed me to download the interviews onto the computer as an accessible permanent file, a small but nonetheless important technical detail which addresses concerns of research dependability.

I decided very early on in the research to personally transcribe the data although I was told by others (not qualitative researchers) to get someone else to type it up as it "took ages". Nonetheless, I felt that having to listen repeatedly to the data as I was typing would allow me to "hear" aspects of the data that I had not perhaps been aware of during the interviews. Replaying sections and noting down some of the analytic thoughts added to the richness of this process but also informed my own understanding.

The transcriptions are in standard orthographic form, losing phonetic and paralinguistic features to further the analysis of linguistic and cultural meaning that are coded as areas of interest. A phonetic transcription in this research would be distracting and 'difficult to follow and assess' (Ochs, 2005, p. 167). I made a choice at the level of lexicogrammatical analysis to use DA as a means to examine the

language of social change and CDA primarily to incorporate critical social theory. This is a direct result of the study questions reflecting the research priorities and my own research background. With this aim in mind I acknowledge that my transcriptions are an interpretive process that lead to the construction of ideological positions that support the theoretical aims of my research. Mishler (1991) argues that no transcription is immune from creating different meaning within the same stretch of talk because it is dependent on the analyst interpretation.

The transcription of the interviews took just over 90 hours to complete and were anonymised with regard to individual and place names. The interview lengths varied widely (Appendix A) and the focus group discussion lasted 54 minutes. The focus group recording was more difficult to transcribe than the interviews and progressed over a few weeks as I transcribed in sections. There were omissions in these data because it appeared more difficult to decipher. Despite returning to the audio tapes repeatedly, I could not fill in gaps of interrupted discussion where participants were engaged noisily with each other with overlapping speech .

4.7.2 Coding Spoken Data

The interviews were semi-structured and followed a pre-designed order of questions (Appendix A) that were formulated through reading literature, discussions with others and my own thinking. I also had a sequence of questions that I intended to follow during the focus group, but similar to the challenges of interviewing, the ensuing discussion at certain sections diverged from this format.

The transcripts were entered into NVIVO for coding and analysis. NVIVO is a qualitative data analysis computer program that not only retrieves and codes qualitative data, but can assist the researcher in developing and testing theory. Categories can be developed from the assigned codes and written memos and linked to hypotheses that have been induced from the data to become formulated and tested. This allows visible connections to be made within the extensive database at all textual levels (Bazeley, 2007; Bazeley & Richards, 2000). Data can also be imported from other sources but for the purposes of this research only the spoken data was entered into NVIVO.

The initial perusal of these raw data form links to theoretical perspectives which is the very first step that initiates the process of coding (Gee, 1999). This follows a broadly constructivist interpretive strategy in the analysis of these data.

There was a lot going on in the data where dominant themes emerged that were wholly relevant to the research questions and the conclusions of this thesis. I repeatedly read the transcripts of both interviews and focus groups as I developed broad categories initially free nodes in NVIVO and then grouped together under 'tree nodes' (Bazeley & Richards, 2000). The process of coding was a similar iterative process at all stages as the data was themed into broad categories which generated other headings as I reduced extracts to one category (Potter & Wetherell, 1987).

Categorisation within and across interviews allows a layered analysis but the purpose remained at its core to identify themes within the data, similar and divergent responses with a constant reference to the whole text. The analysis allowed me initially to examine certain strips of data that were of particular interest, for example, the 'jigsaw metaphor' (Chapter 7) which led to an exploration of the mechanism of learning. This approach is consistent with Dilthey's (1976, p. 10) explication of the 'hermeneutic circle', where individual aspects of the research are expanded by understanding a complex whole 'in terms of its parts' whilst the individual aspects of the research 'acquire their proper meaning within the whole'.

Within the cycle of reading and analysing text many of the original categories ended up being tangential to the aims of the study and analysis and were collapsed into richer categories. As I progressed with the analysis I found the database more of a distraction and decided to return to the original Word documents of the transcriptions. I needed to repeatedly read and reflect on the content of the data, somehow endlessly coding, 'coding fetish' (Bazeley & Richards, 2000) detracted from this process.

I have no doubt in a large study where the author does not gather or transcribe any data NVIVO is invaluable, but in this particular research, I found the software was not vital for my purposes and decided to invest my time in reading and absorbing the data and not the data system.

4.7.3 Working with Historical Data

The majority of these historical data are not in a format that can be easily retrieved at the push of a button. The historical texts used in this research exist in paper photocopies of original documents that were garnered from a number of sources. I undertook several searches of catalogues in a variety of locations and subsequently returned to the library for the copies (the Mitchell Library) or waited for the copies by post (BMA Library, National Archives). I photocopied the Yorkhill Hospital records when I was given an allotted time to attend the library that is only open on certain days. This required a number of visits to have time to peruse original case records and select the transcripts that I found most relevant.

This resulted in several folders of archive documents where the selection of material for research purposes was simultaneously interesting and challenging. I ended up with far more material than I used but in some respects this is true of any approach to qualitative data gathering. I decided that at the outset focusing on descriptions and comments on any aspects of child neglect were most relevant to the study consequently, I either quote extensively from some of the selected material or recontextualise a document in order to draw comparisons with other data. The exploration of ensuing convergent and divergent themes from the historical texts was an important analytic consideration.

4.8 Chapter Summary

A research inquiry of child neglect understanding could not be easily imagined in a biomedical approach, because the challenge of any research of a human behaviour is not to restrict understanding of that behaviour through the demands of causality but to try to find ways of capturing its complexity.

The meaning making of child neglect is almost always a proxy account of the lived in experience of the child who is neglected, but where there are extraneous factors that come into the "equation" of child neglect. Each individual story is not recorded or observed and nor is it possible to do so. I therefore decided to approach a study of child neglect meaning from a different vantage point altogether. By analysing

findings within an epistemological frame that includes political, philosophical, sociological and health perspectives I endeavour to develop an enriched understanding of how child neglect meaning has come about whilst maintaining a degree of stability within its temporal dimension. Reflecting very practical-orientated requirements within the study onto the research questions namely 'how do GPs know what they know?' I was not constrained by one analytic perspective. Consequently, I use a number of writers and their research frameworks as reference points from a variety of intellectual disciplines within the description and commentary of my own work. At first glance it should not be possible to integrate historical text with spoken text of a particular social group and findings of a structured survey analysis. However, following on from Greene's (2008) recommendation, an analytic strategy is possible that imports data findings from each to inform the analysis of other approaches across different methods provided that data integration occurs. Patton (1990) regards concerns of data integration as a fundamental philosophical issue of mixing frameworks to dialectically link distant perspectives of a phenomena with its contextual elements, to cause a 'mind shift' and incorporate the contrasting, sometimes competing assumptions of human behaviours and actions.

Within this analytic frame the research findings can transcend the spheres of individual knowledge production and political and historical dimensions of child neglect without suppressing their relevance to situated meaning explored in a modern health setting. It remains however, that without Habermas's main research programmes of pragmatic theory of meaning, communicative rationality, discourse ethics and programmes of political and social theory, that I would be unable to examine the validity of child neglect meaning within complex and differentiated aspects of society that I have included in this study. The creation of a deliberative democracy partly forged through political institutions, laws and the informal sphere of an engaged civil society exercising autonomy and unrestricted communication, enables a reflective researcher stance that can examine the shared assumptions and background knowledge of neglect meaning that remains, through effective communicative action, open to change and revision (Habermas, 2007).

Habermas's wide ranging theories have given me the philosophical backdrop to a study that employs scientific approaches to an analysis of an abstract concept that speaks to a universal human behaviour. In doing so this research conceptually maps out child neglect meaning across many disciplines 'carving nature at its joints' (Plato, 1973, 265d-266a) only to rejoin the individual elements back together again.

It is from this standpoint that the data findings outlined in Chapters 5, 6 and 7 are considered.

These data are presented in the following three chapters separately. Chapter 5 contains the quantitative analysis findings, Chapters 6 and 7 present the qualitative data findings. Table 2 and Table 3 summarise the research questions, the survey items that provided the data and analytic tools utilised in both research approaches.

Research Question 1	Research Tool	Data Analysis
What do GPs know of child neglect?		
Sub-questions	Survey Item 6: To what extent have the following documents influenced your understanding of child neglect?	Deductive, Descriptive statistics, Inferential statistics
A) How do they know what they know? What is the mechanism for acquisition and development of knowledge?	Survey Item 9: Please rank the five factors that you feel contribute most to child neglect, 1 being the most important and 5 being the least important.	Deductive, Descriptive statistics, Inferential statistics
B) What factors do GPs attribute to the occurrence of child neglect?	Survey Item 7: Has anything or anyone else had a major influence on your understanding of child neglect?	Inductive, Discourse analysis

Table 2: Research Question 1

Research Question 2	Research Tool	Data Analysis
Is there a consensus view from GPs on how they understand child neglect?		
Sub-Questions;	Survey Items 1, 2, 3, 4, 5 - Questions of demographics.	Deductive-Descriptive statistics, Inferential statistics;
A) Are there differences in how GPs perceive their role in child neglect prevention in the current structure of general practice according to demographic factors?	Survey Item 8 - Please tick the box that most accurately reflects how you feel about the following statements	Factor analysis
	Survey Items 11, 12 - Questions of age, gender and years in practice.	Deductive-Descriptive statistics, Inferential statistics;
B) Is there a group ideology with which GPs negotiate and construct meaning of child neglect?	Interviews, Focus Group	Inductive - DA, Critical Linguistics

Table 3: Research Question 2

CHAPTER FIVE; THE QUESTIONNAIRE FINDINGS

5.1 Introduction

This chapter contains the quantitative analysis and conclusions from the structured questionnaire. There is a brief outline at the end of the chapter of the common themes from the open comments of the survey which seemed the most appropriate location for this initial foray into qualitative analysis, and initiated integration at an early stage of data handling.

Of the random sample of 219 GPs, 35% (*n*=77) returned the questionnaire. The survey data was entered into the SPSS database as the study progressed.

Four GPs returned the questionnaires unanswered but with the following comments having evidently struggled with the content or length of the questionnaire which can be an impediment to completing the contents (Jepson, Asch, Hershey & Ubel, 2005),

> 'Apologies - do not have time to complete'
>
> 'Sorry, I am unable to complete this'
>
> 'Sorry I struggled with this questionnaire from question 2. There not being any answers that suited me. I am unsure if you are questioning on child neglect or child abuse. Stopped at 10 mins'
>
> 'No thank you but I wish you every success in this interesting area'

Despite the relatively low return rate the overall response rate of this study is similar to a peer-reviewed study of a survey-design of GP training needs in child neglect and abuse where a response rate of approximately 33% was obtained after two mailings (Bannon, Carter, Barwell & Hicks, 1999). Response rates to paper questionnaires range from 30% to 50% in academic settings (Baruch, 1999) to 70% if the

respondents are from the general public (Dillman, 2000). Response rates of 50% or lower may lead to some questions about the generalisability of a study's results and therefore must be acknowledged within the limitations of the research analysis[27].

5.2 Responders and Non-Participants

The reasons for GPs not participating in this study should be given at least brief consideration because with a non-participant rate of 65%, the overall results of the study are interpreted with caution. GPs do not respond to postal questionnaires for a variety of reasons, for example disinterest in the topic, questionnaire length, confidentiality issues related to themselves or their patients. Being older, with fewer qualifications and working in a single handed practice are also significant factors that impact negatively on response rates amongst GPs (McAvoy & Kaner, 1996). Sending out three postal reminders to recipients can improve response rates (Hocking, Lim, Read & Hellard, 2006), nonetheless it should be noted that there is very little empirical data on this issue that the researcher can refer to.

There was over-representation in the returned questionnaires from 31 GPs working in South Glasgow and that may reflect the researcher is a GP also working in South-West Glasgow. This may have a positive influence of the likelihood of a GP responding but as there are no data of non-respondents this cannot be confirmed. The most common age group returning the questionnaires was the 41-50 years. This is expected as it is posited that the number of older and younger GPs in current employment is much less in comparison. Whilst this age group may represent the majority of the GPs employed within this health board it is not possible to confirm this assumption from existing available health board data made available to the researcher before the process of randomisation.

[27] According to the U.S Office of Statistical Standards response rates of 90% or more are reliable, between 75-90% usually yield reliable results but potential bias should receive greater scrutiny if the rate is below 75%. If rates are below 50% there should be greater caution about inference and quantitative statements. (White House, 2006).

Effects of age and gender can cause non-responder bias and contribute to random and systematic error of the results (Kotaniemi et al., 2001) but other research has found that such effects in a medical setting are minimal (Cull, O'Connor, Sharp & Tang, 2005).

5.2.1 Demographics

The demographic data are summarised in Table 9, Table 10 and Table 11. The reader will note that alpha was set at .05 for all analyses in this section unless otherwise stated. There was approximately equal distribution of female respondents (*n*=38) and male respondents (*n*=39) with the majority of respondents (*n*=46) in the age range of 41-50 years (Table 9).

Twenty-eight of the respondents worked in training practices, 49 respondents worked in non-training practices, 26 worked in practices of low deprivation and 47 worked in practices in areas of high deprivation (Table 10).

5.2.2 Statistical Differences

The number of years worked in general practice was significantly associated with deprivation, where GPs had worked longer in areas of low deprivation (Table 10).

Age did not appear to have any significant association with the practice location or status, nor did age group have an significant association with undertaking child health surveillance (Table 11).

Gender did not appear to have any significant association with practice location, status or undertaking child health surveillance (Table 11).

Gender or GP age group appeared to have no significant association with any of the postgraduate qualifications noted in Table 13.

Deprivation category of the practice appeared to have no significant association with GPs providing child health surveillance (Table 12), possessing the MRCGP qualification, (Table 14) or having further training in child protection (Table 14).

Child Health Surveillance Screening is offered by 95% of GPs within their practice (Table 12). The MRCGP was the most common post –graduate qualification held by 79% of GPs, 70% of GPs had post-graduate Child Health Screening training and 35% of GPs had undertaken some aspect of formal child protection training (Table 13).

5.2.3 Conclusion

These data indicate the respondents have worked professionally for a reasonable length of time, most possess the MRCGP and appropriate post-graduate qualifications, and most have undergone child health training.

5.3 Answering Research Question One; What do GPs know of child neglect?

Survey items 6 and 9 (Appendix A) addressed research question one that was divided into two sub-questions. The first was concerned with mechanisms for acquiring knowledge of neglect "how do they know what they know?". It could be hypothesised that variables gender, age and level of deprivation of practice area may be associated with this process. For example, if neglect is encountered more often by GPs working in impoverished communities, this may be an important catalyst to seeking knowledge.

5.3.1 Descriptive Statistics 'Documents read'.

Survey items were measured using a four-point Likert scale that included 'Greatly', 'Somewhat', 'Very Little', 'Not at all'. This is a bipolar scaling method measuring either a positive or negative response to a question. The results are presented in Table 15 according to variables of gender, age groups, training practice and practice deprivation category .

74% of GPs (*n*=56) felt that they had heard or read about documents that had contributed to their understanding of neglect. That said, none of the documents listed achieved an average score of 1.5. 'Climbie' was scored higher by all GP groups at 1.17 which is nonetheless only slightly above 'very little', but given a score of 1.41

by GPs working in areas of high deprivation which is very close to an average response. GPs in areas of low deprivation gave a considerably lower score of 0.77 (Table 18).

'Hall 4' is a document that has redesigned the structure of child health surveillance in general practice and is widely referenced in health but did not achieve an average score in any GP groups.

5.3.2 Inferential Statistics 'Documents read'

Working in a practice with a high deprivation category appears to have a significant association with GPs reading 'Climbie', p=0.009 and the 'Children's Charter', p=0.015 . Training status appears to have a statistical association with GPs reading 'Hall 4', p=0.037 (Table 16) .

5.3.3 Discussion of Results

From these data there are three documents that have statistically significant differences in the GPs groups. Possible reasons for differences in knowledge of 'Hall4' and practice status is that training practices may be more aware of pending changes to child health surveillance than non-training practices because of the relevance to GP training. The 'Children's Charter' and 'Climbie' have differences in relation to practice deprivation. Working in an area of higher deprivation may be a trigger for exploring documents related to child neglect because of the association of neglect and poverty. Widespread media reporting may also influence how specific documents are received by GPs working in such areas. Within this context then, it is perhaps surprising that GP knowledge of 'Hidden Harm' (Scottish Executive, 2004) had no significant association with regards to deprivation levels, despite GPs in areas of high deprivation being more likely to encounter parental substance misuse .

5.3.4 Summary

A summary of these data suggest that GPs irrespective of gender, age or deprivation category of practice area do not specifically attribute their understanding of neglect to policy documents. It is not clear why there are differences between GPs groups

and awareness of certain documents but as the scores are generally low, drawing comparisons within these data is limited because there is little power to detect differences. Other processes influencing the mechanisms of knowledge acquisition should be considered because the survey responses leave unanswered questions, therefore this requirement influenced the content of the interview and focus group questions explored in the next chapter.

5.4 Answering Research Question Two; Differences in Neglect Prevention

Research Question 2, *Are there differences in how GPs perceive their role in child neglect prevention in the current structure of general practice according to demographic factors?* explores parameters of consensus and difference which relate theoretically to boundaries of ideological thinking within the different GPs groups.

It is hypothesised that the variables that relate to practice demographics and GP gender and age may influence how knowledge is constructed and understood. Table 17 and Table 18 display the analysis of responses from survey item 8 that relate to research Question 2.

The survey item utilised a five-point Likert scale 'Strongly Disagree'(1), 'Disagree'(2), 'Unsure'(3), 'Agree'(4), 'Strongly Agree'(5). Since 5 is the most supportive or favourable result and 1 the least supportive 3 is considered to be the midpoint, therefore items for which there is a mean score greater than 3 can be thought of as being viewed 'favourably'.

5.4.1 Statements about neglect by gender and age

For all GPs surveyed, two of the survey items had means below 3 *'There is enough provision in the GMS contract for undertaking child neglect prevention'* (M=2.03,SD=0.75) and *'I understand the role of the CHCP in relation to child neglect prevention'*(M=2.79, SD=0.85). This may reflect strategic separation of the policy framework from the experiences of working GPs. For example, the GMS

contract as discussed in Chapter 1 has very little reference to child health or matters of child welfare.

Three survey items had very favourable responses *'Child neglect has serious implications for affected individuals'* (M=4.74, SD=0.44), *'GPs should readily share information with other agencies if they suspect child neglect'* (M=4.60, SD=0.59), *'I know who to share information with if a child in my practice is being neglected'* (M=4.48, SD=0.58). A working knowledge of child neglect appears to be developed through experience where health implications of neglect maybe understood within practice from general observations, dealing with the families over a period of time as adverse health outcomes become apparent. Dilemmas of sharing information are not entirely clear either from legislation or policy documents when it relates to matters of child neglect (Chapter 1). From these data however sharing sensitive information with other professionals does not appear to be problematic. The interviews and focus group data will further explore the processes of knowledge acquisition and information sharing.

5.4.2 Correlates of neglect

The possibility of a common understanding of child neglect is represented by the importance given to some correlates associated with child neglect over others. It is initially considered in the responses to survey item 9 where correlates of neglect from the empirical literature are ranked according to level of importance. These data are presented in Table 18 and at this point the variables are re-stated,

- Parental substance abuse
- Parental isolation
- Social Deprivation
- Poor parental educational achievement
- Parent having left care
- Parental learning difficulties
- Parental mental health problems
- Greater number of children less than 5 years living in the household

- Young parental age
- Poor housing conditions

All could be regarded as contributory factors to child neglect but exploring what correlates, if any, that GPs consistently rank more highly than others is conceptually linked to ideological shared social knowledge that defines concepts and structures. Van Dijk (1998, p. 114) explains the basis of shared knowledge as ideologically based, 'an abstract epistemology…many social dimensions that have to do with the establishment of truth, truth criteria and what counts as knowledge '.

All survey items utilised a 5-point interval scale that included 'Most Important' (5) to 'Least Important' (1). The 10 items were ranked as 5,4,3,2,1,0,0,0,0,0 so if ranked at random they would each get an average of 1.5. In these data a mean ranking above 1.5 is 'above average'.

5.4.3 Analysis; Correlates of Neglect

From these data four variables are ranked as 'above average' by all GPs. These are *parental substance abuse*, *parental social isolation*, *social deprivation* and *parental mental health problems*. There is a consistent rating across groups of gender, age, working in training and non-training practices and practices situated in areas of high and low deprivation of the dependent variable *parental substance misuse*. This correlate is close to the rank of 'most important' for all GP categories (M=4.14, SD=1.37) except for the age group 31-40 (M=3.93, SD=1.44). All GPs ranked variables *poor parental educational achievement* (M=0.71, SD=1.25), *parent having left care* (M=0.92, SD=1.43), *greater number of young children* (M=0.69, SD=1.24), *poor housing* (M=0.74, SD=1.24) and *young parental age* (M=0.40, SD=1.19) as 'least important' in their ranking scores that are close to 'not considered'.

GP gender appears to have an association with *greater number of children less than 5 years* living in the household. Male GPs rank this almost one point higher (M=1.07, SD=1.54) than female GPs (M=0.34, SD=0.75) although neither rank this variable 'above average'. The difference is approaching statistical significance, p=0.061.

Parental mental health problems is ranked by the youngest age groups of GPs as 'above average' (M=3.07, SD=1.64) and more than one point higher than the GP age group 41-50 years (M=1.86,SD=1.55). The effect of age on ranking this variable is approaching statistical significance, p=0.057.

Social deprivation as an indicator of poverty and important correlate of neglect in the empirical data is ranked by all GPs as 'above average' (M=2.50, SD=1.80). There is no statistically significant association of gender (p=0.611), or GP age group, (p=0.520) with this variable and neglect .

5.4.4 Summary

Irrespective of the socioeconomic status of the GP practices all GPs rank the variable *parental substance misuse* consistently higher than all others. This finding of data convergence may represent that the process of knowledge acquisition of this subject area is diffuse and not only influenced by working in areas of high deprivation. Knowledge may be acquired from other sources for example, colleagues, media, GP journals that uphold socially constructed and shared beliefs. Van Dijk (1998, p. 113) argues this represents, 'factual beliefs…a value judgment…an evaluative belief or opinion'. This finding may also explain for example why deprivation levels have no statistically significant effect on GP knowledge of 'Hidden Harm' because addiction issues are considered by all GPs to be relevant to the occurrence of child neglect.

Social deprivation was the second most highly ranked item (M=2.50, SD=1.80) by all GPs, *parental mental health issues* was ranked third (M=2.23, SD=1.63) with *parental social isolation* given the fourth highest ranking value (M=1.58, SD=1.80). All four variables are ranked 'above average' and when considered ahead of all others, together they could contribute to ideological constructs of the neglectful parent that all GPs could subscribe to. It is relevant to reflect on issues of addiction and poverty that appear to be historically stable ideological constructs of neglect inculcated into the legislative framework that have informed social practices throughout the evolution of child welfare reform (Chapter 7).

Poor parental educational achievement (M=0.71, SD=1.25), *parent having left care* (M=0.92, SD=1.43), *greater number of young children* (M=0.69, SD=1.24), *poor housing* (M=0.74, SD=1.24) and *young parental age* (M=0.40,SD=1.19) are ranked as 'below average'. These findings could be argued contribute towards an ideology of what neglectful families are not, according to GPs. The lack of importance attached to them is an interesting finding because this does not reflect their prominence in current child maltreatment literature as contributory factors of child neglect.

The following section outlines the use of exploratory factor analysis to examine the association between variables, based on the correlations between them[28].

5.5 Exploratory Factor Analysis; Data Findings

5.5.1 Step 1; Correlation Matrix

The table of the value of Pearson correlation coefficients (Table 19) shows the value between each pair of variables. Using a smaller p-value gives some protection against multiple testing therefore significant correlations (at $p<0.01$) are shaded.

From inspection of this table *GPs should be involved in screening vulnerable families for child neglect* is positively correlated with the statements *Child neglect has serious health implications for affected individuals* (R=0.345, $p=0.001$) and *GPs should have greater resources to undertake screening for child neglect* (R=0.293, $p=0.006$) which seems intuitively correct.

Child neglect has serious health implications for affected individuals is also positively correlated with *GPs should readily share information with other agencies if they suspect child neglect* (R=0.420, $p=0.001$) and *I know who to share information with if a child in my practice is being neglected* (R=0.363, $p<0.001$).

[28] The reader is directed to chapter 3 for an explication of theory of factor analysis.

GPs should readily share information with other agencies if they suspect child neglect is also positively correlated with *I know who to share information with if a child in my practice is being neglected* (R=0.566, $p<0.001$) which is the highest correlation value, and *I understand the Data Protection Act in relation to child protection issues* (R=0.471, $p=0.009$).

I know who to share information with if a child in my practice is being neglected is also positively correlated with *I understand the Data Protection Act in relation to child protection issues* (R=0.471, $p<0.001$).

It is not possible to screen for child neglect without assessing parental health and social issues is positively correlated with *I understand the Data Protection Act in relation to child protection issues* (R=0.427, $p<0.001$).

I understand the Data Protection Act in relation to child protection issues is also positively correlated with *I understand the role of the CHCP in relation to child neglect prevention* (R=0.307, $p=0.004$) and *GPs are often the first professional contact for vulnerable families* (R=0.363, $p=0.001$).

GPs should have greater resources to undertake screening for child neglect is negatively correlated with *There is enough provision for GPs in the GMS Contract for undertaking child neglect prevention* (R=0.301, $p=0.005$). This makes sense as the two statements are basically opposites.

GPs are often the first professional contact for vulnerable families is positively correlated with *GPs should have greater resources to undertake screening for child neglect* (R= 0.508, $p<0.001$).

This completes the first step in the analysis of quantitative data, the next stage proceeds towards formal factor analysis.

5.5.2 Step 2; Kaiser-Meyer Olkin and Bartlett's Test

The method of exploratory factor analysis is applied to survey item 8. In a model of factor analysis Tinsley and Tinsley (1989) suggest that between a minimum of 5 to

10 subjects are required for every variable being analysed. The number of respondents (N=77) to number of variables (N=10) in item 8 of the questionnaire satisfies this requirement.

Before conducting factor analysis it is essential to check sampling adequacy and sphericity of the model (Table 4). An examination of the Kaiser-Meyer Olkin measure of sampling adequacy suggests that the sample is factorable, (KMO = 0.575).

Bartlett's test examines the relationship between variables and at $p<0.001$ it is appropriate to proceed with factor analysis.

Kaiser-Meyer-Olkin Measure of Sampling Adequacy		.575
Bartlett's Test of Sphericity	Approx. Chi-Square	163.277
	Df	45
	Sig.	$p<0.001$

Table 4: KMO and Bartlett's Test

5.5.3 Communalities

SPSS displays the output of principal component analysis, the communalities of variables (Table 21) that shows variability in one variable common to the others as an indication they are linked by an underlying factor. Eigenvalues (Table 20) and communalities are used to determine how many factors must be held in the model.

The initial value of 1.000 is the 100 per cent of variance of each variable but when SPSS extracts the factors the value in the 'extraction' column is the variability of each variable that can be explained by the extracted factors (Hinton, 2004, p. 350).

For example, in Table 21. '*gpsinvolved'* is given an initial communality of 1.000. After extracting the factors it has a communality of 0.697 that indicates 69.7% of its variation is explained by the factors.

5.5.4 Total Variance Explained

One of the challenges of factor analysis is to decide on how many factors to extract. The first part of this process is to calculate eigenvalues of the R-matrix (Field, 2004, p.652). Any factor whose eigenvalue is less than 1 is usually excluded because this essentially means that it is not any better than a single item. From this example the criterion for factor selection is an eigenvalue greater than 1.5. The cumulative % column (Table 20) shows the amount of variance accounted for by each consecutive factor added together. Excluding any item with an eigenvalue of less than 1.5. results in a two factor solution which can explain a cumulative 44.5% per cent of variance in the data.

From these data it appears that it is possible to account for patterns of correlations in two independent dimensions of how GPs understand child neglect.

5.5.5 Scree Plot

The scree plot is shown where the amount of variance explained by each factor is plotted and aids visual judgment in factor extraction (Figure 1). The factors are the X-axis and the eigenvalues are the Y-axis. The factor with the highest eigenvalue is the first component and the second component has the second highest eigenvalue. Where the line levels out is the criterion for selecting the number of factors to extract. This plot shows two factors where the 'scree' appears to be levelling out between the second and third factors (Kinnear & Gray, 2006).

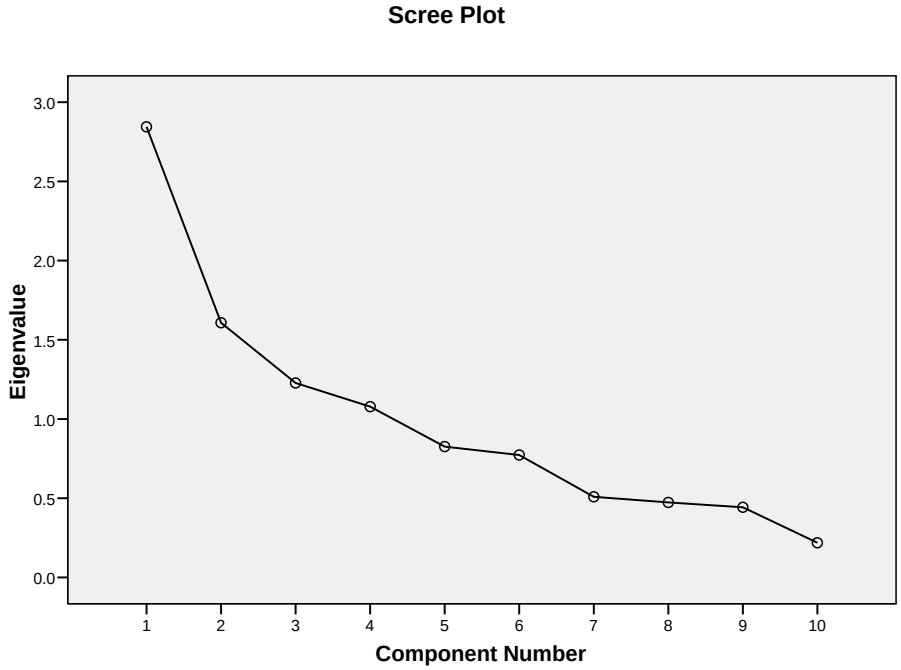

Figure 1: Scree Plot

5.5.6 Component Matrix

After the scree plot a rotation of the component matrix provides a clearer picture of how the variables load onto each factor. Generally, a variable is said to make a significant contribution if its loading is 0.3 or greater. For a simple structure there should be no cross loadings (each variable only loads onto one factor) and each factor should have loadings from at least two variables (Dörnyei, 2007, p. 235).

The Component matrix (Table 22) details the factor loadings onto the two factors before they have been rotated. The matrix is then rotated to give a pattern of loadings easier to interpret than the original factor analysis. Varimax rotation resulted in the following output in SPSS (Table 5) as a 2-factor solution.

	Component	
	1	2
Gpsinvolved	.462	
Health implications		.663
Shareinformation		.852
Knowingsharing info		.746
Assessparental info	.441	
Dataprotectionact	.581	.476
Gmscontract	-.551	
Chcpchildprotect		
Gpscontact families	.608	
Greaterresources	.808	

Table 5: Rotated Component Matrix

Extraction Method: Principal Component Analysis. Rotation Method: Varimax with Kaiser Normalisation.

From Table 5, Factor 1 is determined by the variables *GPs should be involved in screening vulnerable families for child neglect*, *It is not possible to screen for child neglect without assessing parental health and social issues*, *There is enough provision for GPs in the GMS Contract for undertaking child neglect prevention*, *GPs are often the first professional contact for vulnerable families*, *GPs should have greater resources to undertake screening for child neglect*. It is interesting to note in Factor 1 that the statement *There is enough provision for GPs in the GMS Contract for undertaking child neglect prevention* is negative to the other items. This may reflect that there is minimal reference within the GMS contract to any matters of child health.

Factor 2 is determined by variables *Child neglect has serious health implications for affected individual*, *GPs should readily share information with other agencies if they suspect child neglect*, *I know who to share information with if a child in my practice is being neglected*.

The Data Protection Act (Home Office, 1998) seems to have a bearing on both factors. The survey item *I understand the Data Protection Act* in relation to child protection issues was given a favourable response by male and female GPs of all ages (Table 15). The Data Protection Act is an important document that is referred to by other policy documents outlining the role of doctors in matters of sharing information in the context of child welfare (GMC, 2000; RCPH, 2004; Scottish Government, 2004). It establishes the legal framework within health with regards to confidentiality as an important cornerstone of the relationship between GP and patient. It therefore has particular relevance in child neglect where both parental and child health details are relevant in assessment of the parent-child relationship. What is not clear from these data is the depth of the understanding of this act.

5.5.7 Summary of Factor Analysis

From this analysis it is possible to say that a two factor solution has been obtained but the remaining challenge is to identify the common theme that underlies the cluster of variables. This endeavour is not solely objective because my own subjective interpretation is brought to bear in the naming process.

I would suggest that Factor 1 seems to relate to variables that are connected to processes of GP involvement with vulnerable families specifically as a family unit, and could be named '*Requirements of Working with Vulnerable families*'.

Factor 2 seems to relate to adverse health implications of neglect that function as a prerequisite to sharing information about a vulnerable child 'Sharing *Health Concerns of Child Neglect with Other Professionals*'.

These data would suggest that in acknowledging adverse health effects of neglect GPs recognise their role in this and in doing so, they connect this aspect of everyday working to other involved professionals through information sharing. As discussed, the consequences of adverse health outcomes may be the trigger or justification to engage with other professionals for example health visitors, social workers. The constituent parts of professional identity, mechanisms for inter-professional working

and sharing information will be further explored in the interviews and focus group work .

5.6 Questionnaire; Qualitative Data Findings and Inductive Analysis

This chapter has reported the results for two of this study's three research questions. Data for research Question 1 and Question 2 were quantitative in nature and analysed using descriptive and inferential statistics. Question 1 was also addressed by the qualitative data findings beginning with the responses to the open questions in the survey questionnaire. Using inductive analysis as the initial steps in a sequential approach to the data analysis, QUAN →QUAL (Tashakkori & Teddlie, 2010) qualitative approaches constitute the majority of the analytic approach.

Data taken from the written responses to one open ended question *Has anything or anyone else had a major influence on your understanding of child neglect?* (survey item 7) and the comments section (survey item 10) were explored for common beliefs and concerns that GPs might hold. Forty-seven GPs responded but their statements are not attributed to gender, age group or deprivation category of practice area because as concluded from the inferential statistics these factors have very little influence on what GPs may consider relevant to child neglect.

Within this small section of qualitative data a discourse analytic approach examines the language, categorised into themes and patterns of meaning in order to make general statements about the phenomena under investigation. A number of themes were identified from this data, *Close professional identification with HVs*, *Learning from other professionals*, *Learning from specific events*, *Learning from personal experience, Learning from the media* and *Barriers to effective working* (Appendix B).

5.7 Discussion

Choosing mixed methods as the most appropriate approach to answer the research questions poses the challenge of connecting results from both quantitative and

qualitative methods that is an endeavour that pervades the research aims of this study.

Conclusions from inferential statistical analysis would suggest that policy documents are not associated with the process of understanding child neglect. This is an important finding because one aspect of the study is concerned with mechanisms of knowledge acquisition.

In the open question *Has anything or anyone else had a major influence on your understanding of child neglect?* Health Visitors are the professional group that are most frequently identified. The statements *I know who to share information with if a child in my practice is being neglected* and *GPs should readily share information with other agencies if they suspect child neglect* were given favourable responses in the quantitative analysis (Table 15). The importance of sharing information about vulnerable children with other professionals appears to be reflected in the open comments where GPs most frequently cited Health Visitors and Social Workers as professionals that they would work with.

These findings naturally lead to directly questioning GPs about professional relationships that are important when considering the processes of developing and sharing knowledge of complex phenomena. Despite the restricted space of the open survey questions, GPs comment on a political and strategic process that they are disconnected from. This is not generally at a level of engagement with the macro-structure of government policy but at the level of micro-structure, that is, their immediate environment. They outline their concerns in the following comments,

> 'Health visitors attached to practices are crucial – and they are about to be removed!'

> 'Risk of HV not being GP attached in future poses risks for detection. Screening of at risk families time consuming in deprived areas where there are large numbers and extra HVs may be more appropriate for this task'

> 'We have now no Health Visitors in our 12000 patient practice!'

A dialectic focus within the objectives of CDA underpins a critical approach to meaning taken from the text and the projection of beyond what is written to connect with social relations of power, the negotiation of personal and social identity (Wetherell, Taylor & Yates, 2001). The initial look beyond the content of the open questions begins a process which spans categories of language data regarded by the researcher as important to the theoretical assumptions and broad topic area of the research. This research aim continues in the following two chapters which explore the spoken data and archival texts.

CHAPTER SIX; QUALITATIVE FINDINGS – SPOKEN DATA

6.1 Introduction

This chapter contains the analysis of spoken data obtained from sixteen GP interviews and a focus group that address Research Questions 1 and 2. The interviews and the focus group are legitimate starting points for understanding varied influences that impact on the production of knowledge of child neglect that situates interaction in a chain of institutionally and locally interconnected encounters. As this study context is shaped by its health setting, a focus on interactions in an institutional setting is inevitable, because, the relationship between culture and social order becomes the site of production and distribution of knowledge resources (McHoul & Rapley, 2001).

Language is an integral part of social life where the everyday flow of social interaction consists largely of routine exchange of linguistic expressions. In everyday speech exchange we operate mostly at a level of pragmatics[29], using language that we immediately understand and that is inherently linked to cognitive experiences that are personal and subjective. In addition the temporal dimension of neglect meaning explored in the next chapter from documentary analysis addresses a research aim to reach a broader understanding of child neglect by practising 'multi-locale ethnography', that is, choosing a number of sites of study to explore particular issues of concern (Marcus, 1986). Deconstruction of knowledge and reconstruction of meaning in this study is underpinned by the role that language plays in this. Jaworski and Coupland (1999, p. 3) comment,

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[29] Habermas (1999) appropriates linguistic theory for his treatise of formal pragmatics where he locates reason and emancipation in language use to distinguish between communicative and strategic action. He comments,

> The task of universal pragmatics is to identify and reconstruct universal conditions of mutual understanding...to bring about an agreement that terminates in the intersubjective mutuality of reciprocal comprehension, shared knowledge, mutual trust and accord with one another. Agreement is based on recognition of the four corresponding validity claims; comprehension, truth , truthfulness and rightness (Habermas, 1999, pp. 21-23).

> all aspects of experience, are based on acts of classification, and the building of knowledge and interpretations is very largely a process of defining boundaries between conceptual classes, and of labelling those classes and the relationships between them...language...is the key ingredient in the constitution of knowledge.

I have no formal training in linguistics but I was not deterred from adapting aspects of language theory to best understand what I was 'hearing' in the spoken or written texts to address the research questions.

My preliminary reading of texts resulted in a first level of coding in NVIVO, that is an interpretation broadly located within my own understanding of everyday practice. As the research progressed, I realised that the initial themes required further layers of interpretation to progress the analysis at a more sensitive level. I subsequently read around texts of SFL, applied linguistics and the practical use of 'discourse as data' (Wetherell, Taylor & Yates, 2001). Consequently this chapter is divided into three sections to explore the definitional and conceptual approaches to child neglect meaning.

The first section will outline initial findings from selected extracts of spoken data obtained from interviews and focus group work. The individual interview participants are referred to as 'GP' and within the focus group each participant is referred to as 'SK'. The participants of both the interviews and focus group are summarised in Table 7 and Table 8. Throughout the chapter there is a reflection onto the findings of the quantitative analysis to promote research synergism and integration of data as a key feature of an overarching mixed methods approach.

6.2 (Section 1) The Pragmatics of Speech[30]; Initial Codes

The data was initially coded into broad themes which reflected the order of questions in the interview schedule (Appendix A) but on occasions I was side-tracked and explored another dynamic of the interview. I would regard this initial coding as a "lay-person interpretation" with the caveat of belonging to the same linguistic community as the participants. The initial codes are outlined as;

- Advocacy
- Barriers to successful working
- Challenges
- Clinical illustrations
- Closer Professional Working
- Communication barriers
- Consequences of child neglect
- Correlates of child neglect
- Cultural issues
- Data protection
- Expanding knowledge
- External pressures
- Fragmentation of services
- Improved working
- Interprofessional collaboration
- Intuitive definition of child neglect
- Job environment

[30] Habermasian pragmatics lays bare the rational choices as means to a given end in linguistic forms as the best way of shedding light on coordinated actions and social order. Habermas (1990, p. 19) comments,

> pragmatism and hermeneutics have joined forces by attributing epistemic authority to the community of those who cooperate and speak with one another. Everyday communication makes possible a kind of understanding...built into the structure of action orientated toward reaching understanding is the element of unconditionality .

- Lack of autonomy
- Linked professional identity
- Macro-politics
- Micro-politics
- Mindlines/ Mindknowledge
- Muddled concept
- Negative aspects of job
- Negative childhood
- Non-technical language
- Personal identity
- Positive aspects of job
- Positive attributes
- Practice demographics
- Rhetoric (became linked into ideological square)
- Role of GPs
- Sentinel Case
- Support networks
- Training
- Uncertainty

As the analysis progressed some of the codes were conflated with others because they appeared to be related to the same conceptual dimension of neglect. For example,*Barriers to successful working*, *Communication barriers* and *Fragmentation of services* are related concepts. I do not explore all the codes initially listed because of the restriction of word space, but include a number of exemplars that contain important themes and relate to the other analytic strands of the thesis.

6.2.1 Advocacy

From the questionnaire three variables had very favourable responses- *Child neglect has serious implications for affected individuals*, *GPs should readily share information with other agencies if they suspect child neglect* and *I know who to share information with if a child in my practice is being neglected*. These statements

broadly represent issues of clinical knowledge, experience, data protection and patient confidentiality. All are components of the GP patient relationship but the situation is complicated in the research context by the additional dynamic of both parent and child as patients of the same GP. There is a fine balance between disclosing information to other professionals to potentially invoke statutory proceedings against parents who neglect their children when the parents have considerable health needs themselves (Sutton, 2011). The GP role is at the core of this concern and resulted in a common theme 'Advocacy'. This was envisaged often metaphorically within a process that could be damaging, conflicted and has been shown in previous work to be a persistent concern in child protection matters (Bannon & Carter 1991, 1998; Horwath, 2007; Gardner & Brandon 2008). The following concerns were raised by GPs,

> **GP1** 'they may not realise or fully appreciate the impact that their lack of care is having on the child...it can obviously damage the relationship that you may have '
>
> **GP1** 'there would be obvious conflicts with our relationship'
>
> **GP3** 'one is jeopardising the relationship you have with the parents or the family'
>
> **GP8** 'there is perhaps a conflict of interest in the outcome you know because sometimes difficult decisions have to be made'
>
> **GP 13** 'I think clearly the GP is in an invidious situation in the sense that they very often feel that they represent the patients they are the advocates of the patients in some ways'
>
> **SK 2, lines 351-352** 'GPs just see their relationships with parents as confidential em don't want to jeopardise that relationship'

6.2.2 Barriers to Successful Working

From the survey findings GPs should be involved in screening vulnerable families for child neglect is highly correlated with GPs should have greater resources to undertake screening for neglect, which at least suggests engagement with identifying neglect. This is not necessarily supported by the spoken data where constraints are realised as lack of resources, training and time with GPs expressing ambivalence about actively trying to identify neglectful patterns of family behaviour. The interview process differs fundamentally from the questionnaire because it affords the participant an opportunity to express an opinion and not merely rate questions in a structured questionnaire. The analysis of these data show that GPs do not appear to regard screening or accessible resources as possible solutions,

> **GP1** 'I think local management CHCP structures and government are conspiring against us'
>
> **GP1** 'we run into the problems of continuity there is no communication there is no useful method of communication for example between social work and to a lesser extent hospitals - we don't know what's going on outside the practice and there is little attempt apart from the occasional structured case conference in terms of communication with social work and us-the major barrier is the lack of team working'
>
> **GP2** 'it's very difficult to get anyone to work on a regular basis with these families'
>
> **GP3** 'one of the problems I guess nowadays is pulling the information together from disparate sources'
>
> **GP3** 'there are so many disparate parties involved and they all have their own agenda and perception and the degree or level of coordination I don't think is as good as it should be'
>
> **GP4** 'we tried to engage with social work but they didn't work hard at it'

GP6 ‘I think there are several factors one is inertia’

GP6 ‘in Glasgow the main reason is fear and if we notice it we will be swamped’

GP7 ‘Undoubtedly I think our role’s diminishing I think because of the Health Visitor Review’

GP8 ‘there’s nothing you can do because the volume’s so great that it’s very difficult to tackle’

GP8 ‘disengaged from doing this work’

GP8 ‘I would definitely need much more extensive training than I’ve had’

GP9 ‘neglect can take so many different forms I think that’s going to be extremely difficult for example of the four GPs in this place two of them have no paediatric training’

GP9 ‘I don’t even know who would even be competent to train you in that’

GP10 ‘there’s lack of people having had experience of it if you’ve never had experience of it you’ll be doubtful of it’

GP11 ‘Time we don’t have enough time for learning’

Lack of training, confidence in the child protection system, funding issues and the challenges of patient confidentiality are all cited as barriers to GP involvement (Birchall & Hallet, 1995: Bannon & Carter, 1998; Bannon, Carter, Barwell & Hicks, 1999; Gardner & Brandon, 2008; Horwath, 2007). Doubts about being supported in court regarding the validity of evidence was also articulated ‘that’s the nub of the thing so unless there’s been some test cases I think where people are able to stand up in court and defend what they’ve recorded then we’re still going to get this very unhelpful I think guidance’ (**SK 6, lines 416-418**). Perhaps the biggest barrier of all however, is that GPs themselves do not recognise the unmet needs of the child as the parent and child present together (Perez-Carceles, Pereniguez, Osuna & Luna,

2005). This possibly reflects the demands of a child protection system orientated towards evidence gathering. However, the elusive nature of child neglect may partly explain this finding that was evident in the focus group 'it's the things that aren't recorded and we can't define that are the things that I've noticed' (**SK4, lines 321-322**)

6.2.3 Mindlines/Mindknowledge 'it's by osmosis isn't it?'

The survey revealed that GPs on the whole do not read policy documents relevant to child neglect but as they are not specialists, they are not expected to demonstrate a specialist knowledge of child protection policies (Rae, McKenzie & Murray, 2010). The focus group participants were in agreement about why they did not read policy documents 'I just stuck them in a drawer and not read them because I didn't have time I don't know' (**SK 3, lines 474-475**). Pressure of time was restated 'we've got so many other demands on our time that I'm not going to sit and read these documents' (**SK 5, lines 486-487**).

The responses to the open questions in the survey cited various routes to learning about neglect predominantly through interaction with other professionals particularly the Health Visitor, or the child protection system. Learning from other professionals' mistakes was also important 'I think you learn from other people's mistakes how a situation is maybe mishandled' (**GP11**). Learning events were also cited as influential alongside media reports particularly the 'Climbie' report.

> **GP4** 'If I did want to learn more I would probably speak to the Child Protection Unit'
>
> **GP4** 'I personally find going to a dedicated course presented by the people who are leaders in the field I find that very valuable because I get a summary which has been aimed at me and my work'
>
> **GP5** 'Experiential probably the various well published documents like the Hall 4 and other previous documents from way back like Climbie and what not'

GP7 ‘I think there is a place for education and people discussing cases’

GP8 ‘we also did a thing in the practice with our health visitor following that incident who’d had child protection training herself’

GP8 ‘A lot of its by osmosis isn’t it?’

GP9 ‘Just by osmosis I think kind of pick it up as you go along’

GP9 ‘gut instinct and a feeling and you can’t quantify’

GP10 ‘I’d probably go through the Health Visitors I’d speak to them’

GP12 ‘I suppose just doing the job and reading the newspapers’

Bernstein’s (1990, 1996) pedagogy of discourse is an important theoretical explication of the transmission and inculcation of knowledge from trusted individuals. In these research findings it seems to be a preferred mechanism of learning that is language based and rooted in the rich experiences of working in general practice. Gabby and le May (2004) argue that physicians learn via ‘mindlines’ and not guidelines, and is a process underpinned by communicative practices.

6.2.4 Correlates of Neglect

All respondents of the structured survey rated parental substance misuse as close to the rank of ‘most important’. Three other variables were ranked as ‘above average’ by all GPs, *parental social isolation*, *social deprivation* and *parental mental health problems*. It is postulated that these variables could represent ideological constructs of the neglectful parent that all GPs would subscribe too and theoretically should present in the spoken data. The variables *poor parental educational achievement*, *parent having left care*, *greater number of young children*, *poor housing* and *young parental age* are ranked close to ‘not considered’ as contributory factors towards neglect but it is of interest that in a few of the interviews these factors were highlighted .

All GPs interviewed except **GP11** work in areas of significant socioeconomic deprivation and all cited *parental addictions* as a correlate of neglect, apart from **GPs 8**, **9** and **15**. It is noticeable that it was almost always mentioned first before any other possible correlate of neglect.

> **GP1** 'I think locally the big issue of substance abuse is an area that over the years one would view as an at risk group of children of parents with substance abuse'
>
> **GP2** 'Well low intelligence high on the list low intelligence of the parents and I think the other obvious things are drug and alcohol misuse'
>
> **GP3** 'I think child neglect or child harm is much more likely to happen if there is for example mental illness in a family- if there's drug or alcohol abuse'
>
> **GP4** 'Yes - drug use, alcohol use poor parenting skills'
>
> **GP5** 'Yes- age parental age, income employment drug abuse alcohol abuse substance abuse'
>
> **GP11** 'Obviously health issues from either of the parent and probably the commoner ones would be depression maybe alcohol or drug use'
>
> **GP12** 'parents who are more likely to neglect their children I suppose the ones we see probably most commonly are parents who are drug misusers'
>
> **GP13** 'So that's what they start with in life that's how the parents grow up but obviously at a later phase the process of obviously substance abuse enters into the situation'
>
> **GP14** 'I suppose parental mental health issues learning disability I suppose parental addictions alcohol or drug addictions'

GP16 ‘emm I suspect if an adult has been poorly parented as a child that perhaps would be a major thing emm if they have other health issues mental health problems drug and alcohol problems emm’

SK3 lines 82-84 ‘we identify that a child’s been neglected you know they’re not attending school you know the parent has for example mental health problems or drug addiction problems which an awful lot of them do in our area’

The GPs who did not discuss it focused on lower socio-economic class initially as a factor, but socio-economic deprivation did not achieve the level of importance suggested by the current maltreatment literature (Claussen & Crittenden, 1991; Ernst, Meyer & Depanfillis, 2004; Freisthler, Merritt & Lascala, 2006; Lee & Goerge, 1999; Nelson, Saunders & Landsman, 1993; Sidebotham, Heron & Golding 2002; Sidebotham & Heron, 2006; Zolotor & Runyan, 2006).

Parental mental health issues were mentioned by eight of the GPs interviewed ‘Mental illness might be one of them depression substance abuse another one’ (GP10). In this respect the immediate impact of poverty on family functioning appeared to be less relevant than mental health and addiction issues in the parents. This might suggest that factors which more readily affect the immediate parent–child relationship, and are co-morbid in individual patients, are given more importance than ecological factors. This finding is concordant with research of purported indirect effects of poverty on child neglect prevalence discussed in Chapter 2. **GPs 8**, **13** and **16** alluded to the inter-generational transfer of neglect (Kim, 2009; Lounds, Borkowski & Whitman, 2006) but articulated this as deficient ‘parentcraft’, parents having ‘terrible’ lives themselves. GPs are well placed to witness the sustained vulnerability of families as they often have three generations of the same family as practice patients.

GP8 ‘What I think is that some people have had terrible lives’

> **GP13** 'I suppose the main one I would see is a family tradition of it that its handed down that the parent craft that has been handed down by the parents is substandard'

Very detailed accounts of child neglect and the system response were presented by **GPs 6** and **11** who work in practices in areas of low socio-economic deprivation that are nonetheless, representations of experiential knowledge. This is convergent with the questionnaire findings where there was no difference in GPs working in areas of high or low deprivation in the weighting given to correlates of neglect. One of the participants, **GP15** mentioned 'lower socioeconomic' status but was not at ease discussing this displaying an awareness perhaps of the implied moral judgment of neglect as a class issue 'Well I have read that a history of neglect of themselves don't like to say it but lower socio-economic class'.

This is not the language of objectivity but the language of their subjective experience and opinion. It does not necessarily reflect a deficiency of knowledge of the complexity of poverty related issues but a sensitivity towards the language of poverty that is in keeping with other research findings (Cameron, Fryer-Smith, Harvey & Wallace, 2008).

In a therapeutic role GPs would be able to immediately 'do something' about addiction issues for example, refer to addiction services, treat mental health problems or refer to psychiatry. Paradoxically the social effects of poverty, regarded as approximates of child neglect, appear to be out with the job description of GPs .

6.2.5 Sentinel Case

Primary care physicians according to previous research, are influenced by a 'sentinel case' within the context of recognising and reporting child maltreatment. This has a lasting impact on the dynamics of the doctor patient relationship throughout their careers (Flaherty, Jones & Sege, 2004; Regehr, Leblanc, Shlonsky & Bogo, 2010).

Neglect perhaps, does not have the immediate impact on GP awareness that abuse has in a clinical setting and a few GPs in this research described incidents of child

abuse a "conceptual muddle" within the context of a specific discussion about neglect. One GP proceeded to discuss an obvious case of fatal child abuse, 'Absolutely horrific it was a murder the child died' (**GP15**). This particular GP remained uncomfortable when discussing the research topic because of doubts about establishing child neglect in another case, 'I feel a bit uneasy about that actually talking about that I didn't feel strongly enough about to be perfectly honest to pursue it' (**GP15**).

Nonetheless, nearly all GPs discussed in depth a case of child neglect that had resonated with them in their capacity as GPs except **GPs 5**, **13**, **14** and **16**. **GPs 5**, **13** and **16** were very experienced with 29, 26 and 18 years of service respectively whereas **GP14** had only 4 years of service. **GP5** was not particularly engaged with the challenges that child neglect brings to general practice although he talked in a generic sense of child neglect 'I think perceived neglect is not something that we can take a lot or much time over to identify'.

GP13 broadly discussed the challenges of child neglect and reflected on many of the incidents that he had encountered 'over the years obviously I've been party to many instances' but did not refer to a specific case. Another participant outlined generic issues of child neglect but because of his lack of experience had only a narrow repertoire of general practice experience to refer to 'Just through seeing the children as health issues presented I suppose I've seen it's not so much neglect but abuse I've seen people presenting with potential abuse in the neighbourhood and then I suppose small children just failing to thrive maybe' (**GP14**).

One interviewee highlighted physical effects of neglect in general 'I think quite a lot of children are not well nourished or they've not got good diets perhaps not clothed and I presume they're maybe not as warm as they could be' (**GP16**).

This lack of specificity is in contrast to the individual cases which other GPs alluded to, recalling observations made in specific encounters with neglected children either because of the physical effects of neglect 'you get children with disability the one that sticks in mind is we had this week we referred to the weight faltering group' (**GP9**), a late presentation of an untreated squint (**GP4**) and medical neglect 'there is

a definite problem one family in particular I can think of where it's a boy of 12 or 13 who's had almost lifelong incontinence problems you know enuresis and encopresis' (**GP2**).

The subtle challenges of determining neglect as an act of omission is articulated, 'I've had quite an interesting case and exemplifies the difficulty of the insidious nature of child neglect' (**GP7**). Another GP outlined a very challenging encounter on a home visit, 'it was quite kind of worrying I went basically to do a house call to a girl who had just had a baby and walked in to the house to do the postnatal visit and there were two other children crawling about in their own faeces' (**GP10**).

In the focus group data the cases of apparent neglect were discussed in general terms of behavioural difficulties in children and observations made in the surgery. There was discussion of neglect as 'socially constructed' and the impact of GPs' own social positioning in this context, 'we decide its neglect because that's our social construct of it which is interesting because I've been accused of imposing my middle class values on a situation by somebody' (**SK5, lines 55-57**). The difficulty in determining neglect within the boundaries of a consultation was acknowledged 'people don't bring a child in because they're neglected I mean maybe a grandparent might come or some relative might come separately and express concerns and then you have to decide what if anything you can do about' (**SK3, lines 35-37**).

6.2.6 Closer Professional Working: 'Well the first thing I did was speak to the Health Visitor'

The statements *Child neglect has serious health implications for affected individuals, GPs should readily share information with other agencies if they suspect child neglect* and *I know who to share information with if a child in my practice is being neglected* cluster together in an objectified dimension of neglect (Chapter 5). It seems reasonable to conclude that the adverse health implications of child neglect may be the underlying trigger to GPs discussing cases with other professionals, but who are they?

The open question responses in the survey resulted in a theme ‘Close professional identification with HVs’ where the relationship between HV and GP is ‘vital’ according to one respondent. The importance of this professional relationship could be expected to present in the spoken data because of its prominence in the survey responses. In the interviews when GPs were asked about their professional role or involvement with child neglect they almost always immediately discussed their relationship with their Health Visitor,

> **GP2** ‘expressing concerns perhaps initially to Health Visitor or Health Visitor expressing concerns to me and then me seeing the patients and then sort of discussing again with the Health Visitor and trying to get more Social Work input you know that sort of thing’.
>
> **GP6** ‘I think that Health Visitors are the key people in relation to identifying and doing first stage triaging in child neglect’.
>
> **GP9** ‘if I was looking for information on it my first port of call would probably be my Health Visitors if they couldn’t provide it I would tend to use our Community Paediatricians’.
>
> **GP10** ‘Well the first thing I did was speak to Health Visitor’.
>
> **GP11** ‘I think the Health Visitor is the key person in the liaison’.

The Health Visitor as the main contact for information and support was echoed in the focus group data,

> ‘I would if it was an under five I would go to the Health Visitor’ (**SK6, lines 121**)
>
> ‘I think that Health Visitors are in an invaluable position’ (**SK5, lines 137-138**).

Aside from being a profession that GPs frequently discuss sensitive issues of family functioning with, the Health Visitor has a crucial role because of their involvement in

the early stages of family life, where they assess children not only in the surgery setting but also the family home. In keeping with empirical research findings the focus of neglect in the interviews and focus group is predominantly on young children and issues of parenting (Chapter 2),

'You know if there was an increase resource for Health Visitors so that they could be in contact with families right through childhood I think that would be an enormous advantage' (**SK 3, lines 128-130**)

Very few GPs discussed the challenges of child neglect in older children. In primary care children over five years are not routinely seen by Health Visitors as child welfare becomes a function of the education system. The important role of education was discussed in the focus group but not the interviews,

> 'I wonder about the role of the Primary Teacher because obviously these children are in day and daily and you'd think they might the teachers presumably they are picking up some of that' (**SK6, lines 183-185**).

The other professional group that GPs commented on that they would have contact with albeit less frequently than the Health Visitor and not at the immediate level of the primary care team was Social Work,

> **GP4** 'I tried to follow up with written letters and communicating with Health Visitor and Social Work so there's a lot of working behind the scenes'.
>
> **GP2** 'discussing again with the Health Visitor and trying to get more Social Work input you know that sort of thing'.

This was not always a successful liaison notably because of lack of resource and the numbers of children affected, 'apart from our Health Visitors you know if you refer someone like that to Social Work probably not get very far actually because they don't have resources' (**SK3, lines 87-88**), but also the lack of clarity on the referral process, 'I think the referral to Social Work if this child is abused is very clear you have an obligation to do that I'm not so clear about the obligation for neglect' (**SK6, lines 107, 108**).

The responses contrast with **GP6** who has professional contacts that reflects his academic interest. He gleans his knowledge and professional support from a number of sources,'Child Psychiatry, Child Psychology, Paediatrics, Developmental Psychology, Speech and Language Therapy '.

6.2.7 Technical or Ordinary Language; Outside the Esoteric Circle

GPs expressed themselves using an everyday language within this research context, that would be comprehensible to those outside the profession of medicine. I found no overwhelming evidence of an exclusive 'scientific discourse…socially divisive…used by specialists…often inaccessible to the non-expert' (Bloor & Bloor, 2007, p. 60).

I suspect this would not be the case for chronic diseases such as diabetes, hypertension or renal disease that dominate GP workload. In this research there is no technical register shaping the discourse of most GPs and little evidence of an 'occupational register…a practical and convenient shorthand for talking about complex matters specific to a field…largely opaque outside the esoteric circle' (Fleischman, 2001, p. 475).

The ordinary everyday language in the interviews renders meaning visible to all with very little parallel explanation needed because the use of any specialised term is infrequent. The overlap of ordinary language with the technical register of medical language is acknowledged to be grey area (Fleischman, 1999; Hadlow & Pitts, 1991) and the structure of talk within these data seem to support this observation.

The most striking example of the technical aspects of language which reflect an expert discourse of child neglect reside in the interview extracts of **GP6** in his definition of neglect and its consequences,

> 'anything that leads to a failure to engage in sustained human contact I think that the factors involved would be intoxication significant mental illness neurodevelopmental problems which might include learning difficulties in the parents severe social adversity'

> ‘many, many children who have experienced neglect have got disorganised patterns of attachment and long term consequences of those are failure of development of substantial part of the brain prefrontal cortex’.

The other GP participants in contrast outline a generic definition of neglect, albeit related to physical and psychological difficulties. There is no specific reference to neurological development in relation to cognitive-behavioural problems that neuroscience is becoming increasingly focused on. When asked to define neglect the use of ‘I suppose’ is a pervasive discourse marker in all the GP interviews important to modality and the grammar of experiential meaning explored in this chapter.

> ‘I suppose it conjures up more children who are just perhaps not very well cared for both intellectually emotionally as well physically you know they may not be very well nourished’ (**GP2**)

> ‘I suppose child neglect I suppose it’s different from child abuse child neglect no it is abuse but it’s if you regard abuse almost we think of abuse as a positive thing actually actioning and abusing rather than neglect which is the process whereby you don’t it’s an omission of giving the things that children need so definition of neglect for me would be children have certain needs emotionally physically spiritually’ (**GP7**)

> ‘I suppose it could mean a number of different things it could relate to their health needs their social needs their emotional needs so it’d probably quite a long definition but if their or well yeah I would say if their either social their health or emotional needs were not being met then that would lead to neglect’ (**GP11**)

The focus group participants also discussed the identification of child neglect and contrasted this with abuse,

> ‘it’s probably very difficult to define specifically and much broader than abuse obviously’(**SK6, lines 53-54**).

‘I think you’re looking at the physical development of the child social development things like that I think that’s how I would maybe start thinking about neglect emm you know parenting perhaps’(**SK3, lines 29-31**)

‘I’ve been trying to think about the broadest possible terms a bit like you I kindof thought abuse em neglect is obviously a much softer thing (**SK6, lines 43-44**)

6.2.8 The Voice of Experience ‘maybe it’s just because I’m a relatively new GP’

The transcripts of the interviews and focus group represent narratives rooted in experiential knowledge, stored as stories, templates in our memories and not collections of abstracted facts (Norman, 2005). Narratives developed from clinical contact with patients become embedded in individual reasoning and intuitive knowledge which informs decision making.

It is acknowledged that as practitioners mature they move towards more sophisticated individual epistemological beliefs and constructed experiential knowledge (Knight & Mattick, 2006). The genealogy of the language of neglect expressed in these data originates in routine clinical experience, often with the individual GP at the centre of the story. Atkinson (1995) has commented that senior doctors tend to infuse their speech with personal opinion compared to junior colleagues. In this study, age group was not statistically significant in the quantitative data findings with regards to objective aspects of knowledge (Chapter 6). In contrast, within the context of subjective accounts of training and experience divergent discourses emerged which seemed to be partially influenced by time spent as GPs.

GP14 and **SK4** had less experience in practice and they both described professional distance from child neglect issues. This appears to be partly because of their limited work experience but also the absence of any structured approach to this work,

‘looking back I’ve not actually been involved as a GP any way it’s more in A and E where I’ve seen cases presenting’ (**GP14**)

> ‘I suppose I’ve been involved with I suppose it’s case presentation almost case by case you know as cases have come to me then I’ve learned about it and I’ve learned on the hoof sort of thing’ (**GP14**)

> ‘just because I’m a relatively new GP but I think even if I saw things in the consultation that made me wonder about neglect I don’t know how bold or confident I would be to then bring that up or what I’d then try and do about it’ (**SK4 lines, 73-74**)

That said, the notion of professional distance (Horwath, 2007) is not solely attributed to length of GP experience because in this study older GPs articulated a belief that there was little chance of improving outcomes for neglected children or identifying neglect in the first place,

> ‘I’m not sure if I would see a great point of us in (Practice area) adopting a crusade to identify many children who hadn’t gone a holiday in the past three years or how many of them don’t go to bed before midnight or how what criteria you would use what we would use-smoking by the age of eight –very difficult to achieve without diluting core service’ (**GP5**).

GP4 in contrast describes her own active particiaptation and assuredness in child neglect matters that comes with the confidence of experience,

> ‘when I started as a twenty-six year old I didn’t realise the value of my skills and experience and so I realise the value and I have every confidence to speak to Social Work to speak to the Reporter to speak to the Fiscal and they will value what I have to say’.

6.3 Discussion

The vocabulary of family medicine is a rich and detailed language that encompasses human values not the diminished technocratic language residing within a biomedical model (Dixon, 1983).

The stories GPs tell mostly relate to a single case where the GP as narrator 'inscribes personal knowledge' and is clearly 'implicated' in the story of a wealth of experience, each unique to the GP as a 'framework of reminiscence' (Atkinson, 1995, p. 140). It is an internally consistent way of interpreting past experience but inescapably infused with personal opinion.

From the spoken data it is apparent that reference to specific cases is an important mechanism for providing the backdrop to how neglect meaning is located in general practice. Furthermore, it is also an important mechanism for highlighting competing discourses of personal involvement and justification of professional distance from this area of clinical need.

The following section takes an analytic turn to the experience that language conveys in the processes where GPs acquire their knowledge and justify their attitude towards neglect meaning making. Despite each interview being unique to each individual participant, and the focus group representing a unique discursive event, there are convergent themes which underpin the next stage of the analysis.

6.4 (Section 2) Interpersonal Meaning and Transitivity; The Experience in Language

The quantitative analysis measures the strength of correlation between factors that are associated with neglect, statements that together may represent dimensions of a single concept. In this research it displayed a two-factor solution, '*Requirements of Working With Vulnerable Families*' and *'Sharing Health Concerns of Neglect With Other Professionals*' with both concepts linked to issues of data protection. The statistical analysis provides a "confidant" account of the data because the strength of relationship between variables is quantified and becomes statistically significant.

Utilising a theory of language the analyst looks at relationships in the data through patterns of meaning, not with numbers, but units of text and modalisation is one aspect of textual analysis that expresses the likelihood or probability of something happening (Eggins, 2004, p. 172). The parameters of speaker confidence represent the limits of epistemic modality conveyed in the expression of attitudes and

judgments ‘how speakers encode in language their mental picture of reality and how they account for their experience of the world around them’ (Simpson, 1993, p. 88).

Integral to the ideational function of language, and expression of processes as a common thread of language analysis throughout the spoken data, it is expressed as ways of sensing “thinking” and “seeing” child neglect that is evident in these data from the focus group,

> **SK3, line 38** ‘you’ll just kind of look at a child and think they’re not doing too well’
>
> **SK3, lines 40-41** ‘I think is the thing that might make you think about it I think that’s what I would be looking for’
>
> **SK5, lines 254-255** ‘when we do see kids quite often there’s lots of distractors there’
>
> **SK6, lines 266-267** ‘of all the children’s behaviour that I see most often in the surgery that immediately catches my attention is disruptive behaviour’

Mental processes are one important aspect of Simpson’s (1993, p. 89) transitivity model relevant to this study where GP participants actively choose to represent experience in a particular way that is encoded in grammar of experiential meaning.

In the corpus of data, epistemic modal adverbs ‘probably’ and modal lexical verbs ‘I think’, ‘I suppose’ highlight modalised assertions as a weaker commitment to definitions of neglect. Similarly when asked about the GP role in screening families the use of ‘could’, ‘might’, appear to represent aspects of tacit knowledge that ensure ambivalence towards their role. Just as the statements in the survey questionnaire can be measured in terms of statistical significance and compose a picture of neglect by quantifying the strength of correlation between variables, language in the spoken data denotes symbolic measurement of strong and weak commitments to the constructs of child neglect meaning, examined under the analytic lens of modalisation. The following data extracts give support to this theoretical

approach to the data analysis that underpins conclusions about GP attitudes and opinions towards issues of child neglect.

6.4.1 'Thinking about child neglect'

GP3 'I think child neglect or child harm is much more likely to happen if there is for example mental illness in a family'

GP8 'I think it's a child who's not given the opportunity to thrive and it's manifest in many different ways and I think that it can be very difficult to pick up and can be very difficult to do something about'

GP10 'well I think it's not looking after the physical emotional or psychological needs of the child that's what I would say'

6.4.2 Thinking about the adverse outcomes of neglect

GP4 'I think the consequences are enormous'.

GP5 'I think it certainly alters their personalities depending on if they're being fed properly it will affect their physical growth, disturb their emotional development their personality be unable to establish a role and develop a parenting role but others-educational attainments social skills'.

GP12 'I think when you see you know what can happen to children who have been through a difficult upbringing'.

GP14 'Gosh long term I would I mean well for a start they're likely to be parents of they're likely to neglect themselves or likely to abuse the children themselves I would think I mean again I don't know definitely but I'd imagine there are huge health consequences'.

6.4.3 I think It's Someone Else's Job

GP3 'I think the way that general practice has evolved that's become very difficult if not impossible I personally don't think that's something that is

now feasible - I think it would have to be done by a dedicated team which is really committed to child health as its main function'

GP5 'I think if you are screening has only got a point if you can identify and change something there maybe a role for the practice team to screen if we assume that Health Visitors are part of the team'

GP7 'I think our role's diminishing I think because of the Health Visitor review I think what's going to happen is that we are gonna be less able to pick up I think in making a decision about a referral for neglect I think we use a lot of strands including local intelligence like Health Visitor information and I think will be lost and I think we'll be less able to pick it up'

GP9 'I think you'd be better off with experienced Health Visitors'

GP11 'I think it's definitely a Social Work run thing'

The science of child neglect resides within research dominated by statistical modelling that tries to determine causality and generalise findings to a whole population. Without the balance of a worldview experience in the tangled mass of words, clauses, propositions, ways of speaking it remains, in my view, a partial and reduced explication of neglect meaning.

6.5 (Section 3) Belief and Opinion

The following section explores opinions expressed within this study by employing rhetorical strategies namely hedging, metaphor, ideology to examine how GPs justify and mark out certain beliefs as plausible and credible. Despite the restriction of space in the research they require a reasonable depth of analysis because of a pervasive presence in the data and the contribution to the arguments of this thesis.

6.5.1 Hedging

Hedging contributes to interpersonal meaning of language as a result of its role in qualifying categorical commitment and facilitating discussion. It is a useful linguistic

device that spans a continuum of meaning between all and no cases. Brown and Levinson (1987, p. 145) comment that, '(hedging) modifies the degree of membership of a predicate or noun phrase in a set; it says of that membership that it is partial or that it is more true and complete than perhaps might be expected'. Simpson (1993, p. 127) regards hedges as 'softening the impact of the message on the addressee' as one element that contributes to pragmatics of meaning in communication.

Salager-Meyer (2000) comments on the importance of hedging as a useful linguistic tool that allows the speaker to introduce vagueness and ambiguity into the language of a particular social situation. Other scholars have noted that hedges in biomedical research function as speculative language to denote uncertainty in scientific text (Agarwal & Yu , 2010; Kilcoglu & Bergler, 2008; Medlock, 2008).

It is exemplified in this research by the speaker's pervasive use of 'well', 'I suppose', 'emm'. 'I suppose' has already been discussed in the previous section as an important modal lexical verb in denoting commitments to beliefs. Furthermore, it has an important function as a 'hedge' that discursively marks responses to questions of neglect definitions.

In a medical setting hedging appears to function in dealing with uncertainty through four main functions. These are 'approximators' to modify precision of medical terms, 'adapters' to indicate a mismatch between a prototypical description and observed conditions, 'rounders' to indicate a degree of approximation and 'shields' indicating the commitment to the report (Prince, Bosk & Frader, 1982).

It is reasonable to assume that the frequent use of modal verbs as 'shields' in the interview data reflects the interpretive path that the speaker is taking. Constructing an abstract entity requires such a linguistic device because inevitably neglect cannot be reduced to absolute terms, the truth of neglect is tentative. The pervasive use of hedging further strengthens the view that neglect is not a 'diagnosis' that is made by emphasising an empiricist view, stressing objectivity and science, but conveys subjectivity, personal belief and opinion.

6.5.2 I suppose neglect is …

Responses to the question of 'what is neglect' rather than 'what causes neglect' almost always began with 'I suppose', conveying hesitancy and partial commitment to interviewee statements,

> **GP1** 'I suppose it is any treatment or maltreatment of a child'
>
> **GP2** 'I suppose it conjures up more children who are just perhaps not very well cared for'
>
> **GP7** 'I suppose child neglect I suppose it's different from child abuse'
>
> **GP9** 'I suppose you've got physical neglect emotional neglect social neglect psychological neglect'
>
> **GP10** 'well I suppose it's not looking after the physical emotional or psychological needs'
>
> **GP11** 'I suppose it could mean a number of different things'
>
> **GP12** 'I suppose it's where a child is not given the correct and appropriate care'

6.5.3 'Well our role is…'

Three survey items had favourable responses *Child neglect has serious implications for affected individuals*, *GPs should readily share information with other agencies if they suspect child neglect* and *I know who to share information with if a child in my practice is being neglected* that together represent a dimension of child neglect *Sharing Health Concerns of Neglect with Other Professionals*. Alongside the other dimension identified in the factor analysis *Requirements of Working with Vulnerable Families* GPs appear to be a profession that is actively engaged with child neglect challenges.

From the interview findings GPs appear less committed to the process of sharing information by articulating an ambiguous stance towards identifying neglect and the process this represents. Discussing the role of GPs reveals a myriad of response from a commitment to active involvement 'Well, we are ideally placed because of the frequent contact that we have with families' (**GP1**) than others who appear more ambivalent about the contribution of GPs 'Well, I think probably more just liaising with other agencies you know' (**GP2**) 'Well, it's always going to be opportunistic' (**GP14**).

GP4 comments that it is unclear which profession is more relevant, 'Well I think this ties up with whether it should be the GP per se or a Health Visitor with whom the GP work'.

In the spoken data the commitment to sharing information seems less certain as GPs deflect attention onto other professionals as the leaders in this field 'someone else's job' thus minimising their own role.

6.6 Ideological Square and the Paradox of Discourses

Analysing grammar at the micro level of textual analysis and progressing to the macro-unit of analysis to create the textual boundaries of an ideology was a research challenge. To address this concern developing the notion of cohesion within text that connects grammatical structures with ideological constructs is theoretically made possible employing the principles of SFL, conceptual metaphors and ideological function within the system of transitivity.

Epistemic modality is key in this research as speakers express a level of confidence reflecting an ideological stance towards child neglect. If we extend Fairclough's (2003, p. 164) argument that modality choices are an important aspect of textual analysis which reveal how authors identify themselves when a particular viewpoint is expressed, then speaker identity is central to ideology. Ideology resides in the cognitive processing of individuals and are socially constructed to form shared knowledge in societies. To become manifest, ideology requires discursive or communicative events (Van Dijk, 1998). Ultimately an analysis of language is

required to unpick these processes. Drawing on the work of Van Dijk (1998) to theorise the relations between discourse and ideology, the research aims in this section is to show how social groups (*us* vs. *them*) are presented in ideological discourse constructed socio-politically as confirmation of group identity.

To expand the analysis of a varied discourse and make any conclusions about the convergence or divergence within the data I employed aspects of Van Dijk's ideological square. It is, according to Van Dijk (1998, p. 267), an 'overall strategy of ideological communication' which ensures the 'face-keeping' presentation of self by omitting or highlighting information in 'semantic representation' and in doing so also creates the 'negative-other presentation'. His model provides a cognitive account of the ordering of discourse based on the representation of positive in-group interests.

The questionnaire analysis found that statements *GPs should be involved in screening vulnerable families for child neglect* is highly correlated with *GPs should have greater resources to undertake screening for neglect* which would suggest a profession that is motivated to uncover child neglect. In contrast, this is not supported in the spoken data where ideological constructs suggest professional distance and ambiguity towards issues of child welfare.

The discussion of child neglect within the context of general practice is founded upon a structuring of presuppositions, themes and arguments indicative of Van Dijk's model. This is dominated by a dual process of proximity and distance where positive aspects of the system are denoted metaphorically by proximity. Distance tends to represent negative aspects used to apportion meaning to abstract entities, namely the role of GPs within child welfare concerns and neglect prevention. This dualism is apparent in metaphorical expressions in open comments of the questionnaire where child neglect is envisaged within interconnected practices and close working relationships with other professionals albeit within a system that is fragmenting (Appendix B). It would be reasonable to expect that this stance would be echoed in the spoken data.

That said, the analytic framework constructing van Dijk's ideological square is not as symmetrical as outlined in his work (1998, p. 267). Reducing data to emphasise

negative and positive aspects was at times difficult with overlap of concepts. Van Dijk(1998, p. 137) comments, 'it is not the group, nor the organisation, nor any abstract society that directly influences or constrains ideological practices, but the way social members subjectively represent, understand or interpret them'. Nonetheless, convergence within the data further supports the view that findings from the spoken word ripple out to connect with the socio-political structure and its discursive representation of neglect because it extends beyond "specific 'emotional' moments of individuals" (Van Dijk, 1998, p. 122). Despite interviewees giving their own unique narratives of child neglect meaning, the convergence within the data is at least aligned with a 'shared mental construct' that despite individual variation denotes the " 'external' manifestations of social identity…a function of social interaction and negotiation, and of the attribution of identity by other people and other groups" (Van Dijk, 1998, p. 125). In this context language is not only reflective of GPs cognisance of themselves within the welfare structure, but additionally, ideological expressions are recognised as being used politically to convey a negative or positive message to reflect and maintain accepted ideologies (Bloor & Bloor, 2007, p. 73) .

The deconstruction of whole conceptual structures 'neglect' and 'understanding' inevitably invites more of my own influence on the cognition of the text. In order to minimise my own influence on the interpretation I used the function of a deictic centre to better understand how the speakers created a particular point of view. The deictic centre 'refers not just to a speaker or hearer's location in time and space but also to their position in a social hierarchy…encoding of distance … metaphorical as is the case with temporal and social deixis' (McIntyre, 2006, pp. 93-94). Lyons (1977, p. 637) comments social diexis is a necessary requirement to understand speaker stance, 'the location and the identification of persons, objects, events, processes and activities being talked about, or referred to, in relation to the spatiotemporal context'. This allows a consistent approach to the analysis and limits the possibility of reducing the data to selective texts that support solely my own view. This approach can be replicated within other research and contributes to the 'transferability' and 'representativeness' of this research strategy. In conjunction with Van Dijk's model the deictic centre supports the findings of spatial distance created

by GPs in the context of their professional role in child neglect. The purpose of creating spatial distance in other clinical areas such as oncology, has been explored when doctors have to convey difficult news to patients (Vegni, Zannini, Visioli & Moja, 2001; Vegni, Visioli & Moja, 2005).

The ideological square has four elements summarized according to Van Dijk's (1998, p. 267) analytic framework, that either highlight or hide ideological practices,

a) 'Emphasise information that is positive about Us'
b) 'Emphasise information that is negative about Them'
c) 'De-emphasise information that is positive about Them'
d) 'De-emphasise information that is negative about Us'.

The following exemplars contain many examples of metaphoric expression pervasive within the spoken text to denote this duality. It is foregrounded in the analysis because it functions to highlight and hide particular aspects of opinion (Kövecses & Csábi, 2002) that is not a neutral component of language in the construction of a concept 'when thinking and talking about experiences' (Croft & Cruse, 2004, p. 55).

6.6.1 Emphasise Information that is Positive about Us

Creating the ideological in group highlights attributes that relate to work experiences 'an interesting job' (**GP3**), 'privileged job' (**GP4**), the 'best job' (**GP6**). 'Us', 'we', 'I' are pronouns used to denote the GP, Health Visitor and primary care team that fulfil various functions of identification concerned with events and processes. Furthermore, they contribute to personal and spatial dimensions of the discourse process as pointers to readers of the text to denote the complex aspects of working environments and relationships. Using pronouns as deictic exponents of the construction of speech is supported by Halliday and Hassan's (1976, pp. 48-65) work on the complexity of social relations within the tradition of SFL where 'we' , 'us', 'I', represent the world according to the speaker (Halliday & Matthiessen, 2004, pp. 554-556).

Many positive aspects of GP work in this section are emphasised using metaphoric expressions that highlight contact with other professionals or patients with GPs at the centre of these relationships (**GPs 8, 10**). The interpersonal function of language in enacting social relations is context dependent as GPs create their stance in relation to their immediate professional space but also has a referential function creating boundaries in relation to the wider child welfare system.

> **GP1** 'there are a lot of things locally we could achieve and I think we have demonstrated this in the past in a wide a variety of areas where we have collaborated and worked together as a group of practices'

> **GP3** 'I find it's an interesting job- a mix of activities constantly stimulating- never a dull moment - allows the opportunity for clinical medicine which is great- there's a lot of pathology here so in fact it allows one to put into effect a lot of the scientific and medical training that we've had in the area and also it allows one to interact with the patients and get quite a bit of feedback positive feedback from patients'

> **GP4** 'I think my job is a very privileged one we have a small practice population of one thousand nine hundred and because we're small we know everybody and that makes the job incredibly satisfying because there's so much understood and implicit when someone walks in the door I know them'

> **GP6** 'I think it's the best job in the world I like the continuity I like the inter-generational aspect of what I do I mean academically I've got really interested in babies and the reason I've got really interested in babies is that as I've been in the practice longer I've actually seen lots of people grow up and actually there's no other profession has that longitudinal perspective'

> **GP8** 'I like the patient interaction I like the challenges that are presented by the unknown when people come in the door you don't know what's coming I like the continuity of care very much and I must say as I get older I suppose seeing the longitudinal care it becomes ever more important to me'

GP10 'I get a lot out of the consultation sitting down and speaking to people you know you don't get huge amounts of feedback but you get some feedback and you feel good and think alright I've done something good'

6.6.2 Emphasise Information that is Negative about Them; 'Government interference would be would be high on the list' (GP1)

Metaphoric expressions are employed to highlight perceived negative aspects of other agencies, that serves to deflect from GP lack of involvement with child neglect issues. The relevance of metaphor to this thesis analysis is outlined in Section 3 of this chapter but a short overview of the use of metaphor expressions and their function in ideology is given in this section.

Metaphor expressions are predominantly located in ontological structural metaphors with an overarching conceptual metaphor for example, 'relationships are buildings' to convey meaning about a system that is being dismantled and deconstructed, 'I'm particularly upset about is the increasing fragmentation of primary care this seems to be quite a powerful move towards the disaggregating of all different aspects of what the primary care team does' (**GP6**), 'I don't like the fact that I think that general practice is being completely fragmented...to see that disintegrate I think is just a disaster' (**GP8**).

The use of orientational metaphors to suggest disruption of services 'in the loop' (GP3) or removal of services, 'one of your whole problems with that is that they're going to drag health visitors out of General Practice which is just crazy' (**GP9**), emphasise the importance of cohesion within the structure of child neglect prevention and build up a general image-schema of contact. The use of nature metaphors 'deluge', 'run-off' (**GP3**) are being used negatively to suggest change and instability.

This section was expansive as GPs define themselves by highlighting negative aspects of 'Them'. This relates to structures of government, 'Usually the external factors government interference would be would be high on the list, local poor management I would say is a major deterrent' (**GP1**), 'I dislike the external pressures

and conditions we have to work under the government have made so many changes that have been detrimental to the nature of the job itself' (**GP4**). Highlighting local management negatively is evident, 'one of the big problems we face locally is that the local management seems to be hell-bent on dismantling the teams that have worked very well together and to be very averse to listening to input from the professionals on the ground' (**GP1**).

Deflecting attention onto other professionals also serves this function, 'I think the main barriers I think it's very difficult to get anyone to work on a regular basis with these families you know to try and motivate them and give them whatever stimulus they need...I would think that Social Work probably wouldn't see it as a priority because they've got lots of other cases involving definite abuse' (**GP2**) , 'another issue is engaging with other professionals one can't always trust how other professionals are actually going to respond when drawn into the loop' (**GP3**) .

In addition, negative aspects of processes for example dissemination of information, 'in fact there has over the last few years a deluge of information and guidelines and protocols and mission statements which I think have clouded the issues a great deal' (**GP3**) and more abstract notions of issues of trust and transparency of the political agenda are also cited,

> 'I didn't vote for the new contract I think it's a complete and utter disaster I think target driven medicine is a disaster and I think that the slow and insidious rise of private medicine' (**GP7**)

> 'the contract is all about ticking boxes and making money and this is all about gut instinct and a feeling and you can't quantify that by ticking some audit box that they want you to' (**GP9**)

> 'they're probably trying to save money they're probably trying to take resources off you they're probably trying to change statistics so that it looks better when the papers get the statistics' (**GP9**)

‘the contract I think was absolutely forced on us and I think that as years have gone on with the contract its becoming more and more a tick the box culture’ (**GP10**)

‘it’s just the government trying to appease the public but it’s not it’s not solving any problems it’s just creating more difficulties it’s just making the job harder’ (**GP10**).

6.6.3 Suppress Information that is Positive about ‘Them’

Any discussion about progress in working with vulnerable families was frequently qualified by diverting attention away from positive developments by discussing the limits of such progress. Metaphoric speech is important as ‘motion/journey metaphors’ are used negatively to emphasise change and instability and not as a positive representation of progress. This aspect of Van Dijk’s model was limited as the majority of these spoken data denote negative processes.

GP3 ‘There have been likes and dislikes in fact there have been major re - organisational changes over the last 10 years particularly that have changed the nature of general practice and there are advantages and disadvantages to this now some of the disadvantages that comes from this is a move towards making the service delivery chronic disease led so everything is itemised and follows guidelines’

GP4 ‘I think some of the aspects of the new contract were helpful cos they helped us focus on certain disease groups but its made us focus considerably on disease areas and other areas have perhaps taken second place

GP5 ‘the changes the number of changes the acceleration of changes all change can be disturbing of course and but some change is necessary but some recent changes the rationale has not been clear to us and some of it seems duplicitous’

GP8 ‘the thing about the government a lot of things we are asked to implement are definitely for the good sometimes though they are ill thought

through and with a wee bit less view on vote catching and a wee bit more view on what would be best for the patients'

6.6.4 Suppress Information that is Negative about Us

GPs appear to be passive observers in child neglect and in a state of professional and personal collusion with the notion of disengagement,

> **GP2** 'I don't tend to get to grips with families very well and rely quite a bit on health visitors I think to fill us in on information on problem families because by the nature of them being problem families they don't tend to come and see us very often'

> **GP2** 'I think it's probably a lack of any information about it or discussion about it in a wider sense by other professionals'

> **GP3** 'I think the way that general practice has evolved that's become very difficult if not impossible I personally don't think that's something that is now feasible' (GP 3),

> **GP9** 'I think you'd be better off with experienced Health Visitors and have a couple of doctors overseeing the whole thing'

> **GP11** 'I think it's definitely a Social Work run thing although I have to say the experience I've had of our Social Work is that they do try handle it as sensitively as possible'

The reasons given for this are varied, with no one specific factor that fully explains why participants express a professional responsibility by acknowledging child neglect but simultaneously create spatially distant relationships with their patients and the child welfare system regarding this dilemma. This is evident in the spoken data as they discuss the 'pressures' of work (**GP2**), being 'cut out the loop' (**GP3**), a fear of being 'swamped' (**GP6**) with an overwhelming 'volume' of neglect cases (**GP8**) that remains a 'scary issue' (**GP10**) .

Time constraints are mentioned ‘you’re under pressure-very busy-busy surgery you’ve got extras you’ve got interruptions a lot of admin you do feel under pressure because you know you’ve got to get everything finished each day’ (**GP2**), ‘I think perceived neglect is not something that we can take a lot or much time over to identify and refer on or highlight’ (**GP5**), ‘I would definitely need much more extensive training than I’ve had I also don’t have the time because I think if you’re going to do it it’s a very difficult and complicated scenario and I don’t think you can do it in a ten minute consultation’ (**GP8**), ‘I suppose most GPs see themselves as being so busy that you know I suppose a lot of people will say it’s not my job and it’s not my responsibility’ (**GP11**).

A diminution of training or knowledge are contributory factors, ‘I think we could certainly be involved in identifying it - I think yeah if awareness is raised among GPs I think we’d be much better in recognising and looking for it’ (**GP2**), ‘I think there’s also lack of exper .. not expertise but experience there’s lack of people having had experience of it’(**GP10**). The atomistic approaches to child welfare are alluded to,

> ‘the reason things are confused and chaotic there are different agencies different people are jockeying for position you know to develop the service and I don’t think there’s been much clarity in what’s actually come from all of this’ (**GP3**) .

There are also inherent challenges around information sharing and the implied judgment of patients that adversely affect the GP role as patient advocate,

> **GP10** ‘I think it’s scary I think GPs are scared there are all sorts of litigation as soon as you say something about your child maybe neglected your patient doctor relationship is way out the window’

> **GP13** ‘I think clearly the GP is in an invidious situation in the sense that they very often feel that they represent the patients they are the advocates of the patients... and yet at times you’re saying that the child’s interests are paramount and therefore you’re actually working against someone that you may have had a lot of contact with over the years’

GP15 ‘there’s also this perceived fear of Social Work... that you innocently or that you innocently accused someone of child neglect when it hasn’t been the case so that’s a fear’

GP16 ‘Social Work will sometimes phone up or and say what about this child and you don’t know really know why they’re asking and of course you’re bound by confidentiality it’s very difficult to give information if we don’t know why’

Conversely, there is also an issue about sharing information that is not acted upon, ‘I think quite often it’s a thankless task I have referred people to the social work department I think have been in a very difficult situation and it’s taken me a very long time to actually speak to somebody for it to fall on deaf ears’ (**GP8**).

GPs have less scheduled contact with families as child health has become less prominent within the GP contract. This is apparent in the descriptions of becoming less involved and informed about their vulnerable families, ‘I think neglect will go further unnoticed it’ll become an increasing problem but because it’s not really counted and recorded in the contract it will not be acknowledged’ (**GP4**), ‘Undoubtedly I think our role’s diminishing... we use a lot of strands including local intelligence like Health Visitor information and I think will be lost and I think we’ll be less able to pick it up’ (**GP7**). However most pre-school children still have contact with their GP who has ‘more access to families than anyone else’ (**GP2**). In suppressing the negative approaches to this work where there is ‘no happy ending’ (**GP8**) where GPs are inadvertently telling a story based on their own ambivalence towards the challenges of child neglect.

The focus group data was a more difficult fit with Van Dijk’s model because ideological phrases appeared to highlight areas of positive potential change not apparent in the interviews for example, the role of the education system sparked a reasonable length of discussion which was not mentioned in the interviews. The separation of ideological constructs was less distinct as ongoing debate between participants blended some of the concerns of positive and negative aspects of working around neglect issues.

> ‘You know if there was an increase resource for Health Visitors so that they could be in contact with families right through childhood I think that would be an enormous advantage actually because we know what a great job they’re doing with the under fives you know in terms of immunisation early development and all the rest of it certainly we need more resource’ (**SPK 3, lines 128-132**)

> ‘you know there will be one nurse per school cluster I mean I wonder about the role of the Primary Teacher because obviously these children are in day and daily and you’d think they might the teachers presumably they are picking up some of that’ (**SK 6, lines 183-185**)

Challenges of patient confidentiality and sharing information with other professionals were also discussed in some depth in the focus group,

> ‘I don’t communicate with school nurses because I don’t think there are any and I’m always quite uncertain of their boundaries as well about sharing information’ (**SK 5, lines 307-309**)

The focus group participants debated the status of neglect and provision of services sharing their perspectives and opinions rather than the expression of individual thought processes. The production of focus group data appears to be less emotive because the text represents the collective voice that is negotiating meaning. Overlaps of speech and the presence of humour throughout the focus group reinforce the informal nature of the interaction.

6.7 Metaphor Findings

The following data extracts exemplify the contribution of metaphor to the analysis of ideological expression[31]. There are a number of metaphoric expressions that

[31] The reader is directed to Section 3.7 for an overview of metaphor theory.

construct notions of professional distance, cohesive working relationships, the paradox of fragmentation of services and processes of knowledge acquisition.

6.7.1 Path/Journey Metaphors

Journey metaphors relate to any purposeful activity for example achieving a goal, reaching a destination or movement forwards (Semino, 2008, p. 92). In the interviews such expressions represent the process of encountering child neglect in a clinical context,

> **GP4** 'GPs are very well placed to spot child neglect if a child comes their way
>
> **GP7** 'get neglect in all walks of life'
>
> **GP10** 'if you come across a case which I did'
>
> **GP11** 'that's where I would start'

Journey metaphors were also related to questions of learning and skills update,

> **GP4** 'I kept up with all that'
>
> **GP4** 'a huge drive for us to learn'
>
> **GP13** 'work out ways around this'
>
> They were also used in discussing time spent in general practice
>
> **GP5** 'perception of life speeding up'
>
> **GP7** 'rate limiting step for me'
>
> **GP13** 'in the dim and distant past'
>
> **GP16** 'time generally goes very quickly'

6.7.2 Contact Metaphors

Contact metaphors in these data tend to denote physical proximity and good working relationships (Goatly 2007, p. 178) between professionals. The centring of GPs in this structure is a reflection of social deixis where proximity, closeness to patients and to other professions denotes a positive force,

GP2 'patients do get attached to their doctor'

GP5 'we are still the first point of contact'

GP13 'being part of the process'.

Conversely it can also be a negative force conveying a lack of cohesion and distance from families or disengagement with neglect issues which also extends to creating spatial relationships in the ideologically created 'out-groups' discussed in the previous section,

GP2 'I don't tend to get to grips with families'

GP6 'we seem to have lost touch'.

6.7.3 Personification Metaphors

'Personification permits us to use knowledge about ourselves to comprehend other aspects of the world...we comprehend external events as actions...we view events as produced by an active wilful agent' (Kövecses & Csábi, 2002, pp. 49-50).

Personification essentially gives abstract entities human actions and characteristics and induces emotional responses. In the interviews it is used negatively to highlight a lack of attention given to child health in general practice (**GP1**) and critical appraisal of policy documents (for example **GP6** referring to 'Hall 4' in this extract) and disconnected systems (**GP11**). This further expands the notion of subjectivity, personal opinion that pervades the language of child neglect in the interviews.

GP1 'an area that cries out for development'

GP6 ‘scientific bible of child development completely ignores’

GP11 ‘the right half doesn’t know what the left half’s doing’

6.7.4 Orientational Metaphors of Power, The Generic Space

Metaphors which suggest movement can be used in metaphors of power, to denote control and status (Goatly, 2007, pp. 35-37). In the interview data they are used negatively to convey distance from involvement with the child protection system, ‘the only case I can remember that was remotely relevant’ (**GP1**), ‘I think it’s far from easy’ (**GP4**), ‘was way beyond my range of competence’ (**GP6**). They also denote adversity, ‘these factors would all raise the risks’ (**GP3**), ‘highest problems with child protection issues’ (**GP7**), ‘highest deprivation category I certainly know’ (**GP7**), ‘that can level off sad folks in the community’ (**GP5**). In this respect they are connected to the use of journey metaphors.

Just as the metaphors of historical texts (Chapter 7) denote child neglect as a separate function of society, belonging to a stratum of society disconnected to any interested party writing about child neglect, it remains “out there” today, ‘lurking in the background’ (**GP13**), ‘ dotting around in the background’ (**GP13**), ‘problems out there’ (**GP15**).

The underlying image-schema of contact is a pervasive meta-metaphor in this discussion of child neglect.

6.7.5 Nature Metaphors

Nature metaphors according to De Landtsheer (2009, p.67) suggest ‘conformation and natural order’ but also suggest the ‘possibility of change’. In these data they are used to convey change in general practice but with a negative connotation. They denote the hidden nature of the scale of child neglect ‘probably the tip of the iceberg’ (**GP8**), ‘tip of an iceberg’ (**GP11**), ‘clouded the issues’ (**GP3**) and the overwhelming volume or ‘deluge of information’ (**GP3**) with a gradual diminution of services ‘general practice is going to be eroded’ (**GP7**).

6.7.6 Thought and Learning Metaphors

Metaphors that use the body as the source domain specifically denote an abstract target domain 'thought' or 'learning' and are evident in the interviews. According to Semino (2008, p.104) they function to create an image schema 'based in the physical experience of connections between bodies and objects…conventionally applied to abstract concepts and relationships'. The perceived structural similarity of the mind as a container with ideas as objects (to be put together) or travel across mind containers reflect how our sense of thinking and knowing can according to metaphor theory 'facilitate the perception of structural similarities between otherwise conceptually distant domains' (Kövecses & Csábi, 2002, p. 74) .

This is evident in the use of metaphors of the body, 'off the top of my head', 'all about gut instinct', 'you're banging your head off the table' (**GP9**), 'speaking off the top of my head' (**GP14**), 'I'll get my head on' (**GP15**) ,'there's nothing that pops into my head' (**GP16**). Metaphors of thinking are tied to physical perception or sensation, understanding in these data relate to the physical part of the body where the abstract mind is the head, 'you just can't keep everything in your head' (**SK3, 505**). It is also connected to 'experiences where information is gathered through the visual channel' connecting subjective experiences with physical circumstance (Goatly, 2007, p. 271) 'I don't know that I have I've learned maybe a little from well the very first case was a real eye opener' (**GP15**).

Lakoff and Johnson (1980, p. 48) offer an explication of the conceptual mapping UNDERSTANDING IS SEEING as examples of linguistic expression and conceptual domains connected by cognitive metaphor theory. Cameron and Low's (1999, p. 159) description of a metaphor for learning, 'learning is a click' is present in these data 'click click we suddenly put it all together' (**GP13**).

6.7.7 Highly Conventional Metaphors

The semantic transparency of metaphorical fixed expressions are based on general world knowledge that is no longer familiar as meaning contained in conventional metaphor becomes opaque (Moon, 1998). This selection of metaphor phrases

represents overall a small proportion of the data corpus but important nonetheless because conventional metaphors contribute towards fixed ideological beliefs that pre-suppose shared assumptions and apparently require no explanation.

Phrases 'tend to rubberstamp' (**GP9**), 'it's like water off a ducks back' (**GP9**) 'to fall on deaf ears' (**GP8**) 'it does open up a can of worms' (**GP4**), 'my head on the block' (**GP9**) are formalised in larger sections of text. These build up the picture of professional exclusion and disengagement with the child protection system whilst other phrases emphasise the importance of cohesive professional relationships 'face to face interaction' (**GP4**), ' face to face contact' (**GP6**), 'Health Visitors are the key people' (**GP6**).

6.7.8 Slang Metaphors

The emotional aspects of child neglect are conveyed in metaphoric language that relate to emotions per se or the physiological states that thinking about child neglect, remembering incidents of child neglect invoke and are constructed through the use of personification.

Meaning is individual and personal to the interviewee but the use of slang metaphors allude to the notion of physical distance from professional involvement (Gibbs 1994, p. 137) and in the study context, a negative stance towards many welfare concerns. The use of metaphor and slang terms by medical staff to distance themselves from difficult emotional reactions to complex patient problems (Gordon, 1983) may also have relevance to this research subject that is apparently not easily talked about. In these data their presence simultaneously denote a comfortable relationship between the speaker and hearer which reflects informality during the interview process.

GP9 'You really are gobbin' in the wind'

GP9 'if the shit hits the fan'

GP10 'I take all this shit that's been thrown at me'

GP10 'said it was rubbish'

GP14 ‘start noising up the parents’

GP15 ‘the mother was wishy washy’

6.7.9 ‘That Jigsaw Thing’

An important metaphor expression of cohesion between professionals and agencies within the child protection system cited in ‘Climbie’ is the ‘jigsaw’ approach. This promotes the notion that all strands of information pieced together by professionals build a whole picture of the vulnerable child and underpins multidisciplinary working (Laming, 2003).

It is reiterated by GPs that have undertaken child protection training and by GPs who have contact with those that have undertaken training, **GP3** ‘less scope if you like to fit together the jigsaw’ (**GP3**), ‘I think that piece of the jigsaw’ (**GP7**), ‘it was pieces of a jigsaw’ (**GP8**), ‘Victoria Climbie jigsaw thing’ (**GP16**). In this context metaphor is theorised to communicate new concepts and provides a mechanism to learn something that is specifically new (Petrie & Oshlag, 1993, p. 582) as a didactic function of metaphor (Van Rijn-Van Tongeren, 1997).

It appears to satisfy the conditions of the compact hypothesis of metaphor theory (Gibbs 1994), a ‘compacted’ means of communication about the interconnected aspects of child protection and child neglect. The ‘jigsaw’ metaphor whilst not necessarily permeating the stable ideologies of neglect surrounds them instead with historically contingent and shifting language which idealises the processes of working in child welfare. It advances understanding of where GPs are positioned within the child protection system in a larger multi professional structure and represents a higher social order to deal with neglect issues but also a new way of talking about child neglect. It was interesting to note that this was absent in the focus group data.

6.7.10 Limitations of Metaphor in This Context

The research challenges of employing metaphor as an analytic tool are in part due to tensions of the ‘universal’ metaphor e.g ‘Up is better’ and acknowledging that

metaphoricity is gradable, universal mappings are varied and shared across discourses (Hanks, 2006). In this study 'up' has generally negative connotations 'high rates of deprivation' for example, therefore unchecked belief of the universal metaphor may over generalise limited linguistic evidence .

Outlining consistent procedures for identifying metaphors is an additional challenge but there are a number of researchers who describe their own analytic approach and give textual examples[32]. This can at least provide some answers to the discrepancies that arise between theoretical accounts of metaphor and usage and problems of over–generalisation of source-target domains.

Identification of metaphor is in most research 'unilateral'. Essentially the researcher decides what is metaphorical but is limited by subjectivity of this process and the danger of over interpretation of expressions or alternatively under interpretation associated with 'problems of familiarity' (Cameron & Low, 1999). There is no faultless approach to these dilemmas but Cameron and Low (1999) suggest procedures that can strengthen data analysis. I have acknowledged these in this research, for example I outline my own interpretation of metaphor expressions and language use drawing predominantly on theory of metaphor. I also pay close attention to the context of discourse production in order to expand the relevance of metaphor to its social and cultural production and make claims beyond its immediate production.

Gibbs and Lonergan (2009, p. 251) comment on the relevance of context in the analysis 'there is no division between metaphor and discourse, given that metaphors are both products of discourse and creators of discourse'. My interpretation of the data is related to the topic of interest but my explication goes beyond the immediate language of the participants, because as a social grouping, GPs are not 'hermeutically sealed' and are subject to influences outside their own environment. This is the

[32] The reader is directed to the writings of Gibbs (1994), Cameron and Low (1999), Kovesces (2002), Semino (2008), Goatly (2007) and Musolff and Zinken (2009).

aspect of the research process that has most occupied me and is the basis of my justification for connecting metaphor, ideology and CDA within a mixed methods study as a canonical approach to the data.

That said, the best pragmatic solution appears to acknowledge the challenges to metaphor in discourse and validation as never 'problem-free' by constantly referring to the research task and justification of findings in order to pursue a research goal that does not result in an 'impoverished dataset' (Low, 1999, p. 65). Metaphor expressions in this study contribute to clarification of the processes of learning, the constructed knowledge of child neglect, and GP identity in the public sphere of health. Influenced by cultural dimensions and blended with common metaphor expressions they function to situate meaning in a broader societal context. Expressions such as 'in the loop' 'the right half doesn't know what the left half's doing', 'high faluting aspirational thoughts', 'tip of an iceberg' represent a dialectic relationship between cultural metaphors and the medicine that evolves within that culture (Diekema, 1989, p. 19), and are discussed in everyday language that borrows metaphors from other contexts. It is apparent in the close examination of metaphor use in child neglect meaning that GPs are expressing their own exclusion, disempowerment and professional ambivalence. Their particular use of metaphor expression represents a process whereby child neglect is not an illness that presents in the consultation to be "cured" in the conventional approach to medical problem solving and is on the whole regarded as a social issue that is someone else's concern.

6.8 Chapter Summary

To summarise, just as neglect per se cannot be reduced to one variable in a statistical model nor can it be realised within language as a single explanatory category. GPs combine a local level of concretely embodied individual actions and individual mental representations that encapsulate their experiences 'in a kaleidoscope flux of impressions'. Using a variety of rhetorical devices to justify their own professional stance though ideological constructs and metaphor use, in this research context it enables the abstract entity of neglect to acquire meaning 'codified in the patterns of

our language' but also simultaneously reveals how such meaning is constructed (Whorf as cited in Goatly, 2007, p. 23).

This chapter has outlined the functions of language in creating situated meaning of child neglect in contemporary general practice. The following chapter explores the language of the historical dimensions of child neglect from a number of documentary sources.

CHAPTER SEVEN; QUALITATIVE FINDINGS – HISTORICAL TEXTS

7.1 Introduction

> It is a mistake to see history making as a collection of facts about the past. Rather, history making is a combination of fact finding and producing narratives that give those facts sense (Potter, 1996, p. 169).

A variety of social organisations throughout the history of the developing child welfare movement appear to have contributed to change or stability in the construction of child neglect meaning. An exploration of the mechanisms that makes this claim possible requires a methodology that examines the dialogic relationship between discourse and social structures in order to go beyond the boundaries of presupposed knowledge 'what counts as knowledge in any period or community is determined by who has…truth-determining power in society' (Van Dijk, 1998, p. 115).

This section is not an exhaustive account of the historical aspects of child neglect nor an attempt to suggest that there is a linear relationship between the publication of reports and social practices associated with child neglect identification and prevention. Nonetheless textual interpretation can illuminate the possibility of change to the concept of neglect. Within the philosophical boundaries of certain eras of child welfare reform[33] attitudes and beliefs reflected within their cultural setting have evolved into the concerns of contemporary child welfare but retain traces of the earliest approaches to this field. This sets the scene for a research endeavour to uncover interconnected strands of knowledge and interdiscursive connections embedded in data extracts that I regard as recontextualised aspects of neglect meaning.

[33] The reader is directed to as selection of works by Packman (1975), Behlmer (1982), Heywood (2001) and Hendrick (1994, 2003) .

The following analysis is addressed to Research Question 3.

Research Question 3	Data Source	Data Analysis
Are modern child welfare concerns within the context of general practice better understood when situated within its historical context?	Archival Materials	Qualitative
Sub-Questions;		
A) What constructions of neglect are evident by examining the texts of child neglect within a historical-political context?	Legislation Hospital Records Court Documents Prison Records Parliamentary Papers Manuscripts (committee minutes)	Discourse Analysis CDA Habermasian Frame
B) Is this linked to general practice today?	Survey Questionnaire Interviews, Focus Group	Dialectic Paradigm of Mixed Methods

Table 6: Research Question 3

7.2 Early Legislation and Well-Worn Themes

> (T)he legitimacy of statues is measured against the discursive redeemability of their normative validity claim-in the final analysis, according to whether they have come about through a rational legislative process, or at least could have been justified from pragmatic, ethical, and moral points of view...rights of political participation and rights of communication are constitutive for the production of legitimate statutes…these must be exercised in the attitude of communicatively engaged citizens (Habermas, 1996, pp. 30-32).

Certain periods of time mark an apparent progression in society's approach to child neglect. This section will focus on the language of child welfare legislation that consolidated beliefs and represented ideologies that became a rational basis for government. Within this analysis it is pertinent to ask how social action was systemised through such legislation.

The debates that have been present throughout child welfare development sustain, transform and hand down themes that are recognisable today consolidated in statute. The 19th century was regarded as an important period of welfare reform whose philosophical approach changed from 'rescue, reclamation and reform of children' to the involvement of children given a new social and political identity as belonging to 'the nation'(Hendrick, 2003, p. 19).

This philosophy had taken root in earlier 'solutions' to child neglect and cruelty which encompassed a punitive approach. The Poor Law (Amendment Act) 1868 rendered parents liable to punishment if they neglected to provide food, clothing or medical aid for their children however this responsibility was ignored by many guardians (Behlmer, 1982, pp. 78-110). Following on, The 1889 Prevention of Cruelty to Children Act known as the Children's Charter, was amended and extended to allow children to give evidence in court, mental cruelty was recognised and it became an offence to deny a sick child medical attention (Hendrick, 2003, pp. 53-56). Nonetheless, it took a number of years before state obligations towards neglected children would be critically appraised and re-evaluated within tensions of state and parental responsibilities to children.

Statute was amended in The 1908 Children Act, (Dewar, 1910), partly as a response to the events of the Boer war. The poor physical state of conscripts heightened anxieties that working class mothers were unable to raise strong, fit sons required for military purposes 'the supply of robust citizens' (Heywood, 2001, p. 155). The 1908 Act incorporated earlier legislation on infant life protection expanded to cover specific acts of neglect and cruelty. It retained neglect definitions outlining an earlier

distinction of deliberate acts of maltreatment with intent as 'wilful acts of cruelty and neglect',

> If any person…willfully assaults, ill-treats, neglects, abandons or exposes such child or young person, under the age of sixteen years…or exposed in a manner likely to cause…unnecessary suffering or injury to his health[34].

The Act included a comprehensive definition of physical neglect as a failure to, 'provide adequate food, clothing, medical aid or lodging' with adverse outcomes 'endangering health'. Fatal neglect was defined as infant suffocation 'whilst the infant was in bed with some other person…and that other person was…under the influence of drink, that other person shall be deemed to have neglected the infant in a manner likely to cause injury to its health'[35]. This definition linked neglect to parental addictions that remains an enduring concern in contemporary research (Kirisci, Dunn, Mezzich & Tarter, 2001; Dunn, Tarter, Mezzich, Vanyukov, Kirisci & Kirillova, 2002; Ondersma, 2002). The relationship between physical neglect, parental addictions and burns in children was a recurrent theme within statute as a consequence of supervisory neglect of young children where the widespread existence of open fires presumably heightened this risk[36].

In the pursuit of fulfilling legislative goals, the mechanism prompting neglected children to come to the attention of the courts is not specified, however it was acknowledged that this process required direct observation of the child to detect 'evidence' of maltreatment and 'unnecessary suffering'[37]. 'Unnecessary suffering' is inculcated into the legal discourse of neglect and persists in contemporary legislation but is a process dependent on subjective interpretation of the human condition. If understood in very broad terms this would include many of the children we now define 'in need' but in practical terms it can be interpreted within a much narrower definition that supports a rationalised service ensuring that children meet thresholds

[34] The Children Act, 1908 Part II 12(1).
[35] Ibid,. Part II 13.
[36] Ibid,. Part II 15
[37] Ibid,. Part II 24(1).

of risk before the state is required to provide services for them. The act contains another category of the neglected child 'verminous' who would come to the attention of the school medical officer, made visible because of their unclean state 'infected with vermin or.. in a foul filthy condition' to be taken to local authority premises and 'detained until cleansed'[38].

The categories of neglected children outlined in relation to parental addictions, supervisory neglect resulting in burns, physical neglect resulting in the 'verminous child' focused on the impoverished family. Its legal context constructed official accounts of the neglected child re-stated in other archival documents relating to this period that will be discussed in this chapter.

At the time the 1908 Act was passed, there was a was parallel philosophy developed and distributed by the NSPCC that parents should be more responsible for their children, compelled and punished through the courts if they failed in their duty as parents. The hope of such a philosophy was 'the development of respectability among poor-working classes' (Hendrick, 1994, p. 122).

7.2.1 The Children and Young Persons (Scotland) Act 1932

The Children and Young Persons (Scotland) Act 1932 was published alongside The Children and Young Persons Act 1933. Both documents represented significant developments in child welfare legislation between two great wars in an era of widespread economic and social consequences of the Depression. The preface to the Scottish legislation by Cowan 'Occasional Lecturer in Edinburgh Social Science Department' and the foreword by The Hon. Lord Sands in the 1932 Act reflect some of the tensions in the underlying strategic approach to welfare reform. Cowan (1933) comments, 'I have endeavoured in this book to assemble the main statutory

[38] Ibid,. Part VI , 122

provisions affecting certain aspects of the lives of children and young persons… sad and difficult cases'[39].

The act incorporates the 1908 legislation but adapted to the demands of the collective conscience of society acknowledged by Lord Sands 'the gradual change in public opinion regarding the provision of better conditions for the neglected child, involving its removal from environment hurtful to physical or moral well-being'[40]. The influence of public opinion resulted in the virtual abolishment of imprisonment as a punishment for children under the age of 16 years and equal opportunity and early intervention for every child. The latter themes continue to shape contemporary child welfare reform.

The legislation acknowledged that children who offended were living in 'bad home surroundings' but represented a more tempered approach where the connection between 'delinquency', 'depravity' and subsequent neglect was not necessarily a cause for punitive action.

Lord Sands' authoritative voice informs public opinion as he outlines legislative procedures for dealing with children. Within his opening remarks, he positions himself in relation to issues of child welfare embodied in criticism of the preoccupation with provision for juvenile offenders 'Somehow crime and its treatment attract attention more than innocence and its treatment!'[41] and sets himself apart from his more sympathetic co- author. Children who would be categorised today as 'in need' were regarded as 'unfortunates' who required 'rescue and prevention' but not at the expense of 'decent boys and girls in respectable homes'.

Nonetheless, there was optimism in that every endangered child would be identified. Cowan (1933) comments,

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[39] Cowan, 1933, pp. vi- vii.
[40] Ibid, ix, x, xi.
[41] Ibid,. ix, x, xi.

> There is a similar dramatic contrast between the treatment or lack of help meted out to the neglected child sinned against by society...the new Act which should…bring before the Juvenile Court any and every child exposed to moral danger or cruelty of any form for helpful treatment and adjustment of its social and moral education[42].

Neglect fell into three categories, one remains preserved in the definition of children 'in need' in both the 1989 Children Act and the Children (1995) Scotland Act as 'moral danger'. Within this specific legislation it was understood in relation to parental behaviour, 'not exercising proper care and guardianship'[43]. Contemporary researchers also reflect this approach by arguing that neglect definitions should be constructed from parent behaviours alone (Kaplan, Johnson & Bailey, 1987).

Neglect was further defined in relation to criminal activity and educational neglect of the child, with a particular focus on 'Children of Vagrants'[44]. The act includes descriptions of a number of 'typical' cases of children brought before the courts 'the well-worn theme' of the family circumstances and environmental conditions of such children,

> wretched conditions of overcrowding under which the poorest families live and particularly the absence of open spaces in the neighbourhood, do produce the potential criminal…in the cases of delinquency…over one-half were found in homes that were poor or very poor. Defective family relationships accounted for 58 per cent and defective discipline 61 per cent[45].

7.2.2 Children and Young Persons Act (1933)

The introduction and explanatory notes to this act is provided by Alfred E Ikin, Director of Education. His assertion that the act 'marks a definite stage in the formulation of one of the most humanitarian systems of legislation in the world' (Great Britain, 1933) appears to be written from a presumption that the identification of child neglect is a distinct evidential process that ends in the courtroom or a legal

[42] Ibid,. p3.
[43] Ibid,. II (6) 1.
[44] Ibid,. II(6)1, ii, iii.
[45] Ibid,.II S.6(3).

ruling. The descriptive terms used to construct neglect relate to categorisation of situations that 'cause neglect' for example parental addictions, vagrancy, situations of moral danger. Moral danger recontextualised throughout welfare reform was related to begging, homelessness, destitution - essentially issues of poverty.

The legislation was not concerned with the stories behind the presentations of neglect -that was for society to contemplate. It reflected instead, opinions and beliefs of those in authority as they attempted provide a framework to control 'bad parenting' and 'delinquent children'.

There was understanding of the adverse health outcomes of neglect that remain core concerns of the various categories of physical neglect that are present today. It re-iterates the concern of young children suffering burns from 'an open fire-grate' because of supervisory neglect, potential fatal outcomes of physical neglect 'if the child is killed or suffers serious injury'[46]. The adverse consequences of neglect within the setting of the family was acknowledged but it appeared that it was predominantly the effects of poverty that allowed the child to become visible and sanction state intervention.

The ethos at work behind the passing of both acts is summed up by Hendrick (1994, p. 177) who notes that the primary concern was not the plight of the neglected child per se but 'containment of adverse outcomes of neglect namely society's provision for juvenile offenders'. The dualism of children as 'victims and threats' has endured in society's approach to dealing with child neglect where children living in the most adverse circumstances are processed by legislation that traditionally has been pre occupied with these specific concerns (Hendrick, 1994, p. 7).

7.2.3 The Children Act 1948

The origins of legislation supporting children within their family setting was laid out in the Children Act 1948 (Great Britain, 1948). It represented a radical rethink of

[46] Great Britain. (1933). Sec 11.

how the needs of children within the child welfare system would be met and altered the relationship between the state and vulnerable families in a move away from 'child rescue' from their environment to prevention. It also initiated change within child welfare systems mandating agencies and professionals to share information about vulnerable children and families who were regarded as 'problem' families.

It heralded a move away from the imperatives of the Poor Law and established local authority children's departments and children's officers primarily concerned with raising standards of those children received into care (Packman, 1975).

Its stated purpose, 'An Act to make provision for the care or welfare up to the age of eighteen…of boys and girls when they are without parents or have been lost or abandoned by, or are living away from their parents'[47] provides a clue about how the approach to child welfare had evolved. It was not specifically concerned with the neglect of children in their own home and had no specific reference to neglect other than in relation to accommodating a neglected child 'such that he was suffering from neglect or want of proper care'[48].

It is interesting to contrast this ethos with that of the Royal Scottish Society for Prevention of Cruelty to Children (Mitchell Library Archives, 1921, p. 7) who over two decades previously had argued,

> This is the main aim of the Society, to improve home conditions to such extent as shall obviate neglect in future, for all, unless reform takes place in the character and conduct of offenders this work must be largely of a negative nature. The ultimate aim being to improve conditions as to eliminate all causes of neglect and ill-treatment-not only to remedy wrong but to prevent unhappiness and misery and wretchedness.

Nonetheless, child welfare legislation that focused on children going into care would naturally lead to questions of the home conditions of children bringing the state ever more closer to the private sphere of family life. However as Packman (1975, p. 17)

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[47] Great Britain. (1948).Children Act, 1948, Introduction.
[48] Ibid,. Part I Sect 7.

argues, ideals of legislation aligned to practice did not always accompany a change in practice, 'even legislation which imposes duties and dictates administrative frameworks as clearly as the Children Act, is not automatically followed by uniformity of practice at the local level'.

7.2.4 Moving On; Legislation from 1948 Onwards

As the remnants of the Poor Law were laid to rest and the assumption that economic deprivation in the post–war years could be overcome there was optimism in child welfare services in the 1950s and 1960s. Local authorities gained powers to investigate neglect and to take preventative action in the family setting and this new approach was laid out in statutory guidance (Packman, 1975).

The opening clause of the Children and Young Persons Act (1963), to 'make available such advice, guidance and assistance as may promote the welfare of children by diminishing the need to receive children into or keep them in care...or to bring children before a juvenile court' underlines according to Watkin (1975), a philosophy that recognised the ecological influences on neglect occurrence. This incorporated an understanding of the 'emotional development of children and the consequences of maternal deprivation...the importance not only of the family but also of the class and cultural environment to the development of the child' (Watkin, 1975, p. 446).

Progress throughout the 1960s brought agencies including health, into closer working relationships. There was a shift in emphasis from a focus only on a very small group of vulnerable children viewed exclusively under the lens of poverty, to a broader approach to the state's responsibility to all children and families (Packman, 1993). Just as public opinion was acknowledged in the changes to the legislation of the 1930s, the widespread recognition of social pressures on the family resulting in children with unmet needs requiring state intervention, was shaping legislation at this time (Jay, 1962).

A wider understanding of supporting children within their family setting had its roots in the 1948 Act but was made explicit in The Children Act 1989. Nonetheless, the

1980s child care policy was described as an 'uneasy synthesis' of various pressures on the system to develop a coherent response to sometimes conflicting interests of family support, paternalism and the rights of the child (Fox Harding, 1991). Parton (2009) describes these tensions created by an emphasis on a narrow, forensic model of child protection in contrast to a wider supportive child welfare model.

That said, The Children Act 1989 was informed by robust research and respected policy documents and as Stevenson (1999, p. 15) comments it seemed 'social democratic or even collectivist in inspiration'. Underpinned by the belief that parents were responsible for looking after their children, it simultaneously outlined stronger and clearer duties to investigate actual or suspected child maltreatment. It introduced the concept of likely significant harm into the threshold for care or supervision orders. Accordingly, the state has a duty to ensure that all children are properly cared for, parents do not have exclusive proprietary control over their children who have rights of their own to be respected and protected,

> It shall be the general duty of every local authority (a) to safeguard and promote the welfare of children within their area who are in need; and (b) so far as is consistent with that duty, to promote the upbringing of such children by their families, by providing a range and level of services appropriate to those children's needs[49].

'In need' is closely aligned with 'unmet needs' and similar to earlier legislation maintains a focus on the health of the child as an indicator of neglect 'unlikely to achieve or maintain, or to have the opportunity of achieving or maintaining, a reasonable standard of health or development'[50]. Its aims are made possible in statue, at least, to address the dual challenges of providing targeted child protection services and a universal child welfare system (Parton, 1997).

The theme of 'proportionate universality' that recognises the tensions between providing targeted and universal services available to all children to ensure the best

[49] Great Britain. (1989). Part III, 17 (1).
[50] Ibid,. Part III, 17, 10.

start in life and reduce later health inequalities, is the main theme of a recent government commissioned report (Marmot, 2010).

The Children (Scotland) Act 1995 has an extensive definition of 'in need' outlined in Chapter 1 which places the welfare of the child as 'the paramount consideration'[51]. The grounds for compulsory supervision of children include neglect issues and preserves the notions of 'falling into bad associations …exposed to moral danger' from the earliest welfare legislation[52]. 'Evidence' of neglect can be obtained by a compulsory medical examination on the grounds that a child 'is being so treated(or neglected) that he is suffering, or is likely to suffer significant harm...to establish whether or not there is reasonable cause to believe that the child is so treated (or neglected)'[53].

Unlike the categories of neglectful families in previous legislation the 'vagrant' children, 'verminous' children and 'drunkard' parents are now obsolete. The preservation of the moral dimension to child neglect persists however, with an implicit assumption that this is a universally understood term.

7.2.5 Discussion

The language of legislation has constructed the neglectful parent and the neglected child with varied ideological purpose and for different social goals for example, the control of juvenile crime and regulating moral behaviour whilst effectively subverting the needs of the child to other societal interests. Examining discursive constructs of child neglect from other sources provide insight into the co-existence of concurring and competing discourses and is a prerequisite of an evaluative comparison of ideological competition and struggle.

[51] Great Britain. (1995). Part III, 95.
[52] Ibid,. Part II, 52, 2.
[53] Ibid,. Part II, 55.

7.3 Reports to Parliament; 'Reckless Parents, Feckless Parents, Moral Filth, Different Evils'

Legislation did not write itself. In the process of developing the legal discourses of child neglect, Parliament gathered opinion from many sources (philanthropic individuals, medical experts, welfare societies) for guidance, but the category mostly frequently visited was the impoverished child. This following section will examine a number of parliamentary reports that either resulted in further commissioned work or informed developing legislation.

7.3.1 The Poor Law Commission Minority Report 1909

A major inquiry was undertaken to examine the entire functioning of the Poor Laws of 1834 to garner information about 'serious defects in the existing Poor Law system and to suggest remedies' (Watkin, 1975, p. 17). During this process the commissioners of the report consulted widely from numerous government and voluntary organisations whose testimonies of child neglect were cited as respected beliefs and opinions.

From this report there was concern expressed about the never-ending admission to the system by children of 'unfit' parents "the children of 'Ins –and-Out', children of vagrants" (Poor Law Commission, 1909, p168). Parents failing to meet the needs of their children were described as, 'sometimes able-bodied, sometimes feeble-minded or half-witted, or more or less incapacitated or crippled'. Children under poor law care were not afforded sympathy, 'they often bring back disease, dirt, and bad habits…they come and go like buckets on a dredging machine…periodically mixing with the children in the school and…turning their moral filth on them'[54] restating children as threats contained within a moral dimension to underlying concerns.

Children presented as 'neglected and half-starved' but there is little empathy as the rhetoric of the child as threat continues 'starving on scraps and blows amidst filth

[54] Ibid,. p169.

and vice in their periodical excursions in the outer world, exactly as suits the caprice or the convenience of their reckless and irresponsible parents'[55]. Children of vagrants appeared to be viewed with even more disdain 'unfortunate children', 'unhappy children', 'perpetually contaminating others'[56]. The scale of the problem and the failure of the system to cope is attributed to 'chronic poverty' and the impossibility of universal provision, 'official machinery for keeping constantly and automatically under observation the entire child population'. A picture of inadequate home life is painted that suggests neither a desire or compulsion for the system to directly tackle the multiple contributory factors of such abysmal living conditions,

> the homes of these neglected or underfed school children are strikingly alike…There is an absolute lack of organisation in family life…Existence drags along…the children's health is affected by many different evils, overcrowding, want of sleep, dirt and general irregularity of life[57].

7.3.2 Report of the Care of Children Committee (Curtis Report)

The previous section outlined the significance of the Children Act 1948 but acknowledged its limitations. The Curtis Report (Curtis, 1946) informed this legislation and is regarded as one of the most important reforming documents of last century (Hendrick, 1994) precisely because its recommendations were specifically directed to children 'deprived of a normal home life'. Its remit was to consider 'the needs of children temporarily deprived for a variety of reasons of normal home life, as well as the needs of those requiring long term care' but did not extend to investigating the circumstances of children who were neglected or blighted by 'other evils' whilst living at home with their parents. The report drew attention to the mystification and division of responsibility for deprived children outlined in the legislation of the day where the focus remained on the criminal justice system in the penology of neglect (Hendrick, 1994; Stephenson, 1999) .

[55] Ibid,. p172.
[56] Ibid,. pp.173-174.
[57] Ibid,. p204.

The committee commented that children who were 'brought before the court as delinquent or in need of care and protection' were subject to different outcomes depending on which category they were assigned to 'it is often an accident whether a child is brought before the Court for an offence or as a neglected child, and it is equally appropriate that the same methods of treatment should be equally available in either case'[58]. The fragmented and variable approaches to dealing with children 'in need' were also highlighted,

> not only does the responsible department vary, but so does the closeness of State direction and control...it would not be difficult to find children similar in type and circumstances whose treatment has been quite different merely because they have been dealt with by different departments under different statutes[59].

7.3.3 Report on Children and Young Persons (1960); The Ingleby Report

The Ingleby Committee set up in 1956, considered whether children brought before the courts could be helped within their family situation to prevent them being received into care. Its primary concern was the function of the juvenile justice system and recommended that the age of criminal responsibility should be raised from age 8 to 12 (Goldson, 2002, p. 126) . However, as neglect, deprivation and depravation were conceptually linked it inevitably extended its gaze towards the living conditions of children from neglectful homes as and when they came before the courts. The report was published in 1960 when the notion of prevention began to take hold with its recommendations incorporated into the 1963 Children and Young Persons Act (Parton, 1985). The report also highlighted the incompatibility between the penology of the vulnerable family and a progressive child welfare agenda,

> The court remains a criminal court…governed by the law of evidence in criminal cases…to have regard to the welfare of the child…suggest(s) a

[58] Curtis. (1946), 1 (38).
[59] Ibid,. 1 (99).

> jurisdiction that is not criminal. It is not easy to see how these two principles can be reconciled[60].

Prevention of neglect in the home was identified in three stages- detection of families at risk, investigation and diagnosis of the problem and providing facilities and services to meet the needs of the family. It advocated a low level of inquiry 'simple forms of social aid' to ameliorate the plight of the neglectful family identified by parental behaviours 'Ignorance, shame or discouragement on the parts of the parents…deep antagonism,distrustfulness, perverse satisfaction in degradation, self-damaging tendencies and a desire to evade legal responsibilities'[61]. This description of the neglectful family has resonance with contemporary research of the disengaged, isolated families of neglected children (Christensen, Brayden, Dietrich, McLaughlin, Sherrod & Altmeier, 1994; Gaudin, Polansky, Kilpatrick & Shilton, 1993, 1996; Polansky, Chalmers, Buttenwiser & Williams, 1979; Polansky, Gaudin, Ammons & Davis, 1985; Wilson, Rack, Shi & Norris, 2008).

During this time there was also pressure to develop a system of prevention for children being received into care because of increasing numbers of affected children. Consequently family service units were set up to work with vulnerable disorganised families with this aim.

Packman (1975, p. 58) comments that despite the progressive ethos of the legislation 'prevention thus came to be a two-pronged concept; prevention of admission to care; and prevention of neglect and cruelty in the family' there were emergent tensions around enacting the legislation within economic restraints.

7.3.4 Child Neglect Prevention in Scotland; The McBoyle Report.

Around the same time that the Ingleby Report was being recognised in statute, in Scotland the Secretary of State was considering the findings of a committee whose remit was to 'consider whether local authorities should be given new powers to

[60] Ingleby Report. (1960); para 60.
[61] Ibid, paras 38, 45.

prevent the neglect of children in their own homes' (McBoyle, 1963). Child neglect identified within the family setting was vital if the notion of prevention was to be meaningful and support professionals who were working with parents in an endeavour to keep children out of care 'forestall the suffering of children through neglect in their own homes'[62].

The report recognised the importance of early detection of families causing concern and outlined the challenges to identification and prevention by state institutions tasked with intervening in the private sphere of family life. By advocating for support services within the home setting for example, emphasising the Health Visitor role, the aim was to prevent the intergenerational transfer of neglect 'problem families reared problem children who in turn became problem parents'[63].

Neglect was viewed within the context of the 'problem family' as the result of multiple interacting factors that impacted on the family unit exemplified in the following extract from the report,

> Bad parents rear deprived children who in turn become 'bad' parents...Another group arises from financial difficulties… real poverty still exists… Unemployment… families living in bad housing conditions…All these things can cause stress in a family and consequent neglect of children...personal or domestic difficulties…the special problems of the unmarried mother, the permanent or prolonged absence of either parent …frequent child bearing, the presence of an illegitimate or handicapped child, or serious physical illness or mental disorder of a parent or child...immature parents…barely able to cope with ordinary life in a highly organised industrial society…unable, without guidance, to give their children the support they need[64].

The committee recognised that child neglect has multiple dimensions 'there are almost as many causes as there are neglectful parents' and commented on the pervasive presence of child neglect 'in all classes of society...family disunity whether open or concealed, can cause serious emotional harm to children' and acknowledged

[62] McBoyle, 1963. (II), 6.1.
[63] Ibid,. (II), 12.
[64] Ibid., (V), 19,20,21,22,23.

that previous approaches to neglectful parents 'reproach, moralising and punishment' were not particularly productive in promoting parenting skills[65]. It is interesting to note that the impact of parental addictions did not feature in this report.

Health professionals, including doctors, were regarded as important to identifying child neglect within the family unit using their observational skills and experience 'visiting homes...observing material circumstances such as dirt, lack of food or heat, inadequate housing...evidence of unsolved personal problems and an indication at least of possible neglect'[66].

The challenges to identifying neglect within a process orientated to the criminal justice system constituted in the committee's opinion, a barrier to effective communication between welfare professionals that could result in a 'wrong diagnosis' of neglect and a fragmented workforce who would 'counteract each other', disengaged with the process of 'pooling' experience or 'challenging the assumptions of their separate disciplines'[67]. Shared understanding developed from communication between professionals and weighting experiential knowledge as justifiable opinion through interpretive reasoning in child neglect issues, remains an enduring challenge today (White & Featherstone, 2005). Sen and Green Lister (2011) comment that to achieve this 'requires professional barriers to be broken down, clear communication that questions assumptions and a genuine commitment by the individuals and organisations involved to work together collaboratively'.

7.3.5 The Medical Perspective - The BMA and a View on Child Neglect

The members of most child welfare committees were co-opted from religious or legal professions. One particular committee, however, included a multidisciplinary membership from legal and medical backgrounds with representation from general practice. It was formed in 1952 by the BMA and the Magistrates Association until it

[65] Ibid., (V), 23.
[66] Ibid., (V), 25.
[67] Ibid., (VII), 44.

was disbanded in 1961 (BMA, 1956). Its remit within the context of child neglect and 'cruelty' (thereafter referred to as abuse in the report) was to 'consider all matters of common interest, with special reference to observations, prevention and treatment in relation to the medical aspects of legal offence...and for facilitating new legislation' (BMA, 1956, p. 3). It was a significant inquiry of child maltreatment of which child neglect occupied a majority of authorial time.

It addressed in detail very wide ranging issues of child maltreatment including medical perspectives, maltreatment causes, prevention, definitional challenges and considered the legislation of the day. It noted professional opinion and understood the complexity and challenges of value judgments in the knowledge base,

> It is a difficult task to assess increase or decrease in the extent of cruelty or neglect because so many imponderable factors are involved, many of which interact with one another. Judgment can only be made against a background of shifting standards and changing values and any conclusions drawn are inevitably, even if subconsciously, biased by the experience of those making the judgment[68].

The immediate challenge was to develop a research project to investigate the differences between neglect and abuse. This culminated in a structured questionnaire distributed to various child welfare organisations 'placed on record as they represent the opinions of many organisations and individuals'. In contrast to the findings of the questionnaire of this study many written replies referred to the provisions of the legislation of the day, the Children and Young Persons Act 1933[69].

The common themes from the questionnaire findings have resonance with the analysis of this research project's questionnaire findings, where for example, mental health issues, poverty were cited as important contributory factors however

[68] Ibid,. pp. 2,7.
[69] Ibid ,.pp. 12,14.

'feckless parents'[70] is not a term articulated in contemporary discourses of parenting behaviours.

Highlighting economic constraint as contributing to material deprivation and associated maltreatment of children, the committee also focused on the maternal care-giver in this context and concluded this resulted in 'the physical and emotional neglect of the family' because of a necessity of mothers to go out to work[71].

Despite an acknowledgment of the 'classless' nature of child neglect the report detailed the 'methods of detection' of child maltreatment simultaneously constructing the neglectful family predominantly through the lens of poverty with reference to concerns of morality and parental addictions,

> Subnormal or mentally deficient parents, character defects in parents including lack of moral principles…marital disharmony, Illegitimacy, overcrowded or insanitary homes, financial difficulties; drunkenness; growing absorption of mothers into full employment[72].

Without the benefit of contemporary empirical research, the neglectful family was appropriately envisaged within an interactional model of multiple factors contributing to neglect albeit the categories of 'illegitimate children', 'character defects' would not be appropriated into any contemporary study .

The origins of parental behaviours that contributed towards neglect were dichotomised into medical and social behaviours. Medical causes consisted of 'physical illness, psychological issues...emotional instability...mental defective.' A psychological profile of the 'psychopathic parents' was an apparent authoritative account of the neglectful parent who was 'characterised by a lack of a sense of social responsibility…impulsive…selfish…little capacity for affection…no desire to co-operate with others.' The notion of the inter-generational transfer of neglect is re-

[70] Ibid,. pp. 15,.25.
[71] Ibid,. P,.6.
[72] Ibid,. pp. 14,15,24.

stated ‘emotional disturbances and behavior problems...the unhappy emotional pattern tends to be handed on from generation to generation’[73].

The social aspects broadened out from the parent-child relationship to environmental factors cited as, ‘Poor housing conditions and inadequate accommodation…makes it hard for children to be trained as satisfactory members of society’ where parental addiction issues are referred to as a social but not medical concern[74].

In a somewhat contradictory manner the committee adopted a judgmental and critical tone towards impoverished parents and the child’s unmet need ‘Poverty either real or relative presents problems...Relative poverty is often caused by sheer selfishness and irresponsibility in the parents who put their own indulgences before the needs of their children’[75].

The committee proposed a holistic approach as they saw it to the ‘treatment and prevention’ of abuse and neglect. They considered ‘homecraft, parentcraft and citizenship with emphasis on unity in family life and the emotional needs of the child’ as an appropriate response alongside adequate health facilities with input from Health Visitors, GPs, District Nurses, effectively the core primary care team. Nonetheless, they differentiated between parents who neglected their children from ‘decent’ families in the same communities in similar economic circumstances, alluding to the important concept of resilience ‘some moral or spiritual vitality which overcomes the particular handicap producing happier and stable homes in spite of difficult circumstances’[76]. This is outlined in contemporary maltreatment literature as attending church, having supportive neighbours and prosocial networks (Collishaw et al., 2007; Hoge, Austin & Pollack, 2007; Rutter, 2007).

[73] Ibid,. pp.26,27,29,30.
[74] Ibid, p.35.
[75] Ibid,.pp.35,36.
[76] Ibid,. p53.146.

7.3.6 The Court Report

The Court Report (Great Britain, 1976) is referenced because of its specific remit to 'review the provision made for the health services for children up to and through school life'. The changing picture of child health with better nutrition, immunisation, medical and nursing advances meant that the focus of health was shifted towards aspects of the psychosocial functioning of family life (Hendrick, 2003, p. 173) where the emotional development of children was considered as important as their physical development. The report drew attention to effects of poverty and inequality affecting family functioning that resulted in adverse health, education and behavioural outcomes.

It is relevant to this section because of its summing up of the state of child health services at the time, and its comprehensive account of the importance of childhood development and health's contribution to the wider aspects of child well-being. It is particularly relevant to my own profession because of its conclusions that primary care and specifically GPs were vital in providing a holistic child health service.

The child was at the centre of its focus but it acknowledged a pervasive difficulty with engaging communicatively with children about their needs 'Children do not easily formulate their views and have no forum where they can express them' (Great Britain, 1976, p.89). The committee recognised a need to engage directly with parents when working within the unit of the family, thus moving away from a paternalistic to emancipatory approach to vulnerable families 'There is overwhelming evidence that measures that do not involve parents achieve only short-term gains'[77].

The committee stated a firm commitment to universal health services for children,

> to avoid categorisation of children 'at risk' on account of selected social factors…This might limit concern inappropriately to certain groups of

[77] Ibid, p24.

> children at the expense of others among whom their might be still individual children in need of special health surveillance[78].

Habermas's (1984, pp. 285-288) treatise of communicative and strategic action has relevance to the discourses of child welfare, where the system is orientated to asking 'what can be achieved' and not 'what can be understood'. This sentiment is summed up in this extract from the Court Report,

> the standard categories of illness fail to reveal the adverse social factors, family stress or disruption and the delayed developmental or educational failure in the child which may lie behind the diagnostic label…much of the illness coming to primary care has a strong psycho-social element…The problem is that epidemiological machinery and resources have been insufficient to produce morbidity data suitable for local planning[79].

A reductionist vision of child health that is unable to deal with the wider sociological aspects of child well being because it is misaligned with a biomedical model, has resonance today where general practice has failed to commit to a process of gathering information on the social circumstances of children (RCGP, 2004). It is also a concern that is central to the debate of providing universal or targeted screening which has again returned to the arena of current child health provision (Scottish Government, 2011a).

The recurrent themes of this report are the importance of early prevention 'in particular the assessment of the normal development of children and the effect of emotional disturbance on the health of children'[80], closer cooperative working with parents and professionals 'skills in communication on the part of the doctors and time to build up trust and confidence'[81] and remaining child centred 'children have definable rights to health care...because they cannot articulate views of their own, society has a duty to ensure that their rights and special needs are fully recognised'[82].

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[78] Ibid, p139.
[79] Ibid, p. 178.
[80] Ibid, p105.
[81] Ibid, p. 179.
[82] Ibid,. p. 274.

In the end, the report's over-arching recommendations for improving child health were never implemented, it was never debated in parliament because of 'lack of resources and the powerful opposition from sections of the medical profession' (Hendrick, 1994, p. 267).

Its gloomy conclusion is a statement of collective pessimism that is echoed in the GP interviews and focus groups in this study,

> our findings have given us profound anxiety about the state of the child in this country, about the shortcomings of services and those working within them, and about prospects for new generations if they are to grow up in the same deprived physical and emotional circumstances[83].

These are restated as barriers to effective working, fragmentation of services, lack of resource and professional distance that are simultaneously reflected in contemporary research (Bannon & Carter, 1991; Bannon, Carter , Barwell & Hicks, 1999; Horwath, 2007; Gardner & Brandon, 2008).

7.4 The Physician Talking

7.4.1 Introduction

This section examines extracts from medical records and reports to various committees written by doctors as they examined vulnerable children admitted to hospital or in other institutional settings, for example school settings. From these data a picture of the neglected child emerges. Physically frail as a result of starvation and infection, infested and living in inadequate housing with large families blighted with parental addictions and unemployment, keep the notion of the neglected child within the constraints of the effects of poverty.

[83] Ibid.

7.4.2 Hospital Admission Records

Great Ormond St Hospital

The hospital doctors tending to poor children admitted to voluntary hospitals, undoubtedly saw many cases of neglect. This was not usually the main admission criteria but it would be documented as a contributing factor. Children who were unable to access health care were often admitted suffering from malnutrition, pneumonia and rickets[84]. The following extracts contain descriptions of children admitted to Great Ormond St Hospital with many unmet needs which would today constitute physical neglect.

Case 1

William Bence (age 4 years) admitted May 1864. Reason for admission, neglect. Admitting physician writes,

> Family situation–5 other children-have all become rickety-no consumption in family-This child was rickety-no teeth till 2 years old. Father has been sometimes out of work. Child has had bread and butter for food. The child looks pale and cahectic.

This malnourished child died 54 days after admission and at post mortem was noted to have 'scarcely any subcutaneous fat'. Cause of death pneumonia.

Case 2

William Horrogan (age 11 years) admitted October 1869 with starvation, destitution. Admitting physician writes,

> An orphan; Brother died of phthisis; father of bronchitis; step-mother is now very ill; child is the oldest of 7. The boy has generally enjoyed good health until now; but he has been very destitute, obtaining a scanty livelihood by selling the 'Echo'. He gradually improves on the ward both in terms of his

[84] Admission notes Great Ormond St Hospital, available at, www.smallandspecial.org/admissions accessed 10/03/2010.

> respiratory symptoms and energy levels. Today he is sent to Highgate. There is still much debility…but there is marked improvement lately.

He was re-admitted to the same hospital one month later in poor condition from the children's home.

Case 3

Jane Nobbs (age 9 years) admitted 1868 with starvation, admission group 'infectious fever; violence'.

Admitting physician writes,

> The father died of Bright's Disease ,the mother is paralysed and the child is said to have been getting thin for 6 weeks, not well fed, on admission very thin seems very unintelligent, a few spots like purpura on the legs which however might be large flea bites, very pale. After meat diet and convalescence discharged well.

Royal Hospital For Sick Children (Yorkhill), Glasgow

The admission records of Yorkhill Hospital documented children presenting with similar problems.

Case 1

Annabella Johnston (age 7 years) Girls Industrial School Maryhill Admitted 17th January 1898 dismissed 19th May. Diagnosis neglect[85]. Admitting physician writes,

> This girl was only admitted to the Industrial School on the 14th having previously lived with her mother, who is a widow, in lodgings at 15 Candleriggs. There are 2 other sisters in the industrial school one of whom is very pale but otherwise healthy…On admission to the Industrial School the girl was seen to be very pale and delicate looking but there has been no outstanding symptoms. There has been no sickness, no cough and no fever. The bowels are regular; the appetite rather poor. When received into the Industrial School the girl was very dirty, her head especially being thickly crusted and filthy…4th April This girl has steadily improved as regards her

[85] Yorkhill Hospital Archives YH7/1/2.

general health. She has now quite a good colour and has gained 9lbs in weight.

Case 2

Alice McInally (age 2 years 9 months) admitted 7th May 1904 Dismissed 13th May 1904. Diagnosis bronchopneumonia, rickets[86].

Admitting physician writes,

> Patient lives in a room and kitchen house with father, mother and four other children the eldest being 9 years old. Father is a labourer and earns a pound a week. He has been out of employment for the last 3 months. Present illness began about a fortnight ago with cough and she got very weak and short of breath and occasionally gets cyanosed…The child has never walked. During infancy the child did not care to be nursed as she cried…Since the 19th march 1904 she has been kept on milk and porridge and bread and milk as advised by the Dispensary Doctor.

Case 3

William Craig (age 1 and 3 months) admitted 28 April 1904. Dismissed 3rd May 1904. Diagnosis bronchopneumonia, whooping cough. Result Improved –Home[87]. Admitting physician writes,

> Patient lives in a room and kitchen house 2 stairs up with father, mother and one brother 4 and 1/2 years old. Husband earns 22/- per week when working. He has been off work for the last week and only gets 11/-while off. Physical examination. Child is extremely pale and emaciated and is nothing but skin and bone. The skin is hard and dry and has lost much of its natural elasticity and it hangs in loose folds especially in the groins and calves and upper arms. The head looks big when compared with the wasted neck and trunk…Owing to the child having a very suspicious cough he was dismissed to his own home.

Case 4

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[86] Yorkhill Hospital Archives YH7/1/49.
[87] Ibid.

James Davidson (age 8 years 11 months) admitted 20th April 1904, dismissed 15th July 1904. Diagnosis tubercular peritonitis[88]. Admitting physician writes

> Patient lives in a single apartment with father, grandmother and three other children…Mother died of smallpox age 36….One brother dead at 2 years of scarlet fever. The boy is poorly nourished and the ribs stand out prominently. His face is pale and the eyelashes are not long. The boy is the subject of rickets…The skin is harsh and dry.

Case 5

Robert Smith (age 1 year 6 months) admitted 19th April 1904 Dismissed 27th April 1904. Diagnosis Bronchopneumonia. Result well[89]. Admitting physician writes,

> Three weeks ago he was in the poorhouse with his mother for a fortnight. For the last week he has been in lodgings in Carrick Street Anderston in a single apartment with his father, mother and one brother. The father has been out of work for the last five months and the child has not had much nourishment…The child is the subject of rickets.

Case 6

Thomas Russell (age 8 years) admitted 21st November 1883 discharged 28th January 1884. Diagnosis pneumonia[90]. Admitting physician writes,

> Ill for 4 days. Nothing else could be obtained as the parents were not to be got at, the father being in prison and the mother a drunkard. The child was found in the house, on the stairs, hardly any clothes on and no fire although the weather was bitterly cold. On admission the child was in a very filthy condition exhausted with rapid pulse and respirations face flushed and covered with perspiration and herpes on the upper lip and complaining of pain in the abdomen.

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[88] Ibid.
[89] Ibid.
[90] Yorkhill Hospital Archives YH7/1/1.

7.4.3 Childhood Burns and Neglect

Early legislation, as already discussed, cited a strong conceptual link between burns and supervisory neglect exemplified in a case study described in a medical journal in 1832 (Lancet),

> a little child one year and three quarters old, was brought to this hospital with the back part of the head, neck and arms very severely burned, from clothes having caught fire. This little sufferer lingered till about three o'clock the following afternoon when it died. The nurse says that the parents of this child lost another in the same ward about five months since by the same means. Let us hope this is the last of the offspring whose safety appears to be so grossly neglected.

The correlation between childhood burns and specifically fatal neglect is restated in contemporary child maltreatment literature with an additional dimension of parental addictions (Squires, & Busuttil, 1995; Berkowitz, 2001; Chester, Jose, Aldlyami, King & Moiemen, 2006).

7.4.4 Medical Expert Testimony; Children as 'Pigeons, Pilferers and Sneak Thieves'

Doctors were called upon to give expert opinion on child health and welfare matters to a number of committees at local and national levels. Dr Arkle was a physician who was working for the Liverpool Education Authority when he reported to the Poor Law Commission in 1908. He carried out medical assessments of school children observing the effects of physical neglect, that is, mass starvation that was in his opinion 'producing two types of abnormality, both disastrous alike to the future welfare of the community and to the present efficiency of the school' (Poor Law Report, 1909, p. 198)

Dr Arkle comments,

> I noted such cases of children without an ounce of superfluous flesh upon them, with skin harsh and rough, a rapid pulse, and nerves on the strain…an expression of the most lively intelligence…I fear it is from this class that the

> ranks of pilferers and sneak thieves come, and their cleverness is not of any real intellectual value[91].

Another category of children was apparently also causing him concern,

> automata…the poorer sort who…seemed to be in a condition of semi-torpor, unable to concentrate their attention on anything…a condition something like what one gets with a pigeon that has had its higher brain centres removed, and is a very sad thing to see in a human being. I believe both these types of children are suffering from…starvation of the nervous system…these cases were always associated with the clearest signs of bodily starvation, stunted growth, emaciation, rough and cold skin[92].

These textual exemplars contribute to the evidence base of the day, provided by a doctor who appears detached from the suffering of children. His apparent concern is the criminology of the impoverished starving children of the lower classes, from a standpoint of the moral anxieties of an articulate, educated and empowered individual.

Another medical expert advising a local government board was concerned with physical neglect and the 'dirty child' as a consequence of 'bad' parenting,

> When his parents were good, (the child) was cleaned, clothed, fed and educated. When his parents were bad he remained dirty, ragged, hungry and untaught…If he was one of six, his nurture had to fall off as his years increased (Mitchell Library Archives, 1906).

7.5 Report to Local Authorities 'Dirty Children, Incorrigible Fathers and the Seven Evils of Desertion'

During the early years of child welfare reform, Glasgow Corporation had a number of committees concerned with the challenges of extreme economic hardship that affected families and resulted in subsequent neglect of children. Such concerns were imagined in relation to peripheral issues, for example, the uncleanliness of children where statutory powers could be invoked against the 'dirty child' (Mitchell Library

[91] Ibid, p. 197.
[92] Ibid.

Archives, 1903, 1906) to the problem of desertion of children by 'incorrigible' fathers which resulted in applications for Poor Relief (Mitchell Library Archives, 1919).

The categories of 'desertion' of families resulting in poor relief were caused by 'seven evils',

> Pernicious home influence in childhood and youth, drunkenness, immorality, infidelity and gross neglect of parental duty, aversion to work in general, and to settled employment in particular, ignorance of household management on the part of the wives (uncleanliness and dirt), mixed marriages (i.e. between Protestants and Roman Catholics), early marriages, total absence of religious influences (Mitchell Library Archives, 1909).

The prosecution of a neglectful father is discussed in relation to Section 12 of the Children Act 1908

> This was a man, five times previously convicted, father of six children, all of whom had been chargeable to the Parish and if these three are still boarded out…he admitted the charge as framed of neglecting his three children by failing to provide them with adequate food, clothing and lodging and was sentenced to twelve months imprisonment…having the power to send an offender such as this to prison for a period up to two years is likely to have a deterrent effect,one cannot ignore the fact that for that term the man…is being maintained at the expense of the state as well as his dependents

Within this extract are a number of factors that are concordant with current thinking on child neglect. These are high child care burden and low socioeconomic status (Slack et al., 2004) and the high incidence of recividism (Drake et al., 2003; Jonson-Reid et al., 2003; Lipien & Forthofer, 2004), but ultimately, the concern of the committee is the economic burden of the costs of child neglect.

State intervention to ameliorate the adverse socioeconomic conditions of the neglected child was not always viewed positively,

> The real danger to the State in thus extending assistance to people who should be able to do for themselves and their families is not the waste of resourses, but the fact we are unmaking the men.We are taking the best human qualities out of men and women, the qualities of independence, self-reliance, responsibility, self-control, self sacrifice…and substituting qualities which can only drag him further down (Mitchell Library Archives, 1912).

Moral issues and parental addictions as contributory factors of child neglect are constantly restated. The focus on children being rescued has familiar religious overtones,

> I am convinced that the evil is at the root moral and not economic…it is now my opinion that it is on the children we must concentrate our attention, and exercise all the powers granted by the recent Children Act to rescue them from their morality as well as physically unhealthy surroundings[93].

Just as Dr Arkle reported on the effects of mass starvation of school-age children albeit with a preoccupation with them as a threat to society, Glasgow City Council was concerned with the poor physical state of children attending school, exercised about the difficulty of educating an 'underfed and ill-fed child'. It adopted a punitive approach towards parents (Mitchell Library Archives, 1903) of the 'verminous' child, a category of the neglected child within statute,

> (if) a child attending school within their district is in a filthy or verminous state, or is unable, by reason of lack of food or of clothing, to take full advantage of the education provided...(if)the condition of the child is due to neglect they shall transmit a copy of such finding to the parent or parents or guardian of the child and to the Procurator-Fiscal to institute a prosecution[94].

7.6 The Criminal Justice System

7.6.1 A Study into the Problem of the Neglected Child

The criminal justice system within a specific era between the mid 1940s to 1950s reflected important changes to child welfare as attention was transferred to children deprived of normal care within their family home but with a more supportive systems approach towards parents (Stevenson, 1999).

In 1945 the Women's Group on Public Welfare in association with the National Council of Social Service formed a committee to 'inquire into the problem of the neglected child' (National Archives, 1948a). It resulted in several studies including a

[93] Ibid
[94] Ibid Section 6.1.

detailed exploration of the 'intelligence of neglectful mothers' who were imprisoned in Holloway Prison for child neglect.

The inclusion criteria of the study were that women should be married with children aged under five and have a home to return to 'increase the success of the study'. Those suffering from epilepsy TB or venereal disease would be excluded. It was conducted from March 1948 until June 1954 during which time researchers tested the IQs of one hundred mothers of whom fifty seven were classified 'mentally defective' and six considered 'imbecile'.

The results were published by the prison doctor, who detailed in her conclusion that a 'solution to the problem' was a residential course of training at a special centre, 'a neglectful mother might be induced to undertake under the requirement of a probation order…This included the elements of childcare, budgeting, cooking, housework, needlework, laundry and shopping[95].

To better understand the concluding remarks on the study findings, 'the problem of the neglectful mother appears to be primarily a medico-social rather than a penological one' (Sheridan, 1956, p.93) it is illuminating to examine the extensive court and prison reports of the women recruited into the study as the researchers endeavoured to understand the origins and 'treatment' of parental behaviours.

7.6.2 The Court's View

The Governor of Holloway Prison prepared a report to the committee on the various court summings up of the characteristics of the neglectful mother and aspects of the family environment who were given custodial sentences for child neglect (National Archives, 1950). Seven of the convicted women were under twenty years the majority being between the ages of twenty to forty. This is not concordant with contemporary research where young parental age is strongly correlated with child neglect (Gaudin, 1996; Lee & Goerge, 1999).

[95] National Archives, 1946.

Economic pressure on the family is restated in this report where parents abandoned their children as they went out to work but similar to the comments of the Court Report (1976) it specifically focused on the role of the mothers 'employed either part or whole time outside their home, thereby reducing their opportunity to run their homes successfully'[96]. This appears to be an unusual occasion where the state is directly implicated in the occurrence of child neglect when previous reports during this era predominantly focused on parental characteristics.

The report also examined the immediate living conditions of the family, citing frequent changes of address living in an impoverished house where furniture and bedding was 'woefully inadequate'. Disorganised and chaotic housing is thought to contribute to the occurrence of child neglect today (Ernst et al., 2004; Maughan & Moore, 2010)

The role of the mother as the main carer implicated in child neglect is a recurrent concern throughout the development of child welfare policy (Swift,1995; Chee, Conger & Elder, 2009) and relevant today as researchers debate this in relation to the understated role of fathers (Dubowitz et al., 2000; Dubowitz et al., 2001; Lee, Bellamy & Guterman, 2009). The intergenerational transmission of neglect is restated through the mother's perceived failings. Factors considered relevant were women who came from inadequate homes themselves "abnormal environment due to separation, divorce or death of parents, poor parental behaviours such as the father being 'brutal' 'drunken' or 'workshy' and also their own neglectful mothers"[97].

The study estimated that one third of women had come from homes which would give them 'little idea of the standards or work and behaviour required to build up a successful family life', but does not address the question of why the majority of women imprisoned for child neglect but were deemed to have an adequate upbringing themselves.

[96] National Archives, 1950.
[97] Ibid.

A number of common themes emerged from the study findings. These were thought to be the antecedents of child neglect and included poor living conditions, an 'uncooperative, irresponsible' husband, the wife failing to be a 'good housewife', financial difficulties and poor management of the family budget.

Child health issues for example, children who were bed wetting, ill-health in the husband or wife, 'housework being neglected or money being short' and parents overwhelmed with 'the burden of family responsibilities' were commented upon.

The researcher noted that the imprisoned parents were 'aggrieved' at their sentences and reluctant to acknowledge any responsibility in the process,

> to think that what was already a difficult life should be made even more so by a prison sentence...those who excused themselves were on the whole, less intelligent than those who were prepared to admit that they were partly to blame[98].

7.6.3 The Conclusion of the Courts

A reflective summing up of women appearing before the courts concludes that neglect is 'an act of omission and not commission' and comments that neglect was more common than abuse, a conclusion that is reiterated in contemporary literature (Gilbert et al., 2009a; Theodore, Chang & Runyan, 2007). The court records paint a vivid picture of women from impoverished backgrounds, often with learning difficulties, socially isolated and overwhelmed with difficulty in understanding the nature of the charges and legal proceedings nonetheless 'blamed' for failing on a number of fronts,

> In conclusion, it appears that neglect of their children is only part of a general social failure on the part of these women. Their failure is often due to low intelligence, poor social environment in their early years and a lack of a sense of responsibility. They get pregnant before they get married, they change their jobs frequently before marriage, they truant from school ,and they fail to hold their husbands' affection, they fail to make friends and a social life for

[98] Ibid.

> themselves and so on...It is... neglect and not cruelty that brings these women to court (National Archives, 1949).

7.6.4 The Prison Study; 'The Excuses of Neglect'

A multiagency investigation lasted two years to investigate the circumstances leading up to a parent being jailed for child neglect (National Arcives, 1946). Its committee was composed of the Holloway Prison governor, a psychiatric social worker, the prison medical officer alongside representation from the Children's Branch and Probation Branch of the Home Office. It coordinated the study findings to determine the 'excuses of neglect'.

Information was collected in a structured questionnaire that included survey items on physical examination and mental examination (IQ and psychiatric test) of the mother, working capacity of the mother on prison admission, social background, number and ages of children, findings from court proceedings, and socioeconomic factors for example housing situation, social isolation. The preliminary comments on the home conditions of neglected children merit attention,

> dirt, the foul and verminous rooms and bare and dilapidated furnishing, all combine to outrage the feelings of society and to force upon magistrates an order for the immediate removal of the child or children[99].

Despite the 'outrage' it was acknowledged that there was a still a cost to society of the emotional disturbance and insecurity caused by the disruption of the child-parent relationship an 'indestructible link of family affection ' nonetheless the committee considered the distressed reaction of children taken from their families when living in dire circumstances as 'baffling'[100].

To make sense of neglect the research pursued 'a fresh angle' by directly interviewing twelve mothers, an 'attempt to see the offence through the mother's

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[99] Ibid.
[100] Ibid.

eyes and not through those of the prosecution'. The interviewers identified a common theme as far as the imprisoned mothers were concerned,

> It is significant that 75% of the women, living under a variety of conditions, coming as they did from large and small towns and from the country, mentioned specifically, or implied, the lack of help as the cause of child neglect[101].

Social isolation as a characteristic of maternal maladaptive behaviour and correlate of neglect is echoed in current maltreatment research (Polansky, Gaudin, Ammons & Davis, 1985; Christensen et al, 1994; Coohey, 1995; Wilson, Kuebli & Hughes, 2005). Exemplars of circumstances leading to child neglect are stated as marital separation, mothers being forced to work with a young family, families in rent arrears and mothers having to abandon their children because of subsequent homelessness, an unmarried mother who could not afford to keep her baby and a widow who became depressed and could not care for her five children under thirteen years old.

All portray isolated disempowered women either by their immediate circumstances or implicitly by lack of state support. The committee also commented that many women had significantly poorer physical health and were surprised that, despite the weight given to poor environmental conditions by the researchers as a cause for neglect, it was perceived as an insignificant problem by the mothers. The report concluded with a rebuke of the legal system and the penology of neglect,

> It is however a sad commentary on our social and health services that a rest cure for a mother came in many of our twelve cases only through a sentence of imprisonment[102].

Only one woman had legal representation in court. The deficiencies of the legal system resulted in the committee's opinion in the 'double punishment' of mothers convicted of child neglect with regards to their loss of parental rights and also the deleterious effect on the child,

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[101] Ibid.
[102] Ibid.

> The interests of the child must always be paramount consideration… far more help of a practical character should be available for mothers to enable them to maintain a clean, comfortable and well-run home...We need comparable welfare services of a more varied character for the mother who, by reason of health, numerous children, or adverse economic and social conditions, show signs of discouragement and of breaking down in her all important task of running a home and bringing up her children[103].

7.6.5 The Solution; Training Mothers to Accepted Standards of Social Behaviour

Dr Sheridan details the health and social characteristics of the mothers as they enter the training house 'Abbotsfield' (National Archives, 1948b). She notes,

> The mothers arrive usually very pale and hungry...On admission their habits are usually quite uncivilised. They have to be patiently taught the simplest lessons in housework, cooking, laundry, baby care and personal hygiene, but they readily respond even though their progress may be slow[104].

Descriptions of the children reveal evidence of physical neglect and inadequate socialisation, but not the emaciated children described in earlier medical records. Their observed poor dental health is convergent with recent research that regards this as a form of physical neglect (Balmer, Gibson & Harris, 2010). Dr Sheridan comments,

> the children all looked pale and inanimate on their admission, but not wasted, and they were completely untrained in habits of personal cleanliness... There had been no question of actual starvation or physical violence in these cases, and the children were undoubtedly fond of their mothers. It would seem that they had been neglected rather because their mothers had been unable to cope with their domestic responsibilities than because they were not loved[105].

One mother is described sympathetically as, 'the victim of circumstances and needed help rather than punishment'[106]. Another mother is noted to have unrealistic expectations of her children's capabilities,

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[103] Ibid.
[104] Ibid.
[105] Ibid.
[106] Ibid.

> a tiny whitefaced miserable physical specimen with very poor teeth...her manner was deprecating and inarticulate…She seemed vaguely fond of her children but (as the probation officer reported) she appeared to think that once they could walk and speak they should be able to keep themselves clean and tidy[107].

Another resident appears to have learning difficulties,

> a large dull pasty, fat woman with a friendly, rather fatuous smile…She had attended a special school in her childhood and after leaving it had never earned her living... the family were eventually reduced for the past three years to sleeping on bare boards. They apparently relied on other people for their clothing. Food was irregularly obtained…She had no idea how to cook…She had no idea how to make a bed or cot or how to keep herself clean[108].

Whilst the language is imbued with the personal opinion of an empowered professional, such descriptions of maternal caregiver behaviours that are implicated in child neglect reflect empirical findings as absence of empathy and an inability to appropriate children's behaviour in relation to their development. This is restated in language acceptable to current thinking, neglect as a 'non-helping behaviour' (De Paul & Guibert, 2008).

Dr Sheridan sums up her findings of the neglectful mother to the committee,

> The general level of the intelligence is below the average, home circumstances are unusually difficult owing to a variety of causes including pregnancy before marriage, and the general picture is that the mothers neglected their children from sheer inability to cope with their circumstances and not from lack of affection...I would stress the desirability of training these mothers in small homes specially sited and equipped for the purpose, where they may learn to shop sensibly, to benefit from attendance at Welfare Centres and generally to appreciate the need for making the effort to conform to accepted standards of social behaviour[109].

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[107] Ibid.
[108] Ibid.
[109] Ibid.

A widely held approach to the well-being of children is that it is primarily understood through social class where neglect is 'ghettoised' to a context of poverty (Drake & Pandey,1996). A predominant focus on maternal behaviours and the socio-economic context of child neglect continues a historical enactment of its meaning.

7.7 Chapter Summary

> 'Often the regulation of culturally sensitive matters…such as the status of the family…is merely a reflection of the ethical-political self-understanding of a majority culture that has achieved dominance for contingent, historical reasons' (Habermas, 1999b, pp. 144-145).

Language use explored within the tradition of CDA can be employed to legitimately examine pervasive and historical dynamics to child welfare concerns (Slembrouck, 2010) that constitute widely held and accepted viewpoints of child neglect. Exploring a variety of texts that connect language with the social where accepted and socially shared knowledge dominates even today our approach to child neglect is strengthened when it is considered against the horizon of Habermas's (1987c) 'lifeworld'. In this sphere an engaged civil society acquires the ability to create a communicative space that, 'opens a perspective from which the relation between actual influence and the procedurally grounded quality of public opinion can be empirically investigated' (Habermas, 1996, p. 363). This process is mediated through discursive events that are embedded in political and social fields 'a dialectical relationship between particular discursive practices and the specific fields of action' (Weiss & Wodak, 2003, p. 22).

Habermas (1987b, p. 343) expands his treatise of the lifeworld into three components, culture 'the store of knowledge from which those engaged in communicative action…come to an understanding of the world', society 'the legitimate orders from which those engaged in communicative action gather a solidarity…as they enter into interpersonal relationships with each other' and personality ,'acquired competences that render a subject capable of speech and action …able to participate in processes of mutual understanding...and to maintain his own identity in the shifting contexts of interaction'. His project goes some way to explain how child neglect meaning has become altered historically through mechanisms

operating at the nexus of the individual with political and social institutions, because communicative action becomes a connecting force between aspects of social life where according to Habermas (1996, p. 36), 'Problems voiced in the public sphere first become visible when they are mirrored in personal life experiences'.

The remaining challenge today resides in a child welfare system that is unable to meaningfully engage with motivated individuals to improve understanding and outcomes for neglected children. The complexities of addressing such challenges are only possible, provided that the actors involved have communicative competency and are adequately coordinated to reach a consensus of understanding. Within Habermas's theorising this remains an imbalanced expression of social opinion.

CHAPTER EIGHT; CONCLUSION – PIECING THE JIGSAW TOGETHER

8.1 Introduction

Child neglect is an aspect of human behaviour that as a focus of research is impossible to attribute to any one set of circumstances. Like Ariadne's thread it is consideration of the philosophical basis of the language of child neglect embedded within the processes of communicative rationality that has allowed me to navigate through a labyrinth of opinions, policies and empirical research findings in an explication of child neglect meaning. This consitutes contextualised knowledge in general practice with a research aim to enhance a learning process which emerges from experience and observation with implications for policy development and its enactment in this sphere of public life .

There is at present no single, precise technical definition of child neglect. I suspect that such a definition may never transpire from the vast corpus of child maltreatment literature therefore, the analysis in this study, is not pre-occupied with achieving any "Holy Grail" in terms of understanding child neglect. It is constructive in the sense that it assumes an entity called child neglect exists and seeks to understand how that concept has come about. There is no assumption of a unitary rationality of child neglect but an assumption of discursive variability (Edwards & Potter, 1992) in a research approach that actively seeks a multiplicity of subject positions.

One of my immediate research challenges after examining the child neglect literature was do we really need more research when we seem to conclude the same pervasive issues of child neglect? Perhaps it is not more research but 'dynamic' research that doesn't just end at the level of child protection statistics diffusing into a knowledge stratum that few access. This project attempts to add a few more pieces to the jigsaw of child neglect meaning viewed through a variety of lenses that provide their own dimensions to this complex entity, but are rarely brought together within the one research framework.

During my years as a GP I've been called upon to resuscitate an unconscious child in the surgery, deal with family anxiety about a child who is disruptive at school, respond to concerns raised about children growing up in households where all adults are substance abusers, along with clinical cases that are readily aligned with a biomedical model. For example, children with acute respiratory infections or gastroenteritis generally respond to pharmacological intervention but often only require reassurance for the parents and conservative management.All clinical presentations are possibilities within one surgery, all require the skills of an experienced generalist with a knowledge of child health issues and are reasonable requirements expected of a practising GP.

I began my research journey in my own head without the intrusion of the 'paradigm wars' or issues of representation the 'postmodern paralysis' pushing me towards one theoretical direction or the other (Hatch, 2006). I had no formal research training initially unless a wealth of observational data from a multitude of patient contacts with many contextualised to child health matters, simultaneously muddled up with social issues within the dynamics of family function, is regarded as research of sorts .

I undertook my formal research training by returning to university as a mature student to study qualitative and quantitative research modules that were already predetermined by the PhD course requirements. My first class was "Stats I" which is a generic statistical methods course teaching regression analysis to students from a variety of disciplines. As the coursework progressed I believed that whilst I would find value in a technical questionnaire-type instrument in my research I did not see this as the totality of an explanation of understanding child neglect. This is because the work of general practice remains rooted in narratives of patients lives from which the hard scientific facts of their medical problems are sifted out.

I subsequently began to embrace qualitative inquiry as my main research focus to explore the complex and dynamic discourses of child neglect that provide, I believe, a more illuminating explanatory framework.

My research approach was augmented by attendance at the Glasgow Discourse Reading Group. This multidisciplinary group of individuals from varying academic

university departments meets regularly to discuss language function in textual analysis and profoundly influenced my reading material. Bahktin (1981, 1986) and Simpson (1993, 2004) for example, were authors which I would not necessarily have encountered unless I had been pointed in the direction of their work. This is because they are associated with either linguistics (Simpson) or philosophy of language (Bahktin), nonetheless their writing had a direct influence on my own work.

This study has addressed questions of GPs' understanding of child neglect as a way of informing professional development and policy implementation and practice. The research aimed to answer three questions:

1. What do GPs know of child neglect?

2. Is there a consensus view from GPs on how they understand child neglect?

3. Are current child welfare concerns within the context of general practice better understood when situated within its historical context?

This chapter summarises and discusses the findings of the study, offers practical recommendations for improved engagement with GPs in matters of child neglect by firmly acknowledging their contribution to the well being of children and families within the context of child health care. The study also makes recommendations for further investigation of child neglect with an emphasis on collaboration between all interested parties realised through the process of communicative rationality.

8.2 The Importance of Experiential Knowledge

> There is a systematic relationship between the logical structure of science and the pragmatic structure of the possible applications of the information generated within its framework...the technical and practical interests of knowledge...determine the aspect under which reality is objectified, and can thus be made accessible to experience to begin with (Habermas, 1988, p.8).

I would argue that child neglect meaning that is constructed in general practice has evolved almost as a separate system from child welfare and all the disciplines that it incorporates. This section addresses Research Question 1 *What do GPs know*

of child neglect?. GPs appear to have developed a commonsense knowledge that is dependent on experiential knowledge more than any other factor. They express their understanding of child neglect as personal narratives where they are the author of the story, and articulate very little knowledge acquired from prescribed policies of child welfare. This use of narrative is not alien to the belief that medicine is a narrative based profession (Charon 2001; Greenhalgh & Hurwitz, 1998) where the process of acquisition and transmission of knowledge has much in common with a heuristic approach that emphasises the importance of professional wisdom.

In the quantitative findings knowledge does not appear to be influenced by gender, working in areas of high or low deprivation or the age group of the GP. In both quantitative and qualitative findings policy documents appear to be read infrequently with knowledge acquired from other sources, for example, other professionals and media reports. GPs rarely articulate the "science" of child neglect because it is not contained within their knowledge repertoire. Does this matter anyway?

One of the concerns of this study is to argue that common sense knowledge is as appropriate as other knowledge sources in its contribution to child neglect meaning, but divergent findings from the quantitative and qualitative aspects of the research reflect a tension at the point of analysis. The survey responses for example, are concordant with variables of neglect that are frequently cited in scientific and historical texts of neglect. The dimensions of neglect objectified in the quantitative analysis would suggest that GPs know who to share information about vulnerable children with and acknowledge the importance of issues of confidentiality in all aspects of working. In contrast, when working practices are scrutinised within the qualitative data findings there is not the certainty that is expressed in the quantitative arm of the study for either of these concerns. It is the use of critical language awareness that goes some way to explain the theoretical connections between these convergent and divergent data findings

There are many clusters of ideas, opinions and emotions surrounding the concept of neglect, with some emotions expressed strongly than others. The cluster of ideas developed from the quantitative aspect of the study are the result of reducing

variables to factors. These in turn, minimise the complexity of thought to one or two dimensions of a concept that have statistical associations because there is a mathematical formula to show this is the case. I suggested that Factor 1 seems to relate to variables that are connected to processes of GP involvement with vulnerable families specifically, as a family unit, and could be named '*Requirements of Working with Vulnerable families*'. GPs at this juncture are concerned with the systems that either allow or impede working with neglected children and are restated in the interviews and focus group but with an emphasis on a negative perspective.

Factor 2 seems to relate to adverse health implications of neglect that function as a prerequisite to sharing information about a vulnerable child 'Sharing *Health Concerns of Child Neglect with Other Professionals*'. Working within the primary care team and being able to discuss concerns of vulnerable and neglected children is exemplified in the spoken data by the relationship that the GP has with the Health Visitor as the most relevant profession. GPs also acquire their knowledge of child neglect from other professionals, trusted sources of information and media reports but very rarely acquire knowledge from strategy documents. GPs apparently have little cognisance of any of the directives handed down through legislation or policy frameworks that should be shaping their approach to neglect.

The talk of individual GPs emanates from within a larger institutional health structure, which is itself situated within the macro structure of society's political and legal systems. All have something to say to each other through the universality of language and communication. Despite many GPs saying before the interviews that they didn't know much about child neglect, their tacit understanding and tentative explanations of it mirror findings from maltreatment research that is telling us, I would argue, what we implicitly know from dealing with neglected children in general practice on a case by case basis. Neglect, as it is presented in much of the child maltreatment research becomes quite tautological. It is only through exploring language use and how it is conceptualised, that is, expressed "in their own words" that one begins to see what neglect may mean in its various forms. We discover from the interviews that one GP sees it in a child that fails to thrive, another in an unhygienic house and another in a child with an untreated squint, but these may well

be re-categorised within the empirical data as physical neglect, health neglect and so on.

Through an exploration of communicative competence located in textual analysis that connects system and lifeworld, structure and agency, micro and macrolevels of social function "varying degrees of otherness or varying degrees of 'our-own-ness'" (Bahktin,1986, p. 89) a more comprehensive knowledge picture of their attitudes towards and opinions of neglect emerges. If the study conclusions were restricted to the interrogation of the quantitative findings it would produce a partial account of aspects of GP understanding, because it would omit the emergent themes from the spoken data which did not exactly converge with these quantitative data. Conversely, the quantitative findings have theoretical convergence with the emergent, dominant themes of the historical documentary analysis.

8.3 Alternative Definitions of Child Neglect?

> How child maltreatment is defined is central to how it is recognised, managed and prevented…All such definitions include a compromise. On the one hand, a precise and limited definition, which focuses on intentional harm, is necessary for epidemiological and public-health monitoring and to engage constructively with governments and legislators over specific policy responses to maltreatment. On the other hand, a children's rights-based definition will always push these boundaries to encompass social and environmental harm because from a child's perspective these can be indistinguishable (Reading et al., 2009, p. 333).

Research Question 2 'Is there a consensus view from GPs on how they understand child neglect?' highlights similar and differing perceptions of child neglect meaning emerging from the quantitative and qualitative findings.

Doctors train in regulated settings within a hierarchical structure and are expected to acquire professional skills to deal with diverse but distinct categories of illness in their daily contact with patients. This learning journey begins in undergraduate training and continues in postgraduate professional development. In hospital settings, repeating patient case presentations to other colleagues, one learns the language of renal medicine when attached to the renal unit and the language of respiratory medicine in the respiratory unit and so on, 'a linguistic ritual' where doctors learn

and enact normative beliefs and values of medicine (Anspach, 1988). A junior doctor starts off as the youngest most inexperienced member of a team and learns gradually by the experience of "being there" in a process of professional socialisation to move from being newly qualified with a restricted repertoire of clinical skills to a doctor who can "do things".

In general practice the process of normalisation is an altogether different experience where engagement with neglected children is not pre-determined through an organised system, because learning about child neglect is by default. The primacy of language however persists and underpins the learning process. It is fundamental to the theoretical and methodological considerations of the research because within the context of understanding child neglect, GPs express in the spoken data a common-sense ideology of neglect a 'shared lay-knowledge' distinct from 'elite or theoretical formulations or explications of knowledge' (Van Dijk, 1998, p. 102). Furthermore, Van Dijk (1998, p.93) argues that 'variability of ideological expression' is a result of the 'complex interplay of several ideologies and their contextually specific uses'. In contrast the stability of ideological expression is context –free. According to Van Dijk (1998, p.93) it is representative of 'recourse...to similar basic norms, values, principles...and specific attitudes'.

Within these taken for granted explanations, commonsense knowledge is characterised by its absence of scientific evidence 'pre reflective knowledge that accompanies processes of reaching understanding without itself being thematised' (Habermas, 1999, p. 237). For example, in the spoken data GPs do not explicitly refer to theories of child neglect as justification of their beliefs. On the contrary, it is every day practices and observations that underlie the mechanisms used to communicate and constitute their 'practical accomplishments' (Van Dijk, 1998, p. 102). In this respect it is not surprising that GPs express a common sense level of knowledge about child neglect using linguistic devices, for example, hedging and metaphor, to construct ideological beliefs and indirectly create mental models that legitimise a 'bottom up' approach to child neglect meaning. According to van Dijk (1998, p. 273) it is no less legitimate than a top down approach characteristic of

empirical data gathering. In the quantitative findings this was evident from the small percentage of GPs who read policy documents.

All GPs rank the variable in the questionnaire *parental substance misuse* consistently higher than all others and a comment needs to be made about the importance of this parental variable that represents stability of child neglect meaning. This exemplifies how child neglect is understood at the level of the individual, society and across its temporal dimension. Alongside *Social deprivation* , *parental mental health issues* and *parental social isolation* all four variables could contribute to ideological constructs of the neglectful parent that all GPs could subscribe to. It is relevant to reflect on such issues of addiction and poverty as historically stable ideological constructs of neglect because this perpetuates a restricted understanding of child neglect in the face of advancements in the neuroscience of child maltreatment. Emotional neglect is perhaps most damaging of all in, particularly, early years development and is not confined to populations only living adverse economic circumstances(Chapter 2).

Habermas (1989, pp.112-113) distinguishes between 'old and new ideology' through the mechanism of purposive-rational action removed from mutual understanding. He asserts that 'new' ideology that 'violates' accepted linguistic practice 'penetrate(s) beyond the particular historical class interests to disclose the fundamental interests of mankind' . A reading of the language from historical to contemporary texts reveals some mechanisms of change of established ideologies as the 'old' becomes the 'new' but also allows the examination of processes that maintain the 'old'.In the context of child neglect old ideologies, it seems, remain resistant to evaluation and change.

8.4 Neglect's Inheritance/Inheriting Neglect

> The anamnestic redemption of an injustice, which cannot of course be undone but can at least be virtually reconciled through remembering, ties up the present with the communicative context of universal historical solidarity...the decentring counterpoise to the dangerous concentration of responsibility...orientated exclusively toward the future, has laid on the shoulders of a problematic present that has, as it were, been tied in knots (Habermas, 1987b, pp. 15-16).

Research Question 3 ‘Are current child welfare concerns within the context of general practice better understood when situated within its historical context?’ explored the effects of neglect that are documented at the level of society, the family, the child. What is perhaps more interesting is how we inherit neglect and how this is relevant in a study of general practice. I intimated in Chapter 2 that child neglect had only in very recent times been recognised as separate from child abuse. Whilst this may be true of the empirical data, child neglect has been uppermost in the minds of historical writers not necessarily attributing their descriptions of children to the conditions of ‘neglect’. Nonetheless their observations contained in records of children living in inadequate conditions within a climate of economic hardship appear to have shaped the child protection system to a much greater extent than issues of child abuse.

The findings from the questionnaire concluded that *parental substance misuse* was consistently rated as the ‘most important’ correlate in relation to child neglect for all GP categories. Along with *parental social isolation*, *social deprivation* and *parental mental health issues* they are considered important contributory factors of child neglect. In the interviews GPs describe neglect in a number of ways with some discursive constructions more dominant than others. Overall, the cluster of ideas contained within the spoken data are concerned predominantly with issues of parental addictions and mental health problems that ensure an appropriate fit with contemporary and historical perspectives of child neglect as ideological stances. They maintain neglect understanding by linking society’s inheritance of neglect meaning through a complex dialectic of remembering and forgetting.

The stability of ideological expression emerging from the spoken text reflects historically stable ideological constructs of neglect that are symbolic of a child welfare system that struggles to address the dilemmas of child neglect. Why should this be the case when there has been over 100 years of thinking around this subject? The linguistic turn within this work explores and shines a spotlight on inequitable practices. These would remain opaque and unchallenged until the tools of critical discourse analysis are applied to connect the various strands of meaning that emerge from each aspect of the research process. Social constructivism suggests change and

instability and whilst the language of child neglect has changed dramatically from official reports evident in early welfare reform to the language of neglect today, the core beliefs of neglect meaning persist. Does this suggest intransigence at the individual level of cognition, the system or despite the contingency of language are such reflections representative of stable absolute truths ?

In modern health planning and the rationalisation of children services "new" concepts such as inter-disciplinary working and collaborative information sharing (Bridges et al., 2011) to improve identification and prevention of child neglect has apparently no need to look backwards for hints on how this is to be achieved. Ironically, we seem to be perpetually re-inventing the challenges and dilemmas of child neglect that are mirrored in committee meetings, legislation and individual concerns outlined in Chapter 7.

When we do look back we see the epistemic stance of the early child welfare system apparently dominated by a proliferation of a class-specific, morally-conscious perspective on what constituted acceptable parenting (Behlmer, 1982; Hendrick, 1994, 2003; Murdoch, 2006). In contrast nowadays, we have surely become sophisticated beings in our approach to neglect given the volume of scholarly works devoted to describing its identification and prevention. There has been an apparent evolution of thought, but the tensions between scientific dimensions of neglect contained within 'context free language' and reconciling these with interpretive lived in accounts 'intersubjectively shared ordinary language' (Habermas, 1989, p. 93) remain.

As much as I try to differentiate between the language of contemporary child maltreatment research and policy as progressive and forward looking, returning to the themes of historical texts albeit selective extracts, present the same dilemmas of shared working and reaching common understanding to effectively coordinate services to support the child with unmet needs within their family setting. In 1911 a multidisciplinary child welfare council outlined their function with this specific goal 'a valuable means of inter-communication between the officers of those

organisations that were working for the welfare of children' (Mitchell Library Archives, 1911). They were tasked with a very broad remit,

> to consider the life of a child as a whole, and in all its aspects from birth to maturity-in sickness and in health, whether normal or defective, neglected or delinquent-before, during and after school age, those living at home as well as in institutions, so that there might be no gaps. That, it was believed, could be achieved through the medium of existing agencies, which only required linking in order to bring to a common centre their varied knowledge and experience of child life, so that the problems might be considered in relation to each other.

An examination of the historical shifts in the language of child neglect whilst not an absolute explanation in of itself, does give a broader deeper understanding, I believe, of how society has moved from regarding neglected children as 'moral filth' to children 'in need' whilst managing to retain stable ideological beliefs. The politicisation of child neglect has been central in this research aspect where I have endeavoured to trace some of the earliest political interests in the history of child neglect and its relevance to matters of child health.

8.5 Methodological Implications - Disturbing the Eternal Silence of the Universe

> any speaker is himself a respondent to a greater or lesser degree. He is not…the one who disturbs the eternal silence of the universe. And he presupposes not only the existence of the language system he is using, but also the existence of preceding utterances-his own and others (Bakhtin, 1986 p. 69).

On a pragmatic level we cannot in the reception of immediate talk fully comprehend the relation to other discourses in Bahktin's complex chain, and it is only by exploring theoretical approaches to critical language use this can be examined. In order to at least attempt hermeneutic completeness neither the voice of the researcher or the researched is excluded. In this respect, no one aspect of knowledge production is irrelevant to the analysis in the process of assimilation and subsequent integration of data.

Child neglect is often described within comparative observable failures of parenting behaviours but the universalism of child neglect requires an approach that allows for interpretive understanding on many different levels. For example, child neglect may be an emotion that is experienced but not readily visualised therefore, within the context of health and well-being, there should be no dogmatic presumption of child neglect definition.

Focusing on the child within the family, understanding the ramifications of stresses that impact on the parent–child relationship but within a very broad social context requires the best of general practice skills to be retained.

8.6 Limitations and Future Directions-People, Policy, Politics

8.6.1 Getting The Message Across- How We Talk About Neglect

How should we receive and assimilate contemporary thinking on child neglect and inculcate this into approaches to working with vulnerable children and families? Furthermore, how will this best be reconciled with the knowledge gaps that reflect the challenges to holistic family support when working within institutions that are orientated towards a legislative framework that is weighted towards evidence gathering? Definitional issues particularly within health, demand increasingly instrumentalised approaches to neglect meaning, to fulfill the requirements of such legal and technological frameworks, but child neglect has an association with health disparities that cuts across various disciplines and tends to blur the boundaries of meaning.

The reification of child neglect has shades of meaning filtered into discourses of experience from a variety of sources that contribute to commonly held views that are often realised within a verbal encounter. Van Dijk (1998, p. 87) comments,

> Ideologies are not merely learned and changed because of personal experiences, but may also be constructed, at least partially, directly from ideological statements in discourse...Propaganda...has the function of directly affecting the attitudes and beliefs of social members.

At a delicate level of analysis of metaphor and ideology theory, an examination of the narratives of GPs in their approach to dealing with neglect issues, based on experiential knowledge that is stored and subsequently culled from their memories is made possible. Personal opinion and social positioning within the matrices of the discourses of neglect are reproduced within a story telling form that supports whatever point GPs want to get across within the story. Medical language contains metaphors and other linguistic forms used as a function to create a social distance between doctors and patients (Mintz, 1992). Similarly in this research it functions to create the paradox of discourses of child neglect contained within the involved and disengaged professional. They are not however, viewed as disembodied intellectual contents of beliefs about child neglect. In their individual accounts they invoke a wide range of other matters and in doing so they reveal something of the dominant discourses and institutional practices that, as it were, fix their own repertoires of child neglect meaning.

Cumulatively, the analysis of these discursive data encode a particular 'view' of the world, which can be understood as reflecting the social, cultural and ideological factors affecting such choices (Fairclough, 1992). Above all, it is personal experience, knowledge and opinions that define child neglect. A theory of ideology merely provides the interface to relate the social dimension of ideologies with their personal uses (Van Dijk, 1998 p. 126) considered in terms of the implications of this worldview, in connection with issues such as value systems, role relationships and power structures.

Traditionally, medical language has been seen as an abstract discourse of the pathological dimensions of disease effects on the body, however, neglect conceptually challenges this. Neglect per se is not classed as a disease or a tumour growing in an organ that can be surgically removed. Its effects on the physical body and its neurological impact are mostly unseen with its health outcomes obliquely related. Reflecting a lack of medical attention, GPs ultimately articulate a knowledge process that is language based and rooted in experiential learning. It is not consciously linked to any historical dimensions of child neglect or an esoteric

scientific account of this entity but nonetheless, appears to be culturally reflective of wider social beliefs.

Despite the varied number of child neglect studies that I refer to in this thesis consistency of findings do not appear to filter down to the frontline staff interviewed in this study. GPs would certainly be aware of research in other medical disciplines that influence, for example, drug prescribing or thresholds for treatment in hypertension.

The reasons for the lack of child neglect research findings from a number of domains being widely disseminated may reflect a lack of political will, and simultaneously a bigger problem of its relevance to the fabric of societal concerns (Kerner, Rimer & Emmons, 2005).

Habermas (1989, p. 76) comments on the communication barrier between scientific and public knowledge within the technical interests of a rationalised society,

> the client at the gates of organised research…is no longer a public engaged in learning or discussion. It is a contracting agency interested in the outcome of the research process for the sake of its technical application…the memorandum formulated in relation to the contract and the research report aimed at technical recommendations.

This may also explain the apparent division between research production and its influence in decision making (Lenfant, 2003), that exemplifies separation of the ideological debate and empirical information gained in the scientific study of child neglect. That said, it does not appear to influence the strength of belief of parental addictions and to a lesser extent poverty and parental mental health problems as contributing factors to child neglect that is evident in contemporary research .

Landry and colleagues (2006) suggest that this process represents a one way flow of information in the 'knowledge chain' that remains ineffective in the uptake and utilisation of research evidence in decision-making. Despite the systemic lack of attention given to GPs in the role of neglect prevention, their beliefs and opinions are not dissimilar to widely held societal and institutional values suggesting that there is at least another 'knowledge chain' in a parallel direction. It appears that it is possible,

even within the challenges of understanding the complex and multiple dimensions of child neglect, to develop a theoretical framework for knowledge production that incorporates key messages in the transference of research knowledge (Landry et al., 2006; Bridges et al., 2011). Nonetheless, written documents by themselves are usually ineffective in disseminating information and more effective when in conjunction with other methods that specifically promote communication to advance interdisciplinary understanding and shared decision making (Legare et al., 2008, 2011). In this project, policy documents have not figured highly in GP knowledge repertoires, but policy conveyed to them by a trusted individual has the potential to influence and enhance their understanding.

At present the emphasis in EBM means that the cultural shift appears to be in the direction of research evidence in decision-making and informing policy. With barriers at the levels of agency and structure impeding the development of a comprehensive approach to child welfare issues, one must ask how this can be accomplished. Within this context, promoting the role of the individual championing the child welfare cause (Jack et al., 2010) is a possible solution and a necessity, if common understanding at least between professional groups working within the child welfare systems is to be achieved. Highlighting the role of the GP is one potential approach to this.

8.6.2 What Are We Not Saying?

In many respects it is what is not being said about child neglect that is the most illuminating aspect of the research. The notion of childhood resilience is an important one and although it is present in some of the historical texts albeit in notions of improving parental behaviours or learning how to undertake "domestic duties" to enhance the home environment it is not focused on child characteristics. In the study's spoken data it is rarely mentioned but when highlighted it is not called resilience but appropriately aligned with improving support networks,

> 'it's a teacher the cub leader if you get a wee pal and their family's a nice family and they do things if that lets you see a different way of life' **GP8**.

It is possible that this represents a number of gaps between child neglect research findings diffusing into frontline working but also reflects, overall, a negative approach to child neglect prevention (Azar, 2000). This pervasive theme in the interviews reiterates notions of professional distance and pessimism about the GP role in improving family function because the GPs interviewed rarely see positive outcomes for neglected children.

GPs are in dialogue with a very limited number of professionals on matters of child neglect. They regard this work as rather incoherent citing several obstacles to interprofessional collaboration that could improve the lives of neglected children. This contributes to a dilemma of including children in service planning and delivery because children per se are never central to the talk of GP. The family is the unit of analysis where family beliefs and cultural sensitivities potentially impact on interpretation of child neglect meaning but are rarely acknowledged. Whilst policy documents repeatedly cite a child centred approach, this can never be adequately realised if the child as a competent linguistic agent is poorly understood.

Furthermore, the institutions tasked with ameliorating the effects of neglect on child well being appear to be functioning as 'opposite one another as socially and systemically integrated spheres of action' (Habermas, 1987c, p. 309). This results in atomistic approaches to child neglect where neither informal communicative practices nor intuitive knowledge appear to be welcome and, anyway, are 'inaccessible from an external, systems-theoretical perspective' (Habermas, 1987c, p. 186) in deciding who is a neglected child.

A partial account of GPs' own contribution to child neglect issues reflects a pervasive dilemma. From an epidemiological perspective there is a mis-match between the scale of neglect and identifying neglect when it occurs outwith the most easily recognised scenarios of poverty and parental addictions. "Measuring" neglect remains underestimated as we continue to construct it through an incomplete epistemological circle of linguistic meaning. The inclusion of views from children living in neglectful circumstances for example are particularly absent. Until we develop the ethics of humane care and social justice (Mishler, 2004) dialogically

linking the many different perspectives of child neglect through an agenda of inclusive communicative action, it will remain so.

There is therefore, a dialectic dimension to the qualitative and quantitative aspects of the research that provides the possibility of connecting different world views 'inquiring into the meaning individuals, or groups ascribe to a social or human problem' (Creswell, 2007 p. 37) that has at its core universal pragmatics. The skills and knowledge that enable communication and create cohesive stable social relationships and our social reality are contained within rhetorical devices such as ideology and metaphor, that infuse and construct personal opinion and socially shared knowledge at the levels of agency and structure. The reconstruction of objectified dimensions of neglect meaning are representations of cognitive processes that are assumed to be widely held because of their statistical significance. Given the normative assumptions of neglect meaning, adhering to seemingly stable constructs contribute to socially transmitted knowledge that simultaneously creates the context of social amnesia of knowledge acquisition. In many ways it is easier to avoid the moral and ethical dilemmas of child neglect if we on the whole accept a restricted definition of it.

8.6.3 The Value of the Message 'each view is not the absolute truth'

> Corroborating experiences are the foundation on which the everyday practice of our lifeworld rests; they provide us with certainty. But certainties are always subjective; they can be upset at any time by dissonant experiences. From the perspective of the believing subject, certainty is the correlate of the actual validity of a belief. To that extent experience...grounds the truth claims raised in constative speech acts (Habermas, 2001 , p. 88).

This work does not have as its core the purpose of rejection of hypotheses. Reductionism alone has no role to play in meaningfully capturing the construction of knowledge that is often tacit, developed through the iterative processes of reasoning and questioning. Therefore, there has to be an acceptance that a liberal interpretation of the scientific method is necessary to avoid a restrictive theoretical perspective. The complex knowledge beliefs of the actors in this research do not have only one reality because child neglect meaning is pluralistic and apparently both context sensitive and context free. All voices therefore, within this process are acknowledged

including my own autobiographical voice. Thus, the plausibility and probability of truths of neglect constructed within the study are given their existence 'a brief creative close that speaks to the essence of the study' (Moustakas, 1994 p. 184).

The discourses of child neglect in this research are regarded as social products reflective of social practices and representative of group beliefs that are rooted in the institutional production of ideologies (Fairclough, 1992, 1995). Child neglect meaning is dynamically constituted through language that is historically contingent and produces ideologically stable truths of neglect that are not, however, its only truths. There are in addition, emergent dimensions of neglect understanding that can be considered and contribute to its ideological basis bringing it into line with an expansive and not a restricted viewpoint. The treatment of neglect meaning as dynamic and interchangeable allows it to be considered as interactional in its construction, whether it takes place within the domain of qualitative or quantitative approaches. In this respect all facets of knowledge are included as pieces of a jigsaw in the analysis of the truth of child neglect where the interrelationship of practical and theoretical issues are closely aligned and not readily separated.

That said, even within this research framework acknowledging child neglect in health matters sits uncomfortably alongside Habermas' (1984, p. 37) view of health's strategic aims based on 'the truth of corresponding prognoses, explanations, or descriptions'. As I have discussed in Chapter 2 there is no cure for child neglect, and despite its wide ranging and long term adverse effects, it is not regarded as a primary care health challenge. It therefore cannot be realised in general practice via similar mechanisms that are designed to combat chronic diseases such as diabetes, asthma or cardiovascular disease. These disease entities are aligned to a biomedical model with a wealth of empirical data findings that demarcate their pathological boundaries, 'explanation from which technical recommendations can readily be derived in practical contexts' (Habermas, 1984, p.37).

Thus, every aspect of this research leads back to issues of communication. The content that is communicated, how it is communicated and to whom are all considered because the enactment of child neglect meaning is ultimately constituted

through language use. Whatever lens neglect is examined under, and whether meaning is extracted from a statistical table denoting relationships of variables to the concept of neglect or through analysis of language, the purpose of the message needs to reflexively grasped to be explicit and valued. Reducing the meaning of neglect to a few dimensions only makes sense if the breadth and depth of neglect's dimensions are acknowledged.

This project began with a need to understand what child neglect actually meant within my own professional discipline and on my research journey it progressed to a study of an abstract concept within a framework of mixed methods. The evolving exploration of qualitative methods in the analysis that has drawn out meaning of child neglect, originated in a small section of open questions in the structured questionnaire where GPs wrote at length of the importance of close working with other professionals and simultaneously their exclusion from the system. This finding was reiterated very clearly in the interview data but, as an expansive explication of child neglect meaning became analysed at a sensitive level of language use, it emerged as a discourse of professional ambivalence.

I outlined why the idea of a purely quantitative approach would be in this project deficient in answering the research questions but does a predominantly qualitative approach to building up research evidence of child neglect understanding constitute evidence? One interviewee summed up this research conundrum 'it's a bit like qualitative research they'll all give a view but each view is not the absolute truth' (**GP7**).

It is interesting in the sense that as I try to systematically address this concern an internal dialogue opens up not only about the limitations but also the possibilities of the research that could be picked up at a later date and the different directions that the initial research questions could take. This reflects my own learning journey as I explore particular research methods or philosophical theory and relate it to my own work.

In Chapter 4, I outlined the limitations of a mixed methods analysis and made the point that for many academic disciplines it is the concerns of qualitative research that

perpetuate it as being incommensurate with developing acceptable standards of this methodology[110]. It is not the aim of mixed methods to go only one way in the labyrinth of knowledge as the research process unfolds. Nonetheless, once the research gets underway a balance is struck between recognising and exploring the tensions of incompatibility, getting on with the actual research and moving towards integration of accepted dimensions of knowledge.

In this thesis I have actively engaged with the belief that a mixed methods model gives a richer explication of an abstract concept. Whilst I acknowledge the criticisms of qualitative methods I concur with Morse's (2006, p. 403) criticism of the 'myopic vision' in health that undermines the contribution of qualitative research. He comments that it is wrongly considered,

> soft research (with) nebulous outcomes, is not useful to policy planners and those responsible for the health of the nation…is not directly relevant to our health care agenda, which is intent of reducing mortality, lowering morbidity, and reducing costs.

As such I feel justified in orientating my research in this direction because I believe quite the opposite, that in fact, it provides hypermetropic vision of a complex subject that has allowed me to look beyond the boundaries of general practice into other domains. What I have discovered lets me declare that the qualitative approaches if developed and interpreted in a disciplined consistent manner (Cohen & Crabtree, 2008) can contribute to how health can ameliorate the adverse health and economic costs of child neglect to society, to the family and to the individual.

The contribution of the qualitative findings, that there are apparent stable constructs of neglect I would argue, do represent the world as the participants understand it but

[110] A useful clarification of the often perplexing issues of quality in qualitative research is given by Hammersley (2008 , pp. 161-164). He comments that because much of qualitative data is interpreted by 'lay users' of research for example policy makers, it leads to ambiguity in the usefulness of the research findings. An explicit account of the processes such as adequacy of research reports and significance of the findings, to promote trust between the producers of research and receivers of research can negate many of these concerns. In this respect the divergent or counter-intuitive findings of the research as well as convergent findings can all be included within the scrutiny the 'coherence and reasonableness' of the research interpretation.

it remains a restricted 'worldview' because of the endorsement of a partial understanding of child neglect. If GPs for example are not actively encouraged to expand and develop their knowledge of this subject, or indeed if there is no acknowledgment of the multiplicity of neglect observations as valid knowledge, why should they progress to a specialised knowledge repertoire that **GP6** articulated? Equally, if society is more comfortable with the notion that neglect is ghettoised to the poverty and parental addictions, why should society look for neglect elsewhere?

So, perhaps the stated limitations of this research really emanate from the epistemic boundaries of a small scale study where the researcher is not particularly keen to give a definitive account of child neglect. Instead I endeavour to map out the boundaries of child neglect meaning within the study parameters that are themselves situated within a larger landscape of child neglect meaning.

I do argue that the views of GPs are reflective of widely held social beliefs that are contained within stable ideological expression and are context free crossing cultural and historical dimensions. Nonetheless there is also variability of ideology 'explained by the complex interplay of several ideologies and their contextually specific uses'(Van Dijk, 1998, p. 93). In the historical texts, employing a historical discourse analytic approach goes some way to explain how group beliefs have been maintained but also in part how ideological opinion has been shifted by the individual. In this context, child neglect is apparently a metaphor for many concept dimensions used in linguistic repertoires to maintain and sustain beliefs that are held more strongly than others. It would be interesting to expand this aspect of the project and include other professionals as research subjects, but also more importantly begin some of the work that needs to be done regarding the views of children and parents themselves.

8.7 Ethical Considerations

I decided to specifically write a section on the ethical considerations of the research because it is one of the major hurdles to overcome before the research can proceed but tends to fade into the background of the project as it unfolds. Its relevance to the research concerns however is omnipresent as the findings emerge and impact

differently at varying times throughout the research. The initial ethics approval for the study was achieved without too much difficulty where confidentiality of participants in both aspects of the research approaches was key. This does not detract from resultant ethical concerns that mainly centre around the spoken data findings which cannot be completely anticipated until the data is transcribed and examined.

Parry and Mauthner (2004) discuss the ethical concerns of qualitative research. These are challenges of confidentiality, respondent and researcher anonymity and respondent consent, particularly how findings are used and shared within a wider domain. Whilst I would not argue that GPs could be regarded as a vulnerable group, their spoken data in a sense did make them more vulnerable. It seemed that some were perhaps reflecting on their own childhood experiences and others describing views that they would not necessarily articulate if interviewed by a researcher outside of general practice.

This is not a dilemma for the quantitative analysis where respondents are given pre-determined category choices that allow no room for personal opinion. The taxonomic pigeonholing of child neglect with quantitative variables escapes from the critical interpretation of spoken texts. The subtleties of talk allow GPs to position themselves politically where linguistic repertoires function to absolve them professionally of any failures in the child welfare system. It was slightly uncomfortable concluding my findings of the ideological motivation for professional ambivalence because I am trying not to be blindly sympathetic to my profession. I would argue that for this reason the findings of the spoken data are more contentious and ethically tense as opinion, ideologies beliefs infuse the data conveying a pervasive discourse of professional distance.

There are further ethical concerns at the endpoint of the research, that is, who are the intended recipients of the findings and who (if any) will benefit from the research. I did not start this work with a targeted audience in mind as I endeavoured to explore and deepen understanding of a complex entity that challenged me as a working GP. Many questions arose and shaped the methodology of the project because there were no apparent answers that allowed me move on in my quest for re-affirmation of my

own working practices. In this sense the research has been centred on my own personal learning journey. Nonetheless, I would hope its findings could be accessed from a number of domains and contribute to some of the thinking that influences frontline working in general practice.

8.8 Is there a Utopian State –Are We collected and Committed

> (T)he common world is what we enter when we are born and what we leave behind when we die. It transcends our lifespan into past and future alike; it was there before we came and will outlast our brief sojourn in it. It is what we have in common not only with those who live with us, but also with those who were here before and those who will come after us (Arendt, 1998, p. 55).

We were all children once and when we look back on our childhood most will recall a certain contentment, a "good enough" childhood but others will not. It is impossible as adults to remember in our language of childhood, awareness of neglect or how such experiences would be articulated. In contrast, we are surrounded by political and social perspectives of truths of neglect that are realised through ideological practices which theoretically link temporal dimensions of neglect with contemporary understanding. These exist however as restricted constructs that create the limits of our cognition and perpetuate a child welfare framework that upholds short term utopianism. I have quoted from a number of historical documents whose sentiments on the state of the neglected child and society's responsibility towards them could be seamlessly incorporated into contemporary discourses of child neglect. I believe this is because we remain unable or unwilling to reconcile such tensions and child neglect is an unfortunate side effect of that unfinished debate.

Despite a contemporary child neglect strategy that calls for collective, inclusive and committed action to ameliorate the conditions of neglected children it has been an interesting research endeavour to shed some light on my own profession which appears to be outside of this process. Whilst doctors in the earlier part of the 20th century seemed to say quite a bit about child neglect their voice today seems to have diminished. The reasons for this are complex, but increased rationalisation and continued refashioned, strategic planning of health provision are surely part of general practice's dilemmatic approach to child neglect. Habermas (1971, p. 55)

comments, ‘the pragmatic doctrine of the medical art… transformed into the control of isolated natural processes, checked by scientific method…will always have to assume the form of technical control of objectified processes’. His sentiment embodies the dilemmas for a modern general practice profession in the maintenance of a holistic, universal child health service. To acknowledge and promote the role of general practice in prevention of child neglect primarily through strengthening family function, one must also directly engage with the restraints of the politicisation of child neglect.

In matters of the ‘common world’ it is linguistic compatibility that we strive for but in the dominion of child neglect it resides within the language of adults. This is a reflection perhaps, of our own difficulties in acknowledging children as linguistically capable, the ‘born minorities’ (Habermas, 1999b), who are in many respects the ultimately discriminated against social groups in terms of their exclusion in matters of communicative action. The possibility of including them in matters of child neglect remains within positive discursive action to progress understanding of child neglect (Fisher, Bunn, Jacobs, Moran & Bifulco, 2011) as ‘a process of inclusion that is sufficiently sensitive to the cultural background of individual and group-specific differences’ (Habermas,1999b, p.146). In general practice this would require communicative engagement with children in the consultation that is appropriate to their developmental age and communicative competency. This would initially seem a rather onerous burden for generalists who are not experts in child health. I would argue however that their rarely acknowledged expertise and contribution to child welfare concerns resides in the longevity and continuity of care that they provide for entire families under the umbrella term of health, but in reality, encompasses broader concerns of well being.

GPs build up their professional relationships embedded in the personal narratives of the patient. The nuances of everyday life experiences are blended in a plot developed around the presence or absence of a disease or condition that impacts on the patient’s well-being. This enables many social and political discourses to become part of the narrative, for example, a patient who has state benefits withdrawn may appeal a decision on medical grounds by challenging the welfare system. The GP becomes

part of the storyline at this juncture and in a similar disposition, a GP may become directly involved with a child welfare concern around issues of a child's unmet needs. The longevity of the doctor patient relationship, however, allows GPs to unburden themselves from making immediate and sometimes drastic decisions that are often inappropriate when tackling child neglect matters.

Furthermore, GPs are reminded of their advocacy role and its important contribution to social action in helping families who struggle to maintain adequate parenting practices and children who are rendered in need because of this. In this challenge GPs must commit themselves to the notion of internal and external advocacy, and consider as individual GPs and as a collective group belonging to an institution, what must be done. It will remain an aspiration however, if the organisational structure does not fulfil its own role in providing the framework for GPs to adequately fulfil their duties (Popay, Kowarzik, Mallinson, Mackian & Barker, 2007b) towards neglected children both ethically and morally.

Whilst there is no great argument about a lack of an established universal primary care structure, the debate appears to be centred on why children are not receiving the appropriate services and who is best placed to provide those.

Recent recommendations would favour integrated teams at all levels of service provision. GPs should have mandatory paediatric training and work alongside a number of other professionals to address the needs of children and families but at present, the contract arrangements for child health provision are inadequate (Wolfe et al., 2011). There is, according to the GPs interviewed in this study, a partially developed model but the structural constraints and lack of an explicit role for GPs perpetuate this fragmented approach. Coupled with their own professional disengagement this undermines any political rhetoric of universal provision of child healthcare in this country that is not exclusively aligned to a biomedical model of child health.

Gough and Stanley (2007) argue that one solution is to develop parallel processes to develop complementary approaches to inadequate parenting via a refreshed and better informed dialogue between health, social work and the legal system. This

however, remains a complex process with a differing agenda for each professional group that is better resolved when collaborative work begins early during professional training in the community (Bridges et al., 2011). One danger of 'parallel processes' is that separation of services remains, where the only prospect of making them less parallel and more connected is through communication and developing shared understanding .

GP involvement in the dynamic of family function does not usually orientate the consultation towards the discovery of incidents of child maltreatment to invoke statutory proceedings against families. Gough and Stanley (2007) describe these as 'catapults' to involvement of the current socio-legal approach to child abuse and neglect that they argue creates its own dilemma of limited solutions namely more checklists, frameworks, protocols, procedures and timescales.

Moss and Petrie (2005) suggest an alternative pathway for the modern child welfare system that has physically moved away from integration and is criticised for an increasingly piecemeal approach 'atomisation' of the child. With a burgeoning number of children's departments and services as a specialist approach to child protection, any desire to improve coordination and partnership working has an intrinsic difficulty of bringing different systems (and those who work within them) into closer working relationships. This is because services are not linked together or communicatively aligned and display 'social autopoiesis'. Without a common understanding of the language of neglect the parallel lines will never converge. They comment,

> systems continually refer back to themselves for authority and to make sense of the external world...each system sees the world through its own lens, each system formulates problems in terms of its own agenda and perceived competence; direct communication between systems is an impossibility (Moss & Petrie, 2005, p. 93)

If we dismantle the universal nature of child health services in this country we will, I believe, begin to see patterns of neglect outcomes that are unthinkable where parents and consequently children are unable to access primary health care and all its associated complementary family therapies. I have witnessed in my working lifetime

the decline of the child health agenda in general practice where many of the outcomes that I informally track throughout a child's life are never counted in any outcome measurement.

I would hope that unlike many of my colleagues who seem to remain collectively pessimistic about their contribution to child welfare, that general practice is acknowledged as making a difference to the quality of some families' lives and improving outcomes for children. It is important for any population based approach to health to maintain the established infrastructure and public provision for healthcare (Hertzman, & Siddiqi, 2008). It is imperative in my opinion, that we are committed to the agenda of children's wellbeing and uncovering neglect under the umbrella of primary health care by individual GPs who are supported and not impeded by the system. If not, the approach to child neglect within its wider context of child well-being will remain itself neglected (Wolock & Horowitz, 1984).

8.9 Conclusion

In the conclusion to a thesis it is customary to outline the contribution of the research to the established field. I am not convinced that this research can be boiled down to a few statements that can simplistically slot into current child neglect research findings, because I am fundamentally challenging the apparent stagnation of the direction of child neglect research. I hope that whoever reads it will engage with some of the philosophical concerns of containing an abstract concept within categories of meaning that by the very process of creating such boundaries, to my mind, excludes us from understanding child neglect in its entirety and keeps us at an intellectual dead end.

By looking beyond my own limits of knowledge that at the beginning was restricted by my own research ignorance but enriched by my own personal experience, I hope that I can at least add to the existing but limited theoretical understanding of child neglect within the context of general practice. GPs work as public servants, holistic practitioners, healers and small business partners but above all as family doctors where family dynamics of their patients become very well known to them over a long period of time. Their professional role is to advocate for the well-being of

children, to prevent and identify child neglect, but in order for this to happen their accounts of the vulnerable child, the neglected child, the child 'in need' that most GPs in this study had constructed from the consultation should be acknowledged as one aspect of the evidence base of child maltreatment. Furthermore, this should be reflected in the structure of our child welfare system, not merely in the rhetoric of select policies but aligned with support for working practices. This was the state of affairs when the BMA committee met for many years to discuss this very subject in the middle of the last century but I would struggle to find any official GP body today that has this exclusive remit.

In this thesis I have argued that the negotiation and enactment of child neglect within the context of general practice is best understood through a pluralistic discourse that includes its historical influences, because it allows us to understand and critically challenge the limits of our cognition. Coupled with reflexive thinking and communicative action the enactment of child neglect meaning can encompass its multiple dimensions and determinants appropriately, as it emerges at the public and private spheres of social life. General practitioners work at the margins of both and can have a unique contribution to make in this endeavour.

Embracing this research plea would ameliorate the distracting effect of the impact science and technology on modern forms of political and social life and vice versa '*to translate technically exploitable knowledge into the practical consciousness of a social life-world*' (Habermas, 1971, p. 52). This would require that the technical aspects of child neglect meaning obtained from the empirical data is fused with the everyday accounts of child neglect from multiple perspectives and given equal weighting. That is, experience and opinion are commensurate with chi-squares or *p*-values in determining associations between different categories of neglect meaning. This is how, I believe, we will progress as enlightened rationalists garnering knowledge of a complex and abstract entity. As I draw the study to a close I am reminded of a quote from Aristotle (trans 2006, p. 126) who, to my mind, reminds us that any exploration of the veracity of objective or subjective knowledge at its outset is shaped by human experience, memory and interpretation,

So out of sense-perception comes to be what we call memory, and out of frequently repeated memories of the same thing develops experience; for a number of memories constitute a single experience. From experience again…originate the skill of the craftsmen and the knowledge of the man of science, skill in the sphere of coming to be and science in the sphere of being…intuition will be the originative source of scientific knowledge. And the originative source of science grasps the original basic premises, while science as a whole is similarly related as originative source to the whole body of fact.

GLOSSARY; ACRONYMS AND EXPLANATIONS

A&E	Accident and Emergency
BMA	British Medical Association
CA	Conversation Analysis
CDA	Critical Discourse Analysis
CHCP	Community Health and Care Partnership
CHS	Child Health Surveillance
CPS	Child Protection Services
CPT	Child Protection Training
DA	Discourse Analysis
DCH	Diploma in Child Health
MRCGP	Membership Royal College of General Practitioners
SFL	Systemic Functional Linguistics

Emic This term has been applied to systemic functional linguistics where the emphasis is on the structural and functional elements of language. The researcher remains focused on the internal organisation of the text, for example, sequencing and the analytic direction is 'inward looking'.

Etic This term has been applied to critical linguistics where the researcher looks beyond the boundaries of contextually situated meaning to examine the power dynamics and social context that influence the production of a text. The analytic direction is 'outward looking'.

Child Maltreatment is dichotomised to neglect and abuse. It is not used interchangeably in this thesis with child neglect but is used to refer to research where both abuse and neglect have been studied within the same study.

Child protection within the context of this study remains a narrow interpretation of child welfare and child wellbeing and therefore I instead refer to the latter terms. Child protection emphasises the legal framework whilst child well-being as I understand it is a more holistic term. It encompasses health (both psychological and

physical) and the ‘social capital’ of the child and their family taking into account the economic structure (neighbourhood and community, family employment and socio-economic status) that determines and is determined by the overall strategy at macro and micro levels of society to address neglect issues. These are my personal interpretations of such terms which I often found had blurred boundaries of meaning within and across studies when cited in child maltreatment literature.

Research Parsimony This is an important concept for mixed methods research where, in the integration of often large amounts of data, the researcher is attempting to achieve the simplest explanation that includes all explanatory aspects of the data findings.

Vulnerability and ‘in-need’ were used interchangeably as both are conceptually related to child neglect.

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APPENDIX A

1. Study Recruitment Letter

DR ANNE MULLIN
GOVAN HEALTH CENTRE
5 DRUMOYNE RD
GLASGOW G51 4BJ
Tel 0141 531 8440

This informed consent form is for GPs in Greater Glasgow and Clyde Health board who are invited to participate in a research project "GP's Understanding of Child Neglect"

Principle Investigator - Dr Anne Mullin

GG&C HB

Information Sheet

I am a GP working in Greater Glasgow & Clyde and I am doing research in GP's understanding of child neglect. This information sheet is to help you decide if you are willing to participate in the research and if you have any questions about this please ask me as we go through the information sheet.

Child Neglect is a form of child maltreatment that is more prevalent than child abuse but less well understood. There is a lack of research in General practice in how GPs understand child neglect and how they develop their knowledge of this. I want to explore through interviews and focus groups how GPs construct their knowledge of child neglect and how they deal with that knowledge.

The interviews will last approximately 15 minutes and the focus groups will last approximately one hour.

Interviews

Your participation is entirely voluntary-if you agree to participate you would take part in a taped interview in your workplace setting with me lasting approximately 15 minutes. I do not anticipate that there will be a risk of you sharing personal or confidential information or that you would feel uncomfortable about discussing your understanding of child neglect but if you do not wish to answer any of the questions during the interview you may say so and I will move on to the next question. The information recorded is confidential but I would like to have permission to directly quote anything that you say in the interview. No-one else but me will access the information documented during your interview and no-one will be identified by name on the tapes. The tapes will be kept in a locked cabinet and I will be able the only person able to access them.

Focus Groups

The Focus Groups will take place in a health centre with 5-11 other participating GPs. This discussion will be guided by me and my academic supervisor Dr Pam Green Lister.

The group discussion will start with me making sure that everyone is comfortable with the structure of the group and you will be given an opportunity to ask any questions about the research that you may have.

During the focus group discussion I will ask you questions about your understanding of child neglect that you utilise in practice and how you have acquired this knowledge.I will also present certain hypothetical situations in the forms of vignettes to explore further your understanding of neglect. You do not however have to share any knowledge that you are not comfortable sharing.

No one else but the people who take part in the discussion (in addition to my supervisor and me) will be present during the discussion. The entire discussion will

be tape recorded but no-one will be identified by name on the tape. The tapes will be kept in a locked cabinet and no one but me will be able to access them.

You are encouraged not to talk to people outside the group about what was said inside the group –however I cannot stop or prevent participants who were in the group from sharing things that should be confidential.

Confidentiality

I will not share any information about you and the information collected will be kept private. Any information about you will have a number on it instead of your name. Only I will know what your number is and I will keep that information under lock and key.

Dissemination of Results

This research is part of a PhD thesis and the findings will be shared with you before it is disseminated more broadly, through for instance publications and conferences.

Right To refuse or Withdraw

You do not have to take part in this research if you do not wish to do so and you may stop participating in the interview/focus group discussion at any time.

Part II

Certificate of Consent

I have read the foregoing information and have had the opportunity to ask questions about it and any questions have been answered to my satisfaction. I consent voluntarily to be a participant in this study and understand I have the right to withdraw from the interview/focus group discussion at any time.

Name of Participant

Signature of Participant

Date

I have witnessed the accurate reading of the consent form to the potential participant and the individual has had the opportunity to ask questions. I confirm that the individual has given consent freely.

Researcher

Signature of researcher

Date

A copy of this Informed Consent Form has been provided to the participant.

2. Child Neglect Questionnaire

A SURVEY OF GPS UNDERSTANDING OF CHILD NEGLECT

WORK SETTING

1. Please circle all the following boxes that apply to your practice:

Group practice	Training practice	RCGP Accredited
Single handed practice	Non-training practice	

2. Please circle one of the following boxes which best describes your work location:

North Glasgow	South Glasgow	East Glasgow	West Glasgow

3. Please circle one box that best describes the level of deprivation in your practice area:

High Deprivation	Low Deprivation

4. Does your practice undertake child health screening?(please circle one box)

Yes	No

POST GRADUATE QUALIFICATIONS AND TRAINING

5. Please tick the post graduate qualifications you have gained and training you have received:

QUALIFICATIONS	MRCGP	
	DCH	
	Other paediatric qualification (please specify)	
TRAINING DURING	Paediatric surgery	
	Paediatric medicine	

HOSPITAL ATTACHEMENTS	Paediatric A & E medicine	
ACCREDITED POST-GRADUATE TRAINING	Child Health Surveillance	
	Child Protection Training	

CURRENT LEGISLATION AND FRAMEWORKS

In general, have you read (or heard) about any documents that have contributed to your understanding of child neglect?(please circle yes or no)

Yes	No

6. To what extent have the following documents influenced your understanding of child neglect?

	Not at all	Very little	Somewhat	Greatly
Children (Scotland) Act (1995)				
For Scotland's Children: Better Integrated Children's Services (2001)				
Health for all Children 4; Guidance on implementation in Scotland, Scottish Executive (2004)				
Sharing Information About Children at Risk;A Guide to Good Practice ,Scottish Executive(2003)				
Hidden Harm: Responding to the needs of the children of problem drug users, Home Office (2003)				
Children's Charter and Framework for standards for child protection, Scottish Executive (2004)				

It's everyone's job to make sure I'm alright, Scottish Executive (2002)				
Keep me safe: RCGP strategy for child protection (2005)				
The Victoria Climbie inquiry(2003)				
Getting it right for every child, Scottish Executive (2006)				
The Children's Bill, DES (2004)				
Every Child Matters (2003)				
Scottish Executive (2004) Protecting Children and Young People ;Framework for Standards				

7.

Has anything or anyone else had a major influence on your understanding of child neglect? Please give details:

CORRELATES OF NEGLECT

8. Please tick the box that most accurately reflects how you feel about the following statements:

	Strongly Agree	Agree	Unsure	Disagree	Strongly Disagree

GPs should be involved in screening vulnerable families for child neglect					
Child neglect has serious health implications for affected individuals					
GPs should readily share information with other agencies if they suspect child neglect					
I know who to share information with if a child in my practice is being neglected					
It is not possible to screen for child neglect without assessing parental health and social issues					
I understand the Data Protection Act in relation to child protection issues.					
There is enough provision for GPs in the GMS Contract for undertaking child neglect prevention					
I understand the role of the CHCP in relation to child neglect prevention.					
GPs are often the first professional contact for vulnerable families.					
GPs should have greater resources to undertake screening for child neglect.					

9. Please rank five factors that you feel contribute most to child neglect, 1 being the most important, and 5 being the least important:

	Rate 1-5
Parental substance misuse	
Parental social isolation	
Social deprivation	
Poor parental educational achievement	
Parent having left care	
Parental learning difficulties	
Parental mental health problems	
Greater number of children less than 5 years living in the household	
Young parental age	
Poor housing conditions	

10. COMMENTS

Please use this space for any further comments on the role of GPs in assessing children in need.

11. Please circle your age group and sex

25-30	31-40	41-50	51-60	Over 60

Male	Female

12. How many years have you been a principal in General Practice?

…….. years

Thank you for completing this questionnaire; the information gathered will be anonymised and the results may be published in a peer-reviewed journal.

If you are interested in either participating in an interview or focus group concerning this topic please e-mail me at anne.mullin@nhs.net

3. Interview Schedule

Thank you (name) for agreeing to being interviewed today. You've read the information sheet and signed the consent form so you know a little bit about what we will talk about today. Basically I'm exploring working GPs understanding of child neglect and what I would like are your ideas and opinions about this subject however you think you have developed them in your own words. I obviously need to record the interview because the analysis is complex takes time and without the recorded data I would inevitably miss some aspects of the interview. I might take notes but these will be small reminders to myself as the interview gets underway.

When I transcribe the tapes I will be erasing any names that might possible identify you. The interview data will therefore be anonymised and once the transcription is complete I will send you a transcript for your comments. I hope this is ok and makes you comfortable in the interview. Any questions?

Introductory Questions

Name ?

What age are you?

How many years have you worked as a GP principal?

Demographics

Can you tell me a bit about the demographics of the practice that you work within?

Job Characteristics

What do you like about your job?

What do you dislike about your job

Do you have any paediatric training (before or during GP training)?

Do you undertake child health surveillance?

Child Neglect Meaning

I'm going to ask you some questions about child neglect

Can you tell me how you would define child neglect?

There are some important parental attributes that contribute to neglect –can you tell me what they might be?

Do you think that there are longterm consequences in affected individuals from child neglect?

What are they?

Experiences of neglect

Do you think that you have dealt with child neglect in your capacity as a GP?

Can you tell me a bit about that-e.g.-what was your involvement/how did you detect it/what action did you take?

What difficulties or dilemmas are there for dealing with this on a professional or personal level?

Knowledge Acquisition

If you wanted to learn more about child neglect-how would you do this-who would you speak to, would you use any websites, local child protection unit?

How do you think you have learned about neglect?

Working Framework

What role should gps take in the screening of children for neglect?

Do you think there is adequate provision for this in the contract

What do you think would help GPs becoming involved in assessing vulnerable children?

What are the current barriers to this?

The GP Role

Do you think that GPs have a diminishing role in neglect prevention?

What do you think the role of the GP should be?

Personal Viewpoint

In what ways do you think you have changed over the years as you have become more experienced as a GP?

Closing Question

Thankyou very much for sharing your views and opinions before we finish is there anything else that I should know about your understanding of child neglect?

Is there anything that you'd like to ask me?

Once I've transcribed the data I'll send you a copy and you can send any comments back.

4. Interviews and Focus Group Participants

GP Participant No	Gender	Site of Interview	No of Years in Practice	Length of Interview
GP1	M	Surgery	18	17mins 10 secs
GP2	F	Surgery	26	15 mins 4secs
GP3	M	Surgery	20	12mins 35secs
GP4	F	Surgery	17	22mins 30secs
GP5	M	Surgery	29	17mins 20secs
GP6	M	Academic Centre	20	36 mins 42secs
GP7	M	Home	15	25mins 22secs
GP8	F	Academic Centre	21	23mins 39secs
GP9	M	Surgery	11	18mins 4secs
GP10	M	Surgery	16	18mins 17secs
GP11	M	Surgery	12	14mins 9secs
GP12	M	Surgery	8	8mins 17secs
GP13	M	Home	26	25mins 41secs
GP14	M	Home	4	15mins 20secs
GP15	F	Home	16	19mins 50secs
GP16	F	Surgery	18	12mins 5secs

Table 7: Interview Participants

Speaker	Gender	No of years in Practice
SK1(facilitator)	F	14
*SK2	F	N/A
SK3	F	26
SK4	M	<5
SK5	M	21
SK6	F	18

Table 8: Focus Group Participants

*SK 2 is an academic with a sociology background - all other participants are working GPs.

APPENDIX B

		All GPs	Gender		p	Age			p
			Male	Female		31-40	41-50	>50	
Age	N (%) 31-40	18 (23.4%)	9 (23.1%)	9 (23.7%)	p=0.730				
	N (%) 41-50	46 (59.7%)	22 (56.4%)	24 (63.2%)					
	N (%) >50	13 (16.9%)	8 (20.5%)	5 (13.2%)					
Years as GP	Mean (SD)	15.6 (6.8)	16.2 (7.0)	15.0 (6.6)	p=0.599	7.3 (3.9)	16.5 (4.4)	23.9 (3.9)	p<0.001

Table 9: Demographic data of the research participants by age and gender

		All GPs	Training		P	Deprivation		p
			No	Yes		Low	High	
Age	N (%) 31-40	18 (23.4%)	12 (24.5%)	6 (21.4%)	p=0.844	4 (15.4%)	12 (25.5%)	p=0.183
	N (%) 41-50	46 (59.7%)	28 (57.1%)	18 (64.3%)		15 (57.7%)	30 (63.8%)	
	N (%) >50	13 (16.9%)	9 (18.4%)	4 (14.3%)		7 (26.9%)	5 (10.6%)	
Years as GP	Mean (SD)	15.6 (6.8)	15.1 (7.2)	16.5 (6.0)	p=0.470	18.6 (6.6)	14.1 (6.3)	p=0.003

Table 10: Demographic data of research participants by practice status

		All GPs	Gender		p	Age			p
			Male	Female		31-40	41-50	>50	
Working in Single-	**N (%) No**	67 (91.8%)	31 (86.1%)	36 (97.3%)	p=0.107	16 (100.0%)	40 (90.9%)	11 (84.6%)	p=0.335
Handed Practice	**N (%) Yes**	6 (8.2%)	5 (13.9%)	1 (2.7%)		0 (0.0%)	4 (9.1%)	2 (15.4%)	
Working in	**N (%) No**	49 (63.6%)	28 (71.8%)	21 (55.3%)	p=0.159	12 (66.7%)	28 (60.9%)	9 (69.2%)	p=0.844
Training Practice	**N (%) Yes**	28 (36.4%)	11 (28.2%)	17 (44.7%)		6 (33.3%)	18 (39.1%)	4 (30.8%)	
	N (%) North	15 (19.5%)	6 (15.4%)	9 (23.7%)		3 (16.7%)	9 (19.6%)	3 (23.1%)	
	N (%) South	31 (40.3%)	19 (48.7%)	12 (31.6%)		4 (22.2%)	21 (45.7%)	6 (46.2%)	
Practice Location	**N (%) East**	6 (7.8%)	2 (5.1%)	4 (10.5%)	p=0.590	1 (5.6%)	5 (10.9%)	0 (0.0%)	p=0.151
	N (%) West	17 (22.1%)	8 (20.5%)	9 (23.7%)		7 (38.9%)	9 (19.6%)	1 (7.7%)	
	N (%) Other	8 (10.4%)	4 (10.3%)	4 (10.5%)		3 (16.7%)	2 (4.3%)	3 (23.1%)	
Practice	**N (%) Low**	26 (35.6%)	10 (27.0%)	16 (44.4%)	p=0.147	4 (25.0%)	15 (33.3%)	7 (58.3%)	p=0.183
Deprivation	**N (%) High**	47 (64.4%)	27 (73.0%)	20 (55.6%)		12 (75.0%)	30 (66.7%)	5 (41.7%)	
Practice Child	**N (%) No**	4 (5.2%)	3 (7.7%)	1 (2.6%)	p=0.615	0 (0.0%)	3 (6.5%)	1 (7.7%)	p=0.619
Health Screening	**N (%) Yes**	73 (94.8%)	36 (92.3%)	37 (97.4%)		18 (100.0%)	43 (93.5%)	12 (92.3%)	

Table 11: Work setting of research participants by age and gender

		All GPs	Training		p	Deprivation		p
			No	Yes		Low	High	
Working in Single-Handed Practice	**N (%) No**	67 (91.8%)	42 (87.5%)	25 (100.0%)	p=0.088	21 (87.5%)	42 (93.3%)	p=0.412
	N (%) Yes	6 (8.2%)	6 (12.5%)	0 (0.0%)		3 (12.5%)	3 (6.7%)	
Working in Training Practice	**N (%) No**	49 (63.6%)				14 (53.8%)	31 (66.0%)	p=0.327
	N (%) Yes	28 (36.4%)				12 (46.2%)	16 (34.0%)	
Practice Location	**N (%) North**	15 (19.5%)	10 (20.4%)	5 (17.9%)	p=0.969	4 (15.4%)	11 (23.4%)	p=0.751
	N (%) South	31 (40.3%)	20 (40.8%)	11 (39.3%)		11 (42.3%)	17 (36.2%)	
	N (%) East	6 (7.8%)	3 (6.1%)	3 (10.7%)		1 (3.8%)	5 (10.6%)	
	N (%) West	17 (22.1%)	11 (22.4%)	6 (21.4%)		7 (26.9%)	9 (19.1%)	
	N (%) Other	8 (10.4%)	5 (10.2%)	3 (10.7%)		3 (11.5%)	5 (10.6%)	
Practice Deprivation	**N (%) Low**	26 (35.6%)	14 (31.1%)	12 (42.9%)	p=0.327			
	N (%) High	47 (64.4%)	31 (68.9%)	16 (57.1%)				
Practice Child Health Screening	**N (%) No**	4 (5.2%)	3 (6.1%)	1 (3.6%)	p=1.000	2 (7.7%)	2 (4.3%)	p=0.613
	N (%) Yes	73 (94.8%)	46 (93.9%)	27 (96.4%)		24 (92.3%)	45 (95.7%)	

Table 12: Respondent work setting by practice status

		All GPs	Gender		p	Age			p
			Male	Female		31-40	41-50	>50	
MRCGP	**N (%) No**	16 (20.8%)	8 (20.5%)	8 (21.1%)	p=1.000	1 (5.6%)	11 (23.9%)	4 (30.8%)	p=0.153
	N (%) Yes	61 (79.2%)	31 (79.5%)	30 (78.9%)		17 (94.4%)	35 (76.1%)	9 (69.2%)	
DCH	**N (%) No**	71 (92.2%)	37 (94.9%)	34 (89.5%)	p=0.431	17 (94.4%)	42 (91.3%)	12 (92.3%)	p=1.000
	N (%) Yes	6 (7.8%)	2 (5.1%)	4 (10.5%)		1 (5.6%)	4 (8.7%)	1 (7.7%)	
Other Paediatric	**N (%) No**	72 (93.5%)	38 (97.4%)	34 (89.5%)	p=0.200	17 (94.4%)	43 (93.5%)	12 (92.3%)	p=1.000
Qualification	**N (%) Yes**	5 (6.5%)	1 (2.6%)	4 (10.5%)		1 (5.6%)	3 (6.5%)	1 (7.7%)	
Paediatric	**N (%) No**	67 (87.0%)	33 (84.6%)	34 (89.5%)	p=0.737	16 (88.9%)	39 (84.8%)	12 (92.3%)	p=0.898
Surgery	**N (%) Yes**	10 (13.0%)	6 (15.4%)	4 (10.5%)		2 (11.1%)	7 (15.2%)	1 (7.7%)	
Paediatric	**N (%) No**	44 (57.1%)	22 (56.4%)	22 (57.9%)	p=1.000	10 (55.6%)	25 (54.3%)	9 (69.2%)	p=0.656
Medicine	**N (%) Yes**	33 (42.9%)	17 (43.6%)	16 (42.1%)		8 (44.4%)	21 (45.7%)	4 (30.8%)	
Paediatric	**N (%) No**	62 (80.5%)	32 (82.1%)	30 (78.9%)	p=0.780	16 (88.9%)	35 (76.1%)	11 (84.6%)	p=0.568
A and E Medicine	**N (%) Yes**	15 (19.5%)	7 (17.9%)	8 (21.1%)		2 (11.1%)	11 (23.9%)	2 (15.4%)	
Child Health	**N (%) No**	23 (29.9%)	13 (33.3%)	10 (26.3%)	p=0.620	6 (33.3%)	13 (28.3%)	4 (30.8%)	p=0.940
Surveillance	**N (%) Yes**	54 (70.1%)	26 (66.7%)	28 (73.7%)		12 (66.7%)	33 (71.7%)	9 (69.2%)	
Child Protection	**N (%) No**	50 (64.9%)	22 (56.4%)	28 (73.7%)	p=0.153	11 (61.1%)	30 (65.2%)	9 (69.2%)	p=0.893
Training	**N (%) Yes**	27 (35.1%)	17 (43.6%)	10 (26.3%)		7 (38.9%)	16 (34.8%)	4 (30.8%)	

Table 13: Postgraduate qualifications and training by gender and age

		All GPs	Training		p	Deprivation		p
			No	Yes		Low	High	
MRCGP	**N (%) No**	16 (20.8%)	14 (28.6%)	2 (7.1%)	p=0.039	6 (23.1%)	9 (19.1%)	p=0.766
	N (%) Yes	61 (79.2%)	35 (71.4%)	26 (92.9%)		20 (76.9%)	38 (80.9%)	
DCH	**N (%) No**	71 (92.2%)	46 (93.9%)	25 (89.3%)	p=0.662	24 (92.3%)	44 (93.6%)	p=1.000
	N (%) Yes	6 (7.8%)	3 (6.1%)	3 (10.7%)		2 (7.7%)	3 (6.4%)	
Other Paediatric	**N (%) No**	72 (93.5%)	45 (91.8%)	27 (96.4%)	p=0.648	25 (96.2%)	44 (93.6%)	p=1.000
Qualification	**N (%) Yes**	5 (6.5%)	4 (8.2%)	1 (3.6%)		1 (3.8%)	3 (6.4%)	
Paediatric	**N (%) No**	67 (87.0%)	40 (81.6%)	27 (96.4%)	p=0.083	24 (92.3%)	40 (85.1%)	p=0.476
Surgery	**N (%) Yes**	10 (13.0%)	9 (18.4%)	1 (3.6%)		2 (7.7%)	7 (14.9%)	
Paediatric	**N (%) No**	44 (57.1%)	26 (53.1%)	18 (64.3%)	p=0.473	16 (61.5%)	27 (57.4%)	p=0.807
Medicine	**N (%) Yes**	33 (42.9%)	23 (46.9%)	10 (35.7%)		10 (38.5%)	20 (42.6%)	
Paediatric	**N (%) No**	62 (80.5%)	37 (75.5%)	25 (89.3%)	p=0.231	23 (88.5%)	38 (80.9%)	p=0.519
A and E Medicine	**N (%) Yes**	15 (19.5%)	12 (24.5%)	3 (10.7%)		3 (11.5%)	9 (19.1%)	
Child Health	**N (%) No**	23 (29.9%)	17 (34.7%)	6 (21.4%)	p=0.302	7 (26.9%)	15 (31.9%)	p=0.792
Surveillance	**N (%) Yes**	54 (70.1%)	32 (65.3%)	22 (78.6%)		19 (73.1%)	32 (68.1%)	
Child Protection	**N (%) No**	50 (64.9%)	35 (71.4%)	15 (53.6%)	p=0.140	17 (65.4%)	29 (61.7%)	p=0.805
Training	**N (%) Yes**	27 (35.1%)	14 (28.6%)	13 (46.4%)		9 (34.6%)	18 (38.3%)	

Table 14: Postgraduate qualifications and training by practice status

		All GPs	Gender		p	Age			p
			Male	Female		31-40	41-50	>50	
Any, in general	**N (%) No**	20 (26.3%)	11 (28.2%)	9 (24.3%)	p=0.797	4 (22.2%)	13 (28.3%)	3 (25.0%)	p=0.933
	N (%) Yes	56 (73.7%)	28 (71.8%)	28 (75.7%)		14 (77.8%)	33 (71.7%)	9 (75.0%)	
Children Scotland Act	**Mean (SD)**	0.54 (0.82)	0.67 (0.90)	0.41 (0.72)	p=0.180	0.50 (0.79)	0.61 (0.88)	0.33 (0.65)	p=0.647
For Scotland's Children	**Mean (SD)**	0.38 (0.67)	0.33 (0.62)	0.43 (0.73)	p=0.615	0.33 (0.59)	0.39 (0.71)	0.42 (0.67)	p=0.932
Hall 4	**Mean (SD)**	0.80 (0.88)	0.79 (0.89)	0.81 (0.88)	p=0.910	0.67 (0.97)	0.85 (0.84)	0.83 (0.94)	p=0.630
Sharing Information	**Mean (SD)**	0.72 (0.92)	0.82 (0.91)	0.62 (0.92)	p=0.260	0.67 (0.91)	0.76 (0.97)	0.67 (0.78)	p=0.948
Hidden Harm	**Mean (SD)**	0.64 (0.95)	0.77 (1.01)	0.51 (0.87)	p=0.258	0.61 (1.09)	0.65 (0.92)	0.67 (0.89)	p=0.878
Children's Charter	**Mean (SD)**	0.45 (0.76)	0.46 (0.76)	0.43 (0.77)	p=0.780	0.61 (1.04)	0.43 (0.69)	0.25 (0.45)	p=0.739
I'm Alright	**Mean (SD)**	0.55 (0.89)	0.67 (0.98)	0.43 (0.77)	p=0.378	0.50 (0.99)	0.59 (0.88)	0.50 (0.80)	p=0.866
Keep Me Safe	**Mean (SD)**	0.68 (0.88)	0.77 (0.84)	0.59 (0.93)	p=0.237	0.72 (0.83)	0.74 (0.93)	0.42 (0.79)	p=0.476
Climbie	**Mean (SD)**	1.17 (1.02)	1.26 (1.02)	1.08 (1.04)	p=0.461	1.39 (1.04)	1.07 (1.02)	1.25 (1.06)	p=0.514
GIRFEC	**Mean (SD)**	0.61 (0.90)	0.59 (0.82)	0.62 (0.98)	p=0.845	0.61 (0.92)	0.61 (0.93)	0.58 (0.79)	p=0.968
Children's Bill	**Mean (SD)**	0.25 (0.54)	0.31 (0.57)	0.19 (0.52)	p=0.216	0.22 (0.43)	0.30 (0.63)	0.08 (0.29)	p=0.536
Every Child Matters	**Mean (SD)**	0.46 (0.76)	0.41 (0.72)	0.51 (0.80)	p=0.616	0.33 (0.59)	0.52 (0.81)	0.42 (0.79)	p=0.772
Framework for Standards	**Mean (SD)**	0.51 (0.76)	0.51 (0.72)	0.51 (0.80)	p=0.841	0.67 (0.84)	0.46 (0.72)	0.50 (0.80)	p=0.543
Average Document Score	**Mean (SD)**	0.60 (0.51)	0.64 (0.54)	0.55 (0.48)	p=0.457	0.60 (0.54)	0.61 (0.52)	0.53 (0.46)	p=0.951

Table 15: Documents read, by gender and age

		All GPs	Training		p	Deprivation		p
			No	Yes		Low	High	
Any, in general	**N (%) No**	20 (26.3%)	14 (29.2%)	6 (21.4%)	p=0.592	7 (26.9%)	10 (21.7%)	p=0.773
	N (%) Yes	56 (73.7%)	34 (70.8%)	22 (78.6%)		19 (73.1%)	36 (78.3%)	
Children Scotland Act	**Mean (SD)**	0.54 (0.82)	0.56 (0.85)	0.50 (0.79)	p=0.773	0.35 (0.69)	0.67 (0.90)	p=0.110
For Scotland's Children	**Mean (SD)**	0.38 (0.67)	0.29 (0.58)	0.54 (0.79)	p=0.176	0.38 (0.64)	0.37 (0.68)	p=0.765
Hall 4	**Mean (SD)**	0.80 (0.88)	0.62 (0.76)	1.11 (0.99)	p=0.037	0.65 (0.85)	0.89 (0.90)	p=0.270
Sharing Information	**Mean (SD)**	0.72 (0.92)	0.67 (0.88)	0.82 (0.98)	p=0.535	0.69 (0.88)	0.78 (0.96)	p=0.804
Hidden Harm	**Mean (SD)**	0.64 (0.95)	0.56 (0.92)	0.79 (0.99)	p=0.302	0.50 (0.91)	0.74 (0.98)	p=0.257
Children's Charter	**Mean (SD)**	0.45 (0.76)	0.38 (0.70)	0.57 (0.84)	p=0.258	0.19 (0.49)	0.63 (0.85)	p=0.015
I'm Alright	**Mean (SD)**	0.55 (0.89)	0.56 (0.85)	0.54 (0.96)	p=0.669	0.23 (0.51)	0.74 (1.00)	p=0.031
Keep Me Safe	**Mean (SD)**	0.68 (0.88)	0.58 (0.77)	0.86 (1.04)	p=0.369	0.62 (0.85)	0.78 (0.92)	p=0.449
Climbie	**Mean (SD)**	1.17 (1.02)	1.17 (0.97)	1.18 (1.12)	p=0.968	0.77 (0.99)	1.41 (0.98)	p=0.009
GIRFEC	**Mean (SD)**	0.61 (0.90)	0.56 (0.90)	0.68 (0.90)	p=0.556	0.58 (0.86)	0.63 (0.93)	p=0.978
Children's Bill	**Mean (SD)**	0.25 (0.54)	0.29 (0.58)	0.18 (0.48)	p=0.363	0.19 (0.49)	0.30 (0.59)	p=0.393
Every Child Matters	**Mean (SD)**	0.46 (0.76)	0.46 (0.74)	0.46 (0.79)	p=0.910	0.38 (0.70)	0.54 (0.81)	p=0.437
Framework for Standards	**Mean (SD)**	0.51 (0.76)	0.52 (0.77)	0.50 (0.75)	p=0.920	0.35 (0.63)	0.61 (0.80)	p=0.154
Average Document Score	**Mean (SD)**	0.60 (0.51)	0.56 (0.46)	0.67 (0.60)	p=0.595	0.45 (0.42)	0.70 (0.54)	p=0.074

Table 16: Documents read, by practice status

		All GPs	Gender		p	Age			p
			Male	Female		31-40	41-50	>50	
GPs Involved	**Mean (SD)**	3.45 (0.97)	3.45 (0.98)	3.45 (0.98)	p=1.000	3.61 (0.98)	3.41 (1.00)	3.33 (0.89)	p=0.651
Health Implications	**Mean (SD)**	4.74 (0.44)	4.74 (0.44)	4.74 (0.45)	p=0.947	4.83 (0.38)	4.78 (0.42)	4.46 (0.52)	p=0.041
Share Information	**Mean (SD)**	4.60 (0.59)	4.67 (0.62)	4.53 (0.56)	p=0.140	4.72 (0.57)	4.54 (0.62)	4.62 (0.51)	p=0.477
Know Sharing	**Mean (SD)**	4.48 (0.58)	4.54 (0.60)	4.42 (0.55)	p=0.284	4.61 (0.50)	4.43 (0.62)	4.46 (0.52)	p=0.599
Assess Parental Info	**Mean (SD)**	3.93 (0.85)	4.00 (0.93)	3.87 (0.78)	p=0.378	4.22 (0.73)	3.85 (0.92)	3.83 (0.72)	p=0.277
Understand DP Act	**Mean (SD)**	3.64 (0.89)	3.56 (1.02)	3.71 (0.73)	p=0.552	3.89 (0.83)	3.61 (0.83)	3.38 (1.12)	p=0.306
GMS Contract	**Mean (SD)**	2.03 (0.75)	2.11 (0.65)	1.95 (0.84)	p=0.192	1.82 (0.73)	2.09 (0.81)	2.08 (0.49)	p=0.456
CHCP Role	**Mean (SD)**	2.79 (0.85)	2.76 (0.88)	2.82 (0.83)	p=0.876	2.83 (0.79)	2.73 (0.81)	2.92 (1.12)	p=0.663
GP First Contact	**Mean (SD)**	4.01 (0.79)	4.05 (0.72)	3.97 (0.85)	p=0.899	4.17 (0.79)	4.00 (0.79)	3.85 (0.80)	p=0.445
Greater Resource	**Mean (SD)**	3.84 (0.84)	3.79 (0.89)	3.89 (0.80)	p=0.551	3.83 (1.10)	3.87 (0.75)	3.77 (0.83)	p=0.868
Composite (2, 3, 4)	**Mean (SD)**	4.61 (0.43)	4.65 (0.45)	4.56 (0.41)	p=0.263	4.72 (0.42)	4.59 (0.44)	4.51 (0.40)	p=0.263
Composite (5, 6)	**Mean (SD)**	3.79 (0.74)	3.79 (0.87)	3.79 (0.60)	p=0.738	4.06 (0.64)	3.73 (0.74)	3.62 (0.86)	p=0.193
Composite (9, 10)	**Mean (SD)**	3.93 (0.72)	3.92 (0.72)	3.93 (0.72)	p=0.801	4.00 (0.89)	3.93 (0.67)	3.81 (0.63)	p=0.674

Table 17: Statements about neglect, by gender and age

		All GPs	Gender		p	Age			p
			Male	Female		31-40	41-50	>50	
Par Subs Misuse	**Mean (SD)**	4.14 (1.37)	4.00 (1.55)	4.28 (1.17)	p=0.449	3.93 (1.44)	4.08 (1.46)	4.58 (0.90)	p=0.318
Par Social Isol	**Mean (SD)**	1.58 (1.59)	1.43 (1.45)	1.72 (1.73)	p=0.672	1.79 (1.63)	1.54 (1.66)	1.45 (1.44)	p=0.830
Social Dep	**Mean (SD)**	2.50 (1.80)	2.63 (1.94)	2.38 (1.68)	p=0.611	2.57 (1.83)	2.65 (1.86)	1.91 (1.58)	p=0.520
Poor Par Educ	**Mean (SD)**	0.71 (1.25)	0.77 (1.25)	0.66 (1.26)	p=0.686	0.50 (0.85)	1.00 (1.45)	0.00 (0.00)	p=0.061
Par Left Care	**Mean (SD)**	0.92 (1.43)	0.93 (1.36)	0.91 (1.51)	p=0.856	0.21 (0.58)	1.11 (1.51)	1.18 (1.72)	p=0.121
Par LD	**Mean (SD)**	1.08 (1.51)	0.90 (1.49)	1.25 (1.52)	p=0.293	1.21 (1.63)	0.92 (1.46)	1.45 (1.57)	p=0.531
Par MH Probs	**Mean (SD)**	2.23 (1.63)	1.97 (1.67)	2.47 (1.59)	p=0.231	3.07 (1.64)	1.86 (1.55)	2.36 (1.63)	p=0.057
Many Children	**Mean (SD)**	0.69 (1.24)	1.07 (1.53)	0.34 (0.75)	p=0.061	0.50 (0.94)	0.68 (1.29)	1.00 (1.41)	p=0.539
Young Par Age	**Mean (SD)**	0.40 (1.19)	0.60 (1.40)	0.22 (0.94)	p=0.116	0.00 (0.00)	0.51 (1.30)	0.55 (1.51)	p=0.267
Poor Housing	**Mean (SD)**	0.74 (1.24)	0.60 (1.07)	0.88 (1.39)	p=0.472	0.93 (1.27)	0.78 (1.32)	0.36 (0.92)	p=0.422

Table 18: Statements about neglect (ranking), by gender and age

		gpsinvolved	healthimplications	shareinformation	knowingsharinginfo	assessparentalinfo	dataprotectionact	gmscontract	chcpchildprotect	gpscontactfamilies	greaterresources
Correlation	**gpsinvolved**	1.000	.345	.077	.156	.072	.153	-.167	.163	.188	.293
	healthimplications	.345	1.000	.420	.363	.100	.197	.062	.005	.227	.064
	shareinformation	.077	.420	1.000	.566	.078	.274	.086	.179	.146	-.132
	knowingsharinginfo	.156	.363	.566	1.000	.204	.471	-.029	.190	.221	.233
	assessparentalinfo	.072	.100	.078	.204	1.000	.427	-.082	.150	.237	.144
	dataprotectionact	.153	.197	.274	.471	.427	1.000	-.191	.307	.363	.244
	gmscontract	-.167	.062	.086	-.029	-.082	-.191	1.000	-.118	-.049	-.301
	chcpchildprotect	.163	.005	.179	.190	.150	.307	-.118	1.000	-.076	.158
	gpscontactfamilies	.188	.227	.146	.221	.237	.363	-.049	-.076	1.000	.508
	greaterresources	.293	.064	-.132	.233	.144	.244	-.301	.158	.508	1.000
Sig. (1-tailed)	**gpsinvolved**		.001	.257	.092	.272	.097	.078	.083	.054	.006
	healthimplications	.001		.000	.001	.199	.046	.299	.482	.026	.295
	shareinformation	.257	.000		.000	.253	.009	.233	.063	.107	.130
	knowingsharinginfo	.092	.001	.000		.041	.000	.404	.052	.029	.023
	assessparentalinfo	.272	.199	.253	.041		.000	.243	.101	.021	.110
	dataprotectionact	.097	.046	.009	.000	.000		.051	.004	.001	.018
	gmscontract	.078	.299	.233	.404	.243	.051		.159	.339	.005
	chcpchildprotect	.083	.482	.063	.052	.101	.004	.159		.261	.090
	gpscontactfamilies	.054	.026	.107	.029	.021	.001	.339	.261		.000
	greaterresources	.006	.295	.130	.023	.110	.018	.005	.090	.000	

a Determinant = .092

Table 19: Correlation Matrix

Component	Initial Eigenvalues			Extraction Sums of Squared Loadings			Rotation Sums of Squared Loadings		
	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %
1	2.845	28.446	28.446	2.845	28.446	28.446	2.268	22.679	22.679
2	1.608	16.076	44.523	1.608	16.076	44.523	2.184	21.843	44.523
3	1.227	12.275	56.798						
4	1.078	10.782	67.579						
5	.826	8.258	75.837						
6	.773	7.728	83.565						
7	.509	5.089	88.653						
8	.473	4.732	93.385						
9	.443	4.426	97.812						
10	.219	2.188	100.000						

Table 20: Total Variance Explained

Extraction Method: Principal Component Analysis. Extraction Method: Principal Component Analysis

	Initial	Extraction
gpsinvolved	1	0.697
healthimplications	1	0.689
shareinformation	1	0.740
knowingsharinginfo	1	0.646
assessparentalinfo	1	0.557
dataprotectionact	1	0.714
gmscontract	1	0.508
chcpchildprotect	1	0.709
gpscontactfamilies	1	0.778
greaterresources	1	0.720

Table 21: Communalities

Extraction Method: Principle Component Analysis

	Component	
	1	**2**
gpsinvolved	.452	
healthimplications	.531	.412
shareinformation	.524	.677
knowingsharinginfo	.721	
assessparentalinfo	.476	
dataprotectionact	.749	
gmscontract		.561
chcpchildprotect		
gpscontactfamilies	.581	
greaterresources	.508	-.640

Table 22: Component Matrix

Extraction Method: Principal Component Analysis.a 2 components extracted