

Nowhere to Stand

A critical discourse analysis of nurses' responses to child neglect and abuse

by

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Statement of Originality

I certify that, to the best of my knowledge, the content of this thesis is my own work. This thesis has not been submitted for any degree or other purposes.

I certify that the intellectual content of this thesis is the product of my own work and that all the assistance received in preparing this thesis and sources have been acknowledged.

Rochelle Diane Einboden

*I dedicate this thesis to Jesse,
who inspired me to think carefully about child neglect and abuse.*

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Abstract

Nurses working with families are well positioned to respond to child neglect and abuse (CN&A), yet in Canada, their role is poorly defined and they remain peripheral to child protection work. The purpose of this research is to better understand nurses' contributions to addressing CN&A and to support nursing practice in this regard. The research questions ask: how do nurses respond to CN&A; what influences these responses; and what might support nurses to respond more effectively than they currently do? Fairclough's dialectical-relational critical discursive analysis was chosen as a method because of its strength in addressing resistant social problems. Texts that represent and guide nurses' responses to CN&A in British Columbia were collected and discursively analysed. These texts include legislation, policy and practice guidelines, nurse interviews, and popular news media texts. Philosophical ideas from Žižek and Spinoza support the theorisation of violence and suspicion, while Haraway supports the identification of three tropic figurations, which form obstacles to meaningful responses to CN&A. Tracing the operations of these figurations throughout the texts, *The Vulnerable Child* is shown to justify oppressive proprietary relations and surveillance over children, *The Responsible Family* is shown to legitimise social inequity for children and isolate them in the home where they are most likely to experience abuse, and *The Monstrous Perpetrator* is shown to focus attention on spectacular cases, diverting it away from most CN&A. Findings demonstrate how nurses are frustrated by social structures that govern their practice and leave them in challenging ethical positions, often with *nowhere to stand*. In this thesis, I argue that the dominant individualised responses to CN&A are misaimed and call for a social response to interrupt everyday violations that children experience.

List of Abbreviations

British Columbia (BC)

British Columbia's Institute of Technology (BCIT)

Child, Family and Community Services Act (CFCS Act)

Child neglect and abuse (CN&A)

Child Protection Services Unit (CPSU)

Child Protection System (CPS)

Child Protection Worker (CPW)

College of Registered Nurses of British Columbia (CRNBC)

Critical discourse analysis (CDA)

Dialectical-relational critical discourse analysis (DRCDA)

Intimate partner violence (IPV)

Ministry of Children and Family Development (MCFD)

Registered Nurse (RN)

Representative for Children and Youth (RCY)

Shaken Baby Syndrome (SBS)

Society for the Prevention of Cruelty to Animals (SPCA)

United Nations Convention on the Rights of the Child (UNCRC)

United States of America (USA)

University of British Columbia (UBC)

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Chapter 1: Introduction

My location: practice and philosophical questions

As a paediatric nurse, I have encountered many situations in practice where I have questioned health professional responses to child neglect and abuse (CN&A). These questions initially inspired this thesis, and subsequently have guided its development. One of the first times I remember questioning practice was when caring for an infant as a registered nurse (RN) in the neonatal intensive care unit. A social worker asked my opinion regarding a mother's capacity to care for a small, premature infant. At the time, I was 23 years old and had been registered for less than one year. The question reverberated with consequence and I felt completely unprepared to answer. The social worker explained how she assessed the clinical documentation for evidence as to whether or not these parents could meet their baby's complex needs at home. The family was struggling with extreme poverty, as were so many parents whose babies were born prematurely. It was in this role where I became aware of a certain amount of power that we hold as nurses to support or undermine a family's right to custody of their child.

Assuming the family would be working hard to keep their baby, I shared with the baby's mother my understanding of what she needed to demonstrate to be assessed as capable by the social worker. I encouraged her to feed and bath her baby so I could document her ability to provide care. In response, she explained her hesitation to perform care or to get close to her new baby. From a previous experience of having a child apprehended, she knew that demonstrating capacities to provide care for her baby in the hospital were only the first steps. The next steps included an investigation of her health,

home and security, and an evaluation of her 'fitness' as a mother. Given her own vulnerabilities, she believed that an apprehension was inevitable. Appearing incapable was therefore a way of expediting the process and avoiding painful judgments. While I could support her in demonstrating expected parenting behaviours in hospital, I could not offer any assistance with her broader social or health issues. She taught me that what I had assumed was supportive nursing care, would set her up for a painful and intrusive evaluation as an unfit mother.

Expensive and complex care needs of a premature baby are challenging for all parents, but these challenges are amplified and even prohibitive for families already struggling with poverty. At the same time, poverty is a significant correlate for premature birth, and maternal deprivation is a risk factor for prematurity. Vulnerabilities of mothers unfold to become the vulnerabilities of their children, yet mothers' needs are understood by society as separate from those of their infants, and mothers are held responsible for their children regardless of their own lack of personal resources. As a new nurse, I learned that mothering was an opportunity afforded to some mothers and not others, dictated by a hazy threshold of social power and privilege.

A critical perspective

I began graduate nursing studies after my first year working as a RN. In part, my motivation was to seek space to work through a dissonance between what I had expected to be doing as a nurse, and what was expected of me in the clinical setting. At the time, I was not able to articulate my discomfort but struggled with issues of power and my participation in some health care practices. In order to better understand these power issues, I also enrolled in a

collaborative Women's Studies program at the University of Toronto. There I was supported to develop skills as a critical feminist and social scholar.

A critical perspective followed me into various roles and prompted me to question practices and guidelines for nurses in responding to CN&A. When I began teaching an introductory paediatric course, I was responsible in ensuring graduating nurses were prepared with the requisite skills and knowledge to respond to CN&A. I had recently relocated from Ontario to British Columbia (BC) and delved into learning the provincial legislation, mandates of the Ministry of Children and Family Development (MCFD), and practice of the CN&A expert clinics. As I reviewed the legislation and practice guidelines for the curriculum, the uneasiness from my clinical experiences grew. Astute students also queried what I was sharing with them. Research and discussions with students left me with more questions than answers and ultimately led to the questions posed in this thesis.

Developing the research questions

The central questions asked in this thesis are: How do nurses respond to CN&A? What guides their responses? What might support nurses to respond more effectively than they currently do? There were three key issues that stood out in my mind that led to these questions. First, while nurses work closely with children and families, their role in addressing CN&A was poorly defined and they remained peripheral to child protection. Without a defined role, nurses often felt powerless to intervene. Second, there was a lack of clarity regarding mandatory reporting obligations. Third, while neglect was the most common type of abuse, it was rarely discussed in the literature or addressed in practice. These three issues are outlined in this following section to show how I came to see the problem as an issue of social justice, and one that was enmeshed in social discourse.

Poorly defined nursing role

According to BC legislation, interventions on the behalf of children by the MCFD's child protection system (CPS) are initiated only after an unsafe situation has been identified and reported (*Child, Family and Community Service [CFCS] Act, 1996*). Nurses are responsible for the identification and reporting of CN&A concerns to a delegate from the MCFD. This responsibility extends to all citizens, although the practice guidelines indicate that there is an expectation of higher compliance rates for service providers who work with children (Ministry of Child and Family Development [MCFD], 2007). Reports are thus essential and legally mandated.

Constituting nurses' responsibility as reporting ignores the everyday ways in which nurses intervene to prevent violence within their relationships with families. At the core of nursing practice, is an ability to assess situations, identify potential issues and plan interventions to prevent or at least mitigate potential harm. Nurses look for patterns and anticipate possible health issues, and this extends to their responses to safety concerns for children. I was encouraged to think more about how nurses practice with families in relation to child safety when I learned that research on prevention initiatives for CN&A identified intensive home visiting *by nurses* as the most promising intervention to date (MacMillan et al., 2009). Yet, within the legislation and practice guidelines there is no discussion of nurses' *prevention work* as a nursing responsibility in relation to child protection. Addressing CN&A is usually considered beyond the disciplinary bounds of nursing; it is thought to reside in the domain of other professionals, such as social workers or physicians.

Most CN&A nursing literature does not capture the work that nurses do in relation to prevention and there is very little attention to nurses' ideas or suggestions of how to

address unsafe conditions for children. Rather, research defines the nurses' role as identification and reporting, insists that nurses need further education to support *the identification* of child safety issues and highlights the grave consequences of poor adherence to reporting obligations (e.g. Chihak, 2009; Eisbach, 2009; Fraser, Mathews, Walsh, Chen, & Dunne, 2010; Gilbert, Kemp, et al., 2009; Mathews, Walsh, & Fraser, 2006; Representative of Children and Youth [RCY], 2014). Thus, nurses occupy tenuous ethical and practical spaces when initiating interventions in response to CN&A. Nursing responsibility for CN&A depends on the resources, involvement and opinions of other professionals.

The lack of acknowledgement of nurses' prevention work seemed especially curious given that the system carries the label of 'protection'. The usual meaning of the word 'protect' is to keep from harm in the first instance, yet the CPS is set up to rescue children from harm or potential harm, *after it has been identified and reported*. Even the small proportion of abused children who are apprehended into the custody of the MCFD are not guaranteed protection from further abuse. Instead, they suffer further abuse at disproportionately higher rates than children who have not been apprehended (RCY, 2016).

Lack of clarity regarding reporting obligations

When facilitating seminars for nursing students about CN&A, I was surprised by my own ignorance of seemingly simple questions, such as: Is it legal to spank children in Canada? I was also surprised by discrepant, yet passionate, student opinion as to what might constitute abusive or neglectful treatment of a child. Confusion and contradiction were also reflected in the law and practices. Legal permission of corporal punishment in Canada depends on an idea that physical force used against a child can be 'reasonable'. In a 2004 attempt to define 'reasonable force', (see *Canadian Foundation for Children Youth and the*

Law v. Canada [Attorney General] 2004), the Supreme Court of Canada outlined seven limitations, including:

- (a) it is administered by a parent (teachers may not use corporal punishment);
- (b) the child is between the ages of 2 and 12 years, inclusive;
- (c) the child is capable of learning from it;
- (d) it constitutes “minor corrective force of a transitory and trifling nature”;
- (e) it does not involve the use of objects or blows or slaps to the head;
- (f) it is corrective— that is, not the result of the caregiver’s “frustration, loss of temper or abusive personality”; and
- (g) it is not degrading, inhuman or harmful.

(Durrant, Trocmé, Fallon, Milne, & Black, 2009, p. 67)

These limitations fail to delineate acceptable levels of force in a useful way for child protection practice. Instead “*each* of the court’s criteria defining reasonable force actually characterized the majority of cases of substantiated child physical maltreatment” (Durrant et al., 2009, p. 82, emphasis in original).

The lack of clarity in relation to what constitutes CN&A corresponds with a lack of clarity in relation to nurses’ mandatory reporting obligations. For instance, BC child protection law requires reporting when a service provider has ‘reason to believe’ that a child may have been harmed (*CFCS Act, 1996*). Clarification of this phrase in the practice guidelines draws on discourse of simplicity rather than addressing the complexity that is often experienced in practice:

“Reason to believe” simply means that, based on what you have seen or information you have received, you believe a child has been or is likely to be at risk. You do not need to be certain. It is the child welfare worker’s job to determine whether abuse or neglect has occurred or is likely to occur. (MCFD, 2007, p. 40, emphasis in original)

The guideline identifies ‘possible indicators’ for the various types of abuse, which range from obvious (such as a child with visible imprints of identifiable objects on their skin) to obscure (such as a child who is withdrawn or overly compliant) (MCFD, 2007, pp. 27-28). Further, students questioned whether exposure to intimate partner violence (IPV) could be understood as a type of abuse, and if so, what would be the threshold for that? Reviewing the MCFD guidelines left students asking how they would know if they *suspected enough* to warrant a report? Atheoretical attempts to clarify these obligations were not helpful.

In the absence of a critical dialogue as to what constitutes violence, suspicion and how the context influences these constitutions, the identification of abuse remains wide open to dominant and discriminatory social understandings of CN&A, and its abusers and victims. The problem of discrimination in practice is exacerbated by the CN&A literature that profiles abusers and victims based on descriptive statistical data. Without an appreciation of the historical and political context, statistics constitute Aboriginal Peoples of Canada (First Nation, Inuit and Métis Peoples)¹ as likely suspects of child abuse. Yet, the Canadian government has been intrusive in Aboriginal Peoples’ family and community life

¹ In this thesis, I follow the National Aboriginal Health Organization (n.d.) recommendations for use of the term ‘Aboriginal Peoples of Canada’ to collectively describe multiple First Nations, Inuit and Métis Peoples of Canada, as well as the term ‘Indigenous’ to describe parents, families, children and communities, who are amongst Aboriginal Peoples of Canada.

and has used child apprehensions as a tool of colonisation. The legacy of these violent practices has meant that since the early days of the CPS in Canada, a disproportionate number of Indigenous children have occupied spaces in state care. The rate of removal of Indigenous children from their families and communities into state care has intensified across Canada for more than a century. This situation has been intensifying over the past decade. Although Indigenous children constitute less than 10 per cent of the child population in BC, in 2004, approximately 40 per cent of children in care were Indigenous children (Blackstock, Trocme, & Bennett, 2004); in 2008, this number had risen to 52 per cent (Kozlowski, Sinha, Hoey, & Lucas, 2012); and in 2016, it was just over 60 per cent (John, 2016). There are more Indigenous children in state care in BC than ever before in Canada's history, even compared with numbers at the height of the residential school system² (Trocmé, Knoke, & Blackstock, 2004).

The magnitude of CN&A and 'the neglect of neglect'

Establishing the incidence of CN&A is challenging. Inconsistent reporting and shifting understandings of what constitutes CN&A further complicate measurement. While the *Canadian Incidence Study of Reported Child Abuse and Neglect – 2008* found the rate of substantiated cases of CN&A to be 14.19 for every 1000 children, only 36 per cent of reported cases were substantiated (Public Health Agency of Canada, 2010). It is likely that most cases never come to the attention of the MCFD; a Lancet literature review estimated that:

² The residential school system was a federally funded collaboration with religious missionaries (school administrators). Residential schools were established to assimilate the Indigenous children into the language and culture of white settler society. Federal law mandated the attendance of Indigenous children at these schools, and the state forcibly removed children from their communities for generations. See Chapter 3 for a more detailed discussion.

Every year, about 4–16% of children are physically abused and one in ten is neglected or psychologically abused. During childhood, between 5% and 10% of girls and up to 5% of boys are exposed to penetrative sexual abuse, and up to three times this number are exposed to any type of sexual abuse. (Gilbert, Widom, et al., 2009, p. 68)

Analysis of data from the *Canadian Incidence Study of Reported Child Abuse and Neglect – 1998* showed that the most common type of abuse was neglect and of the substantiated cases of neglect, approximately half were due to ‘failure to supervise’ (Trocmé et al., 2001). Further, recent meta-analysis of CN&A studies estimates that more than 15 per cent *of all children* suffer from neglect (Stoltenborgh, Bakermans-Kranenburg, & van IJzendoorn, 2013). Despite having the smallest proportion of investigations and substantiated cases, sexual abuse garners more public and academic attention than neglect (Stoltenborgh et al., 2013). Neglect is ignored in the literature relative to other forms of CN&A (Stoltenborgh et al., 2013; The Lancet, 2003). Everyday discourses matter, thus throughout this thesis I use the term ‘child neglect and abuse’ (CN&A) to recognise the prominence of neglect.³

Reconfiguration of the main categories of abuse types in the *Canadian Incidence Study of Reported Child Abuse and Neglect – 2008*, which included exposure to IPV, described the incidence of neglect as equivalent to the incidence of exposure to IPV (34 per cent of substantiated cases) (Public Health Agency of Canada, 2010). These statistics raise more questions about social and gender inequity and the position and power of the child’s mother, whose welfare is artificially separated from her child’s despite her child’s

³ I am indebted to my astute colleague and fellow doctoral student, Sarah Lake, for this contribution during one of our discussions.

dependency. Substantiated neglect is confounded by social inequity, where a “high prevalence of single-parent homes, social assistance, regularly running out of money, and unsafe housing were found for substantiated cases of neglect” (Afifi et al., 2015, p. 320). Neglect also figures centrally in the overrepresentation of Indigenous children into state care (John, 2016).

From a critical perspective, it is not possible to talk about neglect without consideration of social and economic deprivation of young families. BC does not provide accessible child care programs to young families and is the worst performing province in relation to poverty in the nation. One in every five BC children grow up in poverty (a situation that has persisted for 20 years), and the poverty rate increases to one in every two children within single parent families (First Call: BC Child and Youth Advocacy Coalition, 2016). Further, many “poor families are very poor ... [and live] 39% below the poverty line” (First Call: BC Child and Youth Advocacy Coalition, 2016). Throughout the developed world a disproportionate burden of poverty is shared by children between birth and 5 years of age, while 22.2 per cent of children between birth and 17 years of age live in relative income poverty, and one in every eight children experience food insecurity (Brazier, 2017).

The high incidence of neglect highlights the inadequacy of a CPS that assumes CN&A is rare and that it can be meaningfully addressed on an individual basis. Inefficacy and discrimination within BC’s CPS was described by Judge Hughes in an investigation of the death of 19-month old Sherry Charlie while in a custody arrangement under the supervision of the MCFD. Hughes’ report led to the appointment of an independent Representative of Children and Youth (RCY) in 2006 (Hughes, 2006). Since, the RCY has been as a ‘watchdog’ to monitor the services of the MCFD. Investigations and reports from the RCY’s office demonstrate ongoing problems. A key issue is the lack of funding for recruitment, training,

support and retention of staff (RCY, 2015). Chronic underfunding, coupled with resource intensive approaches and inadequate staffing have left the CPS unable to fulfil a mandate to protect children and have thus allowed CN&A to remain a resistant social problem.

Why dialectical-relational critical discourse analysis?

An orientation to social justice

CN&A is a problem deeply entwined with power inequities and social injustices. Hence, a methodology oriented to social action was needed to address inequities. Unlike traditional objectivist approaches, critical discourse analysis (CDA) supports a research agenda that has a specific interest in, and orientation toward, social justice (Chouliaraki & Fairclough, 1999). CDA offered the opportunity to produce knowledge as a resource for understanding and shaping more effective and equitable nursing responses to CN&A. Discourse analysis also seemed especially fitting given the way language was used by the state and professionals, within legislation, policy and practice guidelines, as well as how some topics were talked about prominently and others left invisible.

Dialectical-relational (DR)CDA focuses on the connections between social structures and everyday social practices. It appreciates how the structures influence the practices and how the practices influence the structures; they exist within a dialectical relationship. As a nurse in a practice-based profession, the dialectical-relational approach made perfect sense to me and seemed like a good fit for studying nursing responses to CN&A. In rapidly changing health care environments much of nursing work requires us to engage in creative approaches to care (practices) that over time become accepted and refined into policies or guidelines (structures). Conversely, there are many instances when nurses' practices do not

follow the policies, such as when they may no longer make sense, are unrealistic in the context, and so on. Those structures then fade into the background and become obsolete. They may be labelled as outdated or irrelevant, perhaps informally at first. It is through the nurses' agency and engagement in everyday practices in alignment with the structures that the structures stay relevant to practice. Thus, this methodology offered considerable appeal because it highlights how changes toward socially just practices are not only achievable, but well within the power of the nurse. DRCDA highlights how, through everyday practices, the social is either reinforced or transformed.

The ability to explore dominant ideologies and highlight how they are stabilised and in turn, *how they may be interrupted* is a strength of DRCDA. According to Chouliaraki and Fairclough (1999), the moments of everyday practice offer the possibilities for change.

"Critical social research aims to contribute to addressing the social 'wrongs' of the day (in a broad sense - injustice, inequality, lack of freedom, etc.) by analysing their sources and causes, resistance to them and possibilities of overcoming them" (Fairclough, 2009, p. 163).

It does this by focusing on relational and structural conditions that support practices, by carefully analysing semiotic processes embedded in texts that represent the problem, as well as a reflexive exploration of how practices are represented in social responses to the problem (Chouliaraki & Fairclough, 1999, p. 30).

DRCDA considers discourse as a social practice, the ways which language and other semiotic signs such as body language and images are used to make meaning or construct our social worlds. Discourses are embedded within the semiotic nature of texts, and texts can be analysed discursively. Patterns and groups of social actors can also be identified by discourses within texts. Discursive practices are performed by social actors and dialectically produced by, and reproduce, their social order. They are central to social life because they

assemble, represent and transform our common realities or social worlds. They carry specific legitimacies through relations of knowledge and power. For example, child protection texts are heavily legitimised by medical and legal discourses, and the knowledge and power of these discourses.

CDA can consider questions of power and social inequity and explore tensions between the way these discourses are both socially shaped and socially constitutive (Fairclough, 1995, pp. 54-55). CDA supports the investigation of how CN&A operates within the social order, why it is so resistant to change, what purpose it serves, what obstacles there are to, and what possibilities exist for, social change. Given that CN&A constitutes a major but preventable public health problem, use of CDA questions how is it possible that nurses remain on the side-lines, largely excluded from responses? How is it that they do not take a more active role? In this way, analyses hold potential to “illuminate the new world that is emerging ... [and] also show what unrealised alternative directions exist” (Chouliaraki & Fairclough, 1999, p. 4).

A strategic approach to a sense of powerlessness

Following Habermas (1987), Giddens (1990, 1991), Harvey (1996) and Thrift (1996), Chouliaraki and Fairclough (1999) describe late modernity as characterised by large global shifts, which “are to a significant degree (though certainly not exclusively) transformations in language and discourse” (p. 4). Further, following Baudrillard (1983, 1988) and Lyotard (1984, 1990), Chouliaraki and Fairclough also note that the magnitude of these economic and communication shifts leaves people with a general sense of being overwhelmed, and a pervasive sense of powerlessness to effect change. A confused sense of self and place, or

what is typically described as ‘a loss of meaning in life’ is common today and deepens these feelings of powerlessness.

Dominant discourses describe these changes in our social world as natural or inevitable, despite that they “are at least in part the outcome of particular strategies pursued by particular people for particular interests within a particular system - all of which might be different” (Chouliaraki & Fairclough, 1999, p. 4). Attributing changes to nature is a tactic whereby social beliefs and structures are made invisible and resistant to scrutiny and change. CN&A discourses are saturated with naturalisms that form obstacles to change.

CDA attends to ruptures in the discourse, discourses embedded within other discourses and other discursive inconsistencies that act as a signal for further analysis. This process draws attention to the way that discourses stabilise the social order and reveals how invisible systems of power operate through ideology to produce and maintain inequities. By attending to how ideologies are legitimised and stabilised, CN&A offers the opportunity to unpack how, despite considerable effort, CN&A remains a resistant social problem. It also holds promise to guide a reconsideration of nurses’ participation in child protection and to support them to find an ethical place to stand.

Shaping a specific method

DRCDA is best described as a methodology rather than a method because it offers a general approach, which requires intense theoretical constructions of *objects of research* (Fairclough, 2009, p. 167, emphasis added). CDA offers the *scaffolding* upon which a specific methodological approach needs to be built, “specific methods used for a particular piece of research arise from the theoretical process of constructing its object” (Fairclough, 2009, p. 167). Applying a DR approach, this study seeks to critically analyse nursing practices in

responding to CN&A as represented discursively. Texts were collected that represent and guide nursing practices in relation to CN&A and were analysed to identify the various discourses operating within them.

CN&A is a social wrong in the most obvious sense, and because of this, there is risk of developing superficial understandings of the problem (Fairclough, 2009, p. 169). Most CN&A research focuses at the most obvious junctures: the specific acts of violence perpetrated against children. This traditional research focuses on individuals involved, the abused child and the perpetrator. Enlisting technology, this approach looks inwards in increasingly detailed ways, whereas critical social theory instructs us to look outward to examine a society that allows, supports and perhaps even requires, this violence. Therefore, the objects of research are not necessarily the process in which the nurse engages when responding to abuse, but how these responses are constituted. The analysis is complicated because it implicates social values and beliefs that are so pervasive and naturalised that they have become invisible. Fairclough instructs the analyst to draw “upon relevant bodies of theory in relevant disciplines to go beyond and beneath the obviousness of the topic” (Fairclough, 2009, p. 169). Guided by the aim to explore issues in their social complexity and to develop contextualised understandings, analysts are asked to use their discretion in choosing theories from across disciplines that support “rich theorisation as a basis for defining coherent object for critical research which can deepen understanding of the processes at issue, their implications for human well-being and the possibilities for improving well-being” (Fairclough, 2009, p. 169).

The three layers of CDA

CDA has three layers that involve “a progression ... from interpretation of the discourse practice (processes of text production and consumption), to description of the text, to interpretation of both of these in light of the social practice in which the discourse is embedded” (Fairclough, 1992, p. 231). In practice these layers overlap, as analysis is an iterative process of moving back and forth between interpretation and description.

Fairclough argues, and it holds true for this study, that most often the social practice is the starting place for examining the discourses. Nurses’ responses to CN&A, and the policy and legislation that guide their practice, are the social practices and structures that provide the entry points to this inquiry and anchor its analysis. Other relevant social practices include state child protection and practices that involve the care of children. The central question from this study sits within nursing practice and is revisited throughout the thesis, but an exploration of the discourses sends the analysis in seemingly far-flung directions as it theorises the objects of discourse.

Layer one – identifying the discourses

Applying DRCDA this study analyses social and nursing practices in responding to CN&A as they are represented discursively. A data corpus was compiled of textual sources that represent nursing practices in relation to CN&A (including interviews with nurses and practice guidelines) and the social structures that these occur within (including new media and legislation) in BC, Canada (see Appendix 2).⁴ The first layer of analysis required scanning across the corpus to identify discourses and the discursive practices that have structured

⁴ Data collection was limited to BC because child protection and nursing practice are regulated provincially, and this also allowed the study to be contained within the scope of a doctoral thesis.

them. Discourses do not form without prior understandings that allow them to become objects that hold meaning; anything new exists through resemblance of, and differentiation from, other objects of knowledge (Foucault, 1972/2010). Historical, social, cultural understandings (or resources) of the object of discourse are incorporated into it, and thus traces of other discourses and how these are drawn upon, transformed or reproduced (e.g. in innovative or normative ways) and the 'rules' by which these objects form can be revealed through the analysis of a discourse (Fairclough, 1992, p. 85; Foucault, 1972/2010, pp. 47-48).

Within this first layer of analysis, several objects and orders of discourse have proved particularly fruitful to providing insights into CN&A and the challenges nurses face in addressing it. In depth analysis of these discourses required intense theorisations of diverse research objects in dialogue between discursive approaches and theorisations that support a better understanding of children and violence within Canadian society. To develop a coherent line of argument and to reconcile what initially appeared as contradictory and disparate discourses, I have drawn together theorisations and philosophical insights from Baruch Spinoza (1677/2000), Slavoj Žižek (2009) and Donna Haraway (1997).

From his theorisation of human knowledge and its relation to our ontology and emotionality, Baruch Spinoza offered the philosophical lens to analyse what happens in the gaps or the spaces *in between knowing*, as is most often the case when responding to CN&A. For Spinoza (1677/2000), perception is limited and confused by emotions, deep connections with other humans and an overreliance on the visual, which lead us to faulty, imaginary types of knowledge. Conceptualising suspicion in relation to CN&A within this imaginary type of knowledge offered useful guidance for analysis. It also supported an

analysis of how violence has come to be understood in limited ways, as only extreme spectacular forms.

Žižek's (2009) understandings of violence provided the framework to trace the relationship between spectacular and structural violence of CN&A. This perspective supported an analysis of the obstacles to addressing CN&A, and appreciated how structural violence stabilises and supports a system of violence, but remains hidden in plain view. As the title of his book suggests, Žižek argues that a more productive way to see violence is from a sideways glance because when looking at this type of violence straight on, it tends to slip from view. Yet, it is precisely this structural violence that sets the conditions for eruptions of spectacular violence, which are then erroneously constituted as random and coming out of nowhere.

At the ideological foundations of CN&A, three central figurations emerged from the data corpus, which seen through Haraway's (1997) lens, are not social actors but discursive figurations. The most central of these is *The Vulnerable Child* who is accompanied by *The Responsible Family* and *The Monstrous Perpetrator*. While children are not essentially vulnerable, they can be rendered more or less vulnerable through a cascade of social relations (including their mother's social position and power). In the same way, families are not essentially responsible, and perpetrators are not essentially monstrous. These ideological tropes play a key role in discourses that underpin responses to CN&A. These figurations obscure the social contexts that sanction violence, and anchor practices of child protection described in the corpus texts.

Together the philosophical perspectives of Spinoza, Žižek and Haraway combine to create a nuanced methodology for the analysis that is specific to questions asked in this thesis regarding what influences nurses' responses to CN&A. How their philosophical

perspectives fit together and build a specific methodological approach to CDA for this study will be discussed in an introductory way in Chapter 2 and will unfold in more detail as they are used throughout the thesis. This approach has linked the philosophical ideas to the data, to allow the data to directly exemplify the ideas rather than a more traditional presentation of them in an abstract way at the outset of the thesis. Similarly, instead of following the traditional research format that moves from literature review, methods, findings, discussion, and conclusions, the remainder of this thesis is organised discursively, according to the discursive figurations traced in the first layer of analysis.

Layer two and three – detailed analysis

Chapters 3, 4 and 5 collect and describe the key discourses identified from the corpus, organised around three key discursive figurations. Each chapter describes the texts drawing on techniques for a detailed linguistic and/or semiotic analysis as needed, but with a primary focus on analyses of the discursive and social practices together with specific attention to the ideological and hegemonic influences of the social structures and practices (second and third layer of analysis). The social practice is a “basis for explaining why the discourse practice is as it is; and the effects of the discourse practice upon the social practice” (Fairclough, 1992, p. 237). This analysis attends to the social matrix of the discourses (the social relations and structures which constitute the practices); ‘orders of discourse’; and ideological and political effects of the discourse. Embedded ideological and political effects can be uncovered by examination of the social practices and careful attention to the social relations and structures that constitute the practices.

The relevant background and review of the CN&A literature is woven throughout the chapters, and the selection of this literature relates to the specific research objects. Instead

of conducting a literature review in the traditional sense, the literature can be best understood as corpus data. The use of literature was undertaken at the outset of this chapter, where the research problem was described in part, from the discourses used in the CN&A literature. In many instances, the demarcation between literature and data is blurred; as the literature itself is under investigation. Organised discursively, Chapters 3, 4 and 5 each present a discussion within which relevant elements of literature review, analysis, findings and possibilities for alternate practices are interwoven. The final chapter concludes the thesis and integrates the recommendations from Chapter 3, 4 and 5.

Chapter 3 begins by presenting an overview of the social constructions of the child and childhood and how these discourses set the foundation from which the figuration of *The Vulnerable Child* took form. A historical discussion of early child-saving initiatives in BC, including how two parallel systems of child protection for Aboriginal Peoples and white settlers existed for until the 1960's, sets the stage for analysis of legislative texts. Close analysis of two statements from BC legislation: 'reason to believe' and 'best interests' was undertaken offering a productive way to trace relations of power in child protection practices. The dialectical analysis of BC's child protection legislation and nursing interview texts offers a challenge to rationalisations within law in relation to their implications for nursing practice. Finally, the emancipatory promises of child rights are considered in the context of positivist practices, monitoring implementation and violation.

Chapter 4 explores mandatory reporting and how a lack of efficacy of child protection is constituted as an issue of *recognising and reporting* CN&A. This chapter offers an account of the figuration of *The Responsible Family*, tracing its origins in state initiatives. The implications constituting children's parents, especially their mothers, as responsible despite their social position and power are explored. Analysis of a report from BC's RCY,

demonstrates how unrealistic expectations of families, especially mothers, stabilise dominant relations of power and allow the poor conditions in which many children are forced to live to be ignored. In the context of a poorly resourced system that maintains an individual case-by-case investigation and substantiation response to CN&A, BC child protection legislation and practices are shown to articulate the efforts of multiple service providers including nurses, police and child protection workers (CPWs)⁵ into a complex series of deferrals. In this chapter, I share narratives of nurses' disillusionment with a system that prioritises reporting, and describe how this priority limits nurses' ability to address child safety issues.

Chapter 5 describes a complementary process of concentrations on the most severe cases of CN&A that results in what Žižek (2015) refers to as a 'game of origins'. Practices within BC's specialty child abuse clinics are shown to participate in this game through an orientation to spectacular forms of violence and retributive justice. These orientations are shown to intensify by being coupled with technologies and forensic practices that identify and contain the perpetrators of CN&A. Next, the figuration of *The Monstrous Perpetrator* is brought out from the shadows, and its various iterations are explored. Monstrous and solely responsible for the violence he perpetrates, this figuration can also be seen as spectacular and a way of containing anxieties triggered by violence. Drawing on Žižek's (2009) theorisations of violence, the spectacles are traced back to their roots within everyday forms of violence. Findings in this chapter show how a focus on the spectacles disavow

⁵ I have used CPW as the title to refer to MCFD child protection workers, although nurse participants in this study generally referred to the CPWs as 'Ministry social workers'. The MCFD uses CPW in the role description and job postings, but 'child welfare worker' in the handbook. CPWs are not necessarily social workers, they might have "a Bachelor of Social Work or Masters in Social Work, or Bachelor of Arts in Child and Youth Care, or Masters in Educational Counselling/Masters Clinical Psychology with completion of a practicum in family and child welfare" (MCFD, n.d., p. 1).

social responsibility for children in ways that form obstacles to developing effective social responses to CN&A.

Chapter 6 collates the findings from Chapters 3, 4 and 5 and focuses on the ways past obstacles that have made CN&A such a resistant social problem. The dialectical relations articulate in social structures and practices as well as discursive practices in ways that resist change, but at the same time point to opportunity for change. Critical analysis dismantles the power of the figurations and exposes key assumptions at the roots of violent relations with children. Describing and disengaging from the games of deferrals and origins offers the opportunity to practice in new ways. Recommendations point to hope for incremental steps towards change through language, common understandings and everyday practices. This thesis ends with highlighting how nurses can support collective responsibility for CN&A, and move towards a more equitable and inclusive society for children and their families.

Towards ethical nursing responses

Using a critical perspective, this thesis addresses complex practice issues in relation to nurses' responses to CN&A. DRCDA was chosen in consideration of CN&A being constituted as a rare problem despite its high incidence and resistance to interventions. It was also chosen in consideration of the poorly defined role for nurses in CN&A responses in legal and practice discourses, which overlook nurses' practice and constitute their primary responsibility as reporting. The critical approach has offered a unique perspective on the problem, and insights into how nurses respond to CN&A, what guides their responses and points to what might support nurses to respond more effectively and more ethically than they currently do. Departing from the usual discourses of CN&A, this methodology has

supported a way of seeing how the social wrong remains constituted within the CN&A literature reviewed as well as contemporary policies and practices. DRCDA's orientation to improving issues of social injustice points to a way beyond feelings of powerlessness characteristic of resistant social problems, and towards child protection practices that are more respectful of children and their families, and ultimately, seeks to obtain an ethical place for nurses to stand.

Chapter 2: Methodology

As discussed in Chapter 1, using DRCDA offers two key advantages to investigating nursing responses to CN&A: it provides a perspective oriented to social justice; and a methodology to tackle resistant problems through everyday practices. DRCDA guides an analysis that considers nursing responses to CN&A within the complexity of the social contexts from which they arise. How this analysis is accomplished is the subject of this chapter.

I begin this chapter by describing fundamental perspectives underlying DRCDA including further clarification of the meaning of discourse and texts. Next, I introduce the ways in which discursive practices are understood and analysed. At the heart of DRCDA are the techniques of interdiscursive analysis, thus an overview is provided of how CDA understands discourses to be ordered through the articulation of different modes of semiosis, which is the meaning-making ways of acting, representing and being. DRCDA argues that discursive formations come together in specific social contexts at certain times yet are in constant flux, and discourses are stabilised or disrupted through their dialectical relations with social practice. Compared with other forms of CDA, the emphasis in DRCDA is the special attention that is paid to how the discursive formations either hold together or shift and change by way of relations between the social structures and everyday practices associated with them. Therefore, the operations and effects of power within these relations are of central importance to the analysis of structures and practices of CN&A responses.

DRCDA supports the analysis of how nurses' responses are shaped by multiple discourses and relations. These include: research literature, legislation, policies and guidelines, society's beliefs about children, families, and violence, practices and relations

with children, families and other professionals (e.g. CPWs, physicians). Textual samples that represent CN&A practices, structures and relations of power between the practices and structures were compiled at the outset of the project. This chapter outlines the process for data collection and the development of a textual data corpus, with a focus on the specific period when interviews were conducted and news media reviewed.⁶ It also outlines how ethical standards for research were met. While the data corpus is extensive, what I consider to be key texts and how these were selected for more detailed analysis is described in this chapter and in detail throughout the thesis. Much of the data collected was not analysed beyond the identification of discourses but nonetheless provided invaluable insights into the discursive landscapes of CN&A, in BC and internationally.

In the second half of this chapter, I describe the process of conducting a DRCD for this thesis. It required a “step back” (Fairclough, 2009, p. 169) to interrogate how social structures prevent effective responses to CN&A. Drawing on transdisciplinary theoretical perspectives, analysis is reflexive and dialectical, and carried out differently depending on the data and theorisations used to guide the analytic perspective. The analysis was engaged dialectically rather than stepwise, however to clarify the process Fairclough has outlined four stages, which I used to structure this discussion. These stages are: 1. Focus upon a social wrong, in its semiotic aspect; 2. Identify obstacles to addressing the social wrong; 3. Consider whether the social order ‘needs’ the wrong; 4. Identify possible ways past the obstacles (Fairclough, 2009). The dialectical organisation will become more apparent in the analysis throughout the thesis.

⁶ From a discourse analyst’s perspective, data collection is not limited to a formal period. For this study, data collection began when forming the research question and extended into the final writing stage. Data was collected iteratively with analysis; early analyses formed the theoretical background for this thesis and offered me the opportunity to practice the methodology, but are not formally part of this thesis (see Einboden, Rudge, & Varcoe, 2011; 2013a, 2013b).

The first stage involved theorisation of the objects of research that reflect the social wrong indirectly, with a specific interest in the semiotic elements of nursing practices and the discursive rules that order objects of knowledge related to CN&A. Suspicion, spectacles, and violence required further theorisation and as described in Chapter 1, I chose to use the philosophies of Spinoza (2000) and Žižek (2009). The next stage of analysis was to identify obstacles to addressing the CN&A. These obstacles emerged from the texts in the form of three discursive figurations, and analysis guided by Haraway's (1997) notions of figuration. In the final two stages, the importance of CN&A to the social order was explored and strategies to disrupt the social order were considered. The final section of this chapter considered the various limitations of CDA, how they were addressed, and their influences specific to this thesis.

Dialectical-relational critical discourse analysis

There are multiple ways discourse is understood. CDA does not follow common understandings of discourse as passive representation, or as the assembly of semiotic elements arising from a neutral reflection of a pre-existing social reality (Chouliaraki & Fairclough, 1999; Fairclough, 1992, 2009). Following Foucault (1972/2010), DRCDA considers discourse as central to the collective process of making sense of the world. From this perspective, discourse is socially defined, a form of social cognition and way of constituting knowledge and social practice through semiotics (Chouliaraki & Fairclough, 1999; Fairclough, 1992, 2009; van Dijk, 1993; van Leeuwen, 2008).

DRCDA uses the term 'discourse' to describe the use or enactment of semiotic elements within the social context (Fairclough, 2009). Semiotic elements include language, images, body language, gestures, and features of communication (such as tone or pace of

speech) (Fairclough, 1992, p. 63). Semiosis is the process of assigning meaning to an abstract symbol such as a letter, word, phrase, or image. Language and other signs are central to social life and they hold meanings that produce, represent and transform our social, material and imagined worlds (Fairclough, 2009). The use of language and other semiotic modalities is a social practice “in dialectical relationship with other facets of the social” (Fairclough, 1995, p. 54).

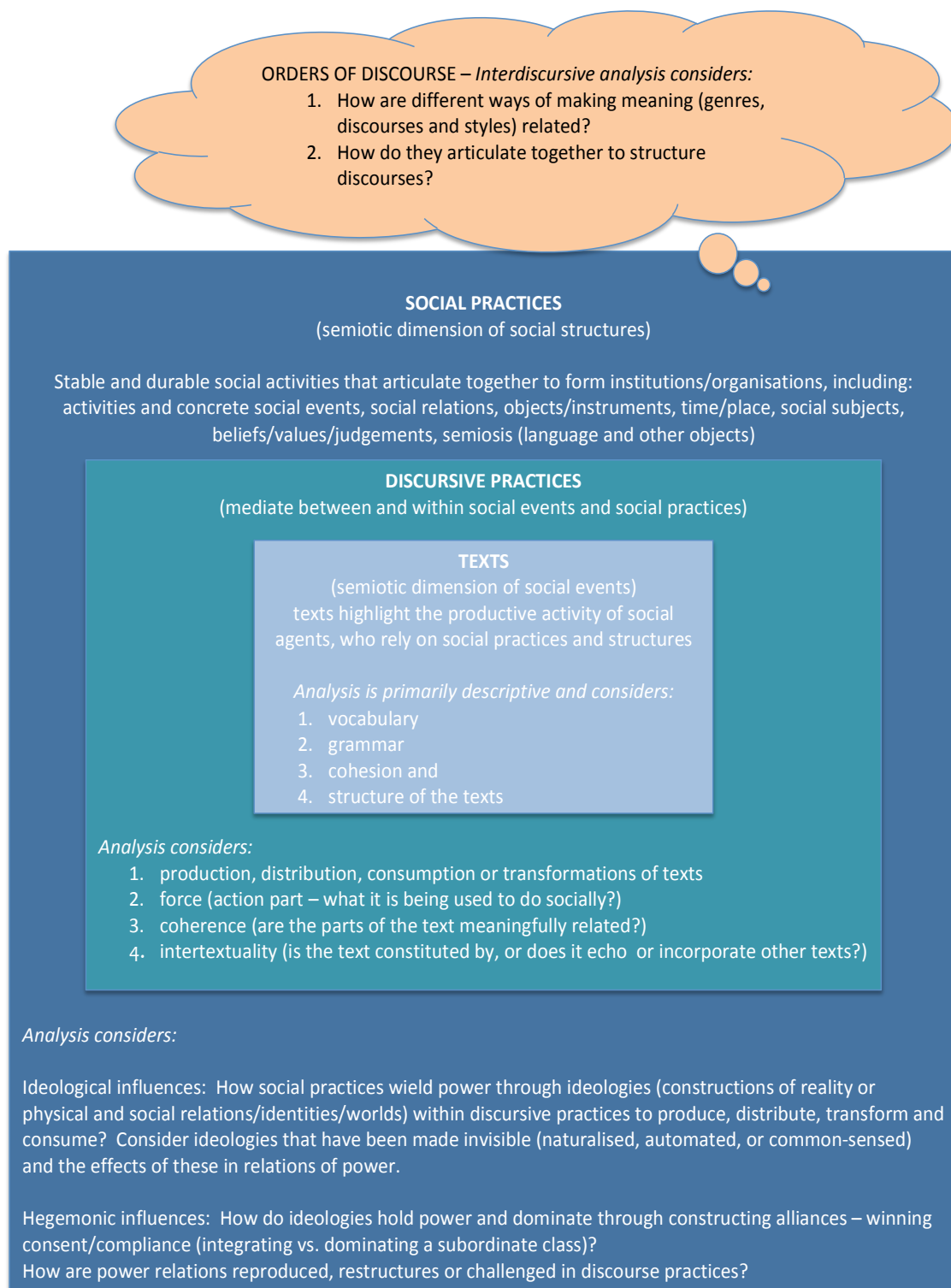
Informed by both historic and current social values and beliefs, we share understandings, shape categories, and establish relationships between material/non-material bodies, phenomena, and events, and thus construct common realities discursively. Discourses are influential and produce aspects of social life as a part of the social structure and as a mode of social action — a way people act upon the world and each other (Foucault, 1972/2010). Foucault explains that discourses,

are not, as one might expect, a mere intersection of things and words: an obscure web of things, and a manifest, visible, coloured chain of words; I would like to show that discourse is not a slender surface of contact, or confrontation, between a reality and a language (*langue*), the intrication of a lexicon and an experience ... in analysing discourses themselves, one sees the loosening of the embrace, apparently so tight, of words and things, and the emergence of a group of rules proper to discursive practice. These rules define not the dumb existence of a reality, nor the canonical use of a vocabulary, but the ordering of objects [of knowledge]. ... [Analysis cannot simply consider] discourses as groups of signs ... but as practices that systematically form the objects of which they speak. (Foucault, 1972/2010, pp. 48-49)

Discursive practices are social activities that extend beyond individuals and their reactions to situations (Fairclough, 1992, p. 63). Actions of individuals in “habitualised ways, tied to particular times and place ... constitute a point of connection between abstract structures and their mechanisms, and concrete events - between ‘society’ and people living their lives” (Chouliaraki & Fairclough, 1999, p. 21).

Discourses construct fields of meaning following patterns, conventions or codes. They carry a tone and authority and are arranged hierarchically. Dominant discourses are highly influential, creating widely accepted or common understandings and knowledge. DRCDA draws on Bourdieu’s insights as to how relations of power are embedded within social practices and language, but have become invisible. DRCDA is effective in exposing these relations by analysing discursive and other forms of social practice. How texts and social and discursive practices are interrelated, as well as what aspects of inquiry are related to each are represented in Figure 1.

This figure was adapted from Fairclough’s (1992, p. 73) diagram. It is essentially the same in that it replicates the three nested boxes in his original diagram but is extended to include notes that both describe what Fairclough means by “texts”, “discursive practices” and “social practices”, and what analysis needs to be undertaken at each layer. It also has been supplemented to illustrate considerations of *interdiscursive analysis*, including how texts are built from discursive practices that are embedded within social practices. I adapted this figure to provide an overview of the analysis as an easy reference to which the reader can refer as I explain the strategies used in this thesis. Providing this reference is especially important because critical discursive analysis is not a common methodology used in nursing and health research, thus many readers may benefit from an illustrated overview to which they can refer back to while reading this thesis.

Figure 1 Fairclough's Dialectical-Relational Critical Discourse Analysis

(Fairclough, 1992, 2009)

Texts, textual analysis and the relationship between texts and discourses

Texts, according to DRCDA, are “the semiotic dimension of [social] events” (Fairclough, 2009, p. 164). Texts are the data of discursive analysis, offering a way to examine social activities of social agents. Social practices mediate between and within social structures and events (texts), connecting linguistic and social analyses to reveal how meaning is made in a specific event. For this thesis, I collected a data corpus of texts that represent a particular social practice: nursing responses to CN&A. DRCDA offers an inclusive understanding of texts as linguistic (such as written, conversational and interview texts) or other semiotic forms (such as images, multimedia, and combinations of these forms). Fairclough argues that subtler semiotic modalities such as pace of speech, intonation, gestures, conversation control and gaze can also be captured, described and analysed as text, a perspective that supports a very detailed systematic linguistic and/or semiotic analysis of textual samples. This level of detailed analysis was used sparingly in this study because the data corpus is so large, and analysis at the level of discourses and social practice was productive.

Distinctions between text and discourse are not entirely clear, analysis of texts overlaps with analysis of the discourses that the texts carry. For analytic clarity and organisation, CDA defines *textual analysis* as that which attends to the more formal features of a text including: uses of vocabulary (individual word choice and possible alternates, such as metaphors); grammar (combinations of words); cohesion (linking together of sentences/phrases, repetition, references, substitutions); and text structure (organisation/architecture of texts, including features that that make a text a news media report, a legal document, or a diagnosis) (Fairclough, 1992, p. 75; 2009). However, understanding the meaning of a text is complicated and there is always a dependence on

interpretation; both linguistic and discursive “texts are usually highly ambivalent and open to multiple interpretations” (Fairclough, 1992, p. 75). Therefore, textual analysis combines questions regarding language form and meaning (Fairclough, 2009, p. 164). “Texts are made up of forms which past discursive practice, condensed into conventions, has endowed with meaning potential” (Fairclough, 1992, p. 75).

Meaning is assigned to social practices and events (texts) in three major ways: through action, representation and identity construction. *Actions* (or interactions) are semiotically performed in a variety of different *genres*. Carrying out activities in any project or job requires interacting or communicating about those activities. These activities are preformed (that is described, understood, demonstrated, guided) through a broad range of genres. Activities related to child protection include genres such as: health literature related to CN&A; policies, legislations and programs that guide practice; child protection related reports; and popular news media (newspapers). The data corpus for this study samples from these various textual sources.

Meaning is also made within social practices by *representation* through *discourses*, which construe aspects of the world generally associated with social actors’ positions in and perspectives on social life, commonly held ideas and beliefs about how the world is, or how it might/should be. Attending to discourses, the conditions and relations within which they exist and operate, and the way they repeat in particular patterns within texts provides access to knowledge about social practices and structures, including specific contexts within which they were developed and how they are used to represent practices (Fairclough, 2009, p. 169; van Leeuwen, 2008). In this study, the analysis explores these representations and commonly held beliefs about how the world is in detail.

Exploring how these discourses are produced and stabilised led to another layer of discursive analysis. The next layer of the analysis showed that the ideological underpinnings are also discursive and tangled within social beliefs and subsequently, identities of children, families and perpetrators. *Identity construction* is the final way semiosis occurs within social practice, and it is considered by analysing various *styles* or ways of being and behaving in different roles (for example nurse, child, parent) (Fairclough, 2009, p. 164).

As discussed in Chapter 1, three discursive figurations were found to be central to responses to CN&A. These figurations are produced through condensations of material and semiotic practices, within relations of power that are difficult to see. Figurations may be presented as real within dominant discourse, but only offer an illusion of material reality (Haraway, 1997). Analysis of these figurations offered the opportunity to see how, as Castañeda (1997) describes, *particular versions* of bodies and worlds are generated. Understood instead as powerful ideological tropes, analysis of the three figurations allowed relations of power that produced them to become more visible.

Dialectical-relational analysis of discursive practices

Analysis of discursive practices of a text includes how and for what purpose texts are produced, distributed, and consumed (Fairclough, 1992). It attends to what the text is being used to do, and the social actors involved such as the intended audience, context subjects and authorship. Attention to other discursive practices that appear as features of the text is also useful. These features include a text's *force*, *coherence* and *intertextuality*. *Force* of the text is used to describe the action component of "its interpersonal meaning, what it is being used to do socially ... (give an order, ask a question, threaten, promise, etc.)" (Fairclough, 1992, p. 82). *Coherence* describes the extent to which the parts (often sentences) make

sense together to the reader (often requiring inferences that rely on common understandings to make connections). *Intertextuality* is the extent to which a text incorporates other texts, or “the property texts have of being full of snatches of other texts, which may be explicitly demarcated or merged in, and which the text may assimilate, contradict, ironically echo, and so forth” (Fairclough, 1992, p. 75).

Conceptually, *intertextuality* draws on the work of Julia Kristeva, who described the historical nature of texts, and how their development and use is socially constrained by power relations (Fairclough, 1992, p. 103). Attention to the *intertextuality* of texts notes how texts are historically related to one another. It also notes ruptures in the flow or the use of various styles within a text, where one text incorporates other texts by referring to or relying on them for previously established meanings (Fairclough, 1992). *Intertextuality* is particularly useful in discursive analysis because it points to relations of power that might otherwise remain invisible. Contradictions and incoherence may be legitimised by appealing to ‘history’ in the use of a text. Strategies in textual and discursive analysis work together to reveal ideological assumptions within the practice, which are ‘common-sensed’ (e.g. children require protection) according to underlying systems of power, and how these assumptions reinforce or resist social structures. CDA is useful for examining social problems that are entrenched in power because “[p]ower relations are exercised, to an exceedingly important extent, through the production and the exchange of signs” (Foucault, 2000c, p. 338). These strategies support the analyst to identify the rules of the discursive formations embedded within texts.

Discourses are understood in relation to, and differentiated from, social *action* (genres) and ways of *being* (styles) (Fairclough, 2009, p. 163). Relational logic investigates the relations around the discourse, including for example the object of the discourse (or

entity), the people involved in the communication around the discourse, power relations, institutional practices, as well as how these converge into social activity or praxis at specific times and places (Fairclough, 2010). Semiosis is one facet of social action, and the relations between this and other practices are interconnected, “different from one another but not ... ‘discrete’ ... and no one object or element (such as a discourse) can be analysed other than in terms of its dialectical relations with others” (Fairclough, 2010, p. 4).

Following Harvey (1996), Fairclough (2009) explains that while closely related, elements of the social process “each ‘internalize’ others without being reducible to them ... e.g. social relations, power, institutions, beliefs and cultural values are in part semiotic; they ‘internalize’ semiosis without being reducible to it” (p. 163). He illustrates this point using the example of discourse and power in modern government. The legitimacy of governing and the power it holds is largely achieved through discourse, while at the same time governing is achieved by way of power in its capacity for physical force. Similarly, child protection practices are legitimised discursively (e.g. discourses of risk/safety), yet hold power beyond discourse in that discourses legitimise and normalise the forcible removal of children from families. Thus, “power is not simply discourse, it is not reducible to discourse; ‘power’ and ‘discourse’ are different elements in the social process (or in dialectic terminology, different ‘moments’)” (Fairclough, 2010, p. 4).

Dialectical logic offers a way to reveal how systems are stabilised relatively, to identify the structured relations that underpin or threaten practices, and to see how practices are stabilised “as an effect of power and a factor in reproducing relations of power” (Chouliaraki & Fairclough, 1999, p. 32). The dialectical analysis,

oscillates ... between a focus on *structures* (especially the intermediate level of the structure of social practices) and a focus on the *strategies* of social agents, i.e. the ways in which they try to achieve outcomes or objectives within existing structures and practices, or to change them in particular ways. This includes a focus on the structuring of semiotic differences, (i.e., shifts in order of discourse) which constitute a part of social change, and on how social agents pursue their strategies semiotically in texts. (Fairclough, 2009, p. 165)

The dialectical-relational approach to CDA is both structuralist and constructivist; it can consider how practices are constituted by systems and social contexts and informed by social values and beliefs. It challenges objectivism by arguing that no research is ever neutral, that all research requires transparency to the internal workings of its own logic and analytic processes. With a focus on practice, CDA appreciates the complexities of these boundaries and the way power weaves through what questions might be asked and what interpretations are available. This transparency must include exposing the underlying assumptions, conditions in which questions are asked and truth claims are made, which are so often brushed over in 'objective' approaches. The analysis is also dialectical in that it is reflexive; it examines theory itself as practice. Thus, it considers the context in which knowledge is developed self-reflectively, taking its own processes including methodological choices and interpretations as relevant. Positions and influences, that is the biases and aims of the analyst are also relevant and need to be as transparent as possible (Chouliaraki & Fairclough, 1999, p. 30).

Object formation and orders of discourse

At the heart of CDA is the analysis of how interdependent discursive formations shift or are stabilised. DRCDA focuses on two levels of analysis: “textual analysis includes both linguistic analysis (and, if relevant, analysis of other semiotic forms, such as visual images) and interdiscursive analysis (analysis of which genres, discourses and styles are drawn upon, and how they are articulated together)” (Fairclough, 2009, p. 170). CDA borrows the term ‘orders of discourse’ from Foucault, who describes how there are various discourses within society, at the level of the structures and at the level of the practices, and the discourses as well as the relationships between these discourses are useful to attend to in analysis (Fairclough, 1992). For example, legislation that governs CN&A is an institutional (legal) discourse but one that is heavily influenced by social discourses and common-sense notions about the child and childhood. How the dominant social discourse constitutes children is integral to how the legislation conceptualises their protection. In this way, both discourses are important and the relations between them are relevant to the analysis as well; for instance, the discourses of childhood stabilise the discourses and practices of child protection in terms of shape and concentration.

CDA extends the idea of analysing orders of discourse to include analysis of linguistic variations as well, where amongst the possible options, linguistic choices are also understood as socially determined (Fairclough, 2003). Analysis of *orders of discourse* was used to explore how linguistic and social analysis connect, by considering how “genres, discourses, and styles are articulated together in a text as part of a specific event, and in more stable and durable orders of discourses as part of networks of practices” (Fairclough, 2009, p. 170).

Any discursive formation is a “dispersion and redistribution” (Foucault, 1972/2010, p. 107) of statements, according to “the interplay of the rules” (Foucault, 1972/2010, p. 33). Foucault describes *statements* as a series or group of semiotic signifiers, a set of words that fit together as building blocks of discourses. Statements are more complex than their grammatical order because in addition to following grammatical rules, they follow discursive rules that define what we can know. The process of constituting and constraining what we know (objects of knowledge) is what makes discourse a social practice (Fairclough, 1992, p. 41; Foucault, 1972/2010). To conceive of objects, certain relations and conditions are needed. Objects do not “emerge from the ground. ... the object ... does not pre-exist itself, held back by some obstacle at the first edges of light” (Foucault, 1972/2010, p. 45). Objects cannot be excavated or emerge, they are formed as we speak and they come to exist as we know them out of a nexus of social relations and understandings.

Foucault illustrates this process of object formation with the example of the emergence of madness in the nineteenth century (Fairclough, 1992, p. 41; Foucault, 1972/2010). Similarly, the emergence of modern understandings of childhood are an object formation. Sociology, anthropology and cultural studies have considered the political, social and cultural relations that supported childhood’s emergence and transitions in contemporary, western understandings (e.g. Jenks, 2005; Prout & James, 1997). These understandings of childhood offer the discursive material for the figuration of *The Vulnerable Child* and set the conditions and rules that order child protection structures and practice.

Once an object of knowledge is culturally pervasive and holds wide social acceptance, its dimensions, origins, and meanings (how they are thought of and practised) become naturalised and disappear from view. For example, childhood and vulnerability

usually go uncontested in analyses of CN&A practices. CDA questions how 'childhood' has become an accepted fact. The process of analysis of the statements, those that build meanings in relation to the child and childhood require historical analysis. The focus however is not about revealing what is hiding, or unspoken truths contained within the discourses. Instead, the analysis questions the existence of such statements. Questioning how do statements come to exist; where do they leave traces; how, when, by whom and within which discourses are they used? What does "it mean to them to have appeared when and where they did - they and not others" (Foucault, 1972/2010, p. 109). Using DRCDA, this thesis has offered the opportunity to re-examine and reframe taken for granted objects of knowledge (e.g. notions about children and appropriate treatment of children) as socially and culturally constituted, rather than as a biological fact or material reality.

The analyst's task is to: uncover the conditions in which statements exist; identify what is included in the text (what ideologies are written/represented/preformed); consider what alternate meanings or understandings are missing, removed from view or marginalised; and describe how the discourses operate socially in relation to the research question. The purpose of this analysis is "to make it emerge in its own complexity. What, in short, we wish to do is dispense with 'things'. To 'depresentify' them ... To define these objects without reference to the *ground the foundation of things*" (Foucault, 1972/2010, p. 47, emphasis in original). Analysis requires that the objects be considered in reference to the "rules that enable them to form as objects of a discourse and ... regularities that govern their dispersion" (Foucault, 1972/2010, p. 48), in effect to take away their 'common-sense' or naturalised way of talking about children, and instead show how power constitutes the child.

Relations of power

Explored in this section are complex relations of power that constitute our understandings of discursive formations relevant to this analysis. A nuanced analysis that appreciated the intersections of social positioning and power was required to better understand subject agency. This aspect of the analysis is supported by Spivak's (1988) notion of the subaltern. Forms of state power that appear in self and family relations (e.g. subjugation and individualisation) were analysed using Foucault's understandings of biopolitical and pastoral power. Finally, the way technoscience intensifies biopolitical relations are described. Supported by these theorisations, analysis of the workings of various forms of power within nursing practices offered a way to highlight how these practices participate in and resist the stabilisation of social structures, as well as pointed to opportunities for social change.

Ideology and hegemony

The durability of discursive formations is influenced by a combination of layered subjecting and dominating relations of power (Chouliaraki & Fairclough, 1999; Fairclough, 2010). Language and other semiotic signs are ideologically influenced, meanings are constructed, understood and represented within semiotic practices. Ideologies are the ways aspects of our world or our identities are represented, which contribute to inequities and unequal distribution of power. Both the way ideologies function and the way they fail to represent or explain aspects of the world or identities are the subjects of inquiry in CDA (Fairclough, 2010). Fairclough draws on Gramsci's concept of hegemony to critically analyse how ideologies circulate and function. Hegemony is a useful concept for analysis within this thesis because it taps into power that is enacted through an alliance rather than overt exercises of power seen in dominating relations (Fairclough, 1992, p. 92). Hegemony draws

on notions of ‘common-sense’ to explain naturalisations or automatizations of ideological objects of knowledge. When nurses are enrolled in practices that are justified ideologically but appear to align with their professional obligations, such as the promotion of a child’s development or acting in the child’s best interest, we can see hegemony operating. Critical attention to hegemonic practices helps the analyst trace social practices within discourse in terms of power relations, to reveal “the ideological investment of discourse practices” (Fairclough, 1992, p. 95).

Subjectivities and agency

Nursing responses to CN&A exist in relation to dominant social ideologies. Nurses’ practices may be considered, at least in part, as an *effect* of the ways children, families and violence are socially constituted. Therefore, central to this analysis is an exploration of the constitution of children and families within dominant social discourses, as well as considerations of the complexity of violence, social understandings about the appropriate treatment of children and expectations of their families. Power analyses are supported by post-colonial feminist theory, which offers a nuanced analysis of the relations of power at different intersections of social marginalisation. These perspectives are especially useful because colonial values persist within BC’s child protection practices and structures, and have led to very different meanings and experiences for Aboriginal Peoples versus white settlers within the CPS.

The issue of subject agency in this thesis thus required theoretical perspectives that attend to the social position of the subjects involved. Drawing on Spivak’s (1988) critique that in the absence of attention to social positions, the subject that emerges is the “ideological subject of the theorist” (p. 68). The agency of the subaltern subject needs to be

respected; that is to speak, the subject needs to be thought of as if they might have something to say. By questioning the structures and practices that silence subjects, Spivak has offered a way to appreciate various relations and operations of colonial power.

In investigating subject agency in relation to nursing responses to CN&A, I considered how all three central social actors: nurses, parents and children are each silenced in different ways. First, as described in Chapter 1 and detailed in Chapter 4, nurses are positioned peripherally to child protection and their practice is shaped by relationships with other professionals. Thus, examining various ways nurses' practices are constituted, mediated and constrained by their social position and power was relevant. Second, while mothers hold the position of primary caregiver for children, women continue to experience significant inequity. The ways in which mothers are valued and how their childrearing practices are regulated was significant to analysis of power relations. Third, while children are revered as society's most precious members, they also suffer disproportionate amounts of violence. While not all children are abused, all are silenced; as hinted to in the adage that 'children are meant to be seen and not heard'. Spivak's (1988) notion of the subaltern supported analysis of how marginalisation operates at the intersections of social positions for these central social actors. Further, analysis of the way power operates at the farthest edges of the margins was traced to see how less visible forms of power colonise all children.

Pastoral power as a technique of biopolitics

Pastoral power is as a technique of biopolitical relations where the inner workings of state power are exercised within and between complex relations of the self and the family (Donzelot, 1979; Foucault, 1976/1990, 2000b). Analysis of these forms of power supports insights into various practices, including those of the state (e.g. child protection legislation),

within the family (e.g. childrearing norms) and singular bodies (e.g. contemporary practices of reproduction (Franklin, 2000). Violations of children sit at the nexus of these power relations. Therefore, tracing these relations and their operations was central to this analysis.

Biopower describes techniques of power enacted on the body, employed by nation states as a mode of governing. Biopower developed during the transition from monarchical to state governance. The power of the monarchy operated through blood and by threatening death, while the nation state applied a subtler form of power that operates through the management of bodies and lives ('let live and make die' versus 'make live and let die') (Foucault, 1976/1990, p. 144). At the outset of capitalism in the 17th Century, the body became a site of political interest because the availability of bodies for production became imperative to economic and political interests. Schools and hospitals proliferated for the management of cooperative and healthy bodies, "docile bodies" (Foucault, 1975/1995, p. 144). Surveillance by others with social power creates an internalisation of the power relation (subjugation) allowing power to be enacted without force or bodily containment. The subject "assumes responsibility for the constraints of power; he makes them play spontaneously upon himself; he inscribes in himself the power relation in which he simultaneously plays both roles; he becomes the principle of his own subjection" (Foucault, 1975/1995, pp. 202-203). Biopower goes unnoticed for two reasons. First, because subjects enact it upon themselves. Second, because the power relation is not complete; subjects preserve agency within its operations, "it is always a way of acting upon one or more acting subjects by virtue of their acting or being capable of action" (Foucault, 2000c, p. 341). Due to its covert operations, biopower has become an insidious, efficient and effective form of power within modern society.

Biopower has intensified with the rise of the idea of 'the self', that is, how we think of ourselves within contemporary society supported by psychology. When industrialisation cleaved work from personal life, a disconnection from production and loss of identity resulted, and concerns and technologies related to the 'self' and subjectivity spread across social classes (Zaretsky, 1976). The 'self' was cultivated within discourses of psychology and psychoanalysis and distorted understandings of the 'self' as separate from society, individualising emotional life and personal and family relations (Zaretsky, 1976). The regulations of the alliances now intensified as regulations of the 'self'. Modern governing understands the strength of the state to be tied to the strength of individuals and thus is invested in fostering the development of "elements constitutive of individuals' lives in such a way that their development also fosters the strength of the states" (Foucault, 2000a, p. 322). Policing then became paradoxical, both exerting the power of the state, but also as a mechanism to "keep the citizens happy – happiness being understood as survival, life, and improved living" (Foucault, 2000a, p. 322).

This paradoxical style of governance, pastoral power, echoes Christian influences but originated from the Hebrews' Shepherd god (Foucault, 2000a, p. 301). The modern state aims to develop a "legal framework of unity, and a power we can call "pastoral", whose role is to constantly ensure, sustain, and improve the lives of each and every one" (Foucault, 2000a, p. 307). In contrast to Ancient Roman and Greek gods who owned the land and provided abundant crops, the Shepherd god held sovereignty over the flock, gathering together dispersed individuals and vigilantly administering daily provisions with kindness. Greek gods had "duty", the Shepherd had "devotedness" (Foucault, 2000a, p. 301). The Shepherd was prepared to sacrifice himself on behalf of the flock, their salvation is tied to his.

The modern state enacts a pastoral form of power in tandem with overt centralised forms of power, whereby the citizens are cared for by political and legislative rule. Like the Shepherd, the government must acquire and hold knowledge of its souls through their “obedience, knowledge of oneself, and confession” (Foucault, 2000a, p. 310). The flock follows not because of rules but in willingness and submission. The relations between the Shepherd and his flock are intimate, he knows individuals within his flock, and what they do and think. Governing in the modern liberal state has thus demonstrated a heightened interest in measurement of and statistical information regarding the populous. Knowing the populous is the project of birth registries, census and taxation data, public health records, and measures of school readiness (Einboden et al., 2013b). Thus, mechanisms of subjection are caught within the benefits of development in civil society, including the emergence of academic disciplines, militarisation, public health, and governance of birth rate, longevity, and migration. Through in-depth knowledge of all individuals, governing has expanded to include a series of rationalisations and strategic actions to increase political power. The Shepherd also encourages “mortification ... a renunciation of this world and oneself ... a death that is supposed to provide life in another world” (Foucault, 2000a, p. 311).

Pastoral care is labour intensive, so modern state politicians enrol professionals to support administration. Doctors, nurses, teachers, pastors and families monitor and minister daily provisions and provide individualised care. Assuring the city’s unity, “virtues” and “popular opinion” bind the flock together and maintain sovereignty (Foucault, 2000a, p. 306). Operations of pastoral power are relevant to this analysis, because the modern state exercises these through discursive social norms about children and families, for instance, ‘family values’ are common values that bind the flock. How state power set social conditions

with serious consequences for children (e.g. families hold private sovereignty over their children) can be traced historically.

The sophisticated system of knowledge-power in contemporary times is the product of a convergence of power over the populous from a totalitarian relation, enacted through Christian pastorship as a mode of biopolitical relations. Foucault (2000a) recounts how, “[o]ur societies proved to be really demonic since they happened to combine those two games — the citizen-city game and the shepherd-flock game — in what we call the modern states” (p. 311). Increasing state power is achieved through interventions enacted discursively for the betterment of the populous. These interventions are hegemonic; they are not motivated nor judged by the needs of the populous. Instead, state interventions are driven by competition for power between nation states (Foucault, 2000a, p. 300); and because they sit at the site of reproduction of populous, the bodies of and relations between children and families are their prime targets.

Technobiopower

Relations of power are influenced by technologies and how social agents use them, and this is particularly so for CN&A responses, which have developed in concert with advances of technoscience. Power is rooted across social networks of people, institutions, ideas and techniques that make up society (or as sociologists describe: ‘the social’). People engage in social practices, act in ways and apply technologies that produce semiotic and material aspects of the social world, thus the social is open to the effects of power and other relations and actions (Chouliaraki & Fairclough, 1999, p. 23). “Social relations ... are frozen into the hardware and logics of technology. Nature is, in “fact”, constructed as a technology through social praxis” (Haraway, 1984, p. 52). Technology is conceptualised here as both the

hardware and the social process that applies knowledge, tools or techniques to affect the social world (structures/relations/practices).

In a dialectical relation, technologies also complicate traditional power relations of domination and subjugation. Dominating relations tend to be structural and include “capitalist relations between social classes ... patriarchal gender relations as well as racial and colonial relations, which are diffused across the diverse practices of a society” (Chouliaraki & Fairclough, 1999, p. 24). Technologies support intensified surveillance of individuals who, aware of this surveillance, internalise power relations. In late modernity, there has been “a condensation in space and time, a speeding up and concentrating effects in the webs of knowledge and power” (Haraway, 1997, p. 50). The result has been a transformation of power relations intensified through the influences of technology, resulting in what Haraway calls ‘technobiopower’. Instead of producing the biopolitical body, technobiopower works through the melding of material and semiotic practices into hybrid bodies that exist in tropic figurations between the real and the unreal. Haraway (1997) explains, technobiopower has “more the temporality of the science-fictional wormhole, that spatial anomaly that cast travellers into unexpected regions of space, than of the birth passages of the biopolitical body” (p. 12). It is in the melding of material bodies and technoscience, amidst discursive and political relations that figurations take form. I applied Haraway’s notion of the figuration extensively in the analysis of this thesis, the details of which are described later in this chapter.

As mentioned at the outset of this section, it was the advances of technoscience, specifically x-ray technology and the medicalization of CN&A that oriented the CPS to investigate and substantiate individual cases of CN&A. While biopower influenced “bodies and works; [now] we have texts and surfaces. Our dominations do not work by

medicalization and normalization any more; they work by networking, communication redesign, stress management” (Haraway, 1991, p. 245). Haraway identifies that texts are inscribed with intensified relations of technobiopower. Practices of medicine have become so intertwined with human life as we live it that it is no longer possible to draw the boundaries, and thus it is more relevant to strive to understand the *consequences* of medicalization than to problematize it (Rose, 2007, p. 701). While longstanding categories of difference (e.g. race, gender and age) persist with technoscientific advances, the ways the distinctions between categories are made have changed, “in complicated and often insidious ways, the older categories may even take on a renewed force ... but more subtly” (Rabinow, 1992, p. 245). New categories of difference emerge that “supersede and eventually redefine the older categories in ways that are well worth monitoring” (Rabinow, 1992, p. 245). Rabinow’s warning supports DRCDA, which attends to the ways structures *are reconstituted* (either transformed or reinforced) by discourse and action. Attending to contemporary power relations includes tracing the history of texts and noting subtle shifts in classifications and categorisations, which renew the force and make distinctions more subtle.

Technobiopower subjects or dominates, but similar to biopower, does so with “space for agency in social practice ... subjects also act (as agents) constrained by these positions, yet in ways which transform them” (Chouliaraki & Fairclough, 1999, p. 24). As I have described elsewhere, the “idea that technoscience may entrench ideologies and simultaneously create opportunities for change, aligns with the perspectives of the dialectical–relational approach of CDA” (Einboden et al., 2013b, p. 552). CDA views capability and restraints of the subject in a dialectic relation, the agency of subjects is not eclipsed by the structures (structuralism) nor is it fully independent or rational (rationalism)

(Chouliaraki & Fairclough, 1999, p. 25). However, effects of power relations are pervasive, “all social practice is embedded in networks of power relations, and potentially subordinates the social subjects that engage in it, even those with ‘internal’ power” (Chouliaraki & Fairclough, 1999, p. 24).

Fairclough positions the dialectical relation as hopeful, it is how CDA holds potential for social change because dominant relations are reinforced or resisted by everyday actions (practices), including discursive practices. This analytic approach appreciates tensions between “structural permanence and the practical activity of people engaged in social practices” (Chouliaraki & Fairclough, 1999, p. 32). Structures constitute both the possibilities for, and limitations of social practices, and the practices depend upon and transform the structures (Chouliaraki & Fairclough, 1999, p. 32).

Data collection: sampling technique and ‘the data corpus’

A data corpus was assembled from textual samples that offered insights about the extent and nature of CN&A as a social problem, attending to these dialectical relations between structures and practice, informed by theoretical understandings of power relations. I specifically chose textual samples that represent structures and practices, as well as those that capture the dialectical relations between them. This section describes details of the data collection for this study.

Nursing practices responding to CN&A are at the centre of the inquiry in this study. Data collection required compilation of a corpus of discourse samples (texts) that represent the practice (Fairclough, 1992). Nursing practice is influenced, guided and legislated from various intersecting places, and text samples for the data corpus were selected across these. Texts were included that describe the legal and political contexts in which nurses practice,

such as professional nursing codes, standards, guidelines and literature, as well as child protection legislation, investigative reports of critical incidents, and prevention programs. I chose to limit the data collection to BC, Canada because nursing registration and child protection are provincially regulated. As noted in Chapter 1, limiting data collection to one province allowed the data corpus to be managed within the scope of doctoral study yet supported a breadth of analysis to include multiple practice, institution, and regional settings. While findings of this study are specific to nursing in BC, the analysis has relevance for disciplines beyond nursing and jurisdictions beyond BC. A wider relevance has resulted because of taking a step back to examine the social context in which provincial legislation and practice are anchored, and because this legislation is guided by national and international legal discourse. In effect, BC could be considered a 'case study' to show the ways in which legislation operates, and findings from this study are relevant for nations with similar mandated reporting legislation and CPSs (e.g. Australia, Canada and the United States of America (USA)).⁷

Following the method recommended by Fairclough (Fairclough, 1992), the data corpus was enhanced by conducting in-person interviews with RNs (n=21) who were actively practising in roles where they provided care to children. Interview participants were invited to bring to the interview any resource they used to support their practice in responding to CN&A (e.g. document, policy, website, or journal/book reference). These practice resources extended the corpus and ensured that the sample was reflective of the practice, drawing on

⁷ Specific relevance of these findings to jurisdictions beyond BC would require comparisons between mandatory reporting, other child protection legislation and programs that respond to safety concerns. However, relevance exists at the level of social discourse in terms of how children, families and perpetrators are understood within western society. This relevance does not hinge on particulars of provincial law but social discourse is dialectically related to policy and legislation at various levels of governance.

“people working within the research site for decisions about which samples are typical or representative of a certain practice” (Fairclough, 1992, p. 227). Some of the texts that the nurses identified had already been included for analysis, and this was a useful way to validate a few key texts.

Finally, data collection of popular news media in BC was conducted during the time of the interviews. This media review documented dominant social perspectives about children and CN&A and captured critical CN&A incidents in the province. An overview of the data corpus is provided in Appendix 2, and the following sections describe the data selected and rationales in more detail. Supplementary texts not included in Appendix 2 were drawn upon to inform the analysis and were needed: for instance, to identify intertextuality and interdiscursivity of texts (e.g. the history of texts; other snippets of text that are referred to within a text; the production, distribution and consumption of texts).

Legislation

BC’s legislative authority for child protection practice is the *Child, Family and Community Services (CFCS) Act* (1996), which mandates reporting of “reason to believe that a child needs protection” and allocates responsibility for child protection services to the MCFD. Other relevant legislation includes: BC’s *Family Law Act* (2011); *Representative for Children and Youth (RCY) Act* (2006); Canada’s *Criminal Code* (1985); and the international *United Nations Convention on the Rights of the Child (UNCRC)* (1989). Relevant sections of these texts were reviewed in their entirety, and specific excerpts relevant to nursing responses to CN&A were chosen for analysis. Guided by the nurse interviews, analysis focuses on the relationship between legal guidelines and nursing practice; specifically, how legal

obligations are maintained and how nurses talked about such obligations when working with families.

The Lost in the Shadows report

The evolution of the CPS in BC has been punctuated by reactions to high profile cases of extreme abuse, notably the death of five-year old Matthew Vaudreuil in 1992 and 19-month old Sherry Charlie in 2002. After Matthew's death, *The Gove Report* instigated numerous reforms for child protection in BC (Gove, 1995). As described in Chapter 1, the investigation into the death of Sherry Charlie similarly instigated numerous reforms, including the legislated appointment of the RCY (Hughes, 2006). Since 2006, the RCY has led investigations of critical incidents involving children in BC, publishing two to three critical injury/death review reports per year. These reports highlight the failures of the MCFD and other health and social services in protecting BC's children, offering this study textual representations of these crisis events (the semiotic dimension of these events).

The RCY's reports from 2008-2016 were collected and reviewed. Together these reports represent a large volume of textual data that offers important insights into the discourses, intersections and relations of the CPS and other health and social services. They supplement the analysis by providing details of historical and social contexts that frame current practices and structures, and describe how these contextual features led to children's deaths. Most reports offer few references to nursing practice, except for the report entitled: *Lost in the Shadows: How a Lack of Help Meant a Loss of Hope for One First Nations Girl* (RCY, 2014). *Lost in the Shadows* details nurses' documentation and responses to safety concerns for a girl for many years, thus I chose to use this report for detailed analysis and discussion.

Professional obligations

Nurses' professional obligations shape their practices with children and families when responding to CN&A. The College of Registered Nurses of BC (CRNBC) is the regulatory body in BC that sets out these obligations in the standards of practice guidelines. Johansen (2014) identified that practice guidelines for responding to CN&A are spread across four CRNBC practice resources. These resources were selected for textual analysis in this study and include: a booklet entitled *Legislation Relevant to Nurses' Practice* (College of Nurses of British Columbia [CRNBC], 2015)⁸; *Standard 1: Professional Responsibility and Accountability, Clinical Standard #2: Functions within own level of competence, within the legally recognized scope of practice and within all relevant legislation* (CRNBC, 2010b); *What were the warning signs? Case study about a nurse's legal obligation to disclose* (CRNBC, n.d.); and the *Privacy and Confidentiality Practice Standard* (CRNBC, 2010a) and its associated online learning module.

Nursing literature

As described in Chapter 1, a review of the CN&A literature is woven throughout the chapters, and selection of this literature is drawn upon as it relates to specific research objects. I approached the literature with curiosity, examining it using a textual and discursive analytic lens. While the body of nursing literature discussing CN&A is vast, there are key discourses repeated across this literature, and which are identified repeatedly in the corpus (e.g. medical discourse that promises to identify abuse, and legal discourse that mandates reporting). These two discourses are central to child protection structures and

⁸ This booklet was updated in 2015, and the most recent version was used.

practices: they are echoed in the recommendations of the RCY reports and emphasised within professional obligations. In addition, excerpts related to CN&A from *Wong's Essentials of Pediatric Nursing 10th edition* (Hockenberry, Wilson, & Rodgers, 2017) were included in the corpus due to the book's international influence on paediatric nursing practice.

Nursing Participant Interviews

Interviews with RNs practising in BC (n=21) were conducted from October 2011 – June 2012. Nurses, as social agents engaged in the practices, offered the opportunity “to probe into issues which go beyond the sample ... to try to discover, for example, whether a person is more conscious of the ideological investment of a particular discursive convention in some situations than in others” (Fairclough, 1992, pp. 227-228). Interview texts offered a dimension of complexity, complementing other textual samples, which is why a relatively small sample (target n=20) was chosen. As anticipated, nurses were well positioned to support the dialectical nature of the analysis, their insights into the operations of the structures and practices of child protection were invaluable to informing analysis of the texts across the corpus.

I chose to interview participants from multiple practice settings and geographical locations across the province. My aim was to capture various practices and perspectives, and ensure that responses did not reflect the particularities of the culture of any specific unit, institution or setting. With this objective, selection criteria were kept broad, participants were required to be: older than 18 years of age; licensed as a RN with the CRNBC; currently practising as an RN in BC with infants, children, youth and their families in any setting; had experienced one or more situations of suspected or known CN&A in the

context of nursing practice; and had access to the Employee and Family Assistance Program to ensure their safety (see Appendix 3). The focus of the interview was professional practice, I was specifically interested the nurses' decision-making and strategies in response to CN&A.

While health is provincially regulated, the province does this through one provincial health authority and five regional health authorities. Participants represented nurses working in each health authority across hospital and community; rural and urban; and primary, secondary and tertiary care settings (see Appendix 4). Settings for the interviews were decided collaboratively with each participant and included private workplaces, community libraries, university rooms, and participant's homes. At the time of the interview, all participants were given a copy of the Participant Information Statement and Consent Form (see Appendix 5). Each participant was thanked by email after the interview and those who consented to feedback will receive a five-page report reviewing the findings of this thesis, as well as an electronic copy of the thesis.

In the semi-structured interviews, nurses were asked eight open-ended questions (see Appendix 6). Prior to interviewing participants, I conducted a practice interview with a colleague who met the selection criteria. All interviews were conducted individually and in-person, and I believe that in-person interviews enriched the data by allowing me to build rapport with interviewees. A good rapport was important because of nurses' concern with current CN&A practices and legal ramifications of certain decisions. Despite efforts to keep recording until we parted, a few participants offered information 'off the record' after the interview was finished. This supplementary information was not included in this thesis. However, the content from these discussions offered contextual depth that informed by my fuller appreciation of interview data, and at times data across the corpus.

Ethical considerations and recruitment of participants

Ethics approval was obtained from the Human Research Ethics Committee at the University of Sydney, and the two BC institutions that supported recruitment for the study: University of BC (UBC) and BC's Institute of Technology (BCIT) (see Appendix 7). There was no straightforward way to access nurses who work with children across practice settings, institutions and/or regional areas of BC, thus UBC and BCIT were chosen because both institutions offer courses that attract paediatric nurses. Recruitment was conducted by dissemination of an advertisement through email at UBC and BCIT, the classified section of *The Canadian Nurse* (September 2011), a notice in the *Emergency Nurses Association of BC Newsletter* (June 2012), and passive snowballing through participants and my professional networks (see Appendix 8). These strategies were effective in recruiting 21 nurses from various practice settings and institutions throughout the province (see Appendix 4). This approach was useful to resist the positioning of nurses as representatives of practice institutions, by loosening responses from associations with specific institutional requirements and allowing the participants space to speak from a professional nursing perspective.

My plan was to interview approximately one to two participants each week, and complete interviews by January 2012. Recruitment was slower than anticipated. I amended the recruitment plan in March, and again in May 2012. A plausible reason for the slow recruitment was an omission of the required time commitment on the original information circulated. Advertisements were amended to include the commitment required, and in the case of email, this information was added to the email subject line. Another plausible reason recruitment was slow was because communications were branded with the

University of Sydney logo, and I may have inadvertently positioned myself as an 'outsider'. In the amendments, the UBC and BCIT logos were added to the information circulated to clarify that institutions within BC approved the ethics of the study. A third possible explanation for slow recruitment may have been a general discomfort with discussing CN&A. However, I find it difficult to argue this point because nurses encounter CN&A in practice, and many seemed enthusiastic to discuss their CN&A experiences informally. However, nurses' marginal position to CN&A responses and a dearth of guidance for practice may have translated into a lack of confidence in their knowledge, which was supported in the interview data where nurses described deferring to other more expert health professionals in practice.

Recruitment strategies ensured no initial direct participant contact by the researcher. Adaptation of the information circular into the format of a business card was added to support recruitment during the study (see Appendix 9). During data collection, occasionally my nursing colleagues expressed interest in participating in the study. I felt uncomfortable that this would constitute direct recruitment and unsure how to respond, I may have left eligible colleagues feeling that I was not interested in their participation. Discussing this discomfort with an experienced colleague, she suggested offering a business card as a strategy to breach these situations. The card offered a useful mechanism to share information about the study and allow colleagues to decide whether to initiate contact. The card also proved useful to support passive snowballing through participants.

Once potential participants initiated contact, I returned their contact by the same method. Most potential participants initiated contact by email, and in a several cases, through a previous participant. All potential participants were provided with the consent form to review, information about objectives of the study, the commitment and possible

risks involved, and were screened as to whether they met the selection criteria for the study. If I heard back from a potential participant, I set a time and place for the interview. If I did not hear back, I followed up by email no earlier than 48 hours from the time which the consent form was sent. Follow up allowed me to reassess the potential participant's interest and ask if they would like to schedule a time and place for the interview. Consent was reviewed and signed at the time of the interview.

Participation was voluntary, and it was communicated to each participant that they could withdraw at any time prior to, during or after the interview. No participants withdrew from the study, and several recruited colleagues as participants. For safety, recruitment was contingent on the participants' coverage and comfort with accessing the Employee and Family Assistance Program.⁹ Immediately prior to starting each interview, safety and confidentiality concerns were reviewed. Appendix 6 describes the verbatim preamble read to participants at the time of the interview and conditions were confirmed prior to the interview.

Interview data, data storage and protecting confidentiality of participants

Interviews were audio-recorded using a digital recorder. Data files were transferred onto a University computer, as well as stored on my personal computer, both under password protection. Consents were scanned and stored under password protection and hard copies stored in a locked cabinet at the University of Sydney as per regulations, and will continue to be stored for seven years after completion of thesis. The data was removed from the

⁹ Only BC nurses employed by the health authorities have free access to this service, thus nursing working outside the health authorities in private or non-governmental organisations were not eligible to participate.

University of Sydney computer in 2013, kept securely on the network server and on my personal computer under password protection as required by ethics approval.

On average, the interviews each lasted one hour and 16 minutes, with the shortest interview at 49 minutes, the longest two hours and 24 minutes and total interview time was 26 hours and 42 minutes. I began analysis of the data corpus at the same time as collection, and while I had intended to transcribe the interviews, early on I found that I preferred the audio-recording to capture meaning accurately. CDA considers transcription interpretive and analysis directly from audio recordings removes one layer of interpretation (Fairclough, 1992). After transcribing approximately half of the interview data I stopped and instead transcribed excerpts as needed, removing or altering any identifying details. NVivo10 was initially used to organise the interview data, but its use was limited as for DRCDAs it was not helpful to quantify the number of times a discourse appeared in the text. Rather, discourses that were the focus of the analysis were chosen by their appearance in the texts that were most relevant to practice, that the participants identified as describing and directing nursing practices, and that were identified by discursive features such as interruptions, inconsistencies, contradictions, interdiscursivity or intertextuality. The nurse interviews were used to support analysis of social structures, and the nurses' discussion of texts offered the signals for further analysis. Specific data choices are described in detail in the discussion and analysis of the texts.

Practice resources

The most consistent practice resource identified by the participants to support their practices were their colleagues including: other nurses, social workers, CPWs and CN&A clinic staff. Second to colleagues, the most popular resource that was identified by six nurse

participants was *The BC Handbook for Action on child abuse and neglect*, for service providers (MCFD, 2007, emphasis in original). The *Code of Ethics* (Canadian Nurses Association, 2008) and two different institutional policies were also identified, including one journal article, a select set of conference proceedings from a 2012 International Conference on Child and Family Maltreatment, and a resource entitled, *Let's talk about touching* (Early Childhood Educators of British Columbia, 1992). All items were reviewed and excerpts have been chosen for more detailed analysis.

News media review

Child welfare practices in BC have a history of reactivity to publicised critical incidents and are “subject to cyclical patterns” (Hughes, 2006, p. 4). When I designed the study, I hoped that conducting a media review concurrently with the interviews would capture critical incidents that might influence nurse participant responses. Four popular news media sources were selected: the *Canadian Broadcast Corporation (CBC) News Online BC*, *The Vancouver Sun*, *The Province*, *National Post (National Edition)*. Together they offered provincial and national media coverage, with a combination of social and conservative leaning perspectives.

In the first week of October 2011, I searched headlines to capture articles with a focus on children's issues. The search terms I used focused on CN&A/child maltreatment, but I soon realised that the search failed to capture many articles related to CN&A. Therefore, from 15 October 2011 search terms were broadened to include anything to do with children: child*; boy; girl; infant*; baby; babies; kid*; teen*; youth*; parent*; school*; class*; student*; and pedophile (added on 24 October 2011). A daily review of these sources from 15 October 2011 to 14 June 2012 was conducted. The headlines for *CBC News*

Online, BC were searched at <http://www.cbc.ca/bc/news/> by selecting the option for displaying “Headlines” on the site and manually scanning them. For the three print sources, I used the internal search engine at PressDisplay.com to conduct a headline search using the same terms, which supported an electronic view of the full newspaper and downloading of the original print layout for each article. I manually searched all articles identified and collected relevant articles using Evernote. Search hits and exclusions were tabulated, and a reason why an article was excluded was noted (e.g. the exclusion of an article about “baby” polar bears).

As my appreciation for the nuances of violence grew, it led to an expanded selection of articles. For instance, there was a provincial teacher strike and work-to-rule as an agreement had not been negotiated by the government. Initially, I discarded these articles with the perception that they were not relevant to the violent treatment of children. After reconsidering how the teachers’ main issues (class size and support for children with special needs) revealed dominant social values regarding children, especially children with special needs in BC, I included the articles.

A large volume of data was generated from the media review (see Appendix 10). While the expansion of search terms meant an arduous review process, it also immersed me in naturalised and ‘common-sense’ understandings of children. Evernote were used to collect and code (tag) content themes and discourses that reflected how children were represented within the article. This review documented dominant social perspectives about children, who were figured within the media with descriptors such as innocent, evil, resources, resource drains, miracles, aliens, brats and delinquents. Violence against children figured strongly in these media texts with over twenty-five per cent of articles coded as describing CN&A. A notable incident was allegations that Scouts Canada had kept secret

files documenting perpetrators of child sexual abuse. Another notable incident was a legal win for a BC couple who took the MCFD to court over the apprehension of their four children after the youngest sustained a head injury diagnosed as Shaken Baby Syndrome (SBS) (see Tomlinson, 2012). This news item was used as a primer for a televised documentary-style investigative report that presented SBS as a contested diagnosis, a claim that was at odds with other texts in this study, and of interest because the only province-wide CN&A prevention program at the time of data collection was an SBS parent education program administered by nurses (*The Period of Purple Crying*®).

No incidents from the media review were referenced by the nurses, so contrary to my expectation, the media items did not explicitly connect to the interviews. Nurses in the interviews very infrequently referenced past critical incidents as well. It was not until I found the RCY report in 2014 that an incident linked to nursing practice, and this was captured through on-going reviews of the RCY reports.

Doing DRCDA

As described in the introduction, CDA is a methodology, rather than a method. It resists clear demarcations of theory and method, or stabilisation of any specific method (Fairclough, 2009, p. 167). The analysis follows the structure outlined by Chouliaraki and Fairclough (1999), which is derived from Bhaskar's model of explanatory critique. While the analysis is an iterative process, I use the four stages articulated by Fairclough (2009) to organise this section, which are: "Stage 1: Focus upon a social wrong, in its semiotic aspect; 2. Identify obstacles to addressing the social wrong; 3. Consider whether the social order 'needs' the wrong; 4. Identify possible ways past the obstacles" (Fairclough, 2009, p. 167).

Fairclough's structure is not prescriptive, but offers an overarching analytic strategy in two ways. First, it provides a consistent perspective on what discourses and texts are, and how they are organised in formations through social structures and practices. As discussed in the outset of this chapter, this method also suggests techniques for analysing features of the texts, discourses, and the orders of discourse. Second, the method acts as a scaffold on which a specific approach to analyse nurses' responses to CN&A was built, using a variety of theoretical perspectives suited to this topic. Its key strength is that it is flexible enough to allow the analyst to exercise liberty to "shed light on the dialectic of the semiotic and the social in a wide variety of social practices by bringing to bear shifting sets of theoretical resources and shifting operationalisations of them" (Chouliaraki & Fairclough, 1999, p. 17). CDA only offers a scaffolding, therefore the approach taken to DRCDA depends on the content of the analysis and the analyst's choice of theoretical perspectives.

In this following section, the theoretical resources and how they were operationalized are described. While I follow Fairclough's stages for clarity, this presentation fails to capture the reflexivity of the process, which is demonstrated in the subsequent chapters. Chapters 3, 4 and 5 are organised discursively and lead the reader through the analytic process in detail, presenting data, methodology, findings and discussion together within each chapter.

Stage 1: Focus upon a social wrong, in its semiotic aspect

As described, operationalising this approach required tailoring the specific research topic and question.

CDA is a form of critical social science geared to a better understanding of the nature and sources of social wrongs, the obstacles to addressing them and the possible ways of overcoming those obstacles. ... [Social wrongs are] aspects of social systems, forms or orders which are detrimental to human well-being, and which could in principle be ameliorated if not eliminated, through perhaps only through major changes in these systems, forms or orders. (Fairclough, 2009, pp. 167-168)

CN&A is an obvious social wrong that could be eliminated, albeit with major changes to the social order. Formulations of the social wrong for this inquiry are the problem statements and align with the research questions: *CN&A negatively effects the well-being of people (in BC); current responses are inadequate and poorly effect the well-being of some children and families; nurses, though well positioned to intervene, are under-utilised, and their practice is not well supported.*

DRCDA identifies discourses as located within a broad “overall frame of social practice” (Chouliaraki & Fairclough, 1999, p. 61). As described above a large data corpus was developed by collecting texts that represented the practices of nurses’ responses to CN&A in BC. The first level of analysis is a ‘macro’ level analysis that focuses on the interdiscursivity, it asks: what is being drawn on to produce or interpret texts? At this stage, texts were organised in broad discursive terms examining how “network of practices ... constitute the social structure” (Chouliaraki & Fairclough, 1999, p. 61). Discourses and discursive practices were identified, and discontinuities or irregularities were noted. Fairclough describes discontinuities as,

‘moments of crisis’ ... where there is evidence that something is going wrong: a misunderstanding which requires participants to ‘repair’ a communicative problem, for example through asking for or offering repetitions, or through one participant correcting another; exceptional disfluencies (hesitations, repetitions) in the production of a text; silences; sudden shifts of style. ... Such moments of crisis make visible aspects of practices which might normally be naturalized, and therefore difficult to notice; but they also show change in process, the actual ways in which people deal with the problematization of practices. (Fairclough, 1992, p. 230)

Moments of crisis expose influences of the social order and the relationships among discourses, practices and power. They do this by making visible aspects of the practices that might be difficult to notice, they illustrate changes in process, and the actual ways in which people deal with practice problems. Hence, DRCDA is ideal for analysis of a practice discipline. Moments of crisis act as discursive signifiers that guide the inquiry, by indicating to the analyst areas that require further investigation. Observed semiotic features, such as intertextuality, interdiscursivity, moments of crisis, inconsistencies, transitions or silences guided the theorisations, and critical questions of the problem, solutions and their effects were asked (Fairclough, 1992, p. 230). For instance, a discursive inconsistency can be observed between the discourse of ‘child protection’ for a system oriented to investigation and substantiation of abuse, rather than its prevention.

Following Bourdieu and Wacquant, Fairclough (2009) argues that specific methods must be developed according to the theoretical construction of the “*object of research*” (pp. 167, emphasis in original). Signifiers guided the analysis and pointed to certain aspects of the research topic, which were translated into coherent research objects. As areas of focus

evolved, theoretical insights were deepened and a more focused analysis conducted. Disciplinary theories were chosen, guided by what contributed to “rich theorization as a basis for defining coherent object for critical research which can deepen understanding of the processes at issue, their implications for human well-being and the possibilities for improving well-being” (Fairclough, 2009, p. 169). Discourse theory supports critical questions about the way these objects, or elements of these objects, are seen as discursively constructed within social practices, rather than as material realities. As data was gathered and explored, different theoretical ideas were used to help make sense of it and to provide alternatives to dominant discourses. Thus, the analytic approach was tailored to the inquiry and the data.

Theorisation of topics into research objects “can productively be approached in a transdisciplinary way, with a particular focus on dialectical relations between semiotic and other ‘moments’ [of social practice]” (Fairclough, 2009, p. 167). Theorisation of the research objects was iterative during data collection and analysis. This process follows the DRCDA process, where “constructing the ‘object of research’ does need to precede subsequent steps, but it also makes sense to ‘loop’ back to it in the light of subsequent steps, seeing the formulation of the object of research as a preoccupation throughout” (Fairclough, 2009, p. 167). As described, this is especially important for obvious social wrongs to ensure that analysis avoids taking the topic at face value, and instead draws upon theorisations from “various disciplines to go beyond the obviousness of the topic” (Fairclough, 2009, p. 169). Research objects in this thesis have been theorised by interdisciplinary concepts from sociology, philosophy, equity and cultural studies as outlined below.

Research object #1: theorising suspicion

In the context of mandatory reporting legislation and obligations, my attempts to support nursing students' learning and practice led me to question the nature of suspicion. In BC law, suspicion is the precursor to reporting, which in turn triggers the involvement of child protection. Theorising suspicion as a research object was a challenge because there are few theoretical discussions of suspicion in the CN&A literature (Einboden et al., 2011; Levi & Loeben, 2004) and it is rarely examined directly in philosophical texts. Ricoeur (1970) identified Freud, Marx and Nietzsche as masters of suspicion in philosophical thought and described the way in which they reconceptualised human consciousness as being produced through interpretation rather than knowledge/truth. It is through their works that the illusionary nature of human perception is understood as inescapable, a core idea that can be traced to the writings of Baruch Spinoza.

Spinoza (1677/2000) appreciated the limitations of and identified two central issues with human visual perception.¹⁰ First, we are oriented visually and the primary way we know the world around us is through images, thus Spinoza described most common type of human knowledge as imaginary. Second, images are produced by shadows and light amongst interactions of bodies, and thus our perception is influenced by our ontological connections with other bodies. Spinoza argued that the human mind is *an idea of the body*, and opposed the dominant belief that the mind is in control of a mechanistic body. From a Spinozian perspective, thoughts arise from affections of the body, or "the trace of one body upon another, the state of a body insofar as it suffers the action of another body" (Deleuze,

¹⁰ In addition to being a philosopher, Spinoza was a practicing lens crafter and was especially thoughtful about human visual perception and images (Parkinson, 2000).

1997, p. 21). Knowledge derived from images is confused by the illusionary nature of images. He cautioned that imaginary knowledge must be interpreted as a sign or indirect knowledge; the effects of relations or imprints of surrounding bodies (Deleuze, 1997; Spinoza, 1677/2000). Our ontological connections with others (our sociality) and the affections of our body together create images (signs) that we must interpret. Spinoza directs that rational thinking must consider these images and signs within the limitations of human perception and affections (interests, preferences and aversions), while also engaging with new ideas, perspectives, concepts, and interpretations. Spinoza (2000) explained that we perceive the sun as if it is 200 feet from earth (imaginary form of knowledge) and despite that we learn that the sun is much further away, “we shall still imagine it to be close at hand. ... not because we are ignorant of its true distance, but because an affection of our body” (p. 144). Thus, rational knowledge appreciates affections and the illusions these create within the human perception.

The last type of knowledge, which Spinoza (1677/2000) calls “intuition” or “true ideas” (p. 149) is an ever-present knowledge that we all have that exists outside of conscious human thought. How we have true ideas without being conscious of them is explained by Spinoza’s ontology. There is only one indivisible substance that he calls ‘God’ (or in contemporary terms what might be understood as ‘Nature’).¹¹ Thus, human bodies are not singular entities but one collective human body, with individuals constituting modes or finite expressions of one infinite substance (Nature).¹² On account of this ontology, humans are deeply connected to each other and all other expressions of substance.

¹¹ While he uses the term ‘God’ Spinoza was accused of atheism because his conceptualisation of ‘God’ was not aligned with dominant Judaist or Christian teachings (Parkinson, 2000).

¹² The essence of substance is expressed by infinite attributes, or an infinite number of finite thoughts and extensions (bodies) (Spinoza, 1677/2000).

True ideas may enter our conscious thought as a persistence of the images from our first perceptions, with a recognition of their symbolic nature as images and signs and our vulnerability to effects of passions and sociability (Spinoza, 1677/2000). An appreciation for the limitations and symbolic nature of perception allows contextualisation of knowledge and loosens illusion. True ideas are derived through careful reasoning because the way we come to know is confused. “The figments of the imagination are just as real – just as appropriate as objects of systematic investigation – as the modifications of matter” (Gatens & Lloyd, 1999, p. 12). Affections flow in patterns that offer opportunities for reflection and reason, insight, wisps of truth (Deleuze, 1997; Gatens & Lloyd, 1999). Therefore, positioning emotions within, instead of in opposition to reason is required to elevate knowledge out of imagination to rational thought (Einboden et al., 2011; Jaggar, 2000).

Knowledge is complicated not only by human perception but an internal drive towards existence shared by all substance; what Spinoza (2000) calls “conatus” (p. 171). Conatus is similar to what is described by as *will to power* by Nietzsche (Schrift, 2000). Conatus moves us towards sensations and ideas that are pleasurable and increase our body’s strength or power, and away from painful sensations and ideas that weaken us. For Spinoza, conatus frames human affections (of which there are only three: pleasure, pain and desire). These are experienced as sensations or ideas associated with an increase or decrease in our body’s power (Spinoza, 1677/2000, p. 171). Conceptually, this explains why it is more comfortable to ignore violence perpetrated on others. Our ontological connections operate so that witnessing or suspecting CN&A creates a painful sensation, which we are driven away from by conatus.

Spinoza’s philosophy of human knowledge offers a rich resource for theorising suspicion in the context of CN&A. Suspicion is often described as an affection, something

that is *felt* in relationship with others and influenced by charged emotions related to the idea or suspicion that a child is suffering abuse. Rather than literal interpretation, careful study of the pattern and flows of images and affections are needed to develop rational knowledge (Spinoza, 1677/2000, p. 237).

Research object #2: theorising violence

Žižek's (2009) philosophy on violence guides this analysis by offering a way to examine how social conditions are linked to more overt forms of violence. Žižek describes a significant relationship between two different but interconnected forms of violence: *objective* and *subjective violence*. *Objective violence* refers to violence that is normalised everyday forms of domination, caused by the usual operations of social structures and systems as well as common-sense notions and ideological 'givens' (Žižek, 2009). While extremes of CN&A are easily identified as an abuse of power, there is no clear threshold where the shift from acceptable to unacceptable occurs, largely because we have normalised dominating relations between adults and children.

For Žižek (2009), *subjective violence* is not subjective in the sense of being an illusion of individual perception or an experience/feeling, instead it refers to tangible forms of violence that we typically think of *as violence*, spectacular eruptions of "violence performed by a clearly identifiable agent" (p. 1). Žižek's theorisation of violence guided me to consider how spectacular forms of violence have captured attention. This results in channelling of resources to address subjective violence instead of to address more commonplace neglect. Subjective violence is abject, it disgusts and is painful, thus we move away, but at the same time as an immediate threat it captivates our attention and eclipses objective violence. Our heightened sensitivity to and focus on tangible forms of violence results in a paradoxical

tolerance for and invisibility of structural forms of violence. Subjective and objective forms of violence are linked in mutually dependent and dialectical relation. This argument resonates when considering how, despite much intention and effort to address spectacular forms of CN&A, structural forms, such as child poverty, remain unaddressed. Appreciating the relations between subjective and objective violence, Žižek (2009) warns that we must “disentangle ourselves from the fascinating lure of this directly visible ‘subjective’ violence” (p. 1) and shift our perspective by taking a sideways glance. This conceptualisation of violence shifts our gaze beyond its obvious forms and towards its roots within the “obscene underground” (Žižek, 2009, p. 145).

Stage 2: Identify obstacles to addressing the social wrong

In its second stage, the analysis shifts to examine the social order and asks:

what it is about the way in which social life is structured and organized that prevents it [the social wrong] from being addressed[?] ... one ‘point of entry’ in this analysis can be semiotic, which entails selecting and analysing relevant ‘texts’ and addressing the dialectical relations between semiosis and other social elements. (Fairclough, 2009, p. 169)

Disparate ideas of what constitutes appropriate or harmful treatment of children exist, in part, because of the contradictory ways in which children are thought of in western society. For example, in our social imaginaries the child has long occupied contradictory positions as angelic but evil, precious but savage or uncivilised. These imaginations continue today, as Lupton (2014) showed in a recent discursive analysis of the portrayals of infant embodiment

in popular media. While childhood is portrayed as universal, it is also described as something that children can lose (e.g. a child who has been abused might be robbed of childhood). These contradictions offered a discursive signal for the social constructions of the child and childhood, forming a point of entry into the analysis. Oriented thus, how children are socially constructed emerged as an obstacle in addressing CN&A.

Figurations

Understanding the child as constructed allowed me to see the figuration of *The Vulnerable Child* in the corpus. Analysis of this figuration considers how it was brought forth through the melding of material and semiotic practices within social structures and relations of power that form entities and views of the world, and their effects generate particular versions of the bodies and worlds (Castañeda, 2002). Following Haraway (1997), Castañeda (2002) describes figuration as what

makes it possible to describe in detail the process by which a concept or entity is given particular form — how it is figured — in ways that speak to the making of worlds. To use figuration as a descriptive tool is to unpack the domains of practice and significance that are built into each figure. A figure, from this point of view, is the simultaneously material and semiotic effect of specific practices. Understood as figures, furthermore, particular categories of existence can also be considered in terms of their uses — what they “body forth” in turn. Figuration is thus understood here to incorporate a double force: constitutive effect and generative circulation.

(p. 3)

Figuration shows the child as malleable, open to use for various social and cultural purposes, including the creation of categories of difference (Castañeda, 1997). After developing an appreciation for *The Vulnerable Child* and its operations, I was able to spot two other prominent figurations within the discourses of CN&A: *The Responsible Family* and *The Monstrous Perpetrator*.

As outlined previously, CDA considers how seemingly immovable social structures are reinforced or eroded through everyday practices, and how opportunities for change are difficult because they require challenging ideological beliefs that are invisible, or taken for granted, common-sense notions. Figuration is a useful analytic tool because it challenges dominant understandings, and requires figures to be understood as tropes that displace and trouble identities, not as “literal or self-identical” (Haraway, 1997, p. 11). A step back and a sideways glance supports a shift in perspective to go beneath the obviousness of the problem and focus on the ideological foundations. As I pointed out in the previous section, the extremes of violence are rooted in everyday violence and hidden in plain view (Žižek, 2009). Without reacting to the violation of *The Vulnerable Child* or the offense of *The Monstrous Perpetrator*, this analysis remains curious about how these figurations were produced and transformed, how they operate and with what effects, and most importantly, how they form obstacles to social change.

Figurations are interdiscursive, consider for example how Haraway’s (1991) most famous figuration of the cyborg is replete with discourses of science and religion. “Figural realism infuses Christian discourse ... and this kind of figuration shapes much of the technoscientific sense of history and progress” (Haraway, 1997, p. 10). Technologies exponentially extend Foucaultian conceptualisations of biopower by way of technobiopower. For Haraway, the cyborg is not a futurist idea of what we might become

but a window to view how we exist with technologies that have shifted what it is to be human.

Foucault's account of four figures, *The Nervous Woman*, *The Masturbating Child*, *The Malthusian Couple* and *The Pervert*, were used in his analysis to describe the rise of mechanisms of subjection as "an explosion of numerous and diverse techniques for achieving the subjugation of bodies and the control of populations, marking the beginning of an era of 'biopower'" (Foucault, 1976/1990, p. 140). These figures were produced within four strategic unities of knowledge/power within the modern discourse of sexuality, which within the state focus on the government of life alongside a capitalist interest in the reproduction of bodies for production, became a topic of intense political interest. Initially, the state regulated kin alliances through marriage, and the family formed as the new economic unit within capitalism (under feudalism the economic unit was the community). The family was a means to support the transfer of identity and the protection of accumulated surplus (or 'private' property). This regulation was followed by another new form of regulation of sexual alliances, deployed through a new discourse of sexuality. Foucault traces a preoccupation with sex to sexual prohibitions that began in the 17th Century, took hold in the 18th Century (Victorian Age) and intensified in the 20th Century with the budding sciences of psychology and psychoanalysis. In Ancient Rome and throughout the Middle Ages, sex was not secret nor was it treasured, it was simply a part of life. Prohibitions elevated the importance of sex, and a new form of sexuality was constituted as a "dense transfer point for relations of power" (Foucault, 1976/1990, p. 103).

Four strategic unities of knowledge/power supported the discursive formations of sexuality, and along with these unities the four figures appeared. First, *The Nervous Woman* appeared with the hysterisation and pathologisation of women's bodies and reproduction.

Second, *The Masturbating Child* appeared with the sexualisation of children. Their sexualisation was replete with contradiction, as children were considered naturally prone to overindulgence in non-productive sex while unnatural precocity represented a collective danger to social reproduction. Third, *The Malthusian Couple* appeared with the socialisation of procreative behaviours and the responsabilisation of couples to control reproduction. Fourth, *The Pervert* appeared with the psychologisation and individualisation of desire as an internal biological and psychological process, rather than a social one.

Disguising political interests, the discourse of sexuality was constituted by discursive unities and their four figures. The family, as the locus of loving affections became the site of deployment of sexuality. Children's sexuality could develop under supervision of parents, supported by doctors, psychologists, nurses and educators. Normal and pathological behaviours were constituted and attributed to failures of parent-child relations. The prohibition of incest became a universal rule in western society, and as forbidden it was pivotal in "saturating the [kin] alliance with desire" (Foucault, 1976/1990, p. 113). Freud and psychoanalysis supported this process, by hunting and inciting incest within the family, revealing repressed desires and treating pathologies that originated in family relations. Treatments however, were initially limited to the bourgeoisie, where children's sexuality was first problematized. Finally, the proletariat were subjected to early child protection campaigns to end incest and the removal of children from incestuous families. Foucault's four figures remain relevant today, the figurations identified in the data corpus of this study are contemporary presentations of these age-old figurations. While Foucault's analysis offers useful historical social and political support for this aspect of the analysis, Haraway offers the challenge that the relations of biopower are intensified by the influence of technoscience. These intensifications of power relations generated by and represented in

the figurations that operate within responses to CN&A. Rabinow (Rabinow, 1992) suggests that the operations of these intensified forms of biopower are worth attending to, a suggestion that I take up in this thesis.

Stage 3: Consider whether the social order ‘needs’ the wrong

In regard to resistant social problems, or clear social wrongs, it is useful to consider why society might need the social wrong. This consideration leads to asking: If CN&A *negatively affects the well-being of people in BC*, why might we need CN&A? The importance of theorising the objects of research, that is to go beyond and beneath the obviousness of the problem is revealed. As is, we might implicate individual perpetrators and their need to mitigate their own powerlessness by exerting power over another (child) to support an illusion of personal power. This is the type of face-value analysis that reproduces dominant discourses that Chouliaraki and Fairclough (1999) warn against. Instead, at this stage of analysis, this question of need will be asked of theorised objects of research. Therefore, the analysis explored the following questions:

- a) What social gains exist from rationalising suspicion?
- b) Of what social importance are the figurations?
- c) What does society gain from the existence of CN&A? What is our attention diverted away from, when we focus on CN&A the way we do?
- d) What would need to change to give space to children’s voices?

Stage 4: Identify possible ways past the obstacles

Stage 4 moves the analysis from a negative to positive critique: identifying, with a focus on dialectical relations between semiosis another elements, possibilities within

the existing social process for overcoming obstacles to addressing the social wrong in question. This includes developing a semiotic 'point of entry' into research on the ways in which these obstacles are actually tested, challenged and resisted.

(Fairclough, 2009, p. 171)

Chapter 6 pulls together key findings from the analysis across the chapters. Obstacles that have made CN&A such a resistant social problem are embedded within our own imaginations. Practical suggestions include ways to disrupt some of the taken for granted notions about children, families and perpetrators. This stage of the analysis offers the recommendations based on the findings, by way of a conclusion.

Limitations

Limitations of DRCDA and how this thesis addresses these limitations are explored in this next section. Challenges discussed here relate to issues of quality and rigour of discursive analysis and include: the definitional issues with discourse; the hybridity of the analysis; critiques of interpretations versus analysis; issues related to subjectivity and agency; and the inherent bias of research that has a political orientation. As a specific method, DRCDA is relatively new and has considerable hybridity, therefore the discussion considers challenges to DRCDA and CDA generally.

Unclear boundaries between discursive and non-discursive

A longstanding concern with CDA is the various ways in which the term discourse has been understood and used, leading to confusion regarding the focus of the analysis. Fairclough (1992, 1999, 2009) includes careful descriptions of what is meant by discourse in DRCDA,

and I described these at length at the outset of this chapter. However, analysis of dialectical relations with other discourses, social practice and social structures, complicates distinctions between discursive and non-discursive elements. For example, figurations are key analytic concepts in this thesis and they fuse materiality and semiotic practices in ways that produce them discursively, but this production is never complete, part of their power relies in their materiality. Thus, they are both discursive and non-discursive.

Jørgensen and Phillips (2002) suggest that perhaps the distinction is not required, and while we come to understand social reality by way of semiosis,

we can still analyse it *as if* social reality is more than meaning-making. This implies that what the researcher points to as non-discursive logics, and where she draws the boundary between the discursive and the non-discursive, is more a result of a theoretical and analytical choice. (p. 90)

Thus, the argument that distinct boundaries are not only not required but also unachievable is a useful one for this thesis and is exemplified by the figurations. Conceptualising the boundary between discursive and non-discursive as fluid allows the analysis of specific ideas to be guided by discursive *and* critical social and philosophical theories as needed.

Interpretation or analysis?

Widdowson (1995) challenged that CDA substitutes interpretation for analysis and is thus invalid. He described interpretation as, “a matter of converging on a particular meaning as having some kind of privileged validity. ...[but] analysis ... seeks to reveal those factors which lead to a divergence of possible meanings, each conditionally valid” (p. 159). Fairclough

(1996) responded to this critique by clarifying ‘interpretation’ at two levels: interpretation-1, which considers all potential meanings where people make meaning using their resources and the text; and interpretation-2 which “show[s] connections between both properties of texts and practice of interpretation-1 in a particular social space, and wider social and cultural properties of that particular social space” (p. 50). The relations between interpretations at different levels yields a systematic *analysis* of texts that moves from interpretation to description to interpretation.

“Within CDA, there is little specific discussion on quality criteria” (Wodak & Meyer, 2009, p. 31), therefore, there is a need to continue to develop more specific quality assessment strategies and modify traditional concepts of validity, reliability and objectivity. Wodak pioneered a process of triangulation used for the discursive historical approach to address quality issues. In a similar way, Fairclough’s DRCDA enlists triangulation of analysis at three levels: broadly identifying discourses, more specifically drawing on techniques for semiotic (linguistic) analysis as needed, and considering discursive and social practices together with specific attention to the ideological and hegemonic influences of the social structures and practices. Analyses from these three angles enhance rigour of this study, drawing on the data from the interviews with nurses to guide analysis. In some cases, voluminous amounts of data were examined to ensure interpretations are both accurate and significant. “Nevertheless, severe ‘objectivity’ cannot be reached by means of discourse analysis, for each ‘technology’ of research must itself be examined as potentially embedding the beliefs and ideologies of the analysts and therefore prejudicing the analysis towards the analysts’ preconceptions” (Wodak & Meyer, 2009, p. 32). This caution is duly noted, objectivity is never fully achieved, and therefore transparency in analytic decisions and positions was maintained.

Subjectivity and agency

Social agents who engage in practices that reinforce or resist dominant constitutions constitute the social. However, Fairclough has not offered a detailed way to conceptualise or analyse the agency of the social actors, or their experiences of subjectification,

including ... how much control people have over their language use. In so far as Fairclough stresses that discourses take part in constructing social identities and social relations (in addition to knowledge and meaning-systems), he cannot be said to have entirely neglected these social psychological aspects, but they are the weakest element of his theory. (Jørgensen & Phillips, 2002, p. 90)

This critique echoes Spivak's (1988) concerns about the assumed subjectivity being that of an ideological subject. The issue of subject agency complicates the analysis throughout this thesis, requiring supplementation of the analytic framework with post-colonial feminist theory. Finally, my subjectivity and social positioning is significant to how I come to understand the data, which is why I have offered an account of how this research question was developed in Chapter 1. In addition, throughout the analysis and interpretation of findings, I have identified and described the discursive signifiers in the text that guided my choices of textual excerpts for more detailed analysis.

Political orientation

Perhaps the main critique of CDA is concerned with its orientation towards addressing social inequities. Again, the weaknesses of CDA and its strengths are one and the same, part of its "power to attract and annoy" (Tenorio, 2011, p. 183). CDA's main focus is on how inequity is

produced and maintained discursively. What is in question is the ability of the analyst to be objective while engaging in “an advocacy role for socially discriminated groups” (Wodak & Meyer, 2009, p. 19). This critique is relevant to this thesis, because my aim is to create knowledge to support nurses to address inequitable social conditions for children.

In response, Fairclough argues that problematising overt political commitments in CDA *implies their absence elsewhere*.

CDA would argue that we are all ... writing from within particular discursive practices, entailing particular interests, commitments, inclusions, exclusions, and so forth. (This claim, by the way, means that CDA is theoretically better-placed to recognise its own ‘partiality’ than most theories) Aspects of these discursive practices may serve to sustain relations of domination and may hence be ideological - no theory or science is immune from that possibility. Whether discursive practices do or do not work ideologically needs to be established through analysis of those practices in relation to the wider social practices and relations that frame them. The implication of this is that a categorical opposition between science or theory and ideology cannot be sustained. (Fairclough, 1996, pp. 52-53)

If knowledge production is a practice (with material and technological resources), the idea that it can be free from political influences and relationships to other practices including dominant ideologies and structures, is questionable. From a discursive perspective, science is one of many languages and its dominance to define what counts as knowledge reveals its power (Fairclough, 1996). Claims that research must be objective divert attention away from the assumptions and interests of the research. These claims also defend against

reflexivity, which acknowledges and addresses the complexity and contradictions of objectivity.

Defending against reflexivity is problematic because research and knowledge is produced from dominant discourses that are not interrogated, but understood as reality or 'just the way things are'. Objectivity and knowledge built on these foundations is faulty. CDA does not claim objectivity rather transparency and rigor from cross referencing between theory, data and context. The focus on the context rather than the content of knowledge, and the dialectical relationship between the social structures and the practices of social agents, appreciates that knowledge is discursively constitutive and constituted (Chouliaraki & Fairclough, 1999). "Dialectical knowledge ... reflexively explores the conditions of possibility of the objectivist knowledge which constructs practices from the outside as a fait accompli" (Chouliaraki & Fairclough, 1999, p. 30). CDA's political orientation and Fairclough's argument in relation to DRCDA offer a new set of challenges for all research knowledge (including CDA).

Selection of texts for analysis

One particularly contentious issue in relation to CDA is the selection of texts for analysis. Wodak and Meyer (2009) caution against 'cherry-picking' samples that only support the analyst's investment, echoing earlier critiques of CDA within linguistics (see Widdowson, 1995). This critique is a key concern for the validity of CDA. In this thesis, I have selected texts for analysis that are not only "retroductable" (Wodak & Meyer, 2009, p. 11) (traceable) and self-reflective, but are central to legislation and policy guiding nursing practice in relation to CN&A. The data is voluminous and excerpts from these texts that I chose to analyse in detail may be different than those chosen by another analyst. The

discursive signifiers were present in the textual sources, pointing up to the research objects, and the discursive formations derived from core texts are so omnipresent across the texts, it is difficult to argue that these were imposed. They stood out because of their semiotic features, for example the use of the metaphor of a monster when talking about perpetrators of child abuse. Sometimes it was the interviews with the nurses or my position as a nurse that was important for bringing discourses to the fore and recognising signifiers. Lengthy excerpts of the original texts are included in the analysis and appendices so that the readers may interpret findings themselves and assess for the presence and influence of these discourses, to understand the nuances of power relations.

Analytic focus on dialectical-relations of semiosis with other elements of the social required a second level of data gathering to supplement the selections from the original corpus so that discourse practices could be analysed. In order to support rigour, I described discursive signifiers from the analysis and how text selections were made. There is always a danger that a signifier is produced by signification, and this poses a tension between whether or not something is hidden or produced. The only way I see around this issue is to consider rigour as related to the ability to follow the theorisations closely, ensuring they guide the analysis, and to recognise that the theorisations chosen do not offer truths but contribute a different perspective.

Hybridity of approaches

The transdisciplinary and eclectic nature of the analysis, and the flexibility to draw on specific theorisations are strengths of this method. However, and at the same time this flexibility leaves the analysis open to inconsistency and contradiction. Tenorio (2011) argues that “Fairclough (2009) denies there is one single way of analysing any problem.

Interestingly, he believes that, after selecting one research topic, scholars construct their object of research by theorising it ... using somewhat unclear methodology” (p. 190). In his critique Tenorio cites Fairclough short summary chapter of DRCDA (Fairclough, 2009), but not the key text that unpacks the complexity of the methodology (see Chouliaraki & Fairclough, 1999). To support methodological rigour in analytic focus in this thesis, I have offered clarifications regarding how concepts are understood and represented throughout the analysis, drawing on Fairclough’s foundational CDA texts (Chouliaraki & Fairclough, 1999; Fairclough, 1992, 1995, 2003, 2010).

Across these texts Fairclough argues that there are many ways to analyse a problem. All research requires choices in analytic focus and how to control for that focus. Judgements on the selection of ideas for theorisation of the research objects are left to the analyst’s discretion, guided by what might produce “rich theorization” (Fairclough, 2009, p. 169). The literature I have selected for these theorisations includes various perspectives from philosophical, sociological, cultural and equity studies. Many of the perspectives chosen fall to the margins, as for example, Spinoza who is rarely cited today. A different selection of theorists would guide the analysis in another direction. Alternate ways of thinking were used to expose invisible and taken-for-granted assumptions on which dominant understandings exist and are reinforced. Knowledge claims that are made are tied to the particular perspectives chosen for theorisations, and detailed contextual information was provided to clarify limits of knowledge.

The findings have been surprising, riddled with contradiction, and the obstacles and ways past them seemed counter-intuitive. I experienced uneasiness in challenging dominant social structures and practices, especially when the findings implicated well-intended programs, some of which I had invested in professionally. Given the gravity of these

findings, I often felt compelled to further investigate, looking for other possible explanations. However, as I continued analysing the research objects from multiple angles, findings became more definitive, which was reassuring methodologically. For example, the media texts that challenged the validity of SBS sent me back to the scientific literature, tracing back to the original papers that put forward the diagnosis, those cited by the American Academy of Pediatrics in defence of the diagnosis, and the research behind its various critiques. I continued the search until it circled back to the same core articles. Despite staunch truth claims, discourse analysis shows how the SBS diagnosis has been built from theorisations, opinions, and legitimations (see Chapter 5). The expertise and support of my supervisors provided the reassurance and confidence needed to pursue and present these findings (see Appendix 1). They urged me not to shy away from the findings or recommendations despite that they demand significant social change.

Qualitative approaches have long been critiqued as ‘soft science’ replete with inconsistency and contradiction. However, for CDA inconsistency and contradiction are important findings, especially for addressing resistant social problems (Chouliaraki & Fairclough, 1999). Quantitative approaches require researchers assign numerical representations to operationalise concepts. While useful in many contexts, ascribing numbers narrows concepts and embeds dominant ideological assumptions (what we think we ‘know’) within them. Thus, entire knowledge regimes can be built on shaky ground. While the approach I have chosen does not lead to ‘definitive knowledge’, it appreciates the fallacies of human perception and wrestles with thinking through nuances, imprints of images, and relations between what and how we know. While this thesis cannot claim definitive truths, it contributes a different perspective to the dialogue about nursing responses to CN&A. Specifically, I have worked politically to uncover and disrupt hegemonic

and ideological roots of current responses, and to show how, if we were to challenge some of these ideological understandings we might see both the problem of CN&A and possible solutions differently.

Conclusion

This chapter has outlined how CDA works to shift the dominant perspective, and offer an alternate way to understand social problems. Intensive theorisation is used to explore interruptions in the discourses or texts, and theoretical choices are tangled within the analyst's perspectives, investments and blind spots. Building a methodology for this thesis required an analysis from a step back and glance sideways. From this perspective, the underpinnings of current nursing responses were exposed and transdisciplinary theorisation was required. During the data collection, my understanding of what counted as relevant data shifted as my appreciation for violence and how it works expanded. Further, my understanding of what might be considered relevant to analysis of relations of power has grown with an ability to see violence beyond the more obvious spaces. I have traced these shifts and made them as transparent as possible within the analysis. What is needed for rigour is not iron clad or stepwise methods, nor clear objectivity or genuine criticality, but a "detailed and compelling" (Toolan, 1997, p. 88) study that is transparent about positioning and analytic choices.

Chapter 3: The Child in Need of Protection

This chapter sets the foundation of analysis for this thesis by examining how children have come to be understood and how those understandings set the possibilities for and responses to CN&A. I begin with an introduction of the figuration of *The Vulnerable Child* and brief description of the social constructions of the child and childhood. Next, I consider the social, cultural and political landscape that supported certain discourses and practices within early and then contemporary child-saving initiatives. From this background, I share a local historical account of BC's child-saving initiatives and how colonisation led to parallel systems of child protection for Indigenous and settler children. This account offers relevant context within which the analysis of BC's contemporary legislative texts and practice can be understood. The analysis then attends to two key statements within BC's current child protection legislation: 'reason to believe' and 'best interests'. 'Reason to believe' that a child is at risk of, or is being neglected or abused, is important because it constitutes the legal condition of mandated reporting according to BC's *CFCS Act* and reports are required to initiate child protection intervention. The second statement, 'best interest', is the legal statement that is central to decision-making on behalf of children in the *CFCS Act*, *Family Law Act* and is embedded within the *UNCRC*, which is important because it is the suggested framework for child protection reform. Together, these statements direct legal action on behalf of children. Analysis considers the features and meanings of each statement and how they operate in practice. Rationalisation, paternalism, individualism and approaches to monitoring are analysed. Framed within discourses of ultimate good, mandated reporting or action in the child's 'best interests' are difficult practices to critique. Legitimisations of these

approaches are traced to the figuration of *The Vulnerable Child* and a parallel iteration of this figuration, *The Developing Child*. Together these figures and statements defend against a much-needed dialogue. While touted as emancipating, approached from a sideways glance they are shown to operate paradoxically, subverting their aims and sustaining the social order.

The figuration of *The Vulnerable Child*

Figuration offers a way to appreciate how *The Vulnerable Child* has been produced through the melding of the material and semiotic discourses, and how this figuration has made it challenging to see children in other ways. *The Vulnerable Child* has also turned the public's gaze away from the structures of a society that render children (and their families) vulnerable in the first instance, and intensified a focus on the child in isolation from others. In this section, the production of the figuration will be discussed starting with how children's vulnerability is socially constructed. Next the socio-political context that supported its production is explored, followed by a beginning analysis of the distribution of the figuration within early and contemporary child-saving initiatives.

The social construction of childhood and vulnerability

Since the Enlightenment, contemporary 'childhood' has been constituted by romantic notions of innocence. Through an historical analysis of art, Philip Ariès (1973) showed that in medieval times 'the child' and 'childhood' did not exist as we know them now. Ariès' thesis stirred controversy and while contested, sociologists have since created a large body of research documenting the social construction of the child and childhood (e.g. see the compilation edited by Jenks (2005)). These constructions vary across children's positions in

historical, geographical and sociocultural contexts (Jordanova, 1989). However, the consistent construction of children as categorically different from adults has significant implications for practices of child protection, which are explored throughout this chapter.

Vulnerability plays a central role in the ideology of childhood. On one hand, the vulnerability of infants and young children is obvious. Yet, a critical social perspective appreciates how within dominant western social discourse, children's embodied vulnerability is *exaggerated* beyond infancy. It also highlights how vulnerability is not located in materiality of the body per se, but is dynamic and contingent on the social and cultural context. Children's vulnerability shifts in relation to: chronological age; skills and capacities; geographical locations; economic contexts; identity (e.g. ethnicity and gender); the child's relations with their family, community and the society in which they live; and the relations of power in and amongst these factors.

Figuration is a useful analytic tool to consider how the child has been constituted through and by discourses. Analysis of *The Vulnerable Child* attends to the large semiotic component of children's vulnerability and its implications for social practice and relations with children, while appreciating its basis in the young child's material dependence and the way in which relations of power have extended the material nature of children's vulnerability. It shows how contemporary beliefs about children's vulnerability work in ways that reaffirm and reproduce it. Monitoring of, and restrictions on, children's opportunities for independent access and participation in public social life have progressed considerably even in the last few decades, justified within discourses of risk/safety (Beck, 1997). In turn, heightened surveillance has limited children's opportunity to build skills and capacity, and has thus intensified their dependence and extended their vulnerability.

The socio-political context of 'childhood'

The production of 'childhood' and children's vulnerability occurred alongside the burgeoning of a middle-class in Britain. This context is relevant because the economic and liberal political within western social thought informs how we understand children and ourselves, specifically in regard to our embodiment. In the shift from feudalist to capitalist economies, the economic unit was redefined in terms of the individual instead of the community or village (Zaretsky, 1976). This redefined the body as holding potential for production, and positioned people in a proprietary relation with their bodies and its capacity (Foucault, 1975/1995). Foucault (1995) explains,

the body is also directly involved in a political field; power relations have an immediate hold upon it; they invest it, mark it, train it, torture it, force it to carry out tasks, to perform ceremonies, to emit signs. This political investment of the body is bound up, in accordance with complex reciprocal relations, with its economic use; it is largely as a force of production that the body is invested with relations of power and domination; but, on the other hand, its constitution as labour power is possible only if it is caught up in a system of subjection (in which need is also a political instrument meticulously prepared, calculated and used); the body becomes a useful force only if it is both a productive body and a subjected body. (pp. 25-26)

Capitalism and liberal political ideology reconstituted society as made up of individuals who identify and relate to themselves and each other as proprietors (of their bodies and capacities) for exchange (Macpherson, 1962). Macpherson (1962) describes this ideological

relation to the body as one of “possessive individualism” and traced its emergence through the writings of Hobbes (1588-1679), Locke (1632-1704) and Hegel (1770-1831) (Macpherson, 1962; Thielen-Wilson, 2012). Possessive individualism was founded on the idea that nature could be improved through reason, and the ability to use rationality to control and improve nature differentiated humans from other animals (Anderson, 2007). The hegemonic discourse of the rational mind as in control of the body set the stage for colonial relations with other bodies.

[P]roperty is first an internal relation between mind and body of a given rational individual. Property is also an external relation between rational individuals and things. Humans who use their rational mind to control their body, i.e., who own their own body as property, are thereby capable of owning external objects as property. (Thielen-Wilson, 2012, p. 55)

The hegemony of possessive individualism also dictated that to appropriate external objects (especially natural ones) all that is required is the mixing “one’s own labour with it” (Thielen-Wilson, 2012, p. 56).

Possessive individualism and its constitution of rationality and control over one’s body as the condition for humanness is problematic for children. Following this logic, the potentiality of the child to develop into an adult is what constitutes the child as human. The discourse of potentiality figures the child as “a becoming rather than a being” (Castañeda, 2002, p. 1), and denies children’s actuality in the present. Possessive individualism and its colonial relation with the body supports the dominance of adults over children, especially

young children. As the vulnerability of children is extended past their physical dependence on adults, so then is their colonisation.

Castañeda (2002) points to how the idea of the child as potentiality has penetrated so deeply that it appears only as a common-sense notion and precludes any other way of thinking. She asks:

What is the child but an incomplete form, which must acquire the necessary traits and skills to live as an adult? ... What else can one hope for but a child but that it will grow physically, intellectually, and emotionally in order to function as an adult in the world? (Castañeda, 2002, p. 1)

The discourse of potential sets up an opportunity to maximise the child's potentiality.

"[T]his notion of improvement, so core to colonial desire, obscures the violence of colonial practices" (Thielen-Wilson, 2012, p. 56). An appreciation of possessive individualism supports an understanding of how fostering the development of children can also be understood as is a mechanism of improving 'nature' and thus, legitimising the appropriation of children.

Individual propriety and private accumulation that began with capitalism accelerated during Industrialisation. Factory efficiency meant a reduction in labour roles for children, and middle-class children were directed away from wage-labour pursuits and towards educational ones. In this shift, children gained protection from exploitative labour situations but lost the benefits of wage labour and the status it provided them as valuable contributors to family survival. Some "children may have gained their childhoods but [all] lost considerable power and status" (Scheper-Hughes & Sargent, 1998, p. 11). As the child's

status shifted to their future potential, the discursive production of the child as a liability spread across social classes (e.g. the idiom: 'another mouth to feed'). Many children continued to work according to their families' socioeconomic needs and still do so today. However, the rise of childhood problematized 'child labour' and meant fewer opportunities for paid work for children, with inconsistent effects on their lives.

Rapid urbanisation of new cities in Britain led to changes in social conditions. Urban poverty had different characteristics than rural poverty, and a key issue was the shift in the economic unit: from the community to the family. Crowding and lack of sanitation led to outbreaks of disease that left many children homeless or orphaned. These children found sustenance on the street by engaging in menial work as newsboys, shoe shiners, baggage carriers, and fruit sellers (Bullen, 1986). Without opportunity for skill building or advancement, this work confined them indefinitely to poor wages and inconsistent employment, constituting criminal activity as a viable option for survival (Bagnell, 2001; Bullen, 1986; Gilfoyle, 2004). In turn, the street was constituted as morally and physically dirty, a contaminating place for children (Platt, 1969).

Naturalisms used to describe vulnerabilities of infant embodiment are also used to figure children as vulnerable to exploitation *and* corruption. Like any binary, the constitution of the child as essentially innocent and vulnerable can only occur in reference to a co-existing social fantasy/fear of the dangerousness and resilience of children. These ideas are co-constitutive and better understood as two sides of the same coin, or as communicated just under the surface where "the image of the horseshoe suits them more than that of two opposing blades" (Donzelot, 1979, p. 187). Thus, *The Vulnerable Child* is both naturally innocent and potentially dangerous.

Oriented to survival, all humans are vulnerable to criminality when hungry or unsafe. Yet, children who lived or worked on the street were excluded from childhood and constituted as a threat to social order (Read, 2010). They were referred to using slang that drew on animalised and racialized discourses and called “gutter-snipes”, “street-Arabs”, “street-rats” (Gilfoyle, 2004, p. 853) who “gnawed away at the foundations of society undisturbed” (Children’s Aid Society (1869) as cited in Gilfoyle, 2004, p. 853). The language highlights their exclusion, and resembles stereotypes of Indigenous children. Attention to these discourses illustrate how othering the child in relation to the adult has allowed figurations of the child to be used in various cultural and social projects, including entrenching social categories of difference (Castañeda, 1997).

Pastoral power emerged as the dominant technique of governing, whereby children were shepherded either by the state through their family (Donzelot, 1979). Children who demonstrated independence living on the street were mandated by the state to attend school and required to purchase street work permits (Read, 2010). The establishment of Britain’s Free Kindergartens relocated young working class children into “morally improving play space” (Read, 2010, p. 4). These kindergartens hosted more intense instruction and normalising agendas compared with educational centres for middle-class children, exemplifying what Foucault called disciplinary technologies of self-regulation. “[F]ocus on the child signified the view that they were an investment in the future, central to the destiny of the nation” (Read, 2010, p. 3).

A rise in child poverty was a sore spot for the state, “[d]estitute and neglected children were not simply the devil’s workshop, but were indicative of the decline of the race, and in the case of Britain, a threat to Empire” (Cradock, 2014, p. 856). Unresolved social issues in the Empire were reproduced later in the colonies, and urban children on the

street in Canada also became a problem of social control (Platt, 1969; Read, 2010).

Legitimisations for child-saving activities have been interdiscursive, including: inherent moral defects of the poor (social Darwinism); pathology/contagion (medicine); and positivisms that constituted crime as biological in origin (criminology) (Platt, 1969, p. 22).

From inception, philanthropic child protection initiatives were confounded with concerns of criminal activity that threatened the personal property of the bourgeoisie, yet it was the medical discourses that had the most traction for social control. “The child-saver's reforms were politically aimed at lower class behaviour and were instrumental in intimidating and controlling the poor” (Platt, 1969, p. 33).

Philanthropy and the state: the “first wave” of child-saving

Dissonance between romantic notions of childhood and the actualities of children's lives provided a platform for the “first wave of the child rescue movement” (Scott, 1995, p. 71). Child-saving was initially led by philanthropic institutions until the mid-late 1900s, and the focus of this early work was on securing provisions for poor, homeless or orphaned children. Initially, the British government offered some support but strategically took a back seat to addressing these issues of social inequity. This meant governing was conducted pastorally, services were administered in a less “policelike” (Donzelot, 1979, p. 124) fashion, while still supporting assessments of the family. The appearance of state non-interference in the family's private domain was preserved and the liberal state was thus protected from assuming responsibility for the needs of the poor. Described as the family's responsibility, the state also avoided criticism for their lack of provisions for poor children. The partnership was a “deliberately depoliticizing strategy for establishing public services and facilities at a sensitive point midway between private initiative and the state” (Donzelot, 1979, p. 55). The

partnership allowed a contained space for resisting the development of an economic system that was cultivating inequity, without disrupting the new social order. Like much humanitarian work today, resisters created limited if any structural change and thus retained their own privilege, while acting in ways that allow them *to feel* like good citizens (e.g. Heron, 2007). The new order was dominant over a large proportion of the globe by the 1900s because the British Empire held significant influence politically, socially, culturally and linguistically.

The Vulnerable Child gave traction to child-saving initiatives in the 19th century by positioning poor and orphaned children as a philanthropic project for volunteers who joined forces with Protestant and Roman Catholic nuns and began operating children's homes and orphanages in Britain (Neff, 2009). Produced within a moral discourse, these initiatives were reserved for women privileged enough to engage in philanthropy, and signified status as both morally good *and* privileged. The homes addressed poor living conditions for children, eased the threat these children posed to the private property of the middle-class, and allowed children to be traded by institutions for cheap indentured labour.

As poverty spread with urbanisation in Britain, the demand for places in orphanages grew. The prospect of supporting young children until adulthood, combined with ongoing new demand for spaces meant that these institutions were unsustainable. Conveniently, requests from the colonies to foster these children "outpaced their supply" (Bullen, 1986, p. 180).

[T]he Canadian government, desperate for colonialists to help open up the West and work the prairie farms, eagerly offered a bonus of \$2 for each young immigrant. For

every 1 child who arrived there were 10 applicants; the children might be small and unused to farm work, but they were, after all, cheap labour. (Gray, 1979, p. 982)

From the late 1800s it became common practice in Canada and Australia to foster children from Britain for domestic and agricultural labour demands (Bagnell, 2001; Fogarty, 2008).¹³ The sale of poor British children to families in the colonies as labourers was justified by the belief “that early exposure to work and discipline would guarantee the development of an upstanding and industrious citizenship” (Bullen, 1986, p. 180). Child-saving was a “moral crusade ... built on and from traditional values and imagery” (Platt, 1969, p. 22). It offered impoverished and corrupted street youth another chance within the “natural setting of a family [that] provided dependent children with a fair opportunity to develop proper social and moral values” (Bullen, 1986, p. 179). Young immigrants were promised a Christian upbringing and laboured for meagre earnings to pay room and board. Yet many of these homestead boys and girls (‘home boys/girls’) remained mistrusted and were regarded as a threat to the values of their new family and society (Bagnell, 2001). Mistrust in combination with the imperative to instil morality and work ethic through discipline resulted in widespread abuse and neglect (Bagnell, 2001; Fogarty, 2008; Gray, 1979).¹⁴

In urban areas of Canada, poor families used their homes as a worksite for manufacturing goods. Exploitive business entrepreneurs offered meagre by-the-piece

¹³ Operating a large London orphanage, Dr. Barnardo spearheaded the deportation initiative. His records show that children were shipped to Canada starting in 1870 (Gray, 1979). An average of a thousand children were sent each year until the 1930s, and approximately 35,000 children were exported by Barnardo alone (Bagnell, 2001).

¹⁴ Approximately one quarter of the child immigrants brought to Canada were British orphans. The violent conditions of their lives and their contributions to settler society are a forgotten part of Canadian history (Neff, 2009).

production contracts, made viable by inconsistent employment and the availability of children to participate in this labour. This exploitation led to

widespread suffering ... [and a] cruel paradox of child workers in a competitive labour market: the more the sweating system exploited the free or cheap labour of children, the less of a chance adults faced of ever receiving a fair wage for their own work. (Bullen, 1986, p. 174)

In an effort to curb exploitative business practices, the Canadian government legislated limits on hours and age of workers in manufacturing (1884). This legislation did not apply in homes, despite that they hosted some of the harshest working conditions (Bullen, 1986). The liberal ideologies of government made parents the scapegoats for cruel working conditions and requiring children to participate in menial labour, while the Canadian government allowed industrial manufacturers to accumulate empires by paying families for work contracted by the piece (Bullen, 1986). From early industrialisation and capitalism, maldistribution of wealth and resultant poverty has been dismissed by lawmakers as the primary social issue for children. Just as children have been figured as vulnerable, families have been figured as responsible (see Chapter 4).¹⁵

The first child protection agency in North America (1874) was formed in New York in response to the case of Mary Ellen Wilson (Bullen, 1986; Lazoritz & Shelman, 1996). A neighbour, privy to the girl's frequent beatings, brought her concern to a community

¹⁵ The perception of stolen childhoods ignores the continuing reality that the experiences of children cannot be separated from the conditions in society in general, but singling out the plight of children implicitly or explicitly blames the adults for their fate (Pupavac, 2001, p. 102).

missionary. The missionary pleaded Mary Ellen's case to the American Society for the Prevention of Cruelty to Animals (SPCA) because there was no institution to protect children from cruelty at the time.¹⁶ The SPCA director had previously attempted to intervene on behalf of another child but had been unsuccessful. This time he publicised Mary Ellen Wilson's case, providing the *New York Times* with details of her abuse and photographs of her battered body (Shelman & Lazoritz, 1999). These images led to a public outcry that levered the director's ability to intervene (Lazoritz & Shelman, 1996; Shelman & Lazoritz, 1999). The spectacular nature of Mary Ellen's abuse supported a shift in public discourse related to acceptable treatment of children, contributed to the figuration of *The Vulnerable Child*, and ignited a proliferation of child protection legislation in the west (Read, 2010).

Technoscience and the state: the "second wave" of child-saving

The discursive shift was a slow one. It was not until the 1960's that a "second wave of the child rescue movement" (Scott, 1995, p. 76) emerged with the 'discovery' of child abuse (Gelles, 1975; Hacking, 1991; Pfohl, 1977). This discovery entrenched a tradition of dismissing the social deprivation as the main issue for children and the constitution of their caregivers as responsible, as will be explored in more detail in the next chapters. As Mayes, Currie, Macleod, Gillies, and Warden (2005) note:

Child abuse is not the prerogative of the 20th century; parents have always beaten, whipped, burned, starved, neglected, over-worked, and raped their children. The

¹⁶ While the Children's Aid Society had existed in New York from 1853 its focus was on the placement of orphaned or abandoned children within foster families, not to address the conditions of children's lives within their homes.

difference is today this is recognised as a social problem worth our attention, and ... great effort is expended to prevent this. (p. 30)

This second wave was given traction by medical interest and authority, was heavily legitimised by the hegemony of the child's potentiality and has resulted in discourses and activities related to improving well-being that persist today. Discursively, the figuration of *The Vulnerable Child* transformed into a complementary iteration of *The Developing Child* within increasingly technoscientific discourses of both child abuse and human development.

The production of *The Developing Child* can be traced to psychology's early days, where it was prophesised that disorders of adult mental health could be traced back to experiences as a child, in "a convergence between the prophylactic cravings of psychiatrists and the disciplinary requirements of the social apparatuses" (Donzelot, 1979, p. 131). The figuration of *The Developing Child* offers an ideology of the child as a material precursor to the adult and as a future commodity. Romantic notions of the child and childhood, meant that *all* children were vulnerable to corruption but also that *all* were salvageable. Thus, children have been subject to scrutiny, surveillance and interventions of betterment, many of which are enacted through the family. The family was important because surveillance was imperative within a pastoral approach to governing. Children were shepherded "back to spaces where they could be more closely watched: the school or the family dwelling" (Donzelot, 1979, p. 47). These notions along with

[t]he bourgeois family drew a sanitary cordon around the child which delimited his sphere of development: inside this perimeter the growth of his body and mind

would be encouraged by enlisting all the contributions of psychopedagogy in its service, and controlled by means of a discreet observation. (Donzelot, 1979, p. 47)

State surveillance of child development was originally kept to the middle-class, but spread across the population throughout the 20th century and intensified in the 21st century. Surveillance was, and is still today, an interdisciplinary affair. Educators offer reform schooling, physicians and psychologists diagnose and treat psychopathologies, and eventually the social worker offered family support and surveillance (Donzelot, 1979).

Critical perspectives, both within and beyond the discipline of psychology have questioned developmental science's stance of objectivity. Drawing on the work of Rose, Burman argues that developmental psychology "is, arguably merely a technology of administration (i.e. testing) masquerading as a body of theory" (Burman, 2008b, p. 41). Tools that monitor children's growth and development are derived from the same measurements and observations that they make claims about, thus are self-referential, reaffirming their own validity (Burman, 2008b; Castañeda, 2002; Walkerdine, 1993). Anchored in the abstract marker of chronological age, tools that measure growth and development claim to define *the normal child* (Kelle, 2010). However,

tracing the genealogy of normality we are returned to the projects of the government of children ... expert notions of normality are extrapolated from our attention to those children who worry the courts, teachers, doctors, and parents. Normal is not an observation but a valuation. It contains not only a judgement about what is desirable ... 'the normal' today awards power to scientific truth and expert authority. (Rose, 1999, p. 133)

Knowledge that results from the melding of techniques of measurement and interpretation is influenced by social beliefs and values, thus interpretations are open to technobiopower (Haraway, 1997). Constituted as unquestionably in the ‘best interests’ of the child, these practices to foster child development conceal their technobiopolitical relations. Charts and checklists have formed around dominant ideas of how society wants children to be and behave (Burman, 2008b; Castañeda, 2002; Einboden et al., 2013a, 2013b; Kelle, 2010; Rose, 1999, p. 133; Walkerdine, 1993). For example, the World Health Organization’s (WHO) growth charts exemplify the influences of technobiopower and the conflation of normality with governing (Einboden et al., 2013a). These charts monitor children’s physical growth according to aged-base scores by comparing percentiles. Instead of reflecting average growth, the WHO growth charts set the standard as *ideal* growth. They do this by establishing norms of children’s physical growth from average measurements of a cohort of healthy, ethnically diverse children from privileged socioeconomic backgrounds who were breastfed by non-smoking mothers (de Onis & Garza, 2006; WHO Multicentre Growth Reference Study Group, 2006). Blurring normality, the charts embody privilege and represent children with ‘good’ homes and ‘good’ mothers (Einboden et al., 2013a).

The figuration of *The Developing Child* remains a powerful one within health, education, and legal discourses. Nurses monitor children’s growth and development, by documenting changes in the child’s body size on growth charts and behaviours on developmental screening checklists. In practice, when a child is measured as not growing *ideally*, or developing according to set milestones, nurses take on a pastoral role. They perform more detailed assessments of the child’s body and maternal behaviours, and provide counselling to the mother to alter her care. Of course, these activities are not

problematic in their own right and they are helpful for some children and their mothers. When enacted at a population level, they can support resource allocation that can mitigate the harm of other social deprivations (Irwin, Hertzman, & Siddiqi, 2007). However, the focus on the *individual* child and family (where something can easily be done), removes it from social deprivations that are constituted instead as *too difficult for nurses to change*. The operations mirror those described at the outset of the chapter where partnership between philanthropists and the state allowed child-savers a contained space for addressing social inequities in the new social order. Similarly, nurses and other professionals, who largely occupy middle-class social positions and are sympathetic to social inequities, can *feel good* by facilitating child development as a means of moving towards equity for children and families with whom they work. Interventions oriented in this way support marginal improvements for some children, while preserving the well-established social order, and will be discussed again in relation to the individualisms in BC's legislation later in this chapter.

Early child welfare work in BC

In the early days of colonial BC, the child-saving initiatives for poor and orphaned white settler children and Indigenous children diverged. Settler families were subject to provincial child protection legislation, while Indigenous families were subject to federal legislation. Aboriginal Peoples of Canada were brought under provincial legislation in the mid-1950s, but the application of it remains inequitable today. With specific attention to the complex relations of colonial politics and the figuration of *The Vulnerable Child*, I offer a brief historical account of BC's child protection legislation and systems in the next section. This account is relevant because it helps identify obstacles that persist in contemporary responses to CN&A and appreciates nuances of social position and injustice.

Divergences in child-saving in BC: Indigenous and white settler child services

During the 1800s, most Aboriginal Peoples of BC were killed. Their genocide was a result of infectious disease manipulated by British colonial power. “By 1840, smallpox, influenza and other diseases kill[ed] roughly 65 to 95 per cent of Indigenous populations in the area” (Union of British Columbia Indian Chiefs, 2005, p. 14). After gaining rule of BC in 1812, Britain established reserves and removed Aboriginal Peoples from their land. These reserves interfered with nomadic sustenance practices and community alliances that had protected Indigenous health for centuries (Furniss, 2010). The situation in BC was amongst the worst in Canada. Although BC joined the confederation of Canada in 1871, the BC’s *Land Act* (1874) set the size of reserve allocations at 20-acres per head of family, disregarding family size and violating Canada’s 80-acre standard (Union of British Columbia Indian Chiefs, 2005, p. 19). Overcrowded reserves, outlawed cultural healing practices, inadequate resources for western medicine, and federally enforced quarantine supported transmission of infection, and left what remained of Indigenous populations devastated further by the Spanish Influenza outbreak in the early 1900s (Furniss, 1999; Kelm, 1998).

Residential schools were set up from the early 1800’s by Anglican, Roman Catholic and Methodist missionaries who offered the state low cost English education for Indigenous children in exchange for “access to a population of children to proselytize without the competing influences of either indigenous religion or rival denominations” (Kelm, 1998, p. 60). Initially well attended, interest waned as the schools enforced norms of settler society and refused Indigenous languages and practices. By mid-1800’s, they were poorly attended and regarded as hostile to Indigenous culture (Furniss, 2010). In addition to mandating school attendance, the *Indian Act* (1879) and its amendments imposed a suite of policies

that gave the federal government “the power to: define Aboriginal identity; demarcate Aboriginal land; limit traditional sustenance practices; undermine Aboriginal community governance practices; and (forcefully) educate and care for Aboriginal children” (Varcoe, Browne, & Einboden, 2014, p. 11).

Despite political control, the discourse of a natural inferiority of the Indigenous body, and racist assumptions about cultural practices, hygiene and diet were used to ignore the culpability of the state and legitimise its paternalisms (Varcoe et al., 2014). The figuration of *The Indian* shifted from wild and strong to weak and *child-like*, and transformed from “hostile savage ... [to] noble savage to be pitied and protected” (Furniss, 2010, p. 19). The deployment of the figuration of *The Vulnerable Child* in these discourses is another example of its use in projects of othering as suggested by Castañeda (1997). Distribution of this figuration in a derogatory and racialized way has had far reaching effects for both Indigenous and white settler children.

Residential schools, juvenile justice and children’s aid services developed concurrently (Platt, 1969).

[T]he distinction between those who entered children’s aid services and those sent to reformatories seemed largely related to age and race. ... The most common reason for committal was “incorrigibility,” which meant the child was beyond the control of parents or guardians. (Callahan & Walmsley, 2007, pp. 12-13)

Incorrigible, wilful children went to jail, while others were reallocated to family life. As the influence of the figuration of *The Vulnerable Child* gained momentum, it emphasised children’s vulnerability to corruption. This ideology of vulnerability combined with racialized

beliefs about the 'wildness' of Indigenous children sanctioned corporal punishment (de Leeuw, 2009; Kelm, 2005), and laid the foundation for the perpetration of severe abuses within these services.

BC experienced a major demographic transformation at the turn of the 20th Century (Barman, 1996). BC had a population of 49,459, with 51.9 per cent of whom identified as Indigenous when the construction of the Canadian Pacific Railway began (1881) (Barman, 1996, p. 379). With the completion of the railway (1886), the federal government encouraged migration to the west. By 1911, BC's population had grown almost tenfold with a population of 392,480, but of these, only 5.1 per cent were indigenous to BC (Barman, 1996, p. 379).

Assimilation had been the intent of government since *The Davin Report* (1879), where the Deputy Superintendent General of Indian Affairs stood before the House of Commons and argued:

I want to get rid of the Indian problem. ... Our objective is to continue until there is not a single Indian in Canada that has not been absorbed into the body politic and there is no Indian question, and no Indian Department. (Duncan Campbell Scott as cited in Titley, 1986, p. 50)

However, it was the demographic shift at the turn of the century that made it a viable colonial strategy.

Indigenous children were the target of assimilation and were separated from their families and immersed in white settler life from a very young age (de Leeuw, 2009). The underpinning ideology of the assimilation strategy was the discourse of the malleability of

The Developing Child. The child's material capacity for transformation combined with the western ideology of possessive individualism made them available for appropriation: "[t]he child is not only in the making, but is also malleable — and so can be made" (Castañeda, 2002, p. 3). Genocidal assimilation policies and the forced removal of Indigenous children from their families were justified by moralisations and discourses of well-being and best interests (de Leeuw, 2009). Assimilation policies had paradoxical outcomes. Due to vast differences between Indigenous communities in relation to language, social, political and cultural practices, 'indigeneity' as a homogenous social category did not exist prior to assimilation attempts; it was produced in a binary relation with white settler identity (Callahan & Walmsley, 2007; Furniss, 1999). Thus, the focus on the erasure of 'indigeneity' produced it.

The 1920 amendment to the *Indian Act* criminalised refusal to send Indigenous children aged seven to fifteen to residential school (Titley, 1986). Thereafter, pupils overwhelmed schools. When the Great Depression hit, transfer payments to the missionaries from both the federal government and churches for school operation slowed; slim per capita grants led to overcrowding and "widespread and institutionalized neglect" (Kelm, 1998, p. 71). Older children were used for labour to sustain the school's functions (Moran, 2010). Hunger and disease increased already high mortality and morbidity rates within these schools.¹⁷ Families who tried to protect their children from the abuse at residential schools ended up in jail themselves, and infrequent inquests did little to change conditions (Furniss, 2010; Kelm, 1998). The separation of Aboriginal Peoples from white

¹⁷ "At residential schools on the Prairies the death rate among students either while in the schools or immediately following discharge was 69 percent" (Bryce (1907) and Sproule-Jones (1996) as cited in Kelm, 2005, p. 375). The genocidal intent towards Aboriginal Peoples of Canada underpins the *Indian Act* and presented as a direct physical assault.

settler society remained unchallenged and poor conditions within federally governed communities, detention centres, residential schools, and hospitals were actively ignored.

The divergence of systems for Aboriginal Peoples and white settler society was highlighted as provincial child-saving legislation and institutions took form. Following the model in Britain, philanthropic BC settlers opened the Protestant Orphans' Home in Victoria (1873) and the Alexandra Orphanage in Vancouver (1892) (Callahan & Walmsley, 2007). These spaces centralised the work of volunteers who had already been finding homes for orphaned and abandoned settler children. The Council of Women of Vancouver successfully lobbied the Legislative Assembly of BC to pass the *Child Welfare Act* (1901), which legally supported their activity (Callahan & Walmsley, 2007). The *Children's Protection Act* (1902) was passed initiating state responsibility for the guardianship of orphaned children, institutionalising child protection, and transforming orphanages into children's aid societies (Callahan & Walmsley, 2007). Many children were in orphanages because of their mother's economic issues, so several BC women's groups petitioned the Legislative Assembly for a mother's allowance. In 1920, the *Mothers' Pension Act* came into effect and relieved congestion in the orphanages (Callahan & Walmsley, 2007). Under federal instead of provincial jurisdiction, Indigenous mothers of BC were not eligible. Thus, in the same year that settler mothers were supported to keep their children in their care, Indigenous mothers had their children forcibly removed.

In contrast to the lack of scrutiny of services for Indigenous children, the practices of the children's aid services for white settler children were both scrutinised and publicised. In 1927, a BC Child Welfare Survey reported scandals within the service, rooted in ideologies of the liberal state. These scandals

enshrined the focus on parents as the source of child maltreatment and established two often-conflicting purposes of child welfare: supporting parents to care for their children and removing children from families where the parents failed to measure up. (Callahan & Walmsley, 2007, p. 17)

The Child Welfare Survey provided a rationale for elevating social work from volunteerism to a profession in BC and across Canada; an emancipating gain for adventurous and well-intended white middle-class women. In its wake, social work became an autonomous profession and a degree program commenced at UBC. Social workers were allocated authority to make decisions about the guardianship of BC's settler families immediately, but were not responsible for Indigenous families until they came under provincial law in 1951. The next section describes the path of child protection for Indigenous children up to current practices.

Convergences in child-saving: the 'Sixties Scoop'

BC social workers called attention to inequitable allocation of provincial child protection resources for Indigenous families, and lobbied for change. In 1951, Section 88 amended the *Indian Act* applying provincial law and child protection services to Aboriginal Peoples, which were previously only available to white settler children. Section 88's immediate extension of child protection legislation and services had devastating results for Indigenous families because BC's social workers lacked an appreciation of colonisation. They transplanted philosophies and practices of "a Western/white view of families and children" (Wharf, 2007, p. 3), and were unprepared for dealing with the terrible conditions they encountered on reserve (Wharf, 2007). Amidst cultural, emotional, and material poverties that plagued

Indigenous communities, effects of this application of child protection practices have been profound. In one decade (1960s), the rate of apprehension of Indigenous children into state care increased from less than one per cent to 32 per cent (Wharf, 2007). The large scale removal of children from their parents into foster care that occurred with Section 88 has been coined by Johnstone (1983) as the “Sixties Scoop” (Wharf, 2007, p. 3). Of course, settler families were also judged based on neoliberal ideologies and dominant social beliefs about children’s needs. Single mothers, and impoverished and new immigrant families faced the same legislative guidelines and disproportionate apprehension. What has been different for Indigenous families is that child protection practices have extended colonialism *into the present*.

In BC and nationally, discrimination experienced by Aboriginal Peoples in child protection is the worst it has ever been (Blackstock et al., 2004; John, 2016; Trocmé et al., 2004). Controlling for presentations and compared to settler children, Indigenous children are much more likely to be reported, investigated and apprehended by the MCFD (Sinha et al., 2011). Indigenous families are profiled as abusive and thus suspected of abuse (as victims and perpetrators) more often than white settler families. Fuelled by figurations of *The Drunken Indian* and/or *The Unfit Mother*, children were and are constituted as especially vulnerable by nature and parental irresponsibility. As described in Chapter 1, Indigenous children make up less than 10 per cent of the child population in BC but 60 per cent of the children in state care (John, 2016). Thus, the figuration of *The Vulnerable Child* and a new figuration, *The Irresponsible Family*, synergistically depoliticised devastating social situations for many Aboriginal Peoples that resulted from genocidal colonial strategies. Parental *irresponsibility* continues to dominate social discourse, allowing state

culpability to remain hidden and further fade from view, legitimising the continued mass removal of Indigenous children from their communities.

In much the same way dependency of children has been cultivated, dependency of Aboriginal Peoples on the state was cultivated (Alfred, 2009). Without knowledge of the language or understanding the customs, children of the residential school system had difficulty reintegrating back into their communities. For generations, survivors had little experience of nurturing relationships and were left parenting without role modelling of emotional skills required (Wharf, 2007).

Ambivalence slowed the transfer of responsibility for Indigenous children from federal to provincial governments and delayed the closure of residential schools by three decades (Wharf, 2007). St. Mary's Mission was the first, last and longest standing of the 21 residential schools in BC, closing in 1984 after 121 years of operation (Wharf, 2007). From 1986 to 1994, Church apologies were issued for their participation in removing Indigenous children from their families and communities, erasing Indigenous identities, and for the emotional, physical and sexual abuse in the schools. A national government apology followed in 2008. Legal action against the schools has gained momentum and traction in the last decade, following a Supreme Court ruling that the Church and the Government of Canada were jointly liable for the abuse in BC's Port Alberni residential school (*Blackwater v. Plint*, 2005). In 2007, the *Indian Residential Schools Settlement Agreement* was awarded following a class action lawsuit by survivors. This settlement led to the commemoration of residential schools, compensation of survivors, funding for Aboriginal Peoples' health, and the Truth and Reconciliation Commission (Troniak, 2011).

The social agents of child protection remain primarily white middle-class women. The historical, social and political landscapes described above contextualise how the child

protection structures and practices are tangled in colonial practices. This context is important to this analysis because it supports the identification of the obstacles to effective and antiracist child protection practice. Despite public awareness and concern about discrimination within the system (see Hughes, 2006; Sinha et al., 2011), in lieu of other perspectives, an ethnocentrism and the inability to interrupt colonialism in practice persists, and forms an obstacle to ethical responses to CN&A in BC.

Contemporary child protection in BC: suspicion and its rationalisation

The discussion in this section focuses on legal discourses and analyses how suspicion and the figuration of *The Vulnerable Child* operate within contemporary child protection legislation in BC. First, a review of the discursive roots of the current legislation is presented along with a discussion of the 1960's shift from a child welfare to child protection orientation. Mandatory reporting of suspicions of CN&A is a discriminating characteristic of CPSs (Gilbert, Kemp, et al., 2009). As set out in the introduction of this chapter, 'reason to believe' is the statement in the *CFCS Act* that directs the practice of mandatory reporting, and through which child protection interventions are initiated. In this section, features of this statement are presented from the legislation and then from the practice guidelines, followed by a discussion of how it operates to discursively rationalise suspicion in practice. Legal texts have a tradition of rationalisation and this discursive practice is typical to the genre, but it remained of analytical interest because of the way the rationalised discourses contrast with the description of suspicion *as a feeling* by the nurse participants. In addition, rationalised discourses foster an inattention to affections. Nurse participants described this inattention as frustrating to their ability to identify and address CN&A. Thus, in this case, rationalisation can also be understood as a mechanism of power and a way of 'organising

ignorance' (Perron & Rudge, 2016). As set out in Chapter 2, analysis here is supported by Spinoza's (1677/2000) ideas about influence of affections on human knowledge.

The medico-legal Child Protection System

As presented earlier in the chapter, the current CPS developed during the "'second wave' of the child rescue movement" (Scott, 1995, p. 76). This wave was encouraged by the advent of X-ray imaging technology within medico-legal discourses. Visualisation of bones at various stages of healing supported the constitution of a new diagnosis: "*The Battered Child Syndrome*" (Kempe, Silverman, Steele, Droegemueller, & Silver, 1962, p. 17). *The Battered Child*, a spectacular iteration of *The Vulnerable Child*, incited passionate public response echoing the response evoked by the images of beaten and bruised Mary Ellen Wilson in the *New York Times*. This time, however, technology promised to reveal physical abuse long after an incident. This promise levered legislative and systemic changes in USA, Canada and later, Australia.

An amendment to BC's *Protection of Children Act* introduced mandatory reporting legislation in 1967. This amendment reoriented the responses to CN&A from the social conditions that underpinned early child-saving onto practices of substantiation by examining the bodies of individual children. This orientation continues, guided by the *CFCs Act (1996)* (Foster, 2007). In these systems, reporting is mandated and these reports are key because they are required to form a child protection case for investigation by the MCFD. Positioning mandatory reporting as the trigger for initiating child protection interventions was not evidence-based and its effectiveness has not been carefully evaluated (McTavish et al., 2017). Nevertheless, it is supported by child abuse experts within CPSs (Mathews & Bross, 2008). As described in Chapter 1, and will be considered in more detail in Chapter 4,

compliance of health and other service providers with reporting legislation is not straightforward (Crisp & Lister, 2004; Eisbach & Driessnack, 2010; Mathews et al., 2008; Mathews et al., 2006; McTavish et al., 2017; Nayda, 2005).

‘Reason to believe’ in the CFCS Act

The *CFCS Act* mandates how and when reports need to be made to the MCFD. Part 3, Section 13 defines the circumstances whereby all citizens are legally mandated to report and Section 14 mandates the act of reporting: “A person who has reason to believe that a child needs protection under section 13 must promptly report the matter to a director or a person designated by a director” (*CFCS Act, 1996*) (see Appendix 11). Linguistically, Section 13 concentrates understandings of abuse and when protection is needed onto a relatively small proportion of cases where children are harmed in severe and proscribed ways. It uses linguistic techniques of repetition of the present perfect tense (“has been”) instead of the past tense (was), which gives current relevance to physical and sexual abuse, but softens its impact with a passive use of the verbs “harmed” and “abused” (*CFCS Act, 1996*). Repetition of a more active form of the verb in future tense (“to be”) also appears, but is modified by the linguistic hedge “likely”, which includes the possibility of harm or abuse. The passive voice decreases the agency of the subject of the sentence (the child) and de-emphasises the clause that identifies the agent that causes harm, “the child’s parent” or “another person” (*CFCS Act, 1996*).

Remarkably, neglect is quantified by physical *harm* and requires protection only “if the child has been, or is likely to be, physically harmed because of neglect by the child’s parent” (except when a child has been abandoned or deprived of necessary health care) (*CFCS Act, 1996*). In relation to emotional abuse, the past passive voice, past participle and

hedge seen for physical and sexual abuse disappear, and “protection is needed ...(e) if the child is emotionally harmed by the parent’s conduct” (*CFCS Act, 1996*). “Harmed” (active past tense) is used for emotional abuse in a definitive way. “[E]motionally harmed” is quantified by presentations of severe mental illness in the present tense: “a child is emotionally harmed if the child demonstrates severe[:] a) anxiety, b) depression, c) withdrawal, or d) self-destructive or aggressive behaviour” (*CFCS Act, 1996*). Extreme consequences are *required* to meet a threshold for protection from emotional abuse. The language of Section 13 is revealing: both neglect and emotional abuse are legitimatised by *their consequences*; without obvious consequence, the abuse is not of (legal) concern (see Appendix 11). The language used in Section 13 guides attention to the most extreme and obvious forms of CN&A (physical and sexual abuse) and away from emotional abuse and neglect, where it requires the child be harmed prior to justifying intervention.

‘Reason to believe’ in the practice guidelines

The MCFD and CRNBC attempt to clarify the *CFCS Act*’s statement ‘reason to believe’. In this section, I present examples of these clarifications of from practice guidelines in the corpus texts. As described in Chapter 2 (and discussed in more detail in Chapter 4), the CRNBC identified texts that guide nurses’ responses to CN&A following a recommendation from the RCY to remind nurses of their legal reporting obligations (Johansen, 2014; RCY, 2014). Analysis of these texts supports the discussion throughout the thesis about the relationships of the discursive structures and practices and how these are assembled.

The BC Handbook for Action on Child Abuse and Neglect, for service providers

The stated purpose of *The Handbook* is to support people who work with children to comply with the *CFCS Act*, and to encourage recognition and reporting of CN&A (MCFD, 2007, p. 6).

The Handbook uses the word ‘suspicion’ interchangeably with the statement ‘reason to believe’. On page 40, the meaning of ‘reason to believe’ is clarified in a highlighted textbox (see Figure 2).

Figure 2 The BC Handbook for *Action on Child Abuse and Neglect: for service providers*

WHAT DOES “REASON TO BELIEVE” MEAN?
In British Columbia, anyone with reason to believe a child has been or is likely to be abused or neglected – and the child’s parent is unwilling or unable to protect them – has a legal duty to report that concern to a child welfare worker.

“Reason to believe” simply means that, based on what you have seen or information you have received, you believe a child has been or is likely to be at risk.

You do not need to be certain. It is the child welfare worker’s job to determine whether abuse or neglect has occurred or is likely to occur.

(MCFD, 2007, pp. 40, emphasis in original)

The language used here constitutes suspecting a child may be suffering CN&A as *simple*. The use of the word “*simply*” describes suspicion definitively, but is softened with the hedge “*likely*”. Direction is given to consider if children are “*at risk*” but this direction carries a tone of ambivalence; what the child is at risk of is missing, as are the original quantifiers in Section 13 of the *CFCS Act* (see Appendix 11). Rationalisations are extended from the legal texts into this practice guideline, but in an inconsistent manner.

The practice guideline highlights visual understandings “*what you have seen*” and knowledge “*information you have received*” (see Figure 2 and MCFD, 2007, p. 40). To support interpretation of what ‘has been seen’ or what is ‘known’ from practice, a list of possible indicators for each type of abuse is provided. For instance, the “*POSSIBLE INDICATORS OF PHYSICAL ABUSE*” are reproduced in Figure 3 and “*POSSIBLE INDICATORS OF EMOTIONAL ABUSE*” are reproduced in Figure 4 (MCFD, 2007, pp. 27-28).

Figure 3 MCFD’s Possible Indicators of Physical Abuse

<i>POSSIBLE INDICATORS OF PHYSICAL ABUSE</i>
<i>Physical Indicators</i> » any injury to an infant who is not yet mobile, especially head/facial injuries » injuries to a toddler or older child for which there is no explanation, the explanation does not fit with the injuries, or the story keeps changing » injuries at different stages of healing » injuries that have a pattern or look like they may have been caused by an object (e.g., hand, stick, buckle, stove element), and » bruising in unusual places such as ears, trunk, neck or buttocks <i>Behavioural Indicators</i> » afraid or reluctant to go home, or runs away » shows unusual aggression, rages or tantrums » flinches when touched » has changes in school performance and attendance » withdraws from family, friends and activities previously enjoyed » poor self-esteem (e.g., describes self as bad, feels punishment is deserved, is very withdrawn), and » suicidal thoughts or self-destructive behaviour (e.g., self-mutilation, suicide attempt, extreme risk-taking behaviour)

(MCFD, 2007, p. 27)

Figure 4 MCFD's Possible Indicators of Emotional Abuse

POSSIBLE INDICATORS OF EMOTIONAL ABUSE
Physical Indicators » bed wetting and/or frequent diarrhea, and » frequent psychosomatic complaints, headaches, nausea, abdominal pains Behavioural Indicators » mental or emotional development lags » isolated and has no friends or complains of social isolation » behaviours inappropriate for age » fear of failure, overly high standards, reluctant to play » fears consequences of actions, often leading to lying » extreme withdrawal or aggressiveness, mood swings » overly compliant, too well-mannered » excessive neatness and cleanliness » extreme attention-seeking behaviours » poor peer relationships » severe depression, may be suicidal » runaway attempts » violence is a subject for art or writing » forbidden contact with other children » shows little anxiety towards strangers, and » unusual severe anxiety or worries

(MCFD, 2007, p. 28)

These lists of possible indicators of abuse range from obvious to vague. Patterns of objects imprinted on a child's skin are amongst the most obvious indicators of violence, ones that has little to do with suspicion. Describing obvious signs of severe physical violence is not unusual within CN&A texts, these signs are repeated in the paediatric nursing textbook (e.g Hockenberry et al., 2017, p. 423) and in numerous texts available that go beyond the corpus. The obvious pervades even advanced CN&A education for nurses. One participant described her experience learning forensic techniques,

They just taught a lot of different patterns of injuries that you would see in children that would alert you to ... abuse. ... We studied lots of diagrams of all the areas on children where you don't get bruising very easily from normal things like a toddler learning how to walk. You would expect bruises on all the bony prominences but if you are seeing bruises on the back and the stomach and chest, that should be worrisome. ... As far as burns go, immersion burns ... when children are held down, just the type of patterned burns you would see from that. ... shaken baby syndrome, the different signs that you would see in brain trauma from that, in babies mostly for that one ... then maybe signs of sexual abuse as well. (RN₁₅)

Equating the obvious as suspicious *simplifies* responses to CN&A and ignores the challenges inherent to the human experience of suspicion.

At the same time, vague indicators are also forwarded as suspicious. While arguably these are more suspicions, they rely on normalised judgements of children's behaviour and body. Suspicion of CN&A is warranted of any child who is: "overly compliant, too well-mannered"; "any injury to an infant who is not yet mobile"; "poor self-esteem"; or "mental or emotional child's development lags" (MCFD, 2007, pp. 27-28). The inability of these indicators to identify CN&A is acknowledged as well: "By themselves, these indicators do not prove that a child has been abused or neglected. They can result from phenomena such as divorce, separation, the death of a significant person or the arrival of a new sibling. That is why indicators must be assessed by child welfare workers" (MCFD, 2007, p. 26).

These discourses operate in contradictory ways. The obvious indicators concentrate suspicion onto the worst and most severe forms of physical violence and the vague indicators diffuse suspicion out to nowhere. The implications of concentrations and

diffusions are central to the analysis in Chapter 5 and Chapter 4 respectively. Discursive practices of rationalisation, concentration and diffusion saturate CN&A in images and knowledge of the imaginary sort. Instead of engaging with the challenging experience of suspicion, these understandings obfuscate it making it more challenging to ethically engage in practice (Einboden et al., 2011).

Professional and Practice Standards (CRNBC)

CRNBC's *Professional Standard #1: Professional responsibility and accountability* states that nurses must function "within the legally recognized scope of practice and within all relevant legislation" (CRNBC, 2010b, p. 8). This standard refers the reader to the booklet: *Legislation Relevant to Nurses' Practice* (CRNBC, 2015). In this booklet, the *CFCS Act* is reproduced almost verbatim, but with one notable difference. Its authors took the liberty to change "reason to believe" to "believes" when explaining nurses' mandatory reporting obligation (see Appendix 12). This change removes the rationalisation and has more discursive force, which from a linguistic perspective, would make reporting more likely in practice.

The first principle of the *Privacy and Confidentiality Standard* requires: "Nurses know what specific legislation applies to their practice and follow legislated requirements" (CRNBC, 2010a, p. 1) and refers nurses to the same booklet mentioned above. However, this same standard also describes that while nurses have a legal obligation to report under the *CFCS Act*, they need to "[u]se professional judgement in deciding the need to report abuse, neglect ... [t]he decision to report may not be straightforward. When this is the case, consult with knowledgeable colleagues (if at all possible) before proceeding" (CRNBC, 2010a, p. 3).

It is notable that the MCFD and CRNBC guidelines differ somewhat in their instructions on how to go about reporting. Section 14 the *CFCS Act* holds individuals

(citizens, nurses) responsible to report, and the MCFD reinforces this message. However, a process of consultation with knowledgeable colleagues was the practice identified by both the nurse participants in this study and the CRNBC's guidelines. Nurse participants described reporting concerns to the nurse in charge, social worker and, in larger institutions, the child protection team (usually in that order). These colleagues are allocated the responsibility to liaise with the MCFD on behalf of the nurses, relieving nurses of their duty to report within these institutions. Most nurse participants appreciated this support. However, a few problematized it, including one nurse who felt her concerns were frequently disregarded and described a hospital social worker as a "gatekeeper" (RN₃) to the MCFD. Most participants talked about times when they felt suspicious but had it excused by colleagues so they did not report. At the same time, they also described how their suspicions were usually disregarded by MCFD workers, who made the decisions regarding what was considered abuse and what required intervention. Vetting the concerns through colleagues leaves the nurse on tenuous legal ground, as seen in the *Lost in the Shadows* report (RCY, 2014), which is discussed in Chapter 4.

A participant in this study shared her experiences of being pressured to ignore her suspicion and overlook concerns of CN&A,

RN₅: I don't think peoples' intuition and gut are usually wrong ... certainly mine is pretty clear. When you are in a situation where your gut is telling you that this isn't okay, you should listen. And act. And not be afraid to have those conversations. ... Maybe it would be easier to not open a can of worms, or maybe it's not your business, or maybe we don't understand the whole picture ... you really do have to make it your responsibility. ... So, addressing the challenges to say, "as sensitive as

this is, and as challenging as this is”, and when the Ministry says: “don’t worry, this is fine”; “don’t worry, this is their culture”; “don’t worry, we are taking care of it”; or whatever, just make sure that your voice is heard. And ... if there is any other avenue that you can go [down] or any other voice that you can enlist on your behalf, then certainly, enlist them.

Interviewer: *Right. Is that something that you think is common? The failure to take responsibility because it’s complicated? Or because it’s uncomfortable? ... Or because people don’t know what to do?*

RN₅: *Uh hmm. Or you get called a racist.*

According to RN₅ advocating on behalf of a child required considerable effort and risk to the nurse. In the context of a longstanding discriminatory systemic response, the accusation of racism is an effective act of silencing.

The CRNBC published a tool to support nurses to follow the professional Standards, a case scenario entitled: *What were the warning signs? Case study about a nurse's legal obligation to disclose* (see Appendix 13)(CRNBC, n.d.). This case describes a nurse who, during administration of an immunisation, identified maternal concerns about a two-month old infant’s fussiness. The nurse referred the mother to a family physician and planned another visit. At the next visit, she noted a bruise on infant’s cheek, which was explained as caused by the sibling. The mother also disclosed that she was pushed by her angry partner. The nurse arranged a home visit two weeks later, but the mother did not keep the appointment nor did she respond to messages. Three weeks later, the infant presented to

an emergency with a lip laceration from ‘bumping’ heads with dad, and at four months of age, the infant presented with “severe abusive head trauma” (CRNBC, n.d.). While this case highlights the serious and escalating nature of domestic violence, it limits the nurses’ responsibility *to reporting*, and reinforces the idea that suspicion should be associated with *obvious* physical signs of abuse. Further, it fails to provide practical guidance regarding when and how to intervene after a disclosure of domestic violence by a new mother. The CRNBC argues that the nurse’s concerns should simply be passed onto the MCFD worker.

‘Reason to believe’ in practice

By reviewing the discourse of ‘reason to believe’ in the law and practice guidelines, rationalisation can be seen entangled with objectifications, simplifications and generalisations. The logic of these discourses can be traced back to the spectacular figuration of *The Battered Child*. In this section, I consider how the legislation and guidelines are experienced by practising nurses.

In contrast to the MCFD’s claims of simplicity, the CRNBC standards corroborate the nurse interview texts and acknowledge that for nurses, reporting decisions are complex. A participant who is also a nurse leader explained how nurses face challenges in the complexity of these situations, but also point to how nurses might be privy to important information:

there is a lot of fear when you don’t know how to take care of something. ... [The nurses] don’t have enough tools, and it stops them from engaging [with children] to say, you know, ‘what happened?’ ... and, ‘that’s not what happened, you know, you can tell me’ ... it’s the grey areas, and these books and scenarios in the workshops,

people need to start getting away from the simple scenarios and get to the complicated grey scenarios because that is where the learning happens ... you need to be able to apply it in real life and it's never straight forward. (RN₂₁)

As this nurse argues, too often scenarios intended to support nursing practice do not address the complexities of violence. The case study provided by the CRNBC is an example of this, where it simplifies signs of CN&A to be physical presentations and misses an opportunity to dialogue about violence. It does not attend to the “grey areas” (RN₂₁).

More often, nurses described not witnessing CN&A directly rather experiencing through subtle visceral sensations, “gut feelings” (RN₁₆). Gut feelings offered nurses insights that were otherwise inaccessible:

I can sort of tell. They don't feel comfortable about someone coming near them. So why is that? They've either been hospitalised too much¹⁸ or it's their parents that have used their hands to control a behaviour. That I pick up for some reason. I kind of watch that to see where it's going. But that's in my first assessment right away. (RN₉)

While this nurse was confident that she could pick up on children's reactions as signals of past violation, she also described how affective clues are confused by a blurred line between acceptable and unacceptable treatment of children in a society where violations are preformed, accepted and sometimes constituted as caring (e.g. hospitalisation).

¹⁸ For young children, hospitalisation can be traumatic because of separations from familiar caregivers and environments, and their exposure to painful procedures.

Nurse participants in this study described the need to be present and move closer to the family. One nurse recalled how building a relationship with a child's mother was key to her ability to assess the situation:

The mum said to me 'I never ever trusted my boyfriend with him' ... It took weeks of getting to that point, that part of the story, but I thought there is so much to be gained by really trying get to know families, you can get so much more information about what is going on with this child.

I often question: 'How do you think this happened?' And [I get in response]: 'Oh, I don't know I wasn't there'. But I'm like: 'What does your gut tell you? What do you think happened?' I always relate as being a mum, I'll say: 'Oh yeah, I know these things can happen, but I know other things can happen too', and I'll often use that way of questioning: 'Do you think this?' and not leading but almost less judgement, that you are not going to be, none of us are perfect parents. ... giving them permission to tell their story. (RN₂₀)

In the context of their relationships with children and families, violence is often disclosed to nurses. Sometimes this disclosure happens before it is even understood as such by the victim. For instance, this was the case in CRNBC's case scenario: *What were the warning signs?* (see Appendix 13). In many cases, and especially in cases of domestic violence, abuse is not straightforward, immediately perceived nor understood, especially when it sits within socially sanctioned treatment of women or children. A nurse participant questioned:

What necessarily is abuse? It's never been anything really tangible, it's bigger picture. After being involved with a client over a period of time, it's just trying to take it in context, this is what I'm seeing and this is what I'm feeling. And your nurse antennae are going off and going 'uh, something is not quite right here'. (RN₈)

Nurses have a key role to play in both supporting an understanding of violence and addressing it. In most situations, this is complex and nuanced work, made more challenging by legal discourses that refuse to acknowledge its complexity. Of the laws and guidelines analysed, the CRNBC guidelines show the most appreciation for the affective and relational influences on reporting.

While common to legal texts, nurses did not use discourses of reason to discuss their experiences of suspecting and reporting CN&A in the interviews. Rather, they gave vivid examples of how suspicion conjures affective, embodied and socially negotiated feelings. For instance, they described how suspecting CN&A evoked “disgust” (RN₂), “rage” (RN₁₀), “horror” (RN₁₆) or “heartbreak” (RN₂₁). In extreme cases, the affections were so intense that they were experienced physically and presented as nausea, vomiting, weakness or pain. The rationalised discourse of ‘reason to believe’ is a poor fit for the affective reactions that nurses describe as essential to guide their response to CN&A. This rupture offered a discursive signal for further analysis, and suggests that ‘reason to believe’ offers a dubious substitute for suspicion.

Stuck in imagination, structuring ignorance

Spinoza’s philosophy of knowledge offers critical theoretical support for analysis of nurses’ affective experiences of suspicion and how they informed practice. This perspective

challenges discursive rationalisations, objectifications, simplifications and generalisations within the legislation and practice guidelines. As discussed in Chapter 2, the human ability to develop knowledge is challenged by our material perceptual capacity (primacy of vision) and influenced by our ontological connections with surrounding bodies (collective sociability) (Spinoza, 1677/2000). Therefore, to develop more accurate knowledge (to move ideas from the imagination to rational thought to 'true ideas') (Spinoza, 1677/2000), careful study of these images *as signs* is required (Deleuze, 1997). However, this requisite study is in opposition to our innate drive to exist (conatus) (Spinoza, 1677/2000). Painful sensations are experienced by our body as a decrease in power, thus conatus moves us away from them (Spinoza, 1677/2000). The untoward effect of avoiding painful sensations is that knowledge derived from negative affections can become stuck within an imaginary form, resulting in simplistic, flat or fallacious understandings.

In contrast to the *CFCS Act's* (1996) discursive rationalisations and the MCFD's (2007) assertions of simplicity, the discourse used in the nursing guidelines by the CRNBC acknowledges the challenges of suspicion in practice, and the influences of nurses' beliefs and professional relationships. However, the CRNBC fails to offer theoretically based resources to support the complexity and nuances of nursing responses. Instead, as discussed above, these guidelines collude in closing off urgently needed dialogue and critique.

As also previously described, organisational policies and practices that vet concerns internally prior to MCFD involvement allocate reporting decisions to social workers or medical experts who have limited contact with the child. The MCFD practices operate in a similar way, where decision-making about a child's need for protection is concentrated in the hands of a few individuals who have minimal contact with the child. In this process,

nurses' situational and experiential knowledge is not valued but absorbed into a systemic response stripped of the nuances of the affect to which the nurse making the report was privy. Deciding whether they were suspicious enough to report their concerns for a child's safety was contextual, influenced by "*gut feelings*" (RN₁₆), "*intuition*" (RN₅) and "*nurse antennae*" (RN₈) as well as their relationships with the child and family, their colleagues and the MCFD. Systematic ignoring of feelings and nuances denies the complexity of how suspecting that a child is being abused unfolds and the significance of this feeling within therapeutic relationships that nurses develop with children and families.

Objectifications of CN&A create images and spaces, open to interpretation and dominant and discriminatory understandings about violence, abusers and victims. Possible indicators of abuse shift with contexts; the dynamic nature of what constitutes CN&A can be seen in the discursive attempts to simplify and objectify CN&A. If nurses practised as per these guidelines, reporting suspicions constituted by these indicators, the MCFD would be overwhelmed with reports. CPWs with no knowledge of the context of the child and family would have to sort out the roots of a child's poor self-esteem or overly compliant behaviour. In practice, nurses who know the child and family make these decisions themselves (see Chapter 4). However, these guidelines leave decisions about when suspicion counts, when child protection interventions are required, and by whom, open to multiple influences, biases and relations of power. In their opacity, possible indicators could be ignored or emphasised; children's behaviours excused or highlighted; nurses' feelings of suspicion diffused or concentrated; and interventions impeded or pursued. Emptying suspicion of its affective nature limits opportunities to move beyond illusion towards rational knowledge or truth (Einboden et al., 2011).

Spinoza's (2000) philosophy of knowledge can be used to explain why and how suspicion with child protection responses have become stuck within the imaginary sort. Conatus offers an alternate way to understand the discursive rationalisations, oversimplifications and practical objectifications of suspicion: as mechanisms to contain and relieve painful affections with a promise of control and certainty. Shifting the type of knowledge in which practices are rooted will shift the practice. As a start, as nurses we might begin to think about how our affections and sociality operate to cultivate our suspicions. By opening these issues to critical philosophical and political dialogue it is possible to challenge the ways suspicion has been emptied of affections. Tracing the figuration of *The Vulnerable Child* through its iterations highlights otherwise invisible operations of power and offers a starting point for these discussions. By challenging taken-for-granted understandings, this approach supports an analysis that resists the seduction of imagination by challenging discursive mechanisms of containment, which have been identified here as an obstacle to addressing CN&A meaningfully.

Child protection reform: child rights and the discourse of 'best interests'

In the final part of this chapter, I describe how the statement 'best interests' appears and operates in textual excerpts from the *UNCRC*, *CFCS* and *Family Law Acts*. The statement 'best interests' and its operations are especially important to consider in this analysis because they are a cornerstone within the discourse of child rights. Further, widespread recognition of challenges with current CPSs have spurred discussion of reform, and CN&A experts agree the *UNCRC* should provide a guide for child protection reform (Reading et al., 2009). The findings in this section show that 'best interests' foster paternalism in ways that solicit but refuse children's agency and views. Its application encourages a discourse of

risk/safety that privileges the perspectives of adults in decision-making about children's lives. Constituted as a rights holder but not the agent who determines those rights, children are subject to decisions made on their behalf, for their own good. These paternalisms are legitimised by the figuration of *The Developing Child*. Analysis describes how the child development discourse operates in a dialectical relationship with the statement 'best interests', they co-constitute each other and as a result the force of the statement is intensified. This relation also widens the scope for child protection: what is constituted as *vulnerable* shifts from the child to the child's *potential*. In a similar way to how vulnerability is constituted, agency and capacity are constituted as a characteristic of the child, rather than produced by the social context.

The discourse of 'best interests' decontextualizes children's interests from those of their parents despite that they are, in most cases, inseparable. This ideology is traced to possessive individualism, which places children within a proprietary relation with their parents or the state. Social perspectives have critiqued individualisms as a mechanism that entrenches social inequity. In the legal texts analysed in this study, individualisms support the prioritisation of state and research interventions that focus on child development rather than addressing the social conditions that undermine children's agency and power. In the final section of this chapter, I offer an example of how the child rights agenda has further been diluted by technocratic practices of quantification. Findings of this analysis show how instead of supporting children's emancipation and freedom from violence, the hegemony of 'best interests' contains resistance to social inequity and maintains dominant social relations of power. By troubling the paternalisms, individualism and quantifications within the texts and practices, these findings caution against the use of a child rights framework for child protection reform.

‘Best interests’ in the legal texts

How legal texts allocate adults the power to decide what is in children’s ‘best interests’ is explored in this section. While parents are given this power at the outset, it may shift if children come to state attention, such as in family breakdown or child protection reports. In these cases, the legal texts direct the inclusion of children’s views but findings describe how ‘best interests’ limit and control how children’s views guide decisions. Decisions are often grounded in normative expectations and ideals, and rely on the figuration of *The Developing Child*, which will be explored in the following section.

It is a key principle of the *UNCRC* (1989) and the primary consideration in decision-making in relation to children’s custody in the *Family Law Act* (2011). The *CFCS* and *Family Law Acts* both define the child’s ‘best interests’. Consider how Part I Section 4 of the *CFCS Act* states:

all relevant factors must be considered in determining the child’s best interests,

including for example:

- (a) the child's safety;*
- (b) the child's physical and emotional needs and level of development;*
- (c) the importance of continuity in the child's care;*
- (d) the quality of the relationship the child has with a parent or other person and the effect of maintaining that relationship;*
- (e) the child's cultural, racial, linguistic and religious heritage;*
- (f) the child's views;***
- (g) the effect on the child if there is delay in making a decision.*

(*CFCS Act*, 1996, emphasis added)

While the child's views are considered relevant in determining 'best interests', they are low on the list of priorities for consideration. The pattern is repeated within BC's *Family Law Act* (2011) (see Appendix 14), where the child's views appear higher on the list, but are overshadowed by the linguistic hedge "*unless it would be inappropriate to consider them*", Thus, the child's views are included when deemed appropriate, by adults.

A similar process is seen in the *UNCRC* (see Appendix 15). *Article 3* states: "*In all actions concerning children ... the best interests of the child shall be a primary consideration*" (*United Nations Convention on the Rights of the Child [UNCRC], 1989*). However, *Article 12* includes children's participation as a right,

the views of the child being given due weight in accordance with the age and maturity of the child ... the child shall in particular be provided the opportunity to be heard in any judicial and administrative proceedings affecting the child. (UNCRC, 1989)

Here the texts together illustrate how 'best interests' can override children's views. Children are not considered capable of "exercising rights themselves ... while Article 12 provides a right to express views and the opportunity to be heard, this cannot be read as a right to determine one's affairs" (Pupavac, 2001, p. 99). *Article 12* constitutes children as active and competent agents but this offers only a thin veneer for paternalisms because

the extent of [children's] involvement has been limited. Problems raised include tokenism, unresolved power issues, being consulted about relatively trivial matters and the inclusion of some children leading to the exclusion of others. Among the

excluded groups are disabled children, ethnic minority groups and younger children ... [one] possible effect of the discourse of the autonomous child is in fact that the responsibility to realize their rights lies with the children themselves. (Reynaert, Bouverne-de-Bie, & Vandeveldel, 2009, pp. 522-523)

The irony of all human rights discourses is that in the absence of external support those without power are not likely to be able to achieve equity or ensure their own rights (Pupavac, 2001).

The fundamental conceptual problem in children's rights arises in the separation of the rights-holder and the moral agent, that is who is empowered to act by the institutionalisation of children's rights. Although the child is treated as a rights-holder under the convention, the child is not regarded as the moral agent who determines those rights. (Pupavac, 2001, p. 99)

This separation is illustrated in *Article 9* where children have little say into their own affairs, and may be removed from a parent regardless of their wishes (see Appendix 15). Notable too, is that children's views are missing from the committee set to develop and monitor the *UNCRC* itself. As per *Article 43*, membership consists "*of ten experts of high moral standing and recognized competence in the field*" (*UNCRC, 1989*)(see Appendix 15).

Following Arendt (1994), Beck (1997) describes how the child rights discourse promises future emancipation for children while justifying suspension of their agency within a discourse of developmental immaturity (p. 153). This discourse figures children as potential rather than actual citizens. Further, the text homogenises children in a

decontextualized way, as if they were “a coherent group or a state defined by identical needs and desires, regardless of class, ethnic, or racial differences” (Fernando, 2001, p. 18). This universalism within children’s rights “does not take into account the social, cultural, and political diversity of the meaning of childhood” (Fernando, 2001, p. 18). This analysis points to the assumptions on which the *UNCRC* rests, the figuration of the child and ideology of ‘childhood’.

‘Best interests’ and the hegemony of The Developing Child

The figuration of *The Developing Child* legitimises paternalisms and universalisms according within the legal apparatus of child protection law. *The Developing Child* places decision-making out of children’s reach, setting up a subaltern subjectivity for children in the present form, justified by promises of voice as they mature. For instance, the *UNCRC’s Preamble* (1989) anticipates the child’s independence in a way that features their dependence. Children are “*entitled to special care and assistance*” and “*the child, by reason of his physical and mental immaturity, needs special safeguards and care, including appropriate legal protection, before as well as after birth*” (see Appendix 15). Ignoring the conditions that support or undermine the space for children to speak or express their views, this discourse places the ability to participate meaningfully in matters related to their lives as if it were a capacity located within the child. The idea of individual capacity limits the inclusion of the child’s views and decontextualizes agency. Children’s agency is socially constituted in a parallel way to the constitution of their vulnerability, which exists in dialectical social relations rather than “straightforwardly a personal capacity or attribute” (valentine, 2009, p. 10).

Individualism: socially constituting agency and capacity out of children's reach

The capacity of a child is judged from an ideology of independence and separateness of individuals from others and society. This view remains dominant within the contemporary social imagination even amidst everyday evidence of our sociality. Notions of separateness offer narrow understandings of agency, autonomy and competency. The legal texts promote and evidence individualisms by using the term *a child* or *the child* instead of *children* (*CFCS Act, 1996; Family Law Act, 2011*). These texts also individualise by decontextualizing the child's 'best interests' from those of their parents. All humans need others to varying degrees, yet the ideology of individualism precludes some forms of human connectedness (especially physical dependency) as a meaningful or valued way to be. From a social perspective, "[t]he subject of child and youth rights ... the autonomous, willing subject of modernity, a subject whose essential nature owes nothing to the social, to historicity, to eventness" (Tarulli & Skott-Myhre, 2006, p. 189) is an abstraction, which fails to engage with the specific conditions and contexts of people's lives (Bauman, 2004; Burman, 1996).

Individualisms are rooted in dualities of mind/body and the idea of possessive individualism, or that the mind is in control of, or in possession of, the body (discussed earlier in this chapter) (Macpherson, 1962). Here again, Spinoza's philosophy of sociality and human knowledge offers an alternate way to appreciate interdependency. For Spinoza (1677/2000), the mind as an idea of the body and the mind's conscious thoughts arise from sensations and imprints on the body when it is affected by relations and interactions with other bodies. From this perspective, the idea of the mind as separate from and in control the body is an illusion, occurring as it does because of the limitations of human perception

and consciousness. Thus, faulty illusions allow us to believe we are separate and independent from one another (Spinoza, 1677/2000).

Children's rights are predicated on assumptions of adult independence and rationality. Requiring preparation for an "*individual life*" in the future, as described in the *Preamble* of the *UNCRC* (1989), denies and excludes young children, and other human beings who must directly rely on relationships for basic survival, from *life* now. Preparation for and the objective of an "*individual life*" casts a shadow over particular forms of very real human *life* in the present.¹⁹ This troubling discourse subtly implements a mode of social ordering by setting a goal that most, but not all children will reach. Of course, the discourse does not preclude children and others who require caregivers for survival from engaging fully in their own world in the present. Even the youngest of infants and the most disabled persons are affected and affect those who are close to them, and their social relationships provide a medium through which their needs can be met. The idea that capacity is required for agency refuses a critique of the social structures and practices that fail to create alternate ways for children to engage. While human rights conventions have historically been used by oppressed groups to lever emancipation, the discourse that children must outgrow their oppression preserves it, and eternally leaves the next generation in the same situation (O. O'Neill, 1992).

Potentiality and waste: a binary at the roots of discourses of child development

The figuration of *The Developing Child* occupies a discourse of potentiality defining children "as potentiality rather than an actuality, a becoming rather than a being: an entity in the

¹⁹ The *UNCRC* (1989) asserts that "a mentally or physically disabled child should enjoy a *full and decent life*, in conditions which ensure dignity, promote *self-reliance* and facilitate the child's active participation in the community" (*UNCRC*, 1989, emphasis added).

making” (Castañeda, 2002, p. 1). The child as potentiality is figured within reference to its opposite: the child as waste (Einboden et al., 2013b; Katz, 2008). While waste “is the dark, shameful secret of all production” (Bauman, 2004, p. 27), nothing is inherently waste but becomes waste when constituted as such (Douglas, 1966/2002). Whether ‘defects’ are defined by biological, psychological, or social discourses, children are constituted as waste by narrowing social definitions of normality and human worth. Whether inclusionary or exclusionary, the figuration leaves “all children to oscillate in the dualism of resource/waste, as the material bodies of these children never consistently fit any one category” (Einboden et al., 2013b, p. 563). The figuration plays on human anxieties of exclusion and insecurities of self-worth contributing to the next generation feeling rejected from society (Bauman, 2004). In global economies,

[a]s humans are increasingly relegated to waste, the irony of liberalism is revealed: the dismantling of state power that free capital requires needs a paradoxical increase in state power to mitigate its effects through identification, segregation and management of human waste. (Einboden et al., 2013b, p. 563)

J. O’Neill (1994) captures the operations of power when he argues,

We sentimentalize the horror of our practices of rendering our children poor, unhealthy, ignorant and unloved. We imagine that such injustice can only be accounted for by the absence of an ideal start in life. But the truth is that we believe in an ideal start that would prepare children for their unequal results in a competition whose next rounds result in the *intergenerational inequality*, injustice,

and ignorance that sets the floor of market society – if not a trap door through which so many children fall into oblivion. ... *Child equality is a myth to which liberalism is committed in order to 'save' the inequality within and between families.* (pp. 43, 45, emphasis in original)

The espoused objectivity and authoritarian knowledge claims made by developmental science are an example of what Haraway calls a “god-trick” (Haraway, 1997, p. 134). Theories of child development are not transparent about the dominant relations of adults over children. Instead, these relations are cloaked in assumptions about the incompleteness and inferiority of a child by *nature*, constituting the child as passive and available for discovery. Efforts to develop children might instead be seen as originating from and continuing to maintain relations of power over children. Further, the figuration of *The Developing Child* is also used to maintain economic inequities (Burman, 2008c; Castañeda, 1997). At the same time that children, and especially young children, shoulder a disproportionate share of poverty in BC and internationally (Brazier, 2017), early childhood development interventions work to mitigate the deleterious effects of economic disadvantage (Irwin et al., 2007). In turn, global economic systems at the root of these inequities are protected (Burman, 2008c).

Part of the reason that this science can be used to preserve inequities relates to the interdiscursivity of politics and science in our contemporary time. Experts from the Center for the Developing Child at Harvard University explain how a political agenda was furthered by “crafting the story of child development” (Shonkoff & Bales, 2011, p. 22). The vast findings of neurobehavioural developmental science were simplified to support policy. Simplifications were justified by the idea that the public has a limited ability to comprehend

findings with their complexity: “[d]espite its considerable interest in science, the public’s attention span is typically short” (Shonkoff & Bales, 2011, p. 22). Experts have developed a

simplifying models process, which is designed to reduce a complex concept or idea to an understandable, concrete analogy or metaphor that helps people integrate information into a clear and coherent picture in their heads. Because simplifying models can serve to concretize and make vivid previously hidden or ill-understood aspects of a scientific or social phenomenon, they can help solve problems in public understanding or “plug” specific cognitive holes in people’s thinking. (Shonkoff & Bales, 2011, p. 25)

Metaphors “such as ‘brain architecture’, ‘toxic stress’, and ‘serve and return’ have been created to explain complex scientific concepts to nonscientists” (Shonkoff & Bales, 2011, p. 17). Metaphors and narratives operate in similar ways to the measurements and images, they require interpretation and are vulnerable to technobiopower. An image that fixes nature offers a snapshot of it at one moment in time providing a decontextualized view that fails to capture life in its dynamic complexity (Duff, 2010). The live body cannot be interpreted from a fixed image of the material body or its parts; these images offer understandings closer to a body in death than one that is alive (Buchanan, 1997; Haraway, 1984; Stabile, 1992). Furthermore, any image that is invested in representing the real precludes its own objectivity at the outset, a paradox appreciated in the disciplines of art and philosophy (Barthes, 1977). This paradox is missed in the translation of developmental science, allowing interpretations to be moved into public discourse espoused as truth and as

nature. The figuration of *The Developing Child* supports the idea of early investment and the child as human capital (Einboden et al., 2013b).

Proprietary relations of adults and their children

Supported by the ideas of Foucault and others, Thielen-Wilson (2012) argues that legal and social institutions, individual rights, freedom and identity have all been significantly shaped by how property and accumulation are defined. “Freedom and property are analytically linked” (p. 54).²⁰ Freedom was constituted as a function of independence from others and a lack of social obligation, where freedom requires control over one’s body, a control considered *natural* for men (Macpherson, 1962). Property unites the dualisms of mind/body, reason/emotion, civil/savage and so on. From this perspective, children’s dependency and lack of bodily control denies their humanity and freedom, binding them to a proprietary relation with their parents or surrogate caregivers.

Parents have come to define themselves through their child’s successes, and in some cases, at their child’s expense. A nurse participant noted this social discourse of possessiveness among parent-child relations, where a parent might say:

‘My child is in elite soccer’. My child? You mean Sally is? ... And Sally is so sick. She is so burnt out. And I see that so much. So, their identity is sometimes warped where they become their children’s identity. ... ‘My child’ [shows] ownership’. (RN₉)

²⁰ Drawing on Macpherson (1962), Thielen-Wilson (2012) offers an excellent in-depth account how identity is intertwined with “possessive individualism” in western social thought and the implications for governing children (in the case of Canada’s past and ongoing colonial practices with Indigenous children).

While the language used to talk about parents, partners and others is similar, the relation of propriety can be seen as an expression of possessive individualism and has different implications at different social intersections. In terms of the parent-child relation, the child offers a way for parents to work through their own failures, is commodified as an investment (e.g. consider the popularity of products designed to make baby 'geniuses', the measurement of children's developmental milestones, and the competition for 'elite' preschool positions).

From a critical perspective, contemporary early childhood research and practices can be seen to appropriate children's agency and self-determination and preclude their freedom to exist outside of prescribed uses (Castañeda, 2002). "As the 21st century picks up speed and settles into place, childhood has become a spectacle ... as accumulation strategy, ornament, and waste" (Katz, 2008, p. 5). *The Developing Child* no longer signifies only prosperity, but hope for human salvation among increasing anxieties of an unstable global environment (Katz, 2008, p. 5). "Investments in children as accumulation strategies are realized socially through some inchoate sense or fantasy wish-dream that they actually will 'save the world' or at least save us from ourselves and the consequences of our actions or inactions" (Katz, 2008, p. 12). Thus, anxious relations of power converge to produce the figuration of *The Developing Child*, who is at once "relatively worthless economically to their parents, but priceless in terms of their psychological worth" (Scheper-Hughes & Sargent, 1998, p. 12). Thus, children figured within narratives of human development are simultaneously and in contradiction overdetermined, stripped of agency and erased (Uprichard, 2008).

Recalling Žižek's understanding of violence, this analysis reveals the objective violence embedded in the figuration of *The Developing Child*. The intensity of the

oppression children face varies with their social position, rights cannot be addressed without consideration of the structural roots of their abridgement.

Rights cannot be safeguarded without meeting the material needs of people and, when talking specifically about children's rights, without dealing with the structural causes of children's vulnerability. Among them, an unsafe environment and chronic poverty are root causes of the tragic situation of the world's children. (Fernando, 2001, p. 12)

However, it is important to note that as a major population group, *all* children face a unique and inconsistent oppression: they are at once revered as potentiality and figured as the most precious members of society, while they are deprived of agency, more likely to live in poverty, and forced to endure disproportionate violence.

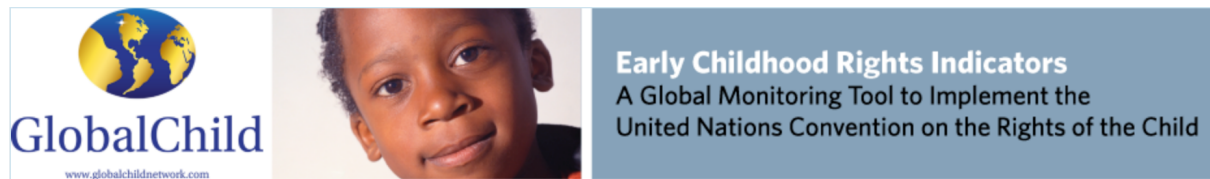
Technocratisations: accounting away inequity

Attention to children's rights casts light on social inequity and poverty, but strategies engaged by nation states remain technocratic and focused on quantifying implementation of the *UNCRC*. This section offers an example of the instrumentalisation of the evaluation of national implementation of the *UNCRC*, *General Comment 7 (GC7)*. Discussion demonstrates the implications of the separation of the rights-holder from the moral agents who uphold these rights and exemplifies how the child rights agendas have morphed into what Fernando describes as "a technocratic discourse that no longer addresses the issue of power relations that is central to understanding and effectively responding to the needs of children" (Fernando, 2001, p. 12).

General Comment 7 and its indicators

GC7 was issued after the first monitoring cycle of the *UNCRC*, when it was noted that issues for young children (birth to eight years of age) were largely absent from national reports from ratifying countries.²¹ Initially the project was led by researchers from BC's Human Early Learning Partnership (HELP), and collaboratively the GC7 Indicator Group developed 15 specific indicators focused on the rights of young children (see Appendix 15)(Human Early Learning Partnership, 2012). Each indicator has three levels on which nations must report progress. The first level reports information about the *structures* that have been either been put in place to address the indicator or have received an explicit commitment to be developed. The second level reports on whether the *process* has been initiated, that is if actions have been taken or planned towards addressing the indicator. The third level reports on whether the *outcome* of actions has been measured. Heatmaps provide a coloured graphic representation used to visualise each nation's progress on each indicator (see Figure 5).

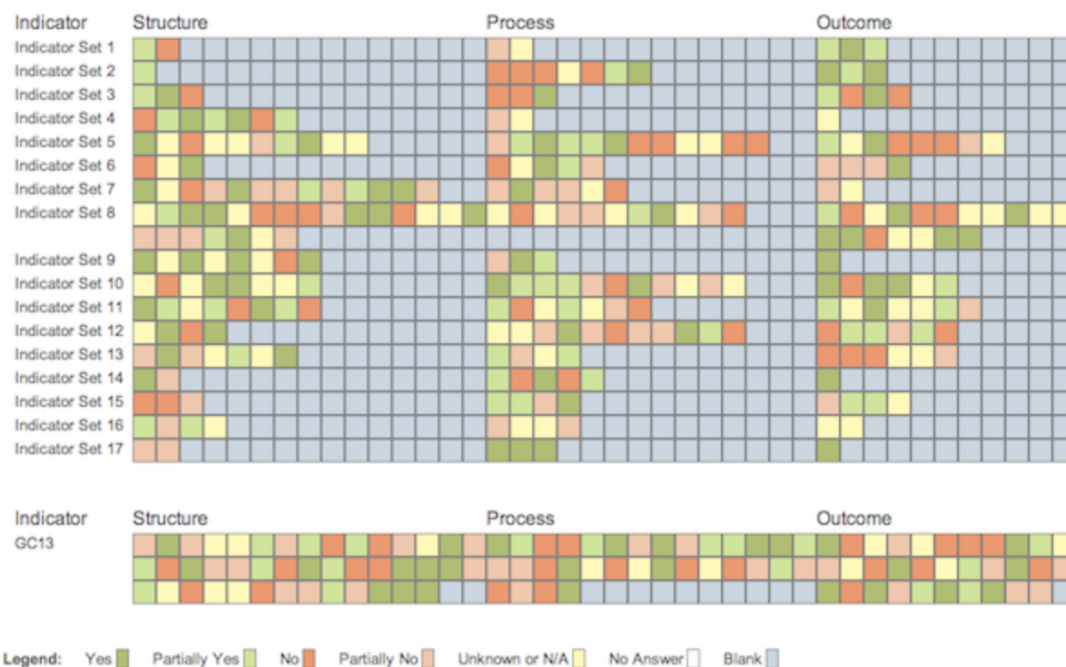
²¹ Within two years of ratifying the *UNCRC*, nations are obligated to submit an initial report to the Committee of the Rights of the Child, and then updated reports every five years thereafter. The Committee offers constructive feedback to support nations to develop an action plan. Since inception, there has been poor compliance with the timelines for reporting (e.g. Canada submitted a report in 2002 and then not again until 2012) and poor response times from the Committee.

Figure 5 Heatmap: Early childhood rights indicators²²

Heatmap

The Heatmap below, based on a fictitious survey, provides a concise overview of the compiled data for this survey. Each box represents a response to an individual question, based on 'yes', 'no' or 'partially met'.

In an actual Heatmap, clicking on an individual box links to the original question allowing the user to see the response in the context of a comprehensive set of questions within each indicator.



(Early Childhood Rights Indicators, 2012)

While increased attention to the abridgement of rights of young children is important for addressing inequity, the GC7 indicators operate paradoxically, by obscuring attainment of rights in a couple of ways. The first four of 15 indicators (Dissemination of GC7; A Positive

²² Reprinted with permission from GlobalChild Research Program, School of Public Health and Social Policy, University of Victoria.

Agenda; Human Rights Training; and Data Collection Systems (Vaghri et al., 2010)) relate to monitoring of child rights implementation, without any reference to the implementation of meaningful resources for children. This emphasis skews the report and the agenda, pointing to initiatives that address the monitoring system and distracting from what it is that is being measured. This decontextualisation “does not take into account the living conditions, the social, economical and historical contexts in which children grow up, which can be very diverse, and which are the environments in which children’s rights are to be realized” (Reynaert et al., 2009, p. 528). While serious issues such as high rates of child poverty and grave child rights violations require attention of research expertise,²³ resources are siphoned to develop processes of measurement as a priority, and rebalancing resource priorities towards intervention is also needed.

Second, while resources for children are also represented in the indicators, they are levelled in a way that minimises the most important issues through a focus on accounting in order to be counted, or of account. For example, *GC7-5 “birth registration”* is equated with *GC7-8 “basic material needs”* and both are equated with *GC7-1 “dissemination of GC7”* (Human Early Learning Partnership, 2012). Child poverty is central to the abridgment of rights of children (and their parents) but it gets buried in this approach to evaluation. It undergoes further dilution by the key questions designed by the *GC7 Indicator Group*, which place another layer of emphasis on assessment and evaluation rather than provisions. The birth registry as a

²³ For example, the Canadian Human Rights Tribunal ruled in January 2016 that the Government of Canada was discriminating against Indigenous children in relation to inequities in funding for services for families on reserve (*First Nations Child and Family Caring Society of Canada and Assemble of First Nations v. Canadian Human Rights Commission and Attorney General of Canada*, 2016).

so-called right may serve the needs of the modern, bureaucratic state to keep tabs on its population (and future workers and consumers) more than the best interests of the newborn. Birth registration is an example of what Michel Foucault (1980) meant when he referred to the state's 'biopower'. (Scheper-Hughes & Sargent, 1998, p. 8)

Here it is evident how political priorities have been inserted into the child rights agenda. The indicators and heatmaps work together to decontextualize and visually equate intention and outcome, as well as flatten the importance of vastly different issues.

Human rights conventions and activities to redress inequities have had very important effects improving the living conditions for many people, including children. However, built on individualism, and operated by paternalism, these conventions internally limit emancipation and pose no real threat to oppressive relations of power. Instead, they provide a platform for the effort required to maintain dominant power relations. Žižek (2009) warns about these type of actions of inaction, or "pseudo-activity, the urge to 'be active', to 'participate', to mask the nothingness of what goes on. ... [Instead, a truly] political *act* ... forcefully confronts us with the vacuity of today's democracies" (p. 183, emphasis in original). The Early Childhood Rights Indicators show how the *ideas* of rights and freedom are socially relevant rather than upholding rights of every person: "even in its watered down form, is effective and real even as an *idea* ... specifically in the arming of state power to make sure that, the idea of freedom, now culturally internalized, not be able to strike a political spark" (Beck, 1997, p. 154). Used rhetorically, it is *the very idea* of freedom and equity, which saturate rights discourses that are violent in Žižek's objective sense.

Focusing on the idea preserves oppression, exclusion and inequity not only within children's social realities, but also across other social positions globally.

Conclusion

Starting with the social construction of the child and childhood, this chapter has offered an overview of social, political and historical perspectives to show how the figuration of *The Vulnerable Child* has oriented and legitimised BC's child protection response as described in the legal texts. The production of children's vulnerability by a society that is, and continues to progress, in ways that are inhospitable to children slips from view. Analysis of the statement 'best interests' traces the transformation and consumption of *The Vulnerable Child* into another figuration of *The Developing Child*, which redefines what is vulnerable and in need of protection within discourses of child development. In this chapter, I traced these figurations back to their ideological foundations. Findings showed how these figurations hide objective violence in plain view and form obstacles to addressing CN&A.

Legislation, from mandatory reporting in the *CFCS Act* to an agenda of child rights in the *UNCRC* have paradoxical effects, caught up in regulatory aims of the state. Using discursive analysis and informed by Spinoza's philosophy of knowledge, rationalisation of suspicion by the statement 'reason to believe' was shown to undermine nurses' affective experiences and flatten suspicion and cultivate ignorance in all except the most overt forms of abuse. From this perspective, this analysis offers a challenge to rationalisations, a possible explanation as to why mandatory reporting misses most of the violence that children experience, and suggests reconsideration of dominant social understandings of children.

Acknowledging issues with current CPSs, it has been argued that the child rights framework would support meaningful reform (Reading et al., 2009). Findings in this chapter offer a serious caution against application of the child's rights discourse in reform of the CPSs. While improving life conditions for some, they draw our gaze away from objective forms of violence embedded within everyday social structures and practices that produce vulnerability and normativity, while undermining children's agency, voice and power. Children's views are considered contingently on vague definitions of their capacity, offering only limited emancipation for children. In a denial of the subaltern position and experiences of children, the "enunciation of rights, the rhetoric of myth and freedom, is intended precisely to cover up their severe abridgement" (Beck, 1997, p. 154). Further, quantifying implementation of the *UNCRC* provides a contained space to address blatant social injustices in a way that does not threaten or destabilise current relations of power.

In conclusion, legal child protection responses are misaimed. They protect the figuration of *The Vulnerable Child* and set up a system that does very little to address the roots of violence for children. Techniques of power used within child protection responses prioritise rational over affective ideas, and efficiency over frank discussions of the implications of social inequity. Child protection legislation and practices are violent in Žižek's objective sense of violence, each operating in exclusionary ways by contributing to the erasure of the child. The implications of this analysis call for critical reflection on the social positioning of children and dismantling the figurations that reify and reproduce themselves in a mode of ordering within our social world.

Chapter 4: A Game of Deferrals

The majority of cases of CN&A in BC, as elsewhere, are of the “*garden variety*” (RN7) that the MCFD does nothing about. Dominant discourses constitute a lack of efficacy of BC’s CPS as an issue of *recognising and reporting* CN&A. While Chapter 3 challenged the idea that recognising violence is the problem, this chapter challenges the idea that failing to report these concerns is the problem. This chapter shows that most CN&A is duly noted but unless severe, very little is done to address it. Instead, BC child protection legislation and practices articulate the efforts of multiple service providers including nurses, police and CPWs into a complex series of deferrals that resemble the childhood game of hot potato. This game diffuses the efforts of these providers and ignores the poor conditions, in which many children are forced to live.

The chapter is organised by two rules that structure how this game is played, as shown within the corpus texts. The first rule, and perhaps the overarching rule, is that children’s immediate family should be held responsible for them regardless of their own resources, power or social position. I start the discussion by establishing the presence and prominence of this rule in the legal texts. Next, by drawing on textual examples from the *Lost in the Shadows* report and nurse interviews, I illustrate how the figuration of *The Responsible Family* legitimises unrealistic expectations of families, and how some children are relegated to, instead of lost in, the shadows. Holding families responsible also justifies a lack of state investment in child protection services. The outcome of centralised authority and inadequate resourcing is described. By tracing the figuration from its production through to its uses today, I show how this figuration remains a major stabilising force for

dominant relations of power, which preserve social isolation, marginalisation and inequity despite serious implications for children's safety.

The second rule of the game is to mandate reporting of CN&A to the MCFD and define reporting as nurses' sole responsibility. In this section, I discuss how reporting, constituted in this way, ignores and in many instances, undermines the work that nurses do to address child safety issues in their day-to-day practice with families. Nurses from this study described how they navigated decisions to report child safety concerns, weighing the impact of their relationship with the family and their ability to monitor the situation. They offered examples of playing and resisting the game, and expressed disillusionment with a system that diffuses responsibility for, rather than addresses, most cases of CN&A.

The final part of this chapter identifies how the game plays out at all levels of the system. Deferrals seen between nurses and CPWs are reproduced by the RCY and the CRNBC. Despite strong advocacy and leadership, these leaders also get stuck in the game and are unable to shift stabilising discourses and relations of power. From this analysis, it is possible to see how the smooth shuffling of the child and family back and forth between services leaves the parents responsible and unsupported and children ignored, in all except the most severe cases of CN&A, which are the subject of discussion in the next chapter.

Rule #1: Position the family as responsible

Provincial, national and international legislative structures of the CPS are constituted by and generative of the figuration of *The Responsible Family*. In this section, I first offer examples of textual excerpts from the data corpus that demonstrate the presence and prominence of this figuration. Next by drawing on the *Lost in the Shadows* report and the nurse interview

texts, I consider how the figuration of *The Responsible Family* operates in practice. Finally, taken as the object of research, the figuration of *The Responsible Family* is discussed from its production, transformations, distribution and consumption. Together the analysis presented in this section outlines how constituting families as responsible works as an overarching rule to ensure a game of deferrals within child protection practices.

The Responsible Family in legal structures

The figuration of *The Responsible Family* appears centrally in child protection legislation. These texts dictate how by biological relation the family is constituted as responsible for its children. For instance, the *Guiding Principles* of the CFCs Act (1996) outline that “*the responsibility for the protection of children rests primarily with the parents*” and that a child requires protection from the state only “*if the child’s parent is unwilling or unable to protect the child*”. Section 215 of the *Criminal Code* (1985) describes the family’s responsibility for the provision of necessities of life and the criminal nature of neglecting to do so (see Appendix 16).

From the side-lines, the government dictates how the game should be played. The figuration of *The Responsible Family* legitimises the case-by-case approach to child protection that assists children only *after* their family has failed to protect them. As described in Chapter 3, the family’s failure to protect the child must be identified and established prior to intervention. However, *The Responsible Family* delimits a sphere of privacy around the home and the child, which makes identification of CN&A challenging and positions suspicion centrally. At the same time, suspicion is noted but ignored through rationalisations (as detailed in Chapter 3).

The privacy and sanctity of the idealised family is rife in legal texts. Without reference to any particular family or family resources the *Guiding Principles* of the *CFCS Act* (1996) claim that “*a family is the preferred environment for the care and upbringing of children*”. The *Preamble* to the *UNCRC* (1989) defines family as “*the fundamental group of society and the natural environment for the growth and well-being of all its members and particularly children*”, and argues, “*that the child, for the full and harmonious development of his or her personality, should grow up in a family environment, in an atmosphere of happiness, love and understanding*”. This idealisation aligns the growth within the family to development of nation states, discursively constituting the family as a way “*to promote social progress and better standards of life in larger freedom*” (*UNCRC, preamble, 1989*).

Under liberal state governance class divisions and social inequities have deepened, affecting young families disproportionately. Social inequities produced by state politics leave families in situations where they are unable to meet their children’s needs, but their responsibility remains unequivocal (J. O'Neill, 1994; Rose, 1999). The text naturalises family responsibility within discourses of affection, diverting attention away from *state irresponsibility* and the abdication of state responsibility to support families. These discourses frame the family as naturally responsible rather than disclose how they have been socially constituted as responsible. There is recognition across the legal texts that families may need support, for instance the *CFCS Act* (1996) reads: “*if, with available support services, a family can provide a safe and nurturing environment for a child, support services should be provided*”. These texts acknowledge family responsibilities as challenging and tasks government with providing them assistance. The *CFCS Act* sidesteps the obligation to support families by describing the provision of “*available services*” as contingent on the family’s ability to “*provide a safe and nurturing environment*”. This argument is tautological;

only when deemed capable in the first place should families be supported. Those who need support the most may be deemed unable to meet their child's needs and thus are not eligible. Born of liberal state and market ideology, this reasoning is inscribed by the figuration of *The Responsible Family*. The practice implications of this tautology are demonstrated in multiple examples in the latter part of this section. The further irony of this tautology is that there are very limited, if any, "*available support services*". In conducting a MCFD website search in 2015 for these services, I found little information about either family services or prevention. At the time, there was a link to a "*child abuse prevention website*" (www.safekidsbc.ca), which made claims of existing services and online resources that circled back on to themselves. While that website no longer exists, the same services are identified on the current website (www2.gov.bc.ca/gov/content/safety/public-safety/protecting-children/keeping-kids-safe). These services are limited to the local MCFD offices and the Kids Help Phone (a service operated by a national charity) (Province of British Columbia, n.d.-a).²⁴ The MCFD has not outlined their responsibility for creating, funding or managing "*available support services*", nor have they been transparent about what is offered.

In contemporary western society, the prioritisation of contractual bonds (legal marriage) over corporeal bonds have fragmented families. Extended kin who played a key role in family life for millennia are now much less available. Scarcity of family child-rearing

²⁴ In August 2017, the website (www2.gov.bc.ca/gov/content/safety/public-safety/protecting-children/keeping-kids-safe) also identified the *Youth Against Violence Line* as a resource. This line was originally initiated by the provincial government to encourage youth to "take an active role in preventing violence amongst their peers", by leaving anonymous messages about youth violence for police. In partnership with a non-profit agency, it now also offers counselling to "youth who are experiencing threatening and violent situations, or other difficult life situations" (Province of British Columbia, n.d.-b).

resources translates into isolation of parents and children. In Canada, this isolation has been further intensified by a growing number of lone-parent families.²⁵ The effects of fragmented corporeal relations could be mitigated by basic measures such as equity in taxation structures, compensation to parents for their work raising children, and access to funded quality childcare, all of which are essential for single parent families or low-income families where both parents must work (see Chapter 6). Yet, the lack of support is legitimised by the figuration of *The Responsible Family*. The next section describes how this figuration operates in practice, then traces its production from its roots in liberal state and market ideology through to its various iterations in the past century.

The Responsible Family *in practice*

In every interview, nurses identified unrealistic expectations of families as closely linked to CN&A. Despite the impact on children, the figuration of *The Responsible Family* shields social injustices from criticism and legitimises social indifference to families who lack resources to support themselves and their children. It displaces culpability from the government and from society and hands it back to the family. If and when the family's social deprivations are noted, rather than being understood as irresponsible for *not providing* for their children (as this would be ridiculous), the issue is recast as the common-sense social notion of the parental irresponsibility for *having children* in the first place. What gets missed within in these common-sense notions is the child.

²⁵ According to 2011 census data lone-parent families comprise 16.3 per cent of all Canadian families, and 15.3 per cent of BC families (Milan & Bohnert, 2012; Statistics Canada, 2012c). Of these, female lone-parent families accounted for 12.8 per cent of all Canadian census families, while male lone-parent families represented 3.5 per cent, and lone-parent families increased 8.0 per cent compared with the 2006 census data (Milan & Bohnert, 2012; Statistics Canada, 2012a, 2012b).

Unrealistic expectations and parental health

The *Lost in the Shadows* report illustrates how BC legislation holds unrealistic expectations for families and provides them with minimal support, even when they repeatedly request help (RCY, 2014). The first request for MCFD help for the girl who is the subject of the report, was initiated before she was born by her pregnant mother. Her mother suffered severe mental health issues that were untreated, in part, due a lack of access to psychiatric services while living on-reserve in a remote area of the province. During deteriorations in her mother's health, the responsibility for the girl and her sister silently rolled onto their grandparents. This arrangement failed to appreciate the family's lack of resources and social and geographic isolation. For years, the grandparents juggled caregiving amongst threats to their own, their daughter's and the children's safety.²⁶ When the family asked for respite or financial assistance, they were met with stipulations that the children were never to be left alone in the care of their mother, and were told they were ineligible for funding because their home was unsafe for the children with their mother living there. Yet there was no action taken by the MCFD to change the unsafe situation for the girl or her little sister. The grandparents felt forced to choose between caring for their ill adult daughter or their granddaughters, and were aware of the threat that the MCFD posed to the family unit (RCY, 2014).

Notwithstanding the involvement of multiple care providers who were aware of the girl's dire situation, her basic needs, especially that of safety, were not met. For 14 years she

²⁶ The *CFCS Act* (1996) has a formal process that allows the parent to transfer custody of the child to family member under a Kith and Kin arrangement, but this was not identified as in place in this case. While Kith and Kin arrangements are very attractive to families in Indigenous communities where their children have been removed as a technique of colonial occupation, they have been created in a way that justifies less state support and fosters an over-reliance on kin who may also be unable to protect the child (Cradock, 2007).

bore the brunt of her mother's psychosis that included voices commanding her mother to kill her. The girl repeatedly contacted the RCMP for support with her mother's violent psychotic outbursts and on another occasion, for sexual assault perpetrated by an older peer. The girl's school counsellor reported her acute suicidality to the MCFD two weeks prior to her suicide. Yet, this family's requests for help were ignored throughout the girl's life (see RCY, 2014, pp. 16-17). The report concludes that invisibility of this girl was produced by a system that often renders children whose parents have mental illnesses invisible (RCY, 2014, pp. 90-92).

Nurse participants from this study echoed this sentiment, even when referring to practice in urban settings. One commented how, *"it just seems like mental illnesses don't get any attention ... let's do that thing where we shove it in the back corner and not think about it. So, you are not helping people who need help"* (RN₄). Another participant described a home where the young children took care of the household and their mother during her acute episodes of mental illness (RN₁₇). Ignoring mothers' mental and physical health is so entrenched it recently resulted in a 15 year-old youth with Down Syndrome being found by neighbours dehydrated, dirty and alone, "huddling tight against her mother's decomposing body" (RCY, 2011, p. 23). It was estimated that this girl spent approximately one week with her mother's dead body before she was found. This occurred despite that her mother's deteriorating mental and physical health and subsequent concerns for the girl were reported to the MCFD on several occasions. Two investigations were conducted by the MCFD in the months prior to this incident in response to reports, including one from the girl's brother who, out of concern, took the girl to stay with him. The girl's brother was asked by a CPW to return her to the care of her mother and reassured him that the home was safe and that they would be carefully monitored. Instead, after each report CPWs

closed the file concluding that there were no child protection concerns and confident that the MCFD's Child Youth Special Needs workers could provide adequate support (see RCY, 2011, pp. 26-27).

Within these unrealistic expectations, regardless of the reasons, parents who are not able to provide for their children are constituted as irresponsible. The parents' internalisation of these expectations, without the ability to meet them, results in toxic feelings of inadequacy, guilt and shame.

You have to be able to do it all on your own all the time, perfectly. ... I think is so huge I think that it's seen as a weakness when families get to the point of being frustrated and they can't do it anymore ... my mum tells stories of when my older brother was born, you got frustrated, you went to your neighbour and said 'hi, I need to go for a walk, please hold' [motioning handing over a baby], and you went for a walk and that's not there anymore. ... you keep it to yourself, you keep it behind closed doors mentality. You don't air your dirty laundry. (RN₁)

Pressure to conform to social ideals of 'good' parents is isolating and dangerous for families who are struggling and unwell. When the family's behaviours or well-being are in question, the sovereignty of the family can be limited by the state. Thus, expectations morph into mechanisms of social control, operating "through 'virtues' and 'popular opinion'" (Foucault, 2000a, p. 306). Internalised, they exacerbate isolation and minimise opportunities for help because families fear judgement and child apprehension.

State interference into the family has not been spread across the population evenly, inequity has been built into the system, since the shift from corporal to contract relations.

[L]iberality of the contract between conjugal partners was coupled with another, tacit contract with the state: this freedom that presides over your union, the ease with which you are able to contract it outside the old exigencies of family and group adherences, and the liberty you have to break it, we grant to you on condition that you turn it to advantage in order to better ensure your autonomy through the observance of norms that guarantee the social usefulness of the members of your family; or else, losing that autonomy, you will fall back into the register of tutelage. (Donzelot, 1979, pp. 91-92)

Tutelage has long been reserved for certain pockets of the population and targeted interventions required (Donzelot, 1979).

Without long-term supports to mitigate the effects of social inequity, the implications of the contemporary CPS for marginalised families are devastating. A study participant illustrated how this system of tutelage persists today,

... I've called the Ministry before and I've said 'hypothetically...', and so then often they will say 'do you have something to report, [RN₂₀]?' and I'll say 'yes, but you know this is my gut instinct I don't think there is blatant abuse, I think this family is struggling' ... and these boys were really a mess, the mum has a disability and extreme poverty and you know the Ministry's response is 'those kids are out of there'. And uh, the expectations of the mum are unrealistic ... so I just feel like there is a lot of grey areas where we know this is not good, children should not be living like this ...

but a lot of it is ... getting those resources to the parents. But you know it's not simple ... how do you train a parent to be a 'good' parent quickly? (RN₂₀)

Significant practical and emotional resources are needed to raise children. Parents are expected to enter their roles prepared, yet they may have not themselves experienced a nurturing family and nor know what that might be or how to create it, as was the case for many children who were forced into the residential school system in BC. As described in detail in Chapter 3, unrealistic expectations of parents resulted in the evacuation of Indigenous children from their families across the province since the 1960s. While some nurses try to support parents to meet the needs of their children, if these parents have not had their own needs met this endeavour takes (too much) time or may require a shift in expectations (RN₇).

Unrealistic expectations and child health

Even well-resourced families may experience challenges depending on their context. Consider for example, how when children are ill, their dependency is intensified. The changing health care context has resulted in tighter criteria as to what constitutes a child sick enough for hospital admission. Increased acuity of hospitalised children is a by-product of both funding restrictions and advances in treatment of conditions such as cancer, cardiac disease, and extreme prematurity. The implications of these changes include more responsibilities for families, especially mothers. If a health professional deems that a child requires hospital admission or discharge is delayed due to the parents' inability to master additional caregiving responsibilities, the discourse shifts to a 'social admission'. If the situation persists, and the family is seen as obstructing the expected flow of patients

through the hospital ('bed blocking'), parenting capacity is questioned, and a report to the MCFD may ensue. The discourse of the 'social admission' problematizes the family and masks austerity cuts to social services (Carter Anand, 2009; McCartney, 2015).

A study participant described a situation that exemplifies the problematizing of parents with a dearth of social support. This nurse was part of a team who had been working with a family in the home to support them in the care of an infant with a cardiac problem who needed time to grow prior to surgical repair. When the infant's condition stabilised and he started gaining weight needed for surgery, he no longer met the eligibility criteria for funding for a visiting nurse. This nurse was certain that the day-to-day interventions were essential and feared the implications for this child. When her rationale for continuing involvement with this family began to sound like child protection, she was met with resistance from her supervisor who advised her that: "[child protection] is not what this program is about" (RN₈). Concerned the nurse attempted to elicit support from the MCFD.

I had a hell of a time trying to get through to the protection social workers. Non-team players, and I found it really difficult to move things forward because they had such a narrow focus, such a narrow focus. ... I'm gearing up to discharge this family and going to this lady: 'Okay I'm going to discharge this family, really, seriously, I need to discharge [them from my care]. And that means I won't be there to monitor ... you're kind of it ... and we're seriously concerned about this child, grandma was force feeding and causing him to aspirate ... meds are not filled on time ... it wouldn't be caught if there wasn't nursing in the home'. So yeah, protection social worker: 'what are you doing about the situation?' And nothing. Nothing. ... The parents

needed parenting support. ... I didn't think that that child was being abused but I think that was real potential ... especially with ... service providers backing out with a family that is already overwhelmed and maxed out and then they have another baby coming ... it's ridiculous how funding works. (RN₈)

Neither the MCFD nor the nurses could justify funding to help because the responsibility was *the family's*. The child's condition had to deteriorate, result in a hospital admission and a case of medical neglect causing harm prior to providing care. Tracing back to the *CFCS Act* (1996), this situation is predictable and would not be an isolated incident because protection is needed when neglect *causes* physical harm (see Chapter 3 and Appendix 11). While funding for community nursing support is limited and deemed too expensive, resources for the CPS, judicial system, cardiac surgery and hospital care are prioritised.

Another participant also described her experience discharging families of sick children from the hospital, without enough time to ensure the parents are capable of caring for their child at home.

So, they're struggling to just take care of themselves and now they really want this baby and they have all the right intentions, but they just don't know how to do it. And, when they are in the hospital for such a short amount of time you can't equip them with all the tools that they need in order to take care of the child when they go home

... frustration comes with the not knowing how to get the resources that the family will need and knowing that there are limited resources available to prevent this [another deterioration] from happening in the future. ... the majority of the time

it's not that the child is severely [abused] ... they are just not going to do as well as if they had the right resources in place. (RN₁)

When expectations of the family supersede their capacity, the system sets up scenarios where ill children relapse, the cycle repeats.

Even within Canada's accessible, universal public health care system, who qualifies for care is not equitable. Children's access to interventions depends on an evaluation of the family's ability to manage the child's ongoing care. One participant explained how she spoke to the ethicist regarding a decision about the allocation of a liver donation when one became available. There were two children she knew who were waiting for a liver transplant, and while one child seemed much more affected by liver disease, *"he was in hospital getting poked getting multiple blood tests and other treatments ... they both had failing livers but he was suffering more"* (RN₅); the liver was allocated to the other child,

who spent very little time in hospital and who came from a higher-class socioeconomic situation ... it's actually part of the protocol ... that they have a decent home, with a reliable family that can make sure that the anti-rejection meds are given on time, that follow up is done, so there is a protocol that dictates who is more worthy of a medical intervention. In this situation, the parents were doing the basic requirements, but ... society is neglecting him

... [it was] explained that this family was not reliable, it was a situation of generations of fetal alcohol syndrome, unreliable, addictions and all of these other things and they couldn't guarantee if this precious liver was given to this child that it would be used as effectively as in the other child. (RN₅)

The Responsible Family is used to justify eligibility protocols for organ transplantation entrenching inequities for marginalised children, and supporting the allocation of intensive medical care and scarce organs to children who are amongst privilege.

Unrealistic expectations and poverty

Social inequity allows some people to be born into, live in, and have children in poverty with very few opportunities to turn that situation around. All participants articulated how the broader social context tolerates and even perpetuates poor conditions for children. Many families are challenged by intersecting forms of poverty that interfere with their ability to provide care.

Poverty ... emotional poverty as well, not just financial poverty. Cultural poverty. Low levels of education. Family origins stuff that hasn't been tidied up and is just rolling through another generation and hasn't been attended to. Substance use, substance misuse. ... If I was going to prevent abuse towards children, I would put a total emphasis on supporting families and making sure everybody had a decent place to live and enough to eat and every kid would be able to go to day care and preschool and that mothers and dads would be involved, [those] who didn't know how to provide a good environment that they would have intense supports during that time. Anything you do for families to support them at a very broad-based level is what you need to do. ... the Ministry just runs on a shoestring and the kind of things that people need they are not in a position to provide. (RN₇)

Wise (2009) aptly points out that “[c]hildren are poor because their parents are poor” (p. 1063), but constituted as their irresponsible parent’s problem, they continue to be denied provisions and services.

Nurse participants empathised with families and imagined how painful it would be to feel responsible yet unable to prevent their own child’s suffering.

If your diapers cost a lot of money, you leave the diaper on a bit longer, and now the child has a big diaper rash, and the diaper rash opened up and now they have a bacteraemia and are in hospital. And now, by the way, they are failing to thrive because you can’t afford formula, all those sorts of things. Is that active neglect or is that a product of what that family’s limitations are and they are doing the best they can? And are those different? (RN₅)

The final question of this passage directs attention back onto social and state responsibility.

These ideas are furthered by another nurse,

I think finances have a huge role in it. ... Maybe mum and dad are just as neglected because they are trying to spread thin every little bit that they have. ... we all need to have a roof over our head, we all need to eat, and it sure as heck would be nice to go to a movie once in a while or do something like that, right? ... When families are under pressure not knowing where that next meal, or if they will have a place to live next month or if they do have a place to live it is horrible, or not what they ever envisioned for themselves.

... you feel alone ... and kids screaming. I have my own kids and there were a few times when they were babies if they were colicky or whatever, that I thought I was going to lose my mind. And I didn't have the stress financially. ... when they have that and a pile of bills right there and they are hungry, because they haven't eaten and they have worked all day. ... It could happen, right?

I don't know why, we see a lot of them are on welfare. ... a lot of them are Native and I don't know why that is either. (RN₁₁)

Hedging at the end, this nurse claimed not to know why children from families who are marginalised suffer disproportionate amounts of violence, despite a carefully argued case that meeting the needs of children independently is too difficult for anyone amidst social isolation, hunger, racism and other stresses.

The concentration of responsibility and unrealistic expectations of parents are part of the techniques of power, and a mechanism to maintain the social order. Another participant explained,

Lack of education, lack of financial needs, not being able to support your child, like the bare minimum ... feelings of guilt ... it just eats at you. ... and then the anger sets in ... so this person [child] is depending on them and they can't deliver it. ... they feel like a failure. (RN₂)

Trying to make sense of the cycle, these nurses draw on common-sense notions that link parental stress causally with CN&A. Making the connections between structural violence and its more spectacular forms shows how this is not the case. It is the final contribution to

examining the first rule of the game, where the legitimisation for the deferral is contextualised by a socio-historical perspective. By contextualising the problem, I aim to disrupt common-sense notions, including the *causative* relations between social marginalisation and CN&A. Instead, tracing how *The Responsible Family* operates offers a more critical appreciation for relations of power and domination and shows the nuanced ways in which violence renders parents unable to protect themselves or their children.

The production of The Responsible Family: governing in modernity

Tracing the figuration of *The Responsible Family* from production in modernity through its transformations in our post-modern era offers insights into the first rule in the game of deferrals. *The Responsible Family* supports liberal state governance and abdication of responsibility for assisting young families. This analysis illustrates how state interventions into the families are discriminatory, built on class divisions that offer temporary solutions to social inequities and solutions that cover the state just enough to prevent social outrage at injustices for children.

The Responsible Family's first shadow is seen at modernity, when the shift in power from a monarchical to liberal government required new techniques of regulation. Capital market production needs labourers, which fostered state interest in family and sexual relations; it was “at the juncture of the ‘body’ and the ‘population’, [that] sex became a crucial target of power, organized around the management of life rather than the menace of death” (Foucault, 1976/1990, p. 147). Prior to this time, sexuality and eroticism were not topics of interest as they are today, they were overt and considered integral to the family and the preservation of life. Family bonds were corporeal, intergenerational and related to

genealogy rather than legal or religious (J. O'Neill, 1994).²⁷ Regulation of kin relations was initiated by the state, required when the economic unit was redefined as the individual (or family) instead of the village, and when accumulation and transmission of private property began (Zaretsky, 1976). Regulating marriage is a recent interest of Christianity. Until modernity, sexuality and family relations were regarded as obstacles to spiritual life and encouraged celibacy (along with the transfer of property to the Church) (Hill, 2012).

In Ancient Roman and Greek society, men embarked on a civilising agenda focusing on arts, culture and politics. While valued for sustenance, women were associated with their own fertility and that of the land, thus they were relegated to a lower status and considered closer to the animalistic aspects of humanity (J. O'Neill, 1994). Under the law of *patria potestas*, the father was accountable for and held discretionary power over his family, including decisions to care for or abandon infants at birth (Donzelot, 1979, p. 49). Enlightenment challenged these paternalisms with its romantic notions of childhood innocence and discourses of individual rights and freedoms.

Initially, capitalism and its value for re/production meant improvements in status for women and children, but these improvements were short-lived. When industrialisation moved production into the factory a gendered boundary between public/private work was drawn. Work in the home became constituted by discourses of altruism. A concurrent rise in proprietary relations meant that women, and their childbearing potential, began to be understood as a part of the family's *property* (Zaretsky, 1976). A similar proprietary relation

²⁷ Families of ancient society were founded around the covenant and an intergenerational duty to care for their dead. The family hearth was sacred because it was also a tomb. At the hearth, the fire was tended and meals were cooked to share across generations, to preserve life (J. O'Neill, 1994). "[W]hat made families private was not the intimacy of the conjugal union but the ... grave ... it was the domestic gods and not the living, labouring individual who had the rights over the land" (J. O'Neill, 1994, pp. 57-58).

emerged over children. The family continued to host “economic functions for capitalism: reproduction of the labour source, socialization of children, exploitation of the unpaid domestic labour of women, [and] compensation to men for the alienating nature of their work” (Rose, 1999, p. 126). The family was set up as a private unit separate from society, amongst a resurgence of patriarchal forces that isolated women and children in the home (Rose, 1999, p. 126).

The constitution of the family as a private domain is so entrenched in the liberal ideology of contemporary society that mandatory reporting legislation was required to justify intrusions.

[L]iberal states value the family as both the primary source of socialization, and the ultimate location of responsibility. Families are both the final bastion against state interference, and the primary means by which affective relations are installed and promulgated. The child protection project is also informed by the traditional European notion of children as possessions of their fathers. Hence, to remove a child from its family is amongst the most serious actions a state can take. (Cradock, 2007, pp. 21-22)

The figuration of *The Responsible Family* grounds the discourse of least intrusive child protection practices. It also sets the conditions under which concerns about all but the worst forms of violence in the home may be overlooked.

Technologies of the 'self' and the government of children through the family

A second divide between personal/work life followed the divide between private/public life. The idea of a 'personal life' and a 'self' is a modern one, initially only available to those with social privilege. These ideas proliferated across society during the 20th century, recognisable today in the current parlance of work-life balance. The breakdown of geographical and intergenerational bonds left the proletariat with a loss of identity that was not replaced by property or a skilled vocation, as it was for the bourgeoisie. Extricating personal life out of work life promoted the idea that "the search for happiness should be limited to our 'personal' relations, outside our 'job' or 'role' within the division of labour" (Zaretsky, 1976, p. 31). Thus, "under capitalism an ethic of personal fulfilment has become the property of the masses of people, though it has very different meanings for men and women and for different strata of the proletariat" (Zaretsky, 1976, p. 30).

Obscuring its production in and connection to the social, personal life spawned its own 'sciences', most notably psychoanalysis and psychology. But psychology and psychoanalysis distort our understanding of personal life assuming that it is governed by its own internal laws (for example, the 'laws' of the mind or of 'interpersonal relations') rather than the 'laws' that govern society as a whole. (Zaretsky, 1976, p. 31)

The idea of the 'self' has supported state governance of individuals (Rose, 1999; Zaretsky, 1976, p. 30). Optimisation of the populous' personal lives became a key political mechanism

by which the state could participate in intimate details of family life, if not directly, but through professionals' health and educative initiatives.

Foucault outlines how sex became a 'lynchpin' of power within this new social order, where norms and taboos offered a mechanism of indirect state governance through the family (Donzelot, 1979; Foucault, 1976/1990). It was "four great strategic unities which, beginning in the eighteenth century, formed specific mechanisms of knowledge and power centring on sex" (Foucault, 1976/1990, p. 103). These unities reinvigorated a patriarchy that was established in Ancient times and institutionalised during capitalism through: psychoanalytic hysterisation of women; medicalisation of women's bodies, sex and reproduction; and problematisation of children's sexuality (Foucault, 1976/1990). Romantic discourses of childhood innocence and market discourses of capital, constituted children's sexuality as precocious, corrupting and unproductive. Fantasies of pathology, social health and hygiene described children's sexuality as a threat to their later reproductive capacity. All children were seen as vulnerable to indulging themselves and thus in need of preservation, for society's sake.²⁸

Since the shift to modernity, damage to intergenerational bonds and an embodied covenant between parents and their children has eroded family power and opened it to uses of the state.

The modern family is not so much an institution as a *mechanism*. ... Its strength lies in ... coupl[ing] an exterior intervention with conflicts or differences of potential

²⁸ By denying children's sexuality and forbidding it, the force of power relations around children's sexuality intensified constituting children as objects of desire (with that desire being for power rather than sex) (Foucault, 1976/1990). Foucault considered desire as productive and generative, instead of constituted by lack (Schrift, 2000), thus children's sexuality has been both solicited and refused in a way that has made them subject to exploitation and prohibition (see Chapter 5).

within the family: the protection of poor children which allowed for the destruction of the family as an island of resistance; the privileged alliance of the doctor and the educator with the wife for developing procedures of saving, educational promotion, and so on.

... A wonderful mechanism, since it enables the social body to deal with marginality through a near-total dispossession of private rights and to encourage positive integration, the renunciation of the question of political right, through the private pursuit of well-being. (Donzelot, 1979, p. 94)

Granting future citizens access to a good family life allowed the shift to internalised governance by the family (Rose, 1999, pp. 159, 171). The goal was to “govern the family such that it could become an educative institution that would school the new generation in the values, conducts, and skills of citizenship” (Rose, 1999, p. 159). With the support of psychologists, physicians, teachers and religious leaders, it was mothers who were given authority in domestic affairs and assigned the responsibility for children. “The dependence of the social order on the proper socialization of children implicitly elevated the nuclear family and, more especially, the role of women as stalwarts of the family” (Platt, 1969, p. 27). Thus, the figuration of *The Responsible Family* often connotes the mother.

The Responsible Family became a site of collusion between feminist and anti-feminist agendas that were instrumental in achieving a limited type of emancipation of middle-class women. As described in Chapter 3, early child-saving initiatives that addressed the plight of the poor, risky and recalcitrant offered prestige for philanthropists and missionaries and produced a profession for women (social work)(Donzelot, 1979; J. O'Neill, 1994; Platt, 1969). In a mechanism similar to current initiatives in BC, “‘problem’ mothers

were targeted for early intervention that included home visits by nurses, clinical social workers, and child welfare workers” (Scheper-Hughes & Stein, 1987, p. 339). The aim of these visits was

not to ‘preserve’ families of the urban masses ... but to organize the conjugal, domestic, and parental relations of the poor in the form of the domesticated family. Assistance was thus conditional upon marriage, good housekeeping, sobriety, moral supervision of children and the search for wage labour. (Rose, 1999, p. 129)

Indirect intervention shielded the liberal state against criticism or revolt regarding the rising social inequity.

After World War II, western states deployed hegemonic idealisations of family life in aim to shift women back into the home to create workplaces for the returning soldiers (Rose, 1999). Marriage was reconstituted as an affection-based contract of love and free choice, loosening it from paternalisms. Romantic discourses encouraged women to take up their roles “under the guise of love and duty ... naturally wishing to have and to cherish its children, the site of self-realization for mothers and of mutual regard and protection of family members” (Rose, 1999, p. 126). As domestic goddesses, some women enjoyed an elevation in social positioning, but only as mothers. The emancipation of women by way of increasing their authority within the home “failed fundamentally to challenge either the patriarchal separation of realms, or the economic power that men wielded over the family unit” (Rose, 1999, p. 127). Instead, it “legitimated the authority of men in the household over both women and children, and obscured the extent to which the state actually shaped

and controlled relations in the intimate sphere for public, political ends” (Rose, 1999, p. 126).

Freud’s psychoanalysis inscribed importance to the minutiae of mother-child relations and by the mid-1900’s psychoanalytic theories of infant attachment and object relations influenced assessments of mothers and initiated the regulation of mother-child relations. Supervision and manipulation of these relations were thought to pre-empt adult disorders and was “prophylactic and pedagogic as much as reactive and reformatory” (Rose, 1999, p. 159). Love, both too little and too much, was constituted as the medium of delinquency and abnormality (Rose, 1999, p. 159). Loving relations between parents and their children were even constituted as the origins of CN&A by Kempe (1971), the same physician who diagnosed *The Battered Child Syndrome*: “battering parents generally love their child, often not very well and perhaps too much” (p. 32).

The constitution of adult psychopathology and CN&A as an individual failure of the mother also discursively preserves an image of society as safe and caring. This discourse of psychopathology contradicts but coexists with the discourses of family relations as natural and private. These contradictions preserve both the power relations over and within the family, state and society, and the discursive mechanism for absolution of social responsibility for children. They can be used to legitimise either intervention or non-intervention; a mechanism to satiate the “overwhelming social desire to get involved in selective and intrusive ways” (Einboden et al., 2011, p. 12). The mother’s power was usurped almost the same moment it was found. The ideology of the family “masks the realities of family life” (Rose, 1999, p. 126). As responsible, mothers are set up and used to preserve the image of safety within a violent society. When a child is harmed she is the primary suspect, it is her duty to protect the child, after all. Contemporary examples abound

of how the violence required to maintain the inequities of the social order is contained by the scapegoating of mothers: she is sacrificed and the social is cleansed (e.g. Einboden et al., 2011, p. 11).

The artificial separation of parents' interests from those of their children

Suspicious about mothers are entrenched by child rights discourses where “a child–parent dichotomy is formulated in terms of ‘parental responsibility’” (Reynaert et al., 2009, p. 524). As discussed in Chapter 3, child rights discourses are rooted in individualisms that constitute parental needs/interests as if they were separate from or in tension with those of their children. The *UNCRC* (1989) demonstrates this tension in Article 3: “*States Parties undertake to ensure the child such protection and care as is necessary for his or her well-being, taking into account the rights and duties of his or her parents*”. State mistrust of parents legitimises state control over decisions about children’s best interests and protection. “The flip-side of children’s rights discourse is the pathologisation of adulthood” (Pupavac, 2001, p. 100).

Liberty is always contradictory and rhetorical in the context of kin relations because it does not appreciate the sociality and corporality of humanity, the birth of an individual always bears the signification of the family because “nobody enters the world except by means of another body” (J. O’Neill, 1994, p. 54). Discourses of parental rights have surged in reaction to perceived threat of state power,²⁹ which have fuelled paternalisms and relations of power over children fail to appreciate alignment of the needs of children and their parents, especially their mothers (Burman, 2008a).

²⁹ The discourses of parental rights are used to oppose ratification of the *UNCRC* in the USA, with the parental right to use corporal punishment as discipline at the crux of the debate (for instance www.parentalrights.org).

Contractual bonds, saturated in idealised discourses of love and affection have led to disillusionment and divorce. With little control over family resources, women and children suffer disproportionately. For the family, divorce is a

loss of a potential intergenerational turn, a failure to transcend the contingencies of two-person love and hatred ... [and] the reduction of the family resources that underwrite intergenerationality.

The indivisibility of the child is the limit of the contract model of family. Indeed, the child can only be inscribed in the contract family through rights discourses that preserve the adult ideology of individualized membership in consensual and revisable contracts. From this standpoint, the child is conceived as the freely chosen by-product of a sexual apparatus. (J. O'Neill, 1994, p. 54)

The notion of the child as a by-product of the family is extended by reproductive technoscience that has opened women's bodies through fusions of political and market forces. "[A]rtificial families" erase intergenerational ties and constitute human life as body parts that supply reproduction (eggs, sperm, surrogate wombs) and their products (embryos, fetuses, infants) (Haraway, 1997, p. 223). Imaging technologies present the fetus amputated from its mother. Within a visually dominant culture, these images support a discourse of foetal rights and constitute the mother's body as potentially dangerous and inhospitable, in need of surveillance and manipulation (Stabile, 1992). Possessive individualism and discourses of ownership of life have reinforced artificial divisions of the mother from the fetus/infant/child (Franklin, 2000; J. O'Neill, 1994; Stabile, 1992).

“[L]ife itself — is a capital accumulation strategy” (Haraway, 1997, p. 65). Amidst market forces,

a bio-proletariat will supply body parts and foetal by-products — of which the latest are ‘designer babies’ and ‘retirement pregnancies’. Here market mothers are served at the price of the extinction of a fetal mother to produce babies whose intergenerational history has been erased. (J. O'Neill, 1994, p. 63)

The organisation of life can no longer be traced through linear bloodlines, it has been respatialised, in a way Franklin (2000) describes as akin to rearrangement of “magnetic letters ... [on] refrigerator doors” (p. 218). Sexual reproduction has been “rendered insignificant by the advent of assisted heredity, clone transgenics and the entire millennial menagerie of unfamiliar kinds. ... All of that became old-fashioned when genealogy was replaced by the gene pool” (Franklin, 2000, pp. 218-219).

As in Chapter 3, child rights discourses are again shown to work paradoxically; not only do the most vulnerable children who lack agency to assert their rights have the most vulnerable parents who are poorly positioned to do so, constituting parents as responsible allows the state to turn away from these children (Chandler, 2002; Pupavac, 2001). The figuration of *The Responsible Family* helps contextualise why it is that CPS is not set up to support families with what they need. A lack of family resources complicated by poverty, disability or mental health is handed down to children by way of unrealistic expectations of their parents. Unrealistic expectations are violent. They erode parental self-esteem and render parents “*apathetic and ... powerless themselves*” (RN₁₀). Positioning families as responsible justifies turning away from children and families who require support.

The consumption of The Responsible Family: justifying inadequate resources

The awful consequence of positioning the family as responsible is that many children are left without adequate support and protection. Built on liberal assumptions that most families can and will protect and provide for children, the CPS has continued inadequately funded since inception. Given the prevalence of CN&A, this funding structure has always been inappropriate for its case-by-case approach. The RCY (2015) describes the chronic underfunding of BC's CPS:

child protection workers deal with extremely heavy workloads caused by a steady stream of incoming reports of child safety concerns ... resulting in a lack of adequate services and protection to the children who need it most. As this report shows, these findings are confirmed by MCFD's own data. The B.C. government has known about these issues for years, yet has not made the necessary budgetary commitments ... Child protection social worker positions remain unfilled because these vacancies have become one of the only ways managers can control budget expenditures. (p. 2)

Concerns about the mismatch between the funding and approach have been longstanding and has also been articulated by CPWs (Bennett et al., 2009) and families (Bennett & Sadrehashemi, 2008). The failure of the BC government to respond could more accurately be framed as a strategic refusal rather than an omission.

Findings from a survey of former BC CPWs found that they left the MCFD as a "result of the frustration they felt for being unable carry out their work effectively or ethically" (Bennett et al., 2009, p. 8). The results detail some of their concerns, which support a

deeper understanding of the system to which nurses are required to report.

Respondents spoke with passion and dismay about a feeling that they were not able to do the type of preventive and supportive work that they thought they were signing up for when they were hired by the MCFD. ... *“MCFD employees are institutionalized to think, act and respond in ways which are unethical, disrespectful and damaging to the families we are meant to care for.”* Survey #55

... in most cases respondents explained that services were simply not available: *“The lack of resources for families and in particular women and babies was awful – the role was essentially to enforce the status quo and punish families for being poor.”* Survey #2

... lack of services often leaves removal as the only viable option: *“The reality of child protection is taking kids away, and posing as a support to the family. You are too bound to offer any real support and can only tear families apart.”* Survey #34

(Bennett et al., 2009, pp. 8, 12, emphasis in original)

Poor resourcing results in prioritisation of the most extreme cases and extreme responses (see Chapter 5), leaving the remaining cases to progress as resources allow. The MCFD's threshold for intervention fluctuates with the timing, number and severity of reports and resources within each office to respond.

Poor resourcing and high staff turnover means fewer services. For the girl in the *Lost in the Shadows* report, a lack of human resources meant the regional MCFD office was dysfunctional and unable to help her.

Between October 2008 and May 2011, there were at least three staff members [out of a team of 7] on significant leave every year due to illness or disciplinary action.

The office environment at the time was described as “toxic”. The team leader ... left her job in the spring of 2010 due to stress and exhaustion. Her departure came just prior to the termination with cause of two suspended employees,

... [A CPW] described it to the Representative’s investigators: “... *it just was kind of a revolving door of different acting team leaders ... I basically show up at work one day and I had no team... I was basically doing delegated work as an undelegated social worker for many months ... there was no plan in place to deal with the fact that, you know, you had one undelegated social worker covering the [entire First Nation] ... I was covering my own caseload, I was covering vacant caseloads, and just sort of whatever was coming in*”. (RCY, 2014, p. 70)

The relationship between this MCFD office and the First Nation it served were tenuous. Retention issues meant relationships were not developed. Further, discriminatory processes of the MCFD and its legacy of colonialism continue to plague the CPS and set up resistance from Indigenous communities whose children are subject to the relational aftermath of generations of abuse within genocidal state projects (prisons, schools and foster homes). Attempts to provide less intrusive care have resulted in isolation and poor access to care. The *Lost in the Shadows* report depicts how the girl experienced isolation, bar a few thwarted attempts to visit her by CPWs, and lack of access to badly needed mental health services. This extends the systemic violence described in Chapter 3, where services for Indigenous children diverged from BC’s settler children.

MCFD offices are required to serve large geographically isolated areas without appropriate levels of staffing or expertise (Bennett et al., 2009). Without decision-making authority junior CPWs, who travel long distances to meet with community leaders and families on reserve, are left impotent and vulnerable themselves. A CPW explained, *“it is hard to go, ‘Can I borrow your phone? Then I’ll tell you why I’m knocking on your door’”* (RCY, 2014, p. 70). For the CPWs, the legacy of colonial violence meant that they faced personal threats and were afraid of visits on-reserve. The RCY (2014) cited a CPW saying: *“I’ve had a hunting knife pulled on me, I’ve had a gun pointed at me out there”* (p. 69). Relations of power mix in ways that provoke emotionally charged responses. Although nurses hold less power over families they too have engaged in colonial practices and oppressive relations. A participant recounted how,

... everyone knows who you are, it's a very small community. ... [the nurse] was woken up and there were all these guys drinking on her front lawn and banging on her door. And she is the only person [in the house]. Well, the police are on call at night and they are at home in their bed. As soon as they get the call they get dressed as fast as they can and go. But the damage is done, right? So, there is a sense of safety, personal safety as well. People have a lot to balance out. (RN₂₁)

In the context of a CPS that can leave both nurses and CPW vulnerable to violence, decisions regarding both reports and responses are always made within the responder’s personal power and circumstance. Thus, like mothers who are unable to protect their children, even when the key players are present and aware, they may not be in a position to address violence, or even report it.

Despite underfunding and pervasive retention issues across the CPS, the MCFD continues to claim authority for child protection decisions. Despite a demonstrated lack of capacity, MCFD authority and decisions are rarely challenged. Concerns about a child are easily squelched by an understanding that a child is 'known to the ministry', a trope introduced by Judge Gove in the investigation of Matthew Vaudreuil's death (see Gove, 1995). Cradock (2007) describes:

This child may have had very little contact with the ministry but insofar as contact had been established a kind of responsibility 'creep' had taken place. This 'creep' had been exacerbated by the activities of the Children's Commission whose investigations covered all child deaths and therefore any circumstances under which a child might have been "known to the ministry" with a corresponding expectation that such knowledge ought to have prevented a child's death. (p. 20)

For the girl in the *Lost in the Shadows* report, multiple reports might have gained the attention of the CPWs who remained on staff. And yet, repetitive reporting about concerns for the same child is not the usual practice of health care professionals. As described in Chapter 3, CN&A concerns are discussed as a team and designated experts (usually the hospital social worker and/or physician) make the decision to liaise with the MCFD on the nurses' behalf. This internal process prevents duplication of work. Reducing multiple provider concerns into a single report has triage implications for the MCFD, and creates culture within nursing of deferring reporting to others, who are considered the experts. Concentration of authority onto the CPWs sustains the game, played out across service providers, where all child protection interventions (except reporting) are kept in the domain

of the CPW who is poorly resourced and often ill-prepared or absent.

Rule #2: Limit the nurses' role in child protection to reporting

In the final part of this chapter, I examine nurses' legal obligations and practices in relation to CN&A. First, I consider how the primacy of reporting coordinates a series of deferrals between the nurses and the MCFD in practice, drawing on examples from the *Lost in the Shadows* report and interview texts. The texts offer examples of how nurses complied with or ignored their reporting obligation, and how nurses often intervened to address the issues themselves. They followed a systematic approach used across nursing practice. Nurses assessed the child and family in context, planned and implemented interventions to address the roots of the problem, then evaluated the effects of their care. Building a trusting relationship with the family was essential to their effectiveness because it granted them access to the private sphere of the family to assess the situation, cooperation of the family with interventions, and access to evaluate the situation. In many instances, mandated reporting was perceived by nurses as an obstacle that undermined their ability to keep children safe because it jeopardised this essential relationship. Thus, nurses described it as a last resort when they found their own interventions to be ineffective. In the final part of this section, I share nurses' disillusionment with MCFD and the game of deferrals they are pressed to play. Finally, I show how this game of deferrals was played at all levels of the system, including by provincial leaders for nursing practice (CRNBC and the RCY).

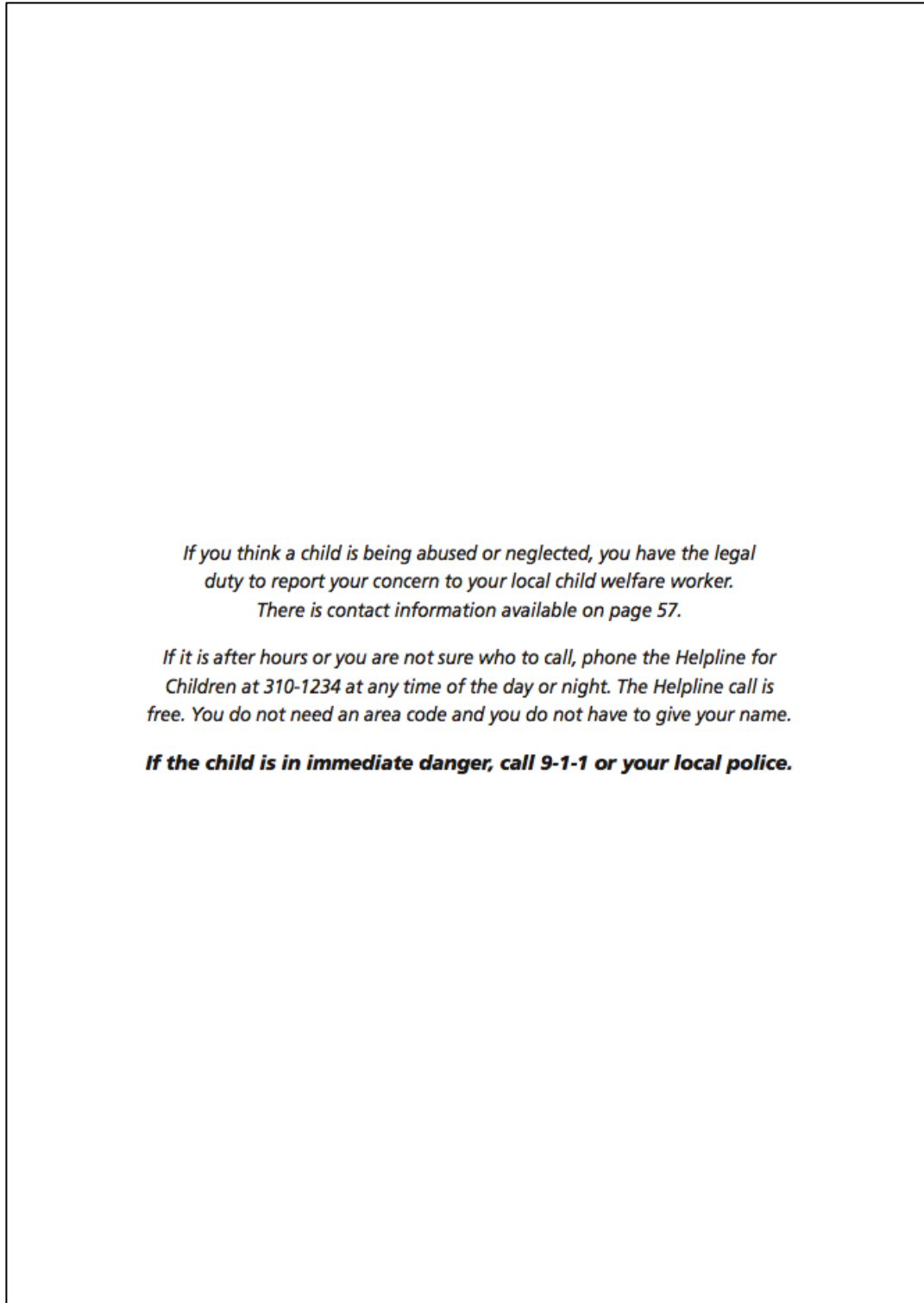
Reporting as 'Action' in the legislation and practice guidelines

As set out the *CFCS Act* (1996) and described in detail in Chapter 3, all BC citizens have a duty to report "*reason to believe that a child needs protection*". The report initiates state

involvement in what has been socially defined as private family matters. Any CPS response hinges on these reports, and thus unsurprisingly, Part 3 Child Protection of the *CFCS Act* starts by describing the process of *Responding to Reports*. Reporting to the MCFD is the only statutory duty for BC nurses in response to CN&A. Following the *Act*, *The B.C. Handbook for Action on Child Abuse and Neglect*, for service providers (*The Handbook*) also constitutes recognising and reporting suspicions of CN&A to the MCFD as the “*Action*” of child protection for all service providers, including nurses. It asserts that their “primary role is to support the child, gather basic information and report it to a child welfare worker as quickly as possible” (MCFD, 2007, p. 37).

The Handbook reiterates the duty to report in a short excerpt that is repeated on seven otherwise empty pages (see Figure 6). Repetition is a discursive technique, and it is noted here as a mechanism that underscores the primacy of reporting. Although participants were invited to identify a resource that supported their practice and bring it or a reference to it to the interview, few resources were identified (see Chapter 2). *The Handbook* was the most commonly identified resource, yet only six participants mentioned it. One participant touted it as the nurses’ “*bible*” (RN₂₁) for responding to CN&A but at the same time claimed that “*new grads did not know about it*” (RN₂₁), and described it as “*overwhelming*” both in length and content, and requiring further interpretation to apply to practice (RN₂₁).

Figure 6 The BC Handbook for *Action* on child abuse and neglect: *for service providers*



If you think a child is being abused or neglected, you have the legal duty to report your concern to your local child welfare worker.

There is contact information available on page 57.

If it is after hours or you are not sure who to call, phone the Helpline for Children at 310-1234 at any time of the day or night. The Helpline call is free. You do not need an area code and you do not have to give your name.

If the child is in immediate danger, call 9-1-1 or your local police.

(MCFD, 2007, pp. 4, 7, 10, 22, 36, 42, 56)

The primacy and constitution of nurses' responses to CN&A *as reporting* was also reflected in the *Lost in the Shadows* report. A 'Key Finding' of the report reads:

Failures by Health Care Professionals to Report a Child in Need of Protection:

Health care professionals who were involved with the family, including physicians, repeatedly failed in their duty to report child protection concerns to the ministry, as required by s.14 of the CFCS Act, when a child is in need of protection as set out in s. 13. The failure to recognize the risk to the girl posed by the mother's mental illness is inexplicable, particularly in circumstances such as these where the mother was repeatedly experiencing auditory hallucinations directing her to harm her children. Failure to report is an offence in the CFCS Act that should be enforced. Children's lives depend on it and no prosecutions for this offence have occurred in many years. (RCY, 2014, p. 73)

The report recommends reminders about reporting legislation and serious consequences for professionals who fail to report.

Recommendation 5:

5(a) That the College of Physicians and Surgeons of British Columbia and the College of Registered Nurses of British Columbia inform their members of the findings of this investigation with respect to reporting a child in need of protection, and **remind** their members of their statutory responsibility to report pursuant to s. 14 of the Child, Family and Community Service Act.

5(b) That the Attorney General of B.C. Review the reasons for a lack of enforcement

of the CFCS Act in the province and take steps to promote compliance, if necessary.

(RCY, 2014, p. 89, emphasis added)

As noted in Chapter 3, the CRNBC identified *The Handbook* as a resource for nurses in response to the RCY prompt to remind professionals (Johansen, 2014). After considering the nursing practice from the *Lost in the Shadows* report and this study's interviews in this next section, I return to discuss these findings and recommendation in more detail at the end of the chapter.

Beyond reporting: nurses' child protection practice

Despite the primacy of mandatory reporting to child protection, nursing and health literature confirm a widespread non-compliance by health care providers internationally (e.g. Eisbach & Driessnack, 2010; Fagan, 1998; Feng & Levine, 2005; Gilbert, Kemp, et al., 2009; Jones et al., 2008; Mathews et al., 2008; Nayda, 2002, 2004). The *Lost in the Shadows* report recounts a blatant disregard for the *CFCS Act* by nurses who repeatedly failed to report documented concerns for the girl's safety to the MCFD for years.

At least 16 community and hospital nurses were involved ... documents confirm that the health care professionals were aware of the mother's risk of harm to her children and the chaos in the family home. The mother's severe psychotic symptoms included command hallucinations to harm the girl and these very real risks to the girl's safety were overlooked by medical professionals. None of these risks were reported to the ministry with the exception of one instance. (RCY, 2014, p. 74)

The lack of compliance with reporting is not well understood. Existing literature tends to describe it as either an inability to recognise CN&A or a lack of appreciation for the significance of CN&A on child well-being (e.g. Chihak, 2009; Fraser et al., 2010).

In a Lancet review, Gilbert, Kemp, et al. (2009) note that:

scarce reporting to child-protection agencies is a cause for concern, and we need to find out whether maltreatment is being recognised and dealt with in other ways.

Doubts are widespread that the benefits of reporting suspected cases of maltreatment to child-protection services outweigh the harms. (p. 176)

These authors acknowledge that child protection activities likely go beyond legislated state reporting and are curious about those activities. The nurses I interviewed identified reporting as their legislated duty, but one that was *separate* from their child protection interventions.

Nursing Assessment: exploring the roots of the problem

As discussing in Chapter 3, legislation constitutes CN&A as if it were straightforward, but an understanding that a child is unsafe often unfolds over time. The more time nurses spend with children and families, the more they get to know them, and the more they are able to identify and address safety concerns. Any professional could do the same, but nurses have a few distinct advantages: presence; relational practice; and social position. The nature of nursing work means that nurses gain important insights from spending more time with families than other health professionals. Nurses are

able to just sit back and listen and ... ask some of the right questions. And avoid the 'if this is child abuse there are four symptoms' ... maybe when they feel comfortable they will start talking about what it is like to actually be them, and how they might be suffering abuse. Um, and how they see that or don't see that. ... and if you have been with them for a while sometimes you can see some ways in, to start talking about how you are worried for them, and maybe you know, push a little bit, the envelope to say, 'have you ever thought of how this might not be okay for you?' But ... it's not something you do in the first day with somebody ... more often it is slow, things come out in the wash you know, after you have sat with someone for a while and got to know them a little bit, and tended their fungus on their toe and things like that. (RN₇)

Nurses aim to understand patients' lives and are most effective when they align their efforts with their patient's specific needs. They are experts at building relationships and work *through* these relationships. Despite the pressure of reporting legislation to hand off concerns of abuse to the MCFD, this nurse identified how in most cases a more appropriate response to their suspicions would be to build trust, assess what is happening over time, create space for the child's voice to be heard and validated, and support the child to develop an understanding of abuse and a challenge to it. This approach resists the child's subaltern position and creates space for agency, which offers protection in the long-term.

They hold more power to monitor and address safety issues for the child from inside a non-threatening alliance with the child and family. Their position means that,

nurses are non-threatening ... so families will open up. They will talk about their

frustrations, their hurdles, their barriers, different things like that without feeling like they are going to be judged or condemned or anything like that.

... People don't like ... asking questions to doctors because they feel like they [doctors] are going to think that they are dumb, they don't want to ask questions to social workers because they are going to judge them, so they keep a lot of things hidden.

... I find that a lot of families will take feedback from nurses, and ask questions, delve deeper ... much quicker because it's a longer-term relationship - doctors are busy. Nurses? Well, we've got you for 12 hours [and we] ... want to know the nitty-gritty. (RN₁)

While nurses do hold some authority over families, the power they hold is indirect. A nurse participant described a situation working in a community role where the family was facing apprehension of their child, after repeated reports to the MCFD for medical neglect and school truancy. The family was not managing their child's diabetes safely. This nurse identified the family's lack of understanding of the gravity of the situation and engaged with them to support management their child's illness as was expected by the physicians and schoolteachers. After a year of ongoing support, the child's diabetes stabilised and the nurse planned a discharge meeting with the father and the CPW. It was first time the three of them had met together. Despite this nurses' respect for the CPW whom she described as *"very professional ... objective and neutral"* (RN₁₇), she witnessed how the CPW embodied the power and apprehension threat of the MCFD in a way that interfered with the father's ability to engage to plan care productively.

When I met with the family, the father for the final time, and the social worker was there, he was different. His back was up. And ... he couldn't even breathe. ... he said 'so you are not going to take my kids from me?' ... at that moment I realised that MCFD sometimes ups the ante. They are there to help the family as well, but ... they would have not been able to communicate, the father was completely, he just couldn't breathe ... the reason that things were able to work with me ... is because there is trust and there is a relationship. So, it could have been another nurse too, but it is all about that trust. ... I felt like he never had his back up with me. (RN₁₇)

MCFD practices and power are threatening even to confident parents, in part because of the expectations of *The Responsible Family*, and in part because of the legacy that haunts the MCFD.³⁰ This nurse participant described how regardless of how supportive CPW could be, that person *represents* the MCFD. The CPW does not have the same opportunities that nurses have to appreciate the situation in a nuanced way. The reputation of the MCFD and other state child protection institutions precede the worker in ways that block their ability to help families.

The nurses interviewed in this study described how what helps them work effectively is that they hold *less authority* over families. Authority undermined the ability to build trust with families. One nurse described feeling like “*a middleman. You are relatively powerless and relatively powerful, it changes all the time, it's very dependent*” (RN₁₉). Using

³⁰ As discussed in Chapter 3, as a state child protection institution the MCFD has a reputation as for imposing middle-class values and perceptions of appropriate child-rearing on impoverished families (Platt, 1969; Stokes & Schmidt, 2011); removing Indigenous children from their families and communities with genocidal intent (Landertinger, 2011; Thielen-Wilson, 2012); poor treatment of children while in custody (Morely & Kendall, 2006; RCY, 2013); and causing more trauma through iatrogenic effects of processes of protection (Cradock, 2014).

the middle pronoun “you” when the nurse meant “me” or “I” further highlights her position in-between and feeling of powerlessness. Reporting or enlisting the CPW for funding support is a precarious activity because nurses have no control over the decisions of the CPWs and cannot reassure the family about the outcome of contact. Most of the nurses interviewed for this study did not describe CPWs as collaborative or collegial. Instead, they described being side-lined as those considered CN&A experts (CPWs, hospital social workers or physicians) took control of the matter. Nurses were rarely thought to have valuable knowledge or expertise.

Nursing Intervention: addressing the roots of the problem

Providers with continuous relationships with children and their families are well positioned to identify abuse but scarcely report (Gilbert, Kemp, et al., 2009). In a study of 434 primary care clinicians, mandatory reporting practices were influenced by relationships with families, their own plans to manage issues, as well as their perception of what might best benefit the child (Jones et al., 2008). When clinicians could do something about the situation they preferred to act instead of report (Jones et al., 2008). A participant from this study similarly explained that reporting is considered after exhausting other options.

I've never reported on a child that is a consistent client of mine. I've made a couple of reports ... [from] clinic visits, just in and out no long-term contact because when you've got the long-term relationship with the client ... and it's not intent of the parent, I don't think, to hurt their child in whatever way, it's due to lack of services and lack of help.

... [In those cases you] can address some of the underlying issues ... especially when calling the protections people doesn't seem to help. You know, if there was really concrete, 'yeah I think that this child is in immediate danger', then I might call, I would call, but when there is something actually proactive that can be done about the situation they are not my first choice. (RN₈)

Nurses caring for the family in the *Lost in the Shadows* report recognised the safety risks to the girl, communicated their concerns for her and her sister, and formally appealed to colleagues for help through nursing documentation, referrals and letters. An excerpt from a letter that was written to an emergency physician by a nurse reads:

Parents are afraid she will harm them so they are also sleep deprived and anxious, while trying to look after the grandchildren. No help from the Child Protection Community, although they [grandparents] have spoken with various staff. Patient has verbally said, 'I am being told to kill my daughter'. (RCY, 2014, pp. 36-37)

The nurse identified the girl as 'known to the ministry' and accepted their inaction as beyond her control. The MCFD was regarded as one of various possible options to help the family, and the nurse moved on to seek more viable options.

In this case, the nurses had spent enough time with the family to appreciate that the threat to the girl was not the mother herself, but the mother's untreated psychosis. The seriousness of the safety issue was clear because the mother experienced "auditory hallucinations [that appeared] in the form of voices telling her to either hurt herself or her daughter ... The voices would at times swear at her or say, referring to her daughter, 'snap

her head” (RCY, 2014, p. 75). A literal interpretation of these hallucinations depicts a sinister intent by the mother to murder her daughter. However, most people who experience auditory hallucinations are tortured by their own symptoms; they too are horrified by the instructions of the voices. Psychosis can be rooted in fears and anxieties, and another way to interpret the mother’s hallucinations instructing her to hurt her daughter is a deep insecurity about *her own ability to protect her daughter*. When she was 20 years old 6 months pregnant with the girl and struggling with depression, she contacted the MCFD³¹ to “discuss placing her unborn child for adoption. ... Records indicate that the mother declined band involvement in adoption planning because of her own history of abuse within her community” (RCY, 2014, p. 14). After the girls’ birth, her mother decided to keep her in her care and moved in with her parents on-reserve, living with them primarily but on and off during the girl’s life. While any interpretations of her psychosis did not diminish the very real threat to the girl during the mother’s acute psychosis, the nurses’ understanding of psychosis engendered a response that highlighted the mother’s urgent need for care and possibly reinforced the nurses’ belief that the mother cared deeply for the girl.

Further, the nurses knew that injectable antipsychotic medication was very effective in resolving the mother’s psychotic symptoms. They also knew that when she was medicated, the girl was safe. When the girl was 9 years old, nurses supported her mother’s request to transition to oral medications *to have a second child*. Prior to her second pregnancy she became very ill when, motivated out of concern of the effect of medication on a foetus, she stopped oral medications (RCY, 2014, pp. 23-24). The mother received no

³¹ In 1996, the MCFD was not yet formed and these services were under the jurisdiction of the Ministry of Social Services.

prenatal care, inconsistent psychiatric care and was perilously un-medicated for over a year prior to the birth of her second child. During labour, she was so ill that she was not aware of her pregnancy (RCY, 2014, p. 23).

Problematizing the mother's psychosis rather than her parenting as a child protection issue led nurses to focus on accessing mental health care for her mother. They repeatedly contacted physicians to treat the mother's psychosis. One nurse arranged consultation with an outreach psychiatrist and drove the mother to the appointment. Over the years, nurses rallied physicians to prescribe injectable antipsychotic medication under an involuntary order in *Mental Health Act* (1996). This eventually actualised after years of patchy psychiatric care, and the community nurses were handed the responsibility to ensure her adherence to injectable medications. By this time, the girl had endured the brunt of her mother's psychotic symptoms and shouldered the responsibility for herself and her little sister for years. The inadequate protection for the girl in the home compounded her vulnerability to abuse outside the home as well, which was also a factor leading to her suicide. Her death was the catalyst for action on her behalf.

Weighing out the risks: to report or not to report?

Constituted as nurses' only "*Action*", reporting limits nurses' responsibility and in many cases, ensures no action at all. The discourse of nurses' response *as* reporting disposes them of responsibilities for child protection interventions. In practice, they oscillate between 'all or nothing' involvement and responsibility, depending on decisions made about child safety by others. These oscillations mirror the 'all or nothing' practices within the system itself, whereby involvement is reserved for extreme (spectacular) cases leaving other cases ignored, as discussed in Chapter 5.

In the *Lost in the Shadows* report, nurses' poor compliance with reporting to the MCFD is provided as evidence that the risks to the girl by her mother were "overlooked" (RCY, 2014, p. 74). However, the report itself offers evidence that the nurses deferred their duty to report to physicians and believed that the CPWs knew about the girl but did not act on her behalf. Inaction on the part of the CPWs to nurses' concerns for children was commonly described in the interviews. In stark contrast to the idea that nurses overlooked, were unaware of, or forgot their duty to report (as implied by the RCY's recommendation to "remind"), participants described taking their decisions to report very seriously. Nurses interviewed in this study both complied with and resisted reporting obligations, depending on the context. This data extends an understanding of non-compliance beyond a matter of education or awareness, as suggested by current literature.

Nurses agonised over reporting decisions because of the gravity of the report for the child and family. One nurse described,

we know that separating them from their parents often isn't ... a lot of help, other than you know this child may be able to eat better now. And that is important, obviously, but ... you know how traumatising that is for these kids ... it makes you really second guess what you should be doing. (RN₂₀)

Early in their careers, participants realised that their attempts to engage the MCFD would be met with either a swift apprehension of the child or their concern would be ignored and the responsibility for the situation tossed back for them to 'watch'. The MCFD's prioritisation of surveillance over support positions nurses in antagonistic ways. Nurses were concerned about the effect that a report could have on their own ability to work with

the family and if they were denied access, the impact that might have on the child. When the nurse was confident the MCFD would be of little assistance, reporting was constituted as not only a futile action but a dangerous one.

By doing this [reporting] now you are going to lose that connection with that family ... now there is one less person that is going to be able to eyeball this child because they [the family] are ticked off that you have called the Ministry

... I'm often trying to tell families that we need to use them [the MCFD] as a resource ... but the reality is ... usually it doesn't fare well for the parents, they feel they are being scrutinised and judged and they have all these restraints put on them. ... So, it's difficult because sometimes you feel like 'urgh, is this really helping the situation? Could we be giving them better resources? and uh, protecting the child?' ... I wish there was a better way of offering support. (RN₂₀)

By alienating the family, the child is isolated within the family, the very place they are most likely to be abused.³² Thus, mandated reporting can operate in contradiction to its stated aim. There were times when nurse participants resisted their reporting obligations to preserve their professional and moral ones. As I have shown, the problem with non-

³² “[I]nfants and toddlers were more likely to be victimized by a member of their own family than any other type of perpetrator. In 2011, 68% of infants under one and 69% of children aged one to three were victimized by a family member, most often a parent or step-parent (Chart 4.2). When children enter school, family members still represent the majority of accused, though to a somewhat lesser extent. ... By the time children reach the age of 9, family members become less likely than non-family members to be responsible for police-reported violence against children. For instance, for youth aged 12 to 17, well over half (57%) of all violent offences were committed by friends or acquaintances, followed by strangers (24%) and family members (18%). This shift in the most common perpetrator can be partly explained by older children’s broadening of activities outside the family” (Sinha, 2013, p. 62).

compliance is not simply one of nursing education or awareness of the legislation or the implications of abuse, nor is it a lack of ability to recognise CN&A. Selective reporting refuses a game of hot potato with the CPWs, a game that undermines the nurse's ability to monitor violence within the family and mitigate harm to children.

Nurses described their ability to predict violent escalations in a similar way to how they could predict a deterioration in patients' conditions, yet their concerns about a children's safety were routinely dismissed by MCFD staff.

You realise how much you are going to impact those peoples' lives and ... you call MCFD and think you are doing the right thing, and then they say, 'Oh, we already know about this. Nothing new. They are being seen by a Ministry social worker' ... that is a little bit frustrating ... [you feel] shut down. (RN₁₅)

After recognising, reporting and being "shut down", what does mandatory reporting mean? When to report *next* is undefined, except that the situation must be worse. Nurses were expected to "rest assured that the Ministry was doing their work, the police were doing their work ... we just had to trust that the certain experts know what they are doing, and we watch" (RN₅). As I explore in more detail below, watching a harmful situation predictably for a child is difficult for nurses, whose professional orientation and practice is aimed towards anticipating issues and intercepting deteriorations in the patients' conditions.

Disillusionment with the system

Participants consistently described their frustration with the inaction of the system. This resonated with current literature that describes a lack of confidence in the CPS to improve

the situation (Eisbach & Driessnack, 2010; Jones et al., 2008; Nayda, 2002). One participant captured this disillusionment:

I think what bothers you the most after you have been in practice for a while is that ... if you make a report it doesn't change that much for people. It's only the most horrendous abuse where people are actually helped. There's certain, you know, garden variety abuse and neglect that the Ministry won't do anything about.

... the options if you are removed from your own parent and placed in care sometimes aren't a whole lot better ... that's the ultimate betrayal, when ... you think you are getting help and something else awful happens to you because you are in care. (RN₇)

Another nurse pointed to unsafe foster care,

There was a teenage boy in foster care and he had taken a lot of drugs and he was really unwell ... I sat down in a meeting with three Ministry social workers and ... I said: 'your system is failing this child' ... the foster family didn't even know he was out getting into drugs ... and this was not the first time.

... they kind of said 'well, you don't know what it's like out there, and we can only do so much, like [as] a parent you can only do so much and you are not going to have teenage children under lock and key', and, and they really, they tried to justify! ... it would be one thing if the foster family was freaking out, 'oh my gosh, they are my responsibility, he's been missing' but we didn't see or hear that from them. ... it's a little bit odd to be advocating for a child to another social service. (RN₅)

Ignoring the youth's needs for connection and support by his caregivers was justified because he no longer fit the figuration of *The Vulnerable Child*. In a poorly resourced system, the figuration of *The Vulnerable Child* is triage technology used to exclude.

A similar justification for non-intervention is seen in the *Lost in the Shadows* report. After visiting the girl,

... the social worker noted: “[The girl was] frustrated with her mother sometimes, maybe embarrassed ... states that she would do the same thing again should her mother become unstable or violent. She would take her little sister and go to the neighbours’ again and call the police ... [The girl] appears to have ‘street savvy’ in understanding her mom’s conditions and how to respond.” ... The investigation concluded with a finding of “no evidence of physical harm or likelihood”. (RCY, 2014, p. 31)

The girl’s “street savvy” signalled ongoing violence and “should have prompted a more assertive approach by the social worker to address the girl’s safety” (RCY, 2014, p. 54). Rooted in values of a liberal state, the MCFD does not support children and families who are suffering from poverty, marginalisation or parental mental illness, these would be of the “garden variety abuse and neglect that the Ministry won’t do anything about” (RN7). The girl’s marginalisation on account of her gender, age, socioeconomic status, ethnicity, learning disability, and her mother’s mental illness, is not incidental to what happened to her. The system ignores members of society who are cast as social liabilities (Bauman, 2004); as described earlier in this chapter, the funding is inadequate for this approach.

It could be argued that the girl did matter to the nurses who wrote of their concerns, the school counsellor, her family and community. However, the system allowed so many threats of severe violence to this girl to remain unaddressed (e.g. sexual assault, being threatened with a knife (RCY, 2014, p. 4). Žižek (2009) counters that “emotional-ethical responses” are limited and predictable, instead he argues that these “remain conditioned by age-old instinctual reaction of sympathy to suffering and pain that is witnessed directly” (p. 36). Witnessing suffering at proximity is more distressing than inflicting it broadly but at a distance, because we are “[c]aught in a kind of ethical illusion. ...This is why shooting someone point-blank is for most of us more repulsive than pressing a button that will kill a thousand people we cannot see” (Žižek, 2009, pp. 36-37). Usually, ethical responses are motivated by proximity and are less urgent at a distance; thus, it follows that distance is the objective of marginalisation.

In the interviews, nurses described ways in which marginalisation narrows interpretations of child protection, siloes services, and responds in short sighted ways that do not acknowledge or act on pending child safety issues. Nurses described the MCFD as unsupportive of their initiatives to prevent abuse through collaboration and building capacity in the home. Nurses’ prevention and advocacy work were not only ignored but undermined. One nurse described working with a couple who,

presented to us pretty early, maybe 20 weeks gestation. This couple, we wondered cognitively where they were at. ... talking to the social workers [we said], ‘This is what we are seeing. We are going to have a problem when this baby is born’. And, no engagement. Like, nothing, we couldn’t set up a case conference around it. They were just hands off. And then the baby was born and shit hit the fan.

And we were like, 'Hello? We told you.' We show up at the first team meeting, [with] no prep for ... [their] intention to apprehend the baby. And we weren't involved in that at all. ... that's our client! And that's been our client for months now. Thanks guys. ... Even though that baby doesn't live with that person anymore, that's still our client and we're still supporting that person.

... It's just ridiculous ... it's just like working in a silo. I understand that it's their objective is to keep kids safe and the rest of it. But you know it's kind of our objective too. Can't we work together? ... Especially prenatally we are doing so much prevention in trying to buffer the shit-show that is about to happen ... It was traumatic for us to be involved in a meeting like that and not know that that's coming ... and I can't imagine what that would have been like for them. ... And it's, it is frightening. It's got shaken baby written all over it. We talked to everybody that we could think of. And ... no baby, no problem. (RN₈)

Despite signs that a family would struggle a “hands off” approach was taken until birth left the baby in a precarious position that the nurse described as “frightening”. CPWs can only attend to immediate child safety risks, and prevention and planning are not priorities.

The nurse participants described their frustration with not being able to follow through with care even when the interventions needed were simple, inexpensive and effective. Nurses anticipated issues, spoke up with concerns, and offered simple strategies to support families, but were challenged when negotiating for preventative care. The system excludes nurses from child protection work and lacks appreciation for their prevention efforts. Similar to CPWs, heavy workloads and fiscal restraints also leave nurses little time for prevention. A participant explained, “we had 120 clients and we were funded

for 35” (RN₈), which meant being reactive instead of proactive in practice and consistently overwhelmed, managing the “*crisis-de-jour*” (RN₈). Such an approach cannot aim to protect children from CN&A but intervene once it occurs.

Žižek’s (2009) critique of the violence of the structures is exemplified in a nurse’s example of how her attempt to advocate for children was silenced by health authority’s risk managers. This silencing was justified because advocacy required the nurse to provide evidence for the children’s mother in a case of domestic violence, and caring for the mother was constituted as outside her role and legal duty.

Hearing about children being hurt, of knowing that they are at risk is extremely challenging, but I’d say what makes it more difficult is the organisational constraints. ... I had a case where the mother was obviously, had been abused and she disclosed how her infant had been harmed. And I contacted the Ministry of Children and Families, they then contacted the mother and went with the RCMP [Royal Canadian Mounted Police] and [the] father was arrested ... both kids were under the age of two who had been hurt. When I wasn’t able to give my statement ... my response was, ‘so we are protecting our health authority over these children?’ ... I was so ticked off ... I said, ‘there are two kids that cannot give their statements because they don’t communicate yet’, they are not verbally communicating, and I said, ‘the mother was able to tell me the story, and yet, when she was questioned by the police ... she actually corroborated the story but because it wasn’t an official statement they needed it recorded and she wouldn’t do it because she’d been numerous, numerous times, assaulted by her partner. Refused. And so did her mother because she had been assaulted by the same person.

So, they contacted me and said they need a statement. ... My Risk Manager wouldn't allow it. ... Risk Management determines what information can be released ... We don't do anything without checking with them. I mean certainly I've chatted with nurses who just say who have gone ahead and released ... had their wrists slapped ... you can certainly see that perspective. However, it's our professional responsibility to maintain our work regulation and policies. ... I remember the first time when I found this out I thought, 'Ah, I should have never asked' ... They said, 'You have done your duty to report. You report to the Ministry. That's your duty to report. Your duty is not to report to the RCMP' and 'the Ministry will do their duty to the RCMP.' ... I recognise that but I, I feel like if we can't stop the abuser because they don't have the right information we are not doing these kids a service, who is advocating for the kids? (RN₂₀)

The Risk Manager used the reporting legislation to silence the nurse, preventing her from giving a statement needed for police to press charges against a well-known repeat offender. The nurse tried to bypass the block by asking the crown to subpoena her documentation, but recognised that *"these aren't like big private lawyers, these are crown lawyers ... unless it's going to go a certain way, they do not proceed. ... The whole system is tricky"* (RN₂₀). The legal system fails to protect abused women and perpetuates misogynistic practices, and the health care authority further silenced the nurse. In the end,

there were no charges ever, he was never found [guilty] of any abuse even though it is on his file. So those issues are definitely crazy-making because that's how it is, that's how the abuse just carries on.

.... there are kids at risk and you know they are at risk, and especially working in a small community like this ... you are aware of it, but you are almost waiting for something to happen because you just don't have enough proof for any authorities to do anything about it. (RN₂₀)

Legal and institutional structures, policies and practices silence voices, of mothers, children and their nurses. In this case, infants and young children are excluded because the way they communicate is regarded as meaningless, and their mothers' and grandmothers' voices are silenced by violence. One of the most challenging aspects of practice in relation to CN&A was knowing that a child was at risk, not being able to address that risk in any significant way, and waiting as dangerous situations unfold predictably.

The Handbook warns: "[r]esearch shows that children often tell about their experiences many times before action is taken to respond" (MCFD, 2007, p. 25). The duty to report leverages against the "*brushing off*" (RN₄) of concerns in practice reporting is irrelevant. In a similar chilling example, a nurse participant described how the police brought a nine-year-old girl to hospital in handcuffs while dismissing the child's disclosure of abuse as "*attention seeking*" (RN₄). She asserted this response was not an isolated one, "*it's easier to not deal with it*" (RN₄). The kind of voice required by the system discredits knowledge even though *everyone knows*. Discrediting this knowledge is a product of power, the subaltern cannot speak (Spivak, 1988). The relations of power within families and communities are central to child safety. Young children are isolated within family home; thus, their safety requires safety for their mothers and grandmothers. Another participant described:

There was a huge incident where ... [the mother was] hospitalised and children have totally witnessed it ... and the Ministry has not been informed. ... they will say 'well the child wasn't at risk' or ... that 'it was a consensual fight', I hear about this all the time. ... 'they were both drinking, they were both doing this', while there is two small children sitting there watching.... the judicial system is the hugest issue ... there has been a male that has been assaulting his wife, and children have been indirectly abused ... everything gets minimised and they down play the abuse for the kids and they will often lower the charges because they do not have enough [evidence] ... the children are taken out of the picture.

And you know, I heard recently a Judge said to this one person, 'stop beating up your wife, your kids are watching, and don't be throwing your kids around while your ...' and I just thought it was so asinine, he was not getting the whole picture. ... those kids are at risk. (RN₂₀)

The discourse that constitutes domestic violence as a “*consensual fight*” refuses to acknowledge the gendered nature of domestic violence. It attributes responsibility to the mother for her own assault and constitutes her safety and the safety of her children as within her power. As such, her need for protection is mitigated and the children slip from view, lost in the lens of the judicial system. In this case, the Judge issued the abuser a slap on the wrist and allowed the situation to remain unchanged, unaware or failing to care that

a home plagued with domestic violence is unsafe for everyone in it.³³ The system preserves and perpetuates violence.

Playing the game of deferrals at all levels of the system

The deferrals seen between the CPWs and the nurses are replicated at all levels of the system. In this final section I show how the RCY and the CRNBC, both provincial leaders with awareness of and intention to improve the situation for children, also get swept into this game of deferrals. The system is highly resistant to change; of the six recommendations in the *Lost in the Shadows* report, two were repeated almost verbatim from previous reports. The report argues that failures to recognise and report the risk to the girl were “*inexplicable*” (RCY, 2014, p. 73, emphasis added), but similar failures can be seen in almost every investigative CN&A report published in BC. Recommendation 5 instructs regulatory bodies to “*remind* their members of their statutory responsibility to report” (RCY, 2014, p. 89, emphasis added). The choice of the word *remind* seems to acknowledge past initiatives to increase awareness about mandatory reporting legislation after previous inquests also found non-compliance with reporting legalisation (e.g. Gove, 1995; Hughes, 2006).

The response from the CRNBC to the RCY constitutes the nurses’ non-compliance with reporting as a lack of understanding of legal obligations and reassures the RCY that

³³ The 2008 Canadian Incidence Study found that of children with substantiated cases of maltreatment almost half had a primary caregiver who was a victim of domestic violence. “For each investigated child, the investigating worker was asked to identify the person who was the primary caregiver. A number of potential caregiver stressors were tracked ... In 78% of substantiated child maltreatment investigations ... at least one primary caregiver risk factor was reported. The most frequently noted concerns for primary caregivers were being a victim of domestic violence (46%), having few social supports (39%), and having mental health issues (27%)” (Public Health Agency of Canada, 2010, p. 5).

nurses have been reminded (twice) of their professional and legal obligations under the *CFCS Act* (Johansen, 2014, p. 2).³⁴ The reminder contained two central messages: it is the nurses' responsibility to know and follow all legislation relevant to their practice; and nurses need to practice in accordance with the institutional policies and procedures. The deferral of responsibility from the CRNBC to the nurses is consistent with the mandate and functions of a regulatory body, so at first glance it is very ordinary. However, it occurs within a shifting international context where regulation and regulatory power is being separated from professional education and support. In this new regulatory context, deferrals onto individuals are structured. Amendments to the *Health Professional Act* (1996) in 2003 required the reformation of the Registered Nurses Association of BC into the CRNBC, a change that prioritised regulatory functions and public protection *over* professional support. Due to the past organisational structure, it has inherited a controversial dual role.³⁵

In an offer of assistance to the RCY to address systemic issues, the CRNBC enlisted a metaphor of a youth who "slipped through the cracks because of systemic shortfalls" (Johansen, 2014, p. 2). While commonly evoked, this metaphor is an ill-fit for BC's CPS. To 'slip through the cracks' conjures an image of a structure that is reasonably solid and functional in its aim to protect children. Likewise, the title of the report *Lost in the Shadows* connotes a passive omission. Yet, the girl was not lost in, but *relegated to*, the shadows. Her relegation to the shadows was accomplished not through shortfalls or cracks in the CPS, but

³⁴ As detailed in Chapter 3, nurses were asked to review two professional standards and the *Legislation Relevant to Nurses' Practice* booklet, which summarises legislation and the nurse's role (see Appendix 12). The CRNBC posted a webpage entitled *What Nurses Need to Know* with links to these resources as identified in Chapter 3 (CRNBC, 2014, March 7).

³⁵ To address this issue, a new organisation the Association of Registered Nurses of BC (ARNBC) has been formed through grassroots efforts of BC's nursing leaders to support development of professional practice. The ARNBC is in its infancy, but has already experienced much opposition, initially from the CRNBC then later from the BC Nurses' Union, which launched a lawsuit regarding the transfer of funds from the CRNBC to the ARNBC.

through the catastrophic consequences of its smooth functioning (e.g. Žižek, 2009, p. 1), which ensured service providers repeatedly refused to help her in a meaningful way.

The word ‘remind’ as it is used in *Recommendation 5* connotes power and is suggestive of an underlying opinion that nurses are choosing not to report, an accusation that is softened by couching it in forgetting. Recommendation 5 also argues that disciplinary measures for individual offenders are overdue and requests enforcement by the Attorney General. This request is justified by hegemonic ideas of children’s vulnerability: “Children’s lives depend on it and no prosecutions for this offence have occurred in many years” (RCY, 2014, p. 73). The force is softened again with the hedge “if necessary”, a vagueness regarding the specific “steps to promote compliance” (RCY, 2014, p. 89), and the preservation of anonymity of the individual service providers.³⁶ Given that the consequences of non-compliance with reporting are constituted as grave and pervasive, it is curious that the RCY chose to defer to the Attorney General instead of making a formal complaint to the respective Colleges regarding the negligence of individual registrants, an option that was well within her power.³⁷ This deferral works in concert with the regulatory reforms to sustain the game, articulating the action of inaction, into a recognisable pattern.

All the nurse participants interviewed for this study were aware of their statutory reporting duty but argued that in practice it articulated with individualistic approaches and underfunding to prevent meaningful responses to CN&A. Problematizing nurses’ responses as lack of recognition and lack of reporting, as is done so often, misses the point. The risks to the girl in the *Lost in the Shadows* report were recognised frequently and reported

³⁶ Investigative reports prior to the establishment of the RCY identified individual service providers by name (e.g. Gove, 1995).

³⁷ In the same way that the MCFD requires a formal report to initiate child protection interventions, the CRNBC must receive a formal complaint to address poor practice of one of its registrants.

infrequently, but it did not matter, because the system ensured that the girl did not matter. To be ignored in this way is not the exception but the rule. It was the girl's suicide that triggered the RCY investigation. Here again, a spectacular form of violence was required to render her visible. In absentia, her case was elevated to be worthy of resources for investigation. If she had not committed suicide the conditions of her life would have continued unnoticed, as they do for many children in BC in similar situations.

The *Lost in the Shadows* report offers a glimpse into how shuttling responsibility back and forth, described so clearly as occurring between the nurses and CPWs in this report and in the nurse interview texts, is present at all levels of the system. Yet, the culpability of the nurses in relation to their lack of reporting offers a way to frame the issue as if it were at least in part a problem of negligent nurses. This framing is what Giroux describes as organised forgetting, a mode of objective violence. A veneer of outrage and action spread across the texts, and recommendations offered new promise to protect children. While significant ignoring of abuse is engaged in by nurses and others (e.g. demonstrated by the need to encourage reporting of even obvious and severe presentations of physical abuse), this analysis also shows how *reminding* nurses of their legislative duty fails to appreciate the work in which many of them are already engaged. Prosecution of a few nurses and other care providers found non-compliant with the *CFCS Act* would be another misaimed action to protect children. Scapegoating foregrounds individual misdeeds, preserving social relations of power and structuring ignorance around how violence is rooted in greed and indifference (Giroux, 2014). Threats of prosecution warn nurses to report, requires them to play the familiar game of deferrals, and alleviates criticism of social and state responsibility for the social inequities, isolation and violence that children and their parents face.

Conclusion

This chapter has shown how, instead of being acted on, children's safety concerns are recognised but deferred amongst service providers and the MCFD. There are two mechanisms that organise these deferrals. First, *The Responsible Family* contains addressing CN&A to individuals and justifies a lack of support for children regardless of the social resources or power of their parents. Social marginalisation and inequities are thus reproduced and handed down to children despite that they sit at the roots of CN&A. By tracing the figuration of *The Responsible Family*, I have shown that despite discourses of love and affection, liberal state ideologies institutionalise paternalism and concentrate governing relations at the site of the family. This figuration also operates as a justification for the poor resourcing of the CPS. The MCFD holds authority on child protection issues in BC but has failed to allocate sufficient resources to employ, train and retain CPWs or to support them to practice effectively and consistently. Attracting and retaining a sufficient number of CPWs to develop relationships and expertise in these roles is not possible in the current funding structure where children are shuttled back and forth between nurses, other service providers, and the CPWs, none of whom have adequate resources to meet the child's or the family's needs. Further, the MCFD dictates an individualised approach to investigation and substantiation to child protection that is resource intensive and does not offer the kinds of support that families need. As a result, most reported concerns of CN&A are ignored because they are not severe enough.

Second, the legislation mandates reporting for all citizens and service providers. This legislation structures the deferral of child protection concerns to an ineffective system, absolving others of responsibility and denying them resources to act. The system

coordinates a game of deferrals that prevents meaningful responses for children.

Professionals from nurses to the RCY are enrolled in the game. Relations of power underpin the deferrals that occur within the usual functioning of the CPS. These relations define child protection as outside the boundaries of nursing practice and set nurses up to defer CN&A concerns (to the MCFD or to other care providers). This discursive mechanism prevents nurses from developing strategies and skills in this area of practice, even though prevention activities were described by several nurses in this study as integral to their role in their everyday work with families. Child protection aspects of nursing work go unseen and unaccounted for, which means that nurses must learn these activities by trial and error, supported in an ad hoc way by each other or other providers. Critical social theory and ideas about power have potential to encourage nurses to appreciate how the social structures and practices preserve situations of violence for children. Developing a theoretically based practice in this area would support nurses to move beyond frustration and nursing practice to more effectively challenge and change the poor situations in which many children grow up.

Chapter 5: A Game of Origins

Chapter 4 demonstrated how a series of deferrals diffuses attention away from most children who are neglected or abused. In this chapter, I explore a complementary process, whereby prioritising scarce CN&A resources to respond to severe cases of abuse, concentrates attention away from most children who are neglected or abused and ignores roots of violence. The mandate of BC's CN&A specialty clinics is to investigate the most severe cases of CN&A in the region or province. These mandates form another obstacle to addressing CN&A meaningfully, and contribute to its resistance as a social problem.

As set out in Chapter 2, severe presentations of CN&A are what Žižek (2009) describes as subjective violence, a tangible form that is “performed by a clearly identifiable agent” (p. 1). While dominant discourses frame subjective violence as random acts of independent individuals, this understanding of violence is too narrow and fails to appreciate its operations. Subjective violence depends upon and responds to objective violence; they are mutually dependent and dialectical (Žižek, 2009). This chapter describes how amidst a heightened sensitivity to, and lowered tolerance for, subjective violence (e.g. beating children) is paradoxically and dangerously accompanied by more brutal forms of objective (systemic) violence (e.g. increasing poor conditions for children). From this perspective, individualised responses are caught within the lure of the spectacular and fail to appreciate the dialectical relations of objective and subjective violence. In practice, this narrow focus on subjective violence articulates responses into a “*game of origins*” (Žižek, 2015), where CN&A is described as the independent actions of an identifiable agent. This agent is *The Monstrous Perpetrator*, the final key figuration of this thesis. *The Monstrous Perpetrator*

legitimises a game of origins, individualises and contains violence, averting our gaze from everyday violence in the contours of the social.

I start this chapter by tracing the roots of this *game of origins* within the rise of imaging technology in the 1960s and its application to CN&A responses. Medicalisation and discourses of diagnosis and cure supported the intensification of the figuration of *The Vulnerable Child* into two spectacular iterations, that of *The Battered Child* and *The Shaken Baby*. Generated from concentrations on severe forms of CN&A, analysis of the discursive production, distribution and consumption of these iterations casts critical questions about the images that produced these figurations. Next, the practices of BC's CN&A specialty clinics and the implications of constituting CN&A as spectacular are considered. Drawing together theorisations of imaginary knowledge (Spinoza, 1677/2000) and technobiopower (Haraway, 1997), attempts to substantiate CN&A and identify *The Monstrous Perpetrator* using visual medico-legal techniques that are shown to operate paradoxically in relation to child protection. Resources and responses to child CN&A are funnelled into the investigation and substantiation of only severe cases, while little is done to *prevent* most types of abuse and neglect that children experience.³⁸ Following Žižek (2009), focusing responses on investigation and substantiation constitutes the action of inaction, where responses stay focused on spectacular eruptions of violence and fail to question the structures that support them, allowing objective violence to remain unchallenged. Amongst these responses, nurses practising with children and families search for an ethical place to stand. Those working within specialty clinics focus on mitigating the harm of the medico-legal investigation and

³⁸ During data collection for this study only one provincial prevention program was in place. This program was a parent education program for Shaken Baby Syndrome, a very rare, severe form of abuse.

system, while nurses in a variety of other roles often experience responses as disruptive to their relations with families, and their ability to assess and intervene on the child's behalf. The unique position and contributions that nurses could make to assessments of children's safety are overshadowed by prioritisation of visual practices for a small number of severe cases. This is a crucial issue because the family is the site where children experience the most violence,³⁹ and a site where nurses could contribute to child safety.

In the last section of this chapter, *The Monstrous Perpetrator* appears indirectly, connoted by legitimisation of the practices of the CN&A experts. Analysis of the constitution of *The Monstrous Perpetrator* offers insights into the persistence of discriminatory child protection responses and how they are stabilised by discourses of risk and safety. Two iterations of the figuration, *The Monstrous Mother* and *The Paedophile* show contours of gendered, racialised and classed discourses. Analysis shows how these figurations intensify the paradoxical operations of the medico-legal responses, entrench dominant discriminatory understandings of marginalised families, and contain anxiety evoked by spectacles of violence. The threat of *The Monstrous Mother* entrenches suspicions of mothers while the threat of *The Paedophile* supports an ever-intensifying surveillance of children and their removal from public spaces into the privacy of their homes, the very place where they are most likely to experience violence.

Analysis of the responses to CN&A provided in this chapter shows how they concentrate attention onto spectacles of CN&A and those who perpetrate it. While the process differs from that seen in Chapter 4, the result is the same, attention is diverted away from most children who are abused and neglected. Limited understandings of what

³⁹ See Chapter 4 for a more detailed discussion.

constitutes violence support responses that distract from the prevalence and the majority of cases of CN&A. By using a sideways glance, these concentrations can be seen to disavow social responsibility and render invisible the everyday violations that children experience.

The “second wave of child protection”: A game of origins

In the 1960s, a shift in understandings of CN&A laid the foundations of the current CPS. This shift arose in tandem with two spectacular iterations of the figuration of *The Vulnerable Child*. In this following section, I trace the production, distribution and consumption of these two iterations. Discourses of science with assumed objectivity produce these spectacular figurations, yet analysis shows how the responses to them are derived from human emotion and sociality.

The Battered Child and The Shaken Baby: the roots of the game of origins

As described in Chapter 3, the child saving movement of the early 1900s constituted cruelty towards children as a social problem, which was transformed into a medical problem in the 1960s marking the “second wave of the child rescue movement” (Scott, 1995, p. 76).

Indirect visualisation of the interior of the human body by increasingly sophisticated technology supported a melding of images with the discursive figuration of *The Vulnerable Child* and produced two new iterations: *The Battered Child* and *The Shaken Baby*. These figurations captivated public and political attention, and evoked a response that contained a “note of hysteria ... somewhat out of proportion to the extent of, and long history of, the problem of child abuse” (Scheper-Hughes & Stein, 1987, p. 340). Led by medical experts in the USA, the response spurred the development of the CPS and of the CN&A subspecialty of paediatric medicine.

As described in Chapter 3, *The Battered Child Syndrome* was advanced as a medical diagnosis in 1962, in *The Journal of the American Medical Association* (Kempe et al., 1962). Kempe (1971) argued that it was possible to diagnose physical abuse using imaging technology even long after an incident: “With any injury that is not easily explained, or has been repetitive, a skeletal X-ray survey must be done, looking particularly for datable fractures with different stages of healing” (p. 32). Imaging technology offered the promise of certainty to diagnose severe abuse. *The Battered Child* was figured by a new form of technobiopolitical governance.

A decade later, figured from the diagnosis of Shaken Baby Syndrome (SBS) and the melding of confession and technoscience, *The Shaken Baby* took form. SBS was hypothesised to reconcile mysterious presentations of a small cohort of infants who, without a history or external evidence of trauma, presented with brain scans that looked identical to those of infants with severe traumatic injury. Mysterious presentations of subdural hematoma (SDH) without a history of trauma, were first described by John Caffey, an American paediatrician (see Caffey, 1946/2011). Some infants with SDHs presented with concurrent “fresh, healing and healed multiple fractures in the long bones” (Caffey, 1946/2011, p. 755), and fit Kempe’s figuration of *The Battered Child*.

Extrapolating from a study that showed Rhesus monkeys could develop SDHs from a whiplash injury “*without direct impact to the head*” (Ommaya, Fass, & Yarnell, 1968, p. 75, emphasis in original),⁴⁰ a British neurosurgeon suggested shaking as a mechanism of injury for these infants (Guthkelch, 1971) and Caffey advanced the diagnosis of *Whiplash Shaken*

⁴⁰ The monkeys (n=50) had been anaesthetized, strapped into a cart around their torso, which was propelled by air compression device at 30 miles per hour, and had whiplash injuries induced by a deceleration braking mechanism that mimicked a rear end collision. Some of the monkeys in the experiment developed SDHs (n=15) (Ommaya et al., 1968).

Infant Syndrome (Caffey, 1972, 1974).

Caffey (1974) argued that the SDHs were traumatic and caused by the infants' caregivers who either concealed an incident or failed to recognise it as harmful: "The medical history of manual WLS [whiplash shaking] is practically never obtained because it is considered innocuous by both the parent-assailant and the questioning physician" (p. 397). The evidence he forwarded was based on the confessions of infant nurse Virginia Jespers, which Caffey obtained through a colleague and popular news media. He wrote:

Although our evidence, based on admission by the assailant, is meagre, it is valuable because it is reliable. By far the most extensive anecdotal proof of the pathogenic manual WLS comes from the confessions to the savage shakings of dozens of infants by an infant nurse who whiplashed three infants to death, maimed two others, and shook uncounted others during a period of nine years.^{3,4} She stated that 'one of her babies' died after she had 'pounded it on the back to get a bubble up'. ...

³ personal communication from Dr. Robert Salinger, Pediatrician, who first detected the guilt of the infant nurse and provided me with much valuable first hand information; ⁴ Benton, R.: Kids get on my nerves. *Master Detective*, 53:44, 1957; ^{4a} *Newsweek*, The Boys Jeered Her, 48, 90, 1956. (Caffey, 1974, pp. 397, 403)

Beyond case confessions, Caffey was not able to establish evidence to support his hypothesis. However, he argued: "Current evidence, though manifestly incomplete and largely circumstantial, warrants a nationwide educational campaign" (Caffey, 1974, p. 401).

Circumstantial evidence continues to underpin the diagnosis of SBS over fifty years later. While the American Academy of Pediatrics remains staunch in their claims of

legitimacy of the SBS diagnosis (American Academy Pediatrics Committee on Child Abuse and Neglect, 2001; Christian, Block, & American Academy of Pediatrics Committee on Child Abuse and Neglect, 2009), questions related to its evidentiary basis have continued amidst failed attempts to model biomechanical claims of shaking as creating the force required for the trauma typical to the SBS diagnosis (Duhaime et al., 1987; Duhaime et al., 1992). The SBS diagnosis includes a triad of cerebral oedema, subdural and retinal haemorrhages, in the absence of external injury (American Academy Pediatrics Committee on Child Abuse and Neglect, 2001). Ommaya, Goldsmith, and Thibault (2002) challenged use of their 1968 study as evidence of SBS:

our experimental results were referenced as providing the experimental basis of the 'shaken baby syndrome' (SBS) by Caffey, Guthkelch and others by analogy not realizing that the energy level of acceleration in our work related to speeds of motor vehicle crashes at 30 mph [miles per hour] (p. 221)

They also claimed the biomechanical assumptions behind the SBS diagnosis are "ambiguous or incorrect" (Ommaya et al., 2002, p. 227), and outlined how prolonged and repetitive infant shaking might generate the forces required to cause SBS, this shaking would lead to analogous "[d]amage to the neck and the spinal cord" (Ommaya et al., 2002, p. 222). Removing the study by Ommaya et al. (1968) leaves the strongest evidence for SBS as case and confession-based to date (see Christian et al., 2009; Findley, Barnes, Moran, & Squier, 2012). Case studies linked with confessions are used in concert with knowledges of technoscience to diagnose SBS.

Confession plays a central role in modern knowledge: "next to the testimony of

witnesses, and the learned methods of observation and demonstration, the confession became one of the West's most highly valued techniques for producing truth" (Foucault, 1976/1990, p. 59). Carefully detailed cases and confession are evidentiary in legal and health care systems. In a 2009 policy statement, the American Academy of Pediatrics acknowledges research that calls shaking into question, but reasserts the validity of SBS by referencing the study by Starling et al. (2004), which describes 81 cases histories where perpetrators admitted abuse in 68% of the cases, with shaking alone admitted in 32 of these cases (Christian et al., 2009, p. 1409). Other SBS researchers also draw on confession as evidence, for example, Dias (2011) argues that: "the consistent and repeated observation that confessed shaking results in stereotypical injuries that are so frequently encountered in AHT [Abusive Head Trauma]—and which are so extraordinarily rare following accidental/impact injuries—is the evidentiary basis for shaking" (p. 370, emphasis in original). However, confessional evidence is also challenged in the literature, for example, in an analysis of medical SBS case literature from 1969-2001, Leestma (2005) argues that this "small number of cases does not permit valid statistical analysis or support for many of the commonly stated aspects of the so-called shaken baby syndrome" (p. 199).

Further complicating the matter, the lack of conceptual clarity of *shaking* as it relates to SBS has left confessional evidence dubious. "In reading and viewing interviews of alleged perpetrators, we find statements of resuscitative shaking or playful bouncing ... [t]his certainly should not be considered 'violent' shaking" (Hyman, Ayoub, & Miller, 2011, p. 201). Findley (2012) also described a case where a defendant confessed to shaking a child only to have his confession overruled by the Judge who believed that the shaking in question was "the proper initiation of CPR [cardiopulmonary resuscitation] for an infant who had collapsed" (p. 259).

Regardless, confession remains tenuous for knowledge production because there are various reasons people may confess, many of which have little to do with whether they committed the crime of which they are accused (e.g. assigning meaning to an infant's death; to plea bargain; or to clear an accused loved one) (Findley et al., 2012). Confession carries specific meanings integral to biopolitical government because it exists only within a system that includes an "authority who requires the confession, prescribes and appreciates it, and intervenes in order to judge, punish, forgive, console, and reconcile" (Foucault, 1976/1990, p. 62). So far, confessions have not been sufficient to provide solid evidence for SBS.

The American Academy of Pediatrics has dismissed the lack of evidence for the SBS diagnosis as one of legal semantic controversy, and to address the biomechanical challenges, has shifted to use of the term 'Abusive Head Trauma' in place of SBS.

Legal challenges to the term "shaken baby syndrome" can distract from the more important questions of accountability of the perpetrator and/or the safety of the victim. The goal of this policy statement is not to detract from shaking as a mechanism of AHT [Abusive Head Trauma] but to broaden the terminology.

(Christian et al., 2009, p. 1410)

Despite questions about the diagnosis, the figuration of *The Shaken Baby* has proved to be compelling and resistant. *The Battered Child* and *The Shaken Baby* have brought attention to the haphazard social supports from liberal governments and widespread social conditions of patriarchy, poverty and marginalisation for children (Nelson, 1984). However, in this second wave of child protection (Scott, 1995), structural violence and social obligations to children have been overshadowed, as the CPS has been oriented to investigating and substantiating

severe physical abuse. By the mid-1970s, sexual abuse was included in these investigations, and since then, child maltreatment research has been “dominated by research on sexual abuse” (Stoltenborgh, Bakermans-Kranenburg, Lenneke, & van IJzendoorn, 2015, p. 37). The spectacular forms of violence act as an ideological “lure” (Žižek, 2009, p. 175), which foster a disproportionate reaction to visible cruelty and paradoxically, a tolerance of more common forms of abuse, especially neglect and social deprivation. The new focus on investigating severe cases of CN&A case-by-case fit better within the individualisms of the liberal state. These responses set the stage for child protection responses seen today (Nelson, 1984).

BC’s CN&A specialty clinics: concentration on the spectacles

BC’s CN&A specialty clinics offer expertise in medico-legal investigation for children who are suspected of being abused. The child’s medical history is reviewed and the child is physically examined with the aim to substantiate CN&A, and where possible, implicate a perpetrator. These clinics legitimise the practices of the paediatricians with specialised knowledge and training in forensic techniques, and supports them to provide expert opinions in court.

The first of these clinics, the Child Protection Services Unit (CPSU), opened at Vancouver General Hospital (1972) and moved to join paediatric services when BC Children’s Hospital opened in 1982 (Jarchow, 2004, p. 68). In response to public outrage in the tragic death of Matthew Vaudreil in 1992, additional funding for the establishment of regional clinics in each provincial health authority was allocated. Matthew was a young boy who was severely abused and killed by his mother despite the family’s longstanding involvement with the state CPS (Jarchow, 2004). In a similar way to the girl in the *Lost in the Shadows* report described in Chapter 4, Matthew was almost invisible prior to his death. Yet following his death, the media provided images and narratives of the spectacular nature of

his murder and a scathing public inquiry figured him central to CN&A discourse in BC (e.g. Gove, 1995).

The mandates of CPSU is to assess “the most complex and serious cases of child abuse from around the province” (British Columbia’s Children’s Hospital, 2017). The CPSU and the regional CN&A clinics adhere to strict forensic and legal protocols to ensure the evidence collected is admissible in court proceedings. The services offered by these clinics are detailed in Appendix 17, and were described by nurse participant who was familiar with the practice in these clinics.

[When children] come to the clinic they will all have a medical assessment done ... [paediatricians] will create a medico-legal report which will then go back to the referral source, plus the family doctor. And then that will accompany the kids to court. ... [The service is] an assessment clinic not a treatment clinic. ... Recommendations to MCFD or RCMP [are developed from the assessments] ... the expectation will be that those people will follow up ... [The clinics are] not providing treatment ... [they are] medical, but ... really ‘finders of fact’ as opposed to looking per se for a diagnosis and therefore treatment. ... [These clinics] follow a medical-legal role. (RN₆)

While the configuration of CPSU and the regional clinics changed over time with availability of experts, support and funding,⁴¹ their core mandate and practice as an assessment clinic has remained consistent. Investigations are streamlined so that various

⁴¹ The Vancouver Island clinic closed in 2009 and reopened in 2012. The clinic in Kamloops was established after the others.

professionals across disciplines can assess children simultaneously, *“everybody can fill their mandate whether it is a protection mandate or a criminal mandate. All the players are here. So, that alleviates multiple interviews with the children, which is great”* (RN₆). In some clinics, the police conduct a forensic interview on site. These clinics offer expertise in CN&A assessment for victims in a setting that is more family-friendly than an emergency department or police station.

Services available at these clinics are modelled after privately funded child abuse centres in the USA, called ‘Children’s Advocacy Centers’ (Newlin & Huizar, 2012). These centres offer a ‘one-stop-shop’ for expertise in CN&A assessment with careful forensic practice that ensures the admissibility of evidence in court. The *advocacy* provided at these privately funded centres is to mitigate further harm to the child and family through the medico-legal investigation process, not advocacy to prevent CN&A. In the same way that the CPS was described as a misnomer in Chapter 3, the “Child Protection Service Unit” provides expert assessment and forensic investigation support, but does not protect children from abuse in the first instance. Unlike the freestanding American centres, BC clinics are primarily publicly funded and co-located with hospitals.

Currently, federal political and judicial interest exists to establish freestanding centres and transition these publically funded clinics to non-governmental organisations. In August 2013, the Canadian Department of Justice (Criminal Justice) made a call for non-governmental organisations to apply for the development of freestanding Child Advocacy Centres (CACs) sponsored by the Victims Fund. The vision was for these CACs to:

provide a coordinated approach to addressing the needs of child and youth victims and/or witnesses in the criminal justice system. CACs seek to minimize system-

induced trauma by providing a single, child-friendly setting for young victims or witnesses and their families to seek services. (Canada Department of Justice, 2017).

Informally, I have heard that this interest has been met with resistance from BC's CN&A experts who appreciate the co-location with public diagnostic services in their usual hospital workplace. The co-location of these services with diagnostic imaging technology is important for access, especially because the service has not yet been privatised in Canada. The production and collection of images from diagnostics are central to assessment because photo-documentation is required and considered to be the gold-standard evidence for legal proceedings.

Implications and operations of the spectacularisation of CN&A

The practices of physical assessment, imaging and the legal requirements for photo-documentation have spectacularised CN&A. These spectacles are subjective forms of violence that Žižek (2009) differentiates from the more insidious objective (structural) forms. This differentiation allows spectacles to be seen and understood as at the centre of violence, when in fact they are symptomatic of structural violence. In this next section, an analysis of how these visual practices operate contrary to their aim to protect children is presented. First, I discuss how the routine practice of photo-documentation creates a *"visibility paradox"* (Zalewski & Runyan, 2015, pp. 446, emphasis in original) because in most cases there are no visible signs of CN&A on the child's body. Next drawing on Spinoza (1677/2009) and Haraway (1997), I show the unstable nature of knowledge derived from images and how, within the fallacies of human perception, relations of power permeate their interpretations. Finally, I consider how the prioritisation of knowledge produced within

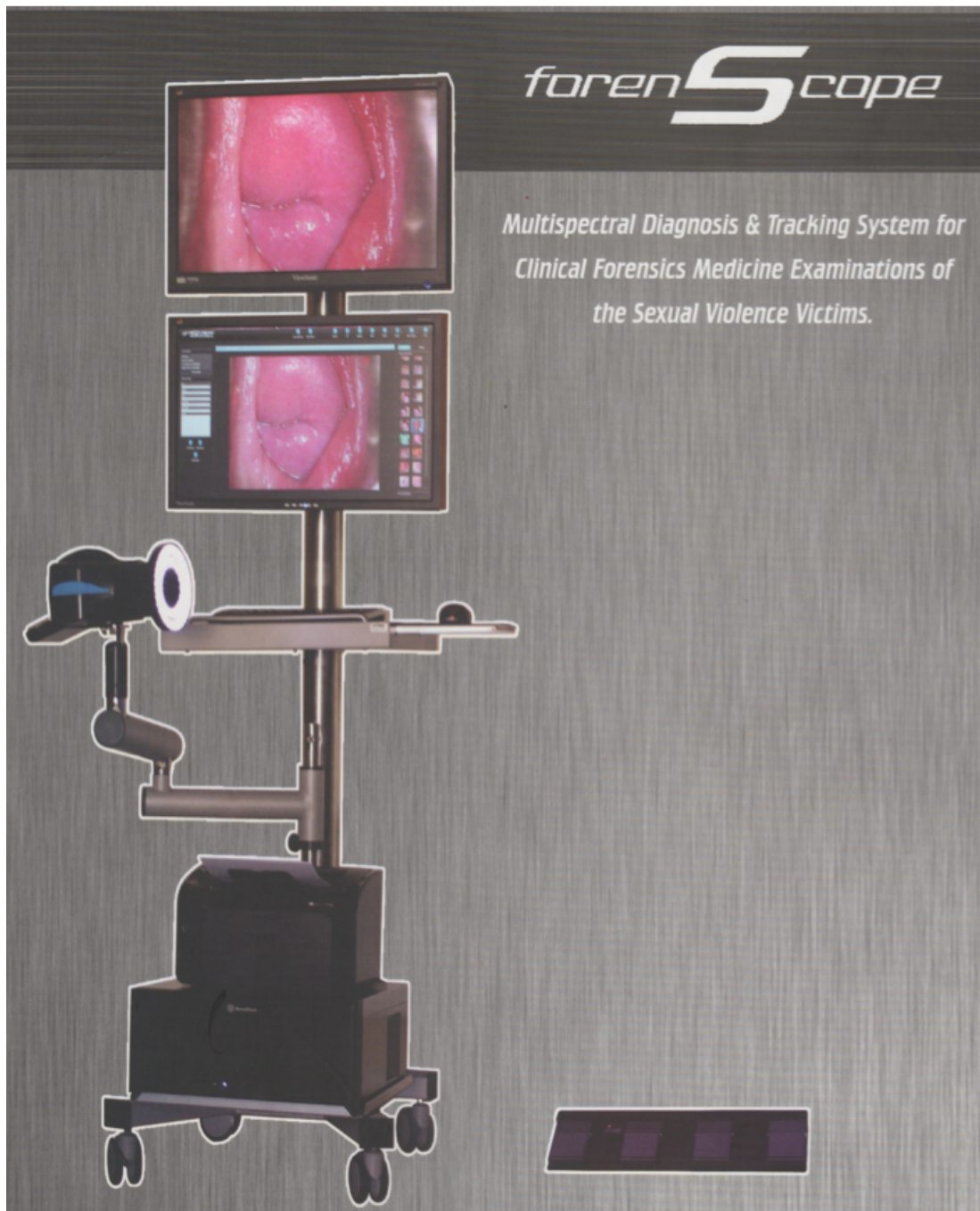
the discourse of objectivity undermines nurses' potential contributions to child protection and their ability to assess and intervene through relationships with families. This section demonstrates how current responses produce CN&A within the realm of the spectacular and are infused with biopolitics that distract from the pervasiveness of violence and negate other ways of responding to it.

Photo-documentation and the “visibility paradox”

Despite advancements in imaging technology and that photo-documentation is required routinely for legal proceedings, visible signs of CN&A on children's bodies are present in only extreme cases. In their critique of medico-legal responses to sexual violence, Zalewski and Runyan (2015) propose that this requirement creates a “*visibility paradox*” (pp. 446, emphasis in original). In practice, the persistent legal requirement for photo-documentation despite that most images show no signs of violence, undermines children's access to retributive justice and access to protection.

This paradox can be seen in the use of colposcopy for photo-documentation after a suspected sexual assault. Colposcopy collects a digital video record of the child's genital areas for court proceedings (see Figure 7).

Figure 7 An advertisement for forenScope ⁴²



⁴²An advertisement for forenScope projected magnified high definition images of parts of children's genitals onto a large screen in main foyer for the duration of the XIXth International Society for the Prevention of Child Abuse and Neglect (ISPCAN) International Congress on Child Abuse and Neglect, Every Child Matters: Promoting Local, National and International Partnerships in Turkey, 9-12 September 2012. This image is the front of the booklet distributed at the conference. Image reprinted with permission from Grimed and Forenscope (HK) Co. Limited (Turkey and Hong Kong).

A nurse participant explained its use:

The colposcope is programmable for recording. ... it is like a big magnifying glass. ... It shows it [the child's genitalia] in the greatest of detail. ... we can change the lighting on it for contrast, we can make it full screen, we can video it. And we can, let's say a child comes in and they have a vaginal tear or something like that, they can come back later and have another examination to show that it has healed. So, if it were to go to court we could say clearly that that was [a trauma]. (RN₁₂)

However, another study participant presented the contradictory application of colposcopy within an aim to protect children:

there are only two things that are absolutely diagnostic of sexual abuse and that is pregnancy or sperm identification. So, the rest all fall into this [category of] highly suggestive of [abuse]. ... The colposcope just illuminates and magnifies what we are seeing. So, it facilitates a good look at what we are seeing, not to say that the naked eye can't also do a good job, but it just helps. But then it is attached to a video, which is creating our photo-documentation.

... Seeing is believing for people. And so, if they don't see injuries it's very hard for them to believe that something occurred. And yet the way kids disclose is very different ... kids often disclose by accident. (RN₆)

While a physical trace of the perpetrator is required for a 'diagnosis' of an assault, colposcopy usually documents its absence. Dr. Joyce Adams, a CN&A expert and the child

sexual abuse “*guru*” (RN₁₂) recently reasserted her original findings that even in cases of legally confirmed sexual abuse and even when conducted shortly after an incident of abuse, very few children will have abnormal genital findings on a medical examination (Adams, Harper, Knudson, & Revilla, 1994; Adams et al., 2016). A lack of physical evidence of abuse persists regardless of the increasing sophistication of imaging technology used for CN&A investigations. “[A] common theme in [expert] testimony is the explanation of the findings and that a physical examination alone does not prove or disprove that sexual abuse occurred” (Adams et al., 2016, p. 7). Routine practices fail to provide evidence and continuously require the ‘fix’ of an expert witness. Zalewski and Runyan (2015) argue that the more readily we are provided with images of violence, the more brutal the evidence of an assault is required to evoke a steady sympathetic response. This paradox points to the sinister underground of objective violence within the ideology of “*seeing is believing*” (RN₆), which is underpinned by the notion that an assault is physically forceful.

As RN₆ described above, children’s disclosures of abuse are often delayed. The asynchronicity between the timing of disclosure and the abuse means that if there were any physical findings, they have long disappeared, making photo-documentation even more contradictory. While children who have been assaulted in the distant past are not always examined and photographed, expectations of healing and how long between the time of assault and examination further complicate the matter because children’s bodies heal much faster than adults’, especially for young children. The same nurse participant described a case where the child’s injury was so extensive that it required surgical repair, and yet within three weeks all traces of the injury and the expert reconstruction had disappeared from the child’s body. Despite colposcopy and its photo-documentation, legal counsel expressed disbelief at the initial extent of the injury and found it difficult to reconcile with the follow

up images of the child's healed body.

Crown Counsel said, 'I never would have believed that if you had not have showed me'. You know we really want to be able to see so that we can actually believe. ... [Nurses are] helping our legal system understand how this works with prepubescent children. ... go back to your forensic interview. That's where your gold is. That's where your information is. ... because we know that 95 per cent of our exams are going to be normal exams. (RN₆)

Again, the nurse points to seeing as believing, and troubles constituting visualisations of the child's body as more valid than the child's voice. She insists that the interview is more valid, yet the child's voice remains less reliable in court.

The disjuncture between expected visible physical trauma and a normal examination, means that the technology that promised to document CN&A works antagonistically. It sets up a requirement for photographic evidence, which, except in the most brutal cases, fails to verify abuse. These practices constitute CN&A as spectacular and in their operations, are objectively violent: they require the child to appear as magnified and digitalised images of body parts, thereby erasing the child.

The elevation of photo-documentation to gold standard CN&A practice also has resource implications, which, as detailed in Chapter 4, contribute to erasure of children who suffer from violence below the threshold for resourcing. BC's expert CN&A clinics are *assessment* clinics not *treatment* clinics. Their resource intensive practices require technologies and expertise to support court proceedings for individual cases. Within this mandate, the workings of technobiopower emerge. The experts and the child are produced

as subjects who must engage in detailed physical assessments. While it could be argued that assessment practices are important from a health perspective as well as a legal one, the time spent creating photo-documentation and attending legal proceedings to provide expert witness testimony to explain *the absence* of visual signs of abuse, is questionable.

Within this visibility paradox, judicial processes appear to be structured in ways that do not simply ignore violence but in the pursuit of justice expect, even require, violence in its most extreme form. As described earlier in this chapter and in Chapter 4, both Matthew Vaudriel and the girl from the *Lost in the Shadows* report failed to meet the threshold for much needed child protection services *until after their deaths*. It was the visible spectacle of death that garnered attention of the community, the MCFD and the RCY. Undoubtedly, many children who live in similar conditions remain unnoticed until the violence they experience escalates into the realm of spectacle.

The illusion of realism and the urgency of affections

The practice of photo-documentation is underpinned by the dominance of visual perception and an assumption that an image can represent reality without interpretation (realism). In medical practice, images are often read literally, as if they were an objective representation. However, any image produced to represent the 'real' undermines its objectivity at the outset (Barthes, 1977). As digitalisation and high-definition allow the image to approximate the object, there is an intensification of the illusion of realism. These illusions encourage us to interpret images without appreciating their mediated nature. When images are conveyed as unmediated, uninterrupted or 'real', relations of power that influence their perception are obscured, and image and technologies that are produced are imbued with impartiality (Haraway, 1984; Stabile, 1992).

Images are a primary way humans come to know the world. However, Spinoza cautions that images offer an illusory knowledge, limited by our material bodies, our perceptive capacity, and our consciousness. Thus, visual orientations of contemporary CN&A assessment practices lead to the first and a most faulty type of human knowledge, imaginary knowledge. Images represent some aspects of a fixed replica of the original, but more accurately represent a relation because they are constituted by the trace of one material form on another. The image is constituted by light and shadow between the camera and what is being photographed. Because of this relation, the image offers more reliable forms of knowledge when understood symbolically, as a sign. Deleuze (1997) explains, “Signs *do not have objects as their direct referent*. They are states of bodies (affects), each of which refer to the other. Signs refer to signs” (p. 23, emphasis in original). Interpretations of images that appreciate the relation between two bodies generate a very different type of knowledge and turn the analytic gaze toward the bodies that are missing from the frame. This approach to interpretation offers the opportunity to diminish the illusive power of the image and develop more reliable knowledge that is contextualised within our sociality. In aiming to move past illusion and imaginary knowledge, Debord (1983) points to the need to refocus on the nature of the relations that are mediated by the image. He cautions that the spectacle has a paralysing effect on critical thought and renders the social relation that it mediates more difficult to appreciate.

From this perspective, it is less surprising that knowledge claims generated from diagnostic imaging are unstable and have led to controversial medico-legal practices. A study participant discussed the controversy about estimating the timing of an injury by analysing the colour and pattern of a bruise (see Langlois, 2007; Nash & Sheridan, 2009). She recalled,

there was a time where they used to date bruises on children. So, they would look at the colour and the sizing and they would think that ... they could say, 'this likely happened five days ago'. What we know now is that it is not consistent ... Different things cause bruises. So, it could be the depth of the pressure that causes a deeper bruise so colouring will be different. So, lighting, when you are looking at a bruise, if you take pictures they alter the colouring of the bruise. ... it is really important to continually read the latest research on child abuse so that you are aware. ... it's an ongoing education, it's not a beginning or an end. (RN₁₂)

In another example, in the 1970s around the rise of moral panic about child sexual abuse in the USA, there emerged a theory that the anus of a child who had been sodomised would elicit an unusual “reflex anal dilatation” when simulated (Collins, Kendall, & Michael, 1998). This theory was disproven and the practice of eliciting this reflex to identify abuse ceased. These examples show how various factors shift perception and interpretation of visual findings. While it is recognised that CN&A knowledge and practices shift over time, the hegemony of objectivity persists within medical CN&A discourse. The power of technology rests in the understanding of its political neutrality (Heidegger, 1977); it renders the social relations of power that it reproduces invisible (Haraway, 1984). Imaging technologies and their application to CN&A diagnoses are no exception. Within imaging practices, technobiopower operates sheltered by discourses of objectivity.

In CN&A practices, children are rendered the objects of examination, while the gaze rarely shifts to examine the interests or biases of CN&A experts. Cloaked in objectivity, the CN&A expert aligns with Haraway's (1994, 1997) figuration of ‘*the modest witness*’ that she

uses to respond critically to the trope of the unbiased scientist. The “*modest witness*” avoids interrogation because he is “not the spectacle ... [but] the author” (Haraway, 1984, p. 52). Žižek (2009) is similarly critical of the rhetoric of objectivity that defines science, he argues that it has replaced religion as the ideological institution that provides security, certainty and hope (pp. 69-70). In some instances, reliance on visual practices leaves CN&A experts open to fallacies of imaginary knowledge and covert and un-interrogated influences of dominant social understandings, social position and power. For instance, while diagnostic imaging and the interpretation of the images generated appear objective, the experts’ belief about whether a child’s parents can protect their child influences whether the child’s body is imaged in the first instance. Even the interpretation of image in isolation from knowledge of the child’s family or social context cannot escape political influences. Dominant and discriminatory beliefs may occur by way of inferences related to the child’s name (e.g. Abdul versus Adam), normalised understandings of the size of the child’s body relative to their age, or by affections evoked by an imaging requisition to query *Non-Accidental Injury*. The potential implications of the findings for a child’s safety also shift the way that the image is interpreted. For example, images that are created for diagnosis of abuse are reviewed by a larger number of physicians than in the absence of suspicion of CN&A (radiologists, paediatricians and consulting CN&A experts), all who are looking for specific findings considered highly suggestive or pathognomonic, such as multiple fractures at different stages of healing on ‘skeletal surveys’ (a series of full body X-rays) for *The Battered Child*; and cerebral oedema, subdural and retinal haemorrhages with no external signs of injury for *The Shaken Baby*.

The power and privilege to produce and legitimise CN&A knowledge and practices are held primarily by the American Academy of Pediatrics. The Academy spearheaded the

development of a CN&A expertise by way of a medical subspecialty for paediatricians and has led the provision of training and certification (Giardino, Hanson, Hill, & Leventhal, 2011). In Canada, The Royal College of Physicians and Surgeons has followed suit and is “developing [CN&A] competency training requirements and setting program accreditation standards” (Hlady & Allchurch, 2015, p. 287). In legal contexts, the triangulated opinions of CN&A experts can constitute evidence. As previously discussed, their power to define is facilitated by:

photo-documentation [which] has to be done with every exam for the purpose of peer review, identifying normals, abnormals ... [for example] when you are looking at normal variants its huge because you are not looking at hymens all the time, or female genitalia, or male genitalia. (RN₆)

In an anthropometric tradition, the child’s body is inspected and measured to constitute distinctions between natural/unnatural and normality/abnormality.

The problem with these practices is illustrated by the example of the construction of a girl’s ‘virginity’ by medical assessment.

Doctors that send in reports [that read]: ‘Examined, hymen intact’. A hymen is a hole. It is not closed off, otherwise you wouldn’t be able to have a period. So, there is education even in the community of doctors. They assume that a child is born with a closed hymen, and they actually need their own anatomy lesson. ... Some doctors are doing exams for children to tell their parents they are a virgin ... that is not appropriate for doctors to be doing those assessments. (RN₁₂)

Shifting politics have created space for resistance of medicine to make claims about a girl's 'virginity', which is itself a contested label. The nurse describes how the CN&A experts advocate against this practice, but the rationale is based on the *inaccuracy* rather than on the practice itself. While this line of reasoning confronts a tradition of ignorance of female genital anatomy and sexuality within medicine (see Tuana, 2004), it fails to confront the violence that treats girls' bodies as family property and the desire for control of girls' sexuality by adults (whether in protection or exploitation). It also illustrates the contradiction of the medicalised approach to child protection because arguing against the accuracy of the examination reaffirms its legitimacy as a practice *if it were accurate*, in the same manner practised in cases of suspected sexual violence.

CN&A experts also hold the responsibility to define how injuries happen, especially when it is in question. Experts are required to assemble the evidence and submit their opinion to support court proceedings. A participant explained,

Everyone is sort of putting the pieces of the puzzle together as to how this injury could have happened. Is that a normal injury? I mean with toddlers we kind of know there are sort of normal areas of the body that you expect to see bruises - up their chins, on their forearms — when you get bruises that are on their backs, side or behind their ears things that don't really match how kids normally get hurt, and then you start to get suspicious.

... [After apprehension of a child by the MCFD they] bring them back two to three weeks later to [the] clinic and [to] be able to say: 'in this new environment three weeks later there's no more new bruises, there's no more fractures, this clearly

was from this environment'. (RN₆)

The logic of a conclusion that a parent must have perpetrated the injury, if the child sustains no further injuries after their removal from the parent, is problematic.

This logic of diagnosis by exception, or ruling out *all other possible known* causes of a child's condition, is commonly used and accepted in diagnosing CN&A. It can be traced back to Kempe who urged physicians to consider abuse in any case where there was "a marked discrepancy between the history given and the findings" (Kempe, 1971, p. 32). Kempe's ideas resurfaced almost verbatim in two of the CN&A expert nurse interviews, shown in the following excerpts:

When parents present and they have a story that is inconsistent with the actual injury that the child presents with, or it could be the length of time that they seek help after an injury to a child. Those are things that make the red flags go up ... triggers make you want to delve a little bit deeper... to look for pieces and put them together. (RN₁₂)

[Tests can] rule out reasons why kids bruise easily ... blood work to support that they don't have some [clotting] factors missing in their blood, [or] brittle bones ... osteogenesis imperfecta. If kid presents with bruises ... skeletal surveys [are done] if they are under a certain age. ... Sort of clinically putting the pictures together, and then helping them heal up and creating a medical report to say basically: 'this is what the family provided this did not match the injuries' and then putting that forward again to the trier of fact, being the judge at the end. (RN₆)

These practices position the CN&A expert with a significant amount of power over the family. The assessments are done amidst uncertainty and significant concern for the child's safety, and thus interpretations are vulnerable to influences of our affections.

Witnessing human suffering evokes affective rather than rational knowledge. Images of suffering "are not much help if the task is to understand. ... Photographs do something else: they haunt us" (Sontag, 2003, p. 89). In severe cases of abuse, visual practices evoke strong affections of simultaneous fascination and repulsion (abjection) (Douglas, 1966/2002; Kristeva, 1982; Rudge & Holmes, 2012). Similar to other areas of health practice (see Holmes, Perron, & O'Byrne, 2007; Rudge & Holmes, 2012), CN&A practice disregards affective responses amidst adherence to claims of objectivity. As described in Chapter 2, emotional responses are not necessarily contrary to rationality (Deleuze, 1997; Jaggar, 2000). They offer important insights and signal fruitful areas for inquiry, but to gain rational knowledge from affections requires careful consideration and an appreciation that painful emotions trigger a drive (conatus) *away* from the inquiry needed, and can interfere with true ideas (Spinoza, 1677/2000). For humans, the drive away from the painful emotion is akin to survival. Conatus dictates that abjection requires containment, and the more intensely it is experienced, the more urgent its containment. Thus, spectacles of violence carry with them "a fundamental anti-theoretical edge ...[t]here is no time to reflect: we have to act *now*" (Žižek, 2009, p. 6, emphasis in original).

The vulnerability of humans to feelings of urgency, or an imperative to act that stems from affective responses, leaves humans open to political exploitation. The staging of spectacular violence creates a space for the preservation of relations of power that might otherwise be resisted. Žižek (2009) details examples of how the left-liberal humanitarian

discourse is characterised by a “fake sense of urgency” (p. 5). At the level of nation states, such urgency has triggered a legacy of humanitarian interventions with contradictory effects on emancipation of nations from oppressive colonial relations that left them vulnerable in the first instance. Through the spectacularisation of CN&A, a similar pattern can be seen. Urgency sanctions practices that might otherwise be resisted. The focus on and reproduction of, or *staging* of, CN&A horrors in textbooks and popular media trigger urgent responses that have contradictory effects for children, entrenching the oppressive social relations that created their vulnerability in the first instance. These responses are caught within the action of inaction, and contain the pain of witnessing CN&A rather than addressing root causes.

Imperatives to act: the example of The Period of PURPLE Crying®

The urgent need for action can be seen in an example earlier in this chapter, with parental education programs about the dangers of shaking babies being initiated prior to evidence that either shaking causes SBS, or education would stop frustrated parents (Caffey, 1974). During data collection for this study, a SBS parental education program called *The Period of PURPLE Crying®* was the *only* province-wide CN&A prevention program in BC. Despite a low prevalence of SBS in the province (a few cases per year)⁴³ and without establishing the

⁴³ A *Three year review of the British Columbia shaken baby syndrome prevention program (2003-2005)* reported that: “The incidence rate of SBS in Canada is at present difficult to assess; a comprehensive surveillance system gathering data from various sources is not yet in place” (M. Barr & Conway, 2006, p. 3). While the report identifies that BC’s only tertiary paediatric hospital “treats several children per year identified as shaking victims” (M. Barr & Conway, 2006, p. 3), data regarding incidence of SBS is still not available, however, it can be crudely estimated. The Canadian Incidence Study reported that there was 12 635 cases of substantiated physical abuse for children 0-15 years of age, and of these, 325 cases suffered “head trauma” (Public Health Agency of Canada, 2010, p. 33). Given that the population of BC represents approximately 13% of the population of Canada, that would mean 42.3 cases of non-accidental head trauma for children 0-15 years of age

efficacy of the program,⁴⁴ the BC government invested \$1.6 million in the program from 2008-2012, with further investments from the federal Ministry of Health, three other Canadian government-funded institutions, and a few philanthropic sources (Province of BC, 2012). While the program is administered by post-partum and community nurses already working with the families, the government funded trademarked education materials (a DVD and booklet from the USA's National Center for SBS) for each new family in BC.⁴⁵

During a presentation about the Shaken Baby Prevention Project (a parent education program in Australia) at the SBS Symposium at the ISPCAN International Congress (2012), a Scandinavian delegate questioned the ethics of parent education programs for SBS. Her critique was related to the allocation of resources to teaching about the dangers of shaking, when the violent shaking required to cause harm is "easily recognizable by others as dangerous" (American Academy Pediatrics Committee on Child Abuse and Neglect, 2001, p. 206). She maintained that, by the same logic, funding for parental education programs about other easily recognised forms of abuse would also be warranted. This discursive

annually in BC. Further, infants < 1 year of age population represent 12% this population, therefore approximately 4-5 cases of non-accidental infant head trauma of any mechanism could be estimated annually (a conservative estimate because infants are more vulnerable to head injury than older children). Additionally, King, MacKay, and Sirnick (2003) conducted retrospective chart reviews in 11 paediatric hospitals in Canada and described 41 cases of infants who were diagnosed with substantiated or suspected shaking with or without impact from 1988-1998, supporting an estimating 4-5 cases of non-accidental infant head trauma in BC annually. Thus, it is likely that only a few cases of SBS occur in BC each year.

⁴⁴ Claims about this program's efficacy are based on investigations of internal validity, specifically one randomised control trial that measured improvements in maternal "knowledge about early infant crying and the dangers of shaking" (R. G. Barr et al., 2009, p. 972). External validity for the program leans on another study of a similar parental education program (Dias et al., 2005, p. 473), which found incidence of substantiated cases (n=49) over six years were compared to substantiated cases (n=21) in the 66 months following implementation of the program in the USA. This study has not been replicated in BC and was too small to provide evidence for the claims (MacMillan et al., 2009, p. 254).

⁴⁵ These materials were developed by Dr. Ronald Barr and the registered trademark owned jointly by Dr. Barr and the USA National Center for SBS, which was founded and formerly directed by his wife, Marilyn Barr (R. G. Barr, 2012, p. 17294).

rupture signifies social contradictions regarding acceptable treatment of children. It is significant that parent education programs have been taken up within nations that legitimise the use of physical force against children as a means of punishment, thereby mitigating potential harm of a general permissiveness towards shaking or spanking as legitimate forms of discipline. If all forms of corporal punishment were unlawful, parental education about shaking or other dangers of physical force would become irrelevant. Yet, action to abolish corporal punishment has had poor traction in Canada. In the USA, the nation that leads CN&A knowledge and practice, a discourse of parental rights to use physical force in discipline of children is protected and has interfered with the ratification of the *UNCRC*. When relations of power are examined more closely, seeming contradictions are revealed instead as contingent. The imperative to act can operate in ways that distract from fundamental issues.

Nursing practices in CN&A: mitigating harm of the spectacular

Other responses to CN&A can also be understood as examples of distractions and the action of inaction, including, for example, photo-documentation. A less obvious example is also the work that nurses do in BC's CN&A clinics, in that a key aspect of their role is to mitigate potential harm to the child and family incurred by the process of medico-legal investigation. The nurses also pre-empt the possibility that an intrusive physical examination might increase the child's vulnerability to future abuse.

Nurses are very skilled at supporting children and their parents through invasive medical procedures and bring these skills to their role in the CN&A clinic, where they prepare children and families for the physical examination. They provide education about the process and rationale of the exam. Children's consent and cooperation is elicited using

play sessions with medical equipment and distraction. Nurses acknowledge that the clinic procedures are difficult for children and offer positive reinforcements (e.g. bravery awards) and carefully monitor the status of children's consent. One participant described:

Prior to the examination ... I bring the kids into the check-up room ... we let them use the doctor's equipment. We tell them: 'nothing is going to go inside you'. If we need a swab or something it's just on the outer edge we don't do anything that will cause any pain. An older child may have a speculum, but even with that they are the boss of their check-up. We get permission from them. We do not hold children down here, ever, ever, ever. Even though we have a painting on the ceiling for them to be distracted we bring them back to the examination ... we do not allow them to do that same thing that they might do when they are abused. Quite often, sexually abused children detach and go somewhere else. So, we actually make sure that they are aware, and that they can say no. Even if they said yes, and changed their mind. If I see a tear trickling down their face we will tell them: 'If this is too much you can come back another time, we can stop right here'. So, we continually give the power back to them. ... we don't hold them down. ... We do not traumatise them, much to the surprise of a lot of people in the community that think: 'Oh, to put that child through that again'. (RN₁₂)

Care is taken during the physical examination to prevent further trauma. Another study participant emphasised how the CN&A clinic environment allocates more time than other health care settings to build trust with a child who has been abused prior to their examination.

In an environment where you did not have that time, and were not able to get them on board like that, I do not think it would go well. And they would remember it forever ... so these clinics are instrumental ... [and] help them understand the difference. ... [Assessments provide the opportunity to discuss] any worries you have about your body today? This is a really good place if you have any questions for the doctor about your body. Really empowering them making them part of that. They have lost their power they are feeling a bit guilty, they are feeling a bit shameful often. Which is not theirs to own, but that is what happens. So, it can be really great and healing in part too, I think. (RN₆)

Finding an ethical place to stand, the nurse turns the encounter into one where children have an opportunity to discuss their embodied experience of abuse.

Another participant echoed how examinations offer a way to reassure children of their privacy and that they are not at fault for the abuse.

RN₁₂: [Reassurance] is huge. It is absolutely huge. You cannot believe how many teens and even young children feel that the rest of the world knows about them [the abuse] and they are different now. So, when you tell them: 'Oh no, not even a physician can tell if they are checking you out and doing an examination. They wouldn't know unless you told them' ...

Interviewer: I wonder where they get that message?

RN₁₂: *I think it is about their own self-esteem, where they feel different. Perhaps [they think] that they caused it, because we do see: 'Well he only hit me or she only hit me when I was being bad'.*

Children's experiences of guilt and shame are consistent with narratives of victims of sexual assault. Nurses counter to shame, reassuring children that they are not to blame and that no one can tell what has happened to them by looking at their body as they imagine, or perhaps, as is suggested to them by the examination itself.

What has been most helpful for me is that I found that at the very end of exams when you are able to turn to that child whatever age they are and say: 'Today you have had a thorough head to toe assessment by medical people, there is nothing about your body today that is different than any other child your age. You are completely healthy and normal. Nobody will know by looking at you that anything has happened to your body. You are absolutely 100 per cent perfect just the way you are'. ... they really worry that their bodies are different ... [and] that people would be able to know. ... it is a way of healing to know that they are just like everybody else, which is so very important to them. ... it has made the job easier. Because that was tricky for me at first. (RN₆)

This participant pointed to a tricky ethical space for nurses. Initially, she had felt distressed by eliciting consent from the child for physical examination and photo-documentation that failed to provide evidence of an assault. She explained further,

getting the kids ready for the exam was very exhausting when I first started working here. I had this real worry that by putting, you know the legal system actually wants us to do medical assessments, regardless, with sexual abuse. And you want to rule out ... [health] problems.

... But I would struggle when I first started practising, as my uneducated self, with: 'these kids have already been traumatised enough, and now we have to put them through a total exam, with these complete strangers, where they are undressing, we are looking at their genitals. How can I? That doesn't feel right for me, I don't know if I can be part of this'.

... embracing that role and my responsibility - this needs to be done. It's kind of like starting an IV [intravenous]. This needs to be done, how can I make this best? How can we buy the kids into this so that they are empowered? So that they feel good? And what I have really come to know is when ... you are honest and you are informative and you make them part of the process, and give them some power, they do well. (RN₆)

The nurse drew on the discourse of empowerment to describe how she supported children during a physical examination. She resolved her distress by legitimising the requisite medico-legal examination as necessary and therapeutic, in that she could provide reassurance that others could not see that the child's body was harmed, even when the child *felt* their body was different.

The nurse was enrolled in this practice through an assemblage of medical and legal discourses and techniques. Rudge (2013) describes how nurses are enrolled into health care programmes of efficiency by 'desiring machines'. Desire assembles managerial techniques

that produce efficiency through the nurse. Similarly, child protection responses desire certainty and visualisations, which assemble medical imaging and legal techniques that motivate the nurse to “endorse and enact the programme” (Rudge, 2013, p. 201). As in many other practice instances, despite discomfort, nurses legitimised the practice and disavowed their position within the system (e.g. Chambliss, 1996; Rudge, 2011, 2013).

Disrupting nurses’ abilities to assess children’s safety

Resource intensive CN&A investigations occur at the expense of other potentially important contributions that nurses could make to child safety assessments. In settings beyond the CN&A clinic (e.g. hospital or community) these investigations disrupt the nurse’s ability to build effective therapeutic relationships with the family, relationships that are essential to nurses’ ability to assess and address child safety concerns. One nurse participant explained the precarious nature of relationships amidst investigations of CN&A.

You have to toe a careful line with those families because one minute you could think that they abused their child and ten minutes later that scan is over or that blood test comes back and no, they didn’t do anything wrong. Now they love their kid, and they are the traumatised family that we are trying to care for because they have just been accused of shaking their baby. ... I’m extra nice to those people, because they already feel judged they already feel that everyone is watching them. This is not a safe place for them.

... there is other stuff going on that the parents don’t always know about and I think at that point the transparency stops. Right? Because there is a certain level of protection that we offer to our child until we know what has happened. And I don’t

feel a bit guilty about that. But when I'm with those parents I don't treat them like they did anything wrong. Until we know what has happened. (RN₁₄)

In general, nurses practised collaboratively with families but when the family was suspected of abuse this approach shifted. Covert practices of investigation disrupted nurses' engagement in therapeutic relationships and were justified by a child safety discourse. The nurse recognised the hospital was *"not a safe place"* for these families and compensated by being *"extra nice"*. At the same time, she took a protective stance towards the child by using the possessive pronoun *"our"* in reference to the child, and a non-possessive pronoun *"those"* in reference to the parents.

During investigations violence can escalate, compromising the safety of the family and the nurse. The nurse described the shift in her relationship with the family as one defined by governance:

You can't run away ... You are the only one who is going to be in that room, right? So, you just have to be really brave and just do it and you've got to get in there and communicate ... and set the tone about the expectation of behaviour in the hospital and what is allowed and what is not allowed and if [there is] something else you want to do, you need to take it outside. It can't be here. I'll call security and they will be in here and they will take you out - against your will if you don't comply with the way that we are here. You have to be really clear with them and so sometimes you are afraid inside but you just have to ... say it like it is. (RN₁₄)

From this position, the nurse must abandon the trusting relationship that might provide

insights into the child's safety.

Overshadowing nursing knowledge

Disruption of the relationships that nurses develop with families illustrates how these relationships are not valued and how nursing knowledge is overshadowed. A participant who was working in a community health role, described how the interpretation of a toddler's brain imaging scans by a CN&A expert as 'inconsistent with abuse' resulted in a dangerous decision to discharge back into parental care. She had received a referral to follow up in the home:

The child was X-rayed and scanned four ways for Sunday and there was nothing on the summary that was sent to us anyways, acknowledging the parental history of substance abuse and violence. ... the biological father was in jail for [a violent crime] ... granted she [the mother] may not have divulged that.

... I walked into the home blind. I just wanted to meet this toddler. Right away I thought, 'oh, things aren't good' ... [the] mother was not engaging at all with the child, there were no toys in the house, there were stairs that were not barricaded, and this child was walking before his head injury and he was no longer walking ... he was getting into plants. And within a week we had him apprehended. But that sounds terrible, we — but she needs help. This baby is not doing well. (RN₂₀)

The scans offered an illusion of certainty that the child was safe at home. The CN&A experts were so confident that the child was not abused, they did not report to the MCFD. The caregivers who were concerned in the first instance, referred the child to the CN&A clinic

instead of reporting to the MCFD. The nurse explained:

RN₂₀: *[The paediatricians] said they did not feel this was caused by abuse so the Ministry was not informed. ... As a nurse it's tricky, your gut is telling you something is not right, this family is not doing well, this child is at risk. ... Going to the house you get a way better eyeball. ... [The referral] had come to me, which was good because as soon as I was starting to feel – I have a good enough relationship with the [MCFD] social worker, that I was like: 'are you aware of this family?' And [she replied] 'Nooooo'.*

Interviewer: *So, this child went ... for an investigation of query abuse and this was never reported [to the MCFD]?*

RN₂₀: *No. No, [it was not reported] because the child protection team deemed the fracture, uh the skull fracture ...*

Interviewer: *Sorry, and didn't even involve the Ministry at all?*

RN₂₀: *They deemed it 'not inflicted harm', then no, you aren't going to notify the Ministry. ... It didn't matter anyways ... and yet, if you don't have, I think of [a neighbouring community] they do not have someone in my position right now ... the job has not been filled in three years ... it makes you think: 'Oh, gosh how easily it could be missed'.*

In this case, suspicion hinged on the interpretation of diagnostic imaging. While a social history is part of the CN&A assessment (British Columbia's Children's Hospital, 2017), it is taken in the clinic by providers who do not have a relationship with the family. The community nurse had the unique advantage of knowing the history of violence in the family because it was known within the community, and was able to identify safety risks by going into the home. While she also engaged in visual practices (she “eyeball[ed]” the home environment), a layer of context supported a different interpretation of child safety concerns. This safety net is missing in many geographically isolated areas in BC, where the community nurse role often remains vacant for years (RN₂₀). The narrow focus of the images prevented the CN&A experts from *seeing* ongoing risks to the child's safety. Concentrating in this way allowed them to ignore the social conditions that rendered the mother and her child vulnerable.

Another study participant described how nurses' knowledge of the family and their ability to assess whether children are safe with their parents was considered invalid when contrary to the results of diagnostic tests. She described a situation where:

The nurses felt that there was no way that this family would have harmed this child. ... They had a strong relationship between husband and wife and they had a loving relationship with their child and they were kind, respectful people.

... the police ... showed up in their uniforms and their guns ... and I was furious, furious. ... they were sending a message, guilty until proven innocent ... the mum is crying and it's just her worst nightmare. ... and we [the nurses on the unit] are all saying, 'it is your worst nightmare'... and they truly are like looking innocent, but tests are coming back you know, so. Those situations are really challenging. (RN₅)

The nurses struggled to believe that this family had hurt their child, defended them from intimidation from uniformed police officers, and empathised with the mother's "*worst nightmare*". They anticipated that the test results would explain the child's injuries by some underlying pathology, but as they failed to, the family's innocence dissolved. Even the nurses deemed their own knowledge as less valid compared with the test results, which support the diagnosis of CN&A *by exception*.

The spectacularisation of CN&A documented in this section has shown that while the knowledge gained from visual orientations is illusory, it acts as a formidable lure leaving spaces for relations of power to operate unfettered. In our visual culture, when there is a way to look, there is an imperative to look, despite that imaging technologies might be implemented in ways that are contradictory to their original aims (in this case of protecting children). This analysis suggests that the focus on imaging technologies for diagnosing CN&A is accelerating us away from, rather than towards, the development of true ideas needed for effective and ethical responses to CN&A.

As discussed in Chapter 3, affective responses are signals that invite a closer examination of complexity. However, the human drive (*conatus*) urges a response that contains or distances us from painful sensations. Responses have persisted and become entrenched, not because of their efficacy in *addressing CN&A* but because of their efficacy in *addressing the anxiety* that is caused by violence. They satiate the urgent need to do something. In this way, settling on literal interpretations of the problem of CN&A might be a strategic turning away from further rational inquiry, a mechanism used to contain the painful experience and maintain ignorance and distance. These responses also constitute a veneer of action and absorb resources, while failing to respond meaningfully to child

protection concerns. Further, technologies extend social relations of power covertly, constituting certain forms of knowledge as less valid. These constitutions have negative implications for understanding nurses' potential contributions to child protection responses, and undermining the importance of building trusting relationships with families and working with the family to support children's safety.

The Monstrous Perpetrator: iterations and effects

Ever-present as a legitimising force for the spectacular medico-legal responses to CN&A, *The Monstrous Perpetrator* is the last of the three figurations that emerge from the discourses of child protection in BC. *The Monstrous Perpetrator* lurks in the shadows of the data corpus enjoying relative anonymity across the texts,⁴⁶ but, aligned with spectacular violations that have been constituted as CN&A, when he emerges he too is spectacular. In this section, I show how *The Monstrous Perpetrator* participates in deepening the focus on subjective violence and distracting attention away from structuring objective violence.

Starting with the text of the classic paediatric nursing textbook, I trace the production of the figuration of *The Monstrous Perpetrator* and find it enmeshed in discriminatory (racialised, gendered and classed) discourses. Figuring *The Monstrous*

⁴⁶ Anonymity of perpetrators was notable even in the news media texts. This absence is especially noteworthy because it is inconsistent with the genre. News media texts focused on the details of violent acts, identified victims, and emphasised their social marginality and vulnerability. In this way, the victims shoulder a disproportionate burden of attention and association with the violence. A similar focus on the victim was seen in the recent national tour of the Truth and Reconciliation Commission. The commission offered an important space for recognition of victim's experience, many whom have been denied acknowledgement of state sanctioned abuse perpetrated against Aboriginal Peoples of Canada. However, the acts of violence and the victims continue to share a disproportionate burden of attention and association with the violence, while the abusers retained anonymity and remained in the shadows. Perhaps more concerning is that the origins of violence within the social structural were obscured, and discourses such as the transmission of generational family violence were perpetuated (Maxwell, 2014).

Perpetrator in these ways allows the dominant group to protect itself by externalising the problem of CN&A to that of the ‘other’, who is associated with or *as* the painful problem. A similar dynamic was documented in an ethnographic study of nursing responses to violence against women in Canadian emergency departments, “[i]nstances of abuse that were recalled almost exclusively concerned obvious physical abuse, racialized women, or poor women” (Varcoe, 2001, p. 105). Othering has serious implications for children in BC. Children suffering abuse perpetrated within the dominant social group and within nuclear families are overlooked, while the marginalised groups and non-nuclear families are subject to a disproportionate amount of suspicion and intervention. The over-representation of Indigenous children in BC’s CPS points to these discriminatory practices.

Next, I explore psychopathologies of *The Monstrous Perpetrator*. In these iterations, the perpetrators are no longer ‘other’ but hidden amongst us. Their monstrosity is intensified and attempts to develop new markings to identify perpetrators ensued. The incomplete constitution of *The Monstrous Perpetrator* as ‘other’ acknowledges our anxiety that, despite our defences and illusions otherwise, the monster is not actually the stranger or outsider but within (Shildrick, 2002, p. 4).

Finally, the effects of the figuration of *The Monstrous Perpetrator* are explored drawing on a discursive rupture in the constitution of *The Paedophile* in psychological texts. The discourse of pathology is shown to deflect responsibility for CN&A onto individuals and refuse to acknowledge how spectacles of CN&A extend from social structures that are inherently violent towards children. Cloaked in discourses of risk and safety, *The Monstrous Perpetrator* embodies the threat of violence, representing and reproducing social hierarchies. *The Monstrous Perpetrator* preserves the illusion that society is safe and caring while turning attention away from the majority of CN&A that children experience.

Discriminatory practices: producing the perpetrator as 'other'

As discussed in Chapter 3, risk and statistics work in a dialectical relation. The statistics describe a higher prevalence of CN&A in marginalised populations and these descriptions have led to profiling perpetrators, thus aiming suspicions of CN&A in discriminatory ways based on ethnicity, class, culture, age, or other categories of difference. Marginalised populations once described as 'dangerous' were discursively transformed to 'high-risk' or 'risky' cohorts but remained the target of a disproportionate amount of suspicion (Cradock, 2004). These mechanisms are seen in action in several texts in the data corpus, for example, *Wong's Essentials of Pediatric Nursing (Tenth Edition)* describes characteristics of victims, parents (abusers) and environments (Hockenberry et al., 2017). These "characteristics" follow normative and naturalised social values and beliefs about what children are of value and what kind of families are safe for children. While embedded within dominant social relations, hegemonies of good and bad parents, families and even children structure how suspicions are developed and cast and how child protection decisions are made. Following Gramsci (1971), Fairclough describes how hegemonic processes, such as these, are configured within layers of discourse, or in orders of discourse, naturalised and reduced to common-sense notions (Fairclough, 1992, 2010).

Profiling marginalised parents as abusive is legitimised by discourses of risk: "Parental Characteristics: Some identified characteristics occur more frequently in parents who abuse their children and are therefore considered risk factors" (Hockenberry et al., 2017, p. 420). Descriptions of the "parental characteristics" and "environmental characteristics" show discursive crossover (see Appendix 18). For example, parental characteristics are described as "low-income", "younger parents", "single-parent families"

and “substance abuse”; while the environment is described as “one of chronic stress, including problems of divorce, poverty, unemployment, poor housing, frequent relocation, alcoholism, and drug addiction” (Hockenberry et al., 2017, p. 420). This crossover shows how the child’s environmental context is limited and constituted as the parental (family) context. It also shows a lack of appreciation for the impact of social inequities on the family (especially for parents who are single, young, poor, isolated, or coping with addiction). Of course, the influence of alcohol and drug addiction on violence is not confined to families from low socioeconomic status, but it is more likely to be ignored if the family is from a high socioeconomic status. Outright race-based claims are avoided in this text, however because the burden of structural violence (poverty, poor housing, social isolation, etcetera) is experienced by racialised groups at higher rates and more intensely, discursively constituting these as “risk factors” reinforces racist understandings of these parents as abusers. Discriminatory discourses in this textbook also have implications for children, where the characteristics of children who are at risk for abuse are described as “infants and small children [who] require constant attention and must have all their needs met by others. ... [or who are] unwanted, brain-damaged, hyperactive, or physically disabled” (Hockenberry et al., 2017, p. 420).

Nurse interview texts also offer several examples of discriminatory racial and cultural profiling. One nurse participant described a situation where a *“father wasn’t violent to his children, but there were ... cultural expectations for families and how they are supposed to behave and [how] if they don’t meet those expectations, sometimes we decide it is neglect”* (RN₁₇). This nurse described a case of a child who was diagnosed with diabetes soon after the family’s migration to Canada. The child’s schoolteachers were concerned about the child and her poor adherence to the diabetic diet. However, the child’s diet instructions from the

diabetes clinic did not account for the family's religiously motivated vegetarianism. This nurse expressed frustrations with assumptions about the family and the provision of a diet plan that was not tailored to the child's specific needs. Regardless of oversights by health professionals, *"issues of neglect ... [became] all messed up with subjective opinions"* (RN₁₇).

In another example, a father was racially profiled as the perpetrator when a child presented with injuries and without an explanation of how they occurred. A nurse shared her angst:

There was a black man ex-military as the dad, a big black man. ... although nobody really said it clearly, the dad specifically said, 'I am viewed as a perpetrator. When the doctors walk in the room I feel like they think I've done this.' ... and the dad actually looked me right in the eye and tears were rolling down his face and he said, 'can you imagine how it must feel for me to have everybody believing that I've hurt my baby girl?' ... right then and there I felt like there was no way that that man could have done it, but that everyone was thinking he did. ... it was a default to look at him. ... because of who he is and how he looks. (RN₅)

Without other ways to organise suspicion, racialisations prompted the care providers to suspect the infant's father in such a blatant way, he verbalised it. He embodied a persistent stereotype of the aggressive (ex-military), dark, male perpetrator.

The Monstrous Perpetrator is usually figured as male, aligned with the naturalisation of aggressive behaviours with masculinity. However, as the domestic lead of *The Responsible Family*, the mother is the primary caregiver responsible for protecting the child, and thus in any failure to protect becomes the prime suspect in situations of CN&A. The

hegemonic effects of the figuration of *The Vulnerable Child* works in tandem with *The Monstrous Perpetrator* to emphasise the mother's monstrosity at failing to adequately care for her children. Perhaps the most dramatic monstrous mother in the data corpus was in the *Lost in the Shadows* report (discussed in detail in Chapter 4), where the mother's auditory hallucinations instructed her to "*snap her [daughter's] head*" (RCY, 2014, p. 4). The horror of a mother who harms her child strikes twice because it violates naturalisations of motherhood as altruistic, protective and caring.

Within dominant social relations, semiotic practices mix in ways that constitute young, racialised, poor, unwed mothers as indistinguishable from *The Monstrous Perpetrator*. For example, in the wake of the death of Matthew Vaudreuil, quality concerns within the MCFD evoked a managerial response that included introduction of the formal Risk Assessment Tool into the routine practice (Callahan & Swift, 2007). The tool provided a standardised psychometric measurement that was both auditable and could justify and protect decisions of social workers. However, implementation was rushed and had considerable issues, including that the CPWs often lacked requisite information to complete the tool (Callahan & Swift, 2007, p. 165).

[S]ome social workers also stated that although risk assessments appear to document their decisions and make plain the evidence they used to make such decisions, they actually obfuscate the values and assumptions that come into play as they think about evidence and scoring. (Callahan & Swift, 2007, p. 173)

Concealed by objective discourses, the Risk Assessment Tool cemented the longstanding classist, racist and ageist relations of power into the structure of BC child protection

(Cradock, 2004).⁴⁷ The use of this tool (a semiotic practice) was lined the social judgements of Matthew's mother in a way to concealed her vulnerability and need for care. As a result, there was a spike in the percentage of Indigenous children in MCFD care after risk assessment was implemented and continues to rise.⁴⁸ "[O]ne worker noted, 'I have the general feeling that for Aboriginal people it is a white instrument'" (Callahan & Swift, 2007, p. 176). Risk assessment did not allow more parents to,

get the help they needed to prevent further child maltreatment, which is what the social workers hoped for, and the caseload in child protection was not reduced, as the managers had hoped. After the introduction of risk assessment in 1997, child protection activities increased markedly. (Callahan & Swift, 2007, p. 173)

The alignment of the Indigenous parent with the figuration of *The Monstrous Perpetrator* allows the genocidal state project to continue uninterrupted, despite attempts to address discrimination and reconcile with Aboriginal Peoples of Canada.⁴⁹

These textual examples demonstrate an absence of critical analysis of the effects of marginalisation, oppression and colonisation on young families, their children and the environments within which they live. Hegemonic understandings of what constitutes a 'good' family, parent, child or home translate into discourses of what constitute a safe family for children. In an excellent critical analysis of the ontologies of BC's child welfare

⁴⁷ Haraway (1984, 1997) describes the process of how tools cement relations of power.

⁴⁸ The percentage of Indigenous children in MCFD care rose from 31-33 to 37 after the implementation of risk assessment (Callahan & Swift, 2007, p. 176). Currently, the percentage is at 60 (see Chapter 1).

⁴⁹ For a more detailed discussion of Canada's ongoing genocidal state project in its apprehension of children (e.g. de Leeuw, 2014; Landertinger, 2011; Thielen-Wilson, 2012).

system, de Leeuw (2014) applies Gramsci's concepts of hegemony naturalised to 'common-sense notions' to analyse and disrupt ways in "which Indigenous peoples are conceptualised and consequently governed by child-welfare systems that ... perpetuate non-Indigenous states of power" (p. 61). As discussed earlier in this thesis, Indigenous families are more likely to be investigated for CN&A and children are "OVER 15 TIMES MORE LIKELY TO BE IN CARE THAN NON-INDIGENOUS CHILDREN" (John, 2016, p. 11, emphasis in original).

Accounting for this overrepresentation, Fluke, Chabot, Fallon, MacLaurin, and Blackstock (2010) analysed the 1998 data from the *Incidence Study* and found that "Aboriginal status of the child and structural risk factors affecting the family, such as poverty and poor housing" (p. 57). However, analysis of the 2003 *Incidence Study* data showed that "the higher the proportion of investigations of Aboriginal children, the more likely placement was to occur" (Fallon et al., 2013, p. 47). Simply put, the more Indigenous parents are profiled as abusers, the more they will be investigated, and the more they are investigated, the more their children will be apprehended.

Further, neglect is the primary reason (73.9 per cent) Indigenous families have their children apprehended (John, 2016, p. 11). Families must navigate the effects of over a century of dispossession of land, prohibition of sustenance practices, and removal of children from families. Colonisation has significant implications for parenting resources. Yet, discourse ordered in a dialectical way produce common-sense notions of 'good' parenting and 'safe' family environments. These texts show how practice guidelines and the way they operate constitute suspicion by profiling abusive and neglectful parents in racist and classist ways because these descriptions fail to "disentangle markers of being colonized from indicators of neglectful or harmful parenting" (de Leeuw, 2014, p. 69). In BC, "common sense plays an important role in decisions about child welfare in Indigenous families" (de

Leeuw, 2014, p. 69). It is part of the structural violence of the system that some BC families are constituted as neglectful and abusive of their children due to persistent racialised and classed social inequity. Critical dialogue about how decisions about the safety of families and environments for children in BC is needed, currently the texts and practices “skirt around material injustices” (de Leeuw, 2014, p. 71), in ways that reproduce colonial practices and deepen social inequity. Critical dialogue could appreciate how colonisation has ‘marked’ Indigenous parents as neglectful or abusive, and offer alternate ways of interpreting and assessing safety for children is needed.

Another counter discourse with alternate assessments and responses that appreciate how poverty or other forms of marginalisation mark parents as abusers is needed. Within a contemporary discourse of ‘vulnerability’ instead of ‘risk’, profiling by maternal characteristics (class, age, indigeneity) is still used to allocate scarce resources. For instance, a pilot CN&A prevention initiative the Nurse-Family Partnership (NFP) targets BC’s young, low-income first-time mothers (Catherine et al., 2016; Jack et al., 2015).⁵⁰ The NFP focusses on the development of therapeutic relationships and family strengths through intensive nurse home visiting and has been evaluated positively by nurses and mothers (Dmytryshyn, Jack, Ballantyne, Wahoush, & MacMillan, 2015; Landy et al., 2012). The NFP offers an alternate response that holds potential to address conditions of marginalisation and reframe the way families are assessed for children’s safety. However, the intervention is vulnerable to entrenching inequities and reproducing colonial practices, as happened with the risk assessment tool. Thus, strategic resistance of dominant understandings of child and

⁵⁰ Evaluation of the NFP has shown efficacy has with a ‘vulnerable’ cohort and is one of the only prevention programs which has been evaluated and shown to decrease CN&A (MacMillan et al., 2009), an effect that was documented by longitudinal randomised control trials across three sites in the USA and when administered by nurses (Olds, 2006; Olds et al., 2002; Olds et al., 2014).

parental measures and behaviours is needed to prevent extending dominant relations of power. As described throughout this thesis, nurses are dispositioned from decision-making power in matters of child protection. However, they are still enrolled in colonising practices despite caring discourses that position them otherwise (Lupton, 1995). Some of BC's First Nations communities, especially those which already have established, innovative and more inclusive programs of support for new mothers, have resisted the implementation of the NFP and argued that funds might be better used to evaluate their programs already in place and developed by the community (Schwartz & BC First Nations and Aboriginal Maternal and Child Health Promising Practices Working Group, 2015). There was also concern that because the NFP has been funded through reallocations of existing budgets rather than additional funding, implementation would require cuts in other areas (Schwartz & BC First Nations and Aboriginal Maternal and Child Health Promising Practices Working Group, 2015). In Australia, the program is being trialled exclusively with women "pregnant with an Aboriginal or Torres Strait Islander baby" (Australian Nurse Family Partnership Program, 2014), raising further questions about targeting 'vulnerable' families in light of a similar pattern of overrepresentation of Indigenous children in state care. To ensure the program is culturally safe, an "Indigenous Family Partnership Worker or Aboriginal Community Worker" has been added (Australian Nurse Family Partnership Program, 2014). The targeted allocation of resources, to those who need it most, seems to be paradoxically caught within marginalising discourses.

Suspensions about poor, young and unwed mothers can be traced back to Victorian sensibilities and have since contributed to women and children's vulnerability to violence. In

Victorian England, the shame associated with having an 'illegitimate child'⁵¹ meant young unwed mothers paid for confinement within maternity homes in the late stages of their pregnancy, their care at delivery and adoption of their newborn infants. Commodification of these services left these mothers and their infants vulnerable to exploitive and abusive practices.⁵² In Canada, the BC Adoption Act (1920) and Children of Unmarried Parents Act [CUPA] (1922),

legally codified single motherhood as wrong and laid out the government's rights when it occurred. The CUPA established the need to investigate all out-of-wedlock births and gave the task of investigation to Children's Aid Societies around the province, while the Adoption Act reinforced the government's right to take children into its care. (Strega, Callahan, Rutman, & Dominelli, 2002)

As discussed in Chapter 4, during World War II women enjoyed some emancipation. This freedom was revoked at the end of the war and a resurgence of Victorian ideologies of motherhood and female sexuality expedited their return to the home. This time however, the discourse around unmarried mothers transformed from morally suspect to pathological and contaminating (Andrews, 2011).

Reflecting social values of the day, Kempe and colleagues wrote: "In our experience perhaps 20% of all young mothers have serious problems in mothering, sufficient to require

⁵¹ The epithet 'illegitimate child' was a mechanism of controlling women and their reproduction, preserving wealth/power and entrenching social hierarchies.

⁵² The vulnerability of young women and children during this time is illustrated in the case of Amelia Dyer, an infant nurse. Her trial exposed practices of 'baby-farming', which made lucrative the disposal of unwanted infants. She was hung in 1896 for evidence in the murder of 12 infants, but estimates were that she murdered 50 babies before custody was regulated, making her one of most prolific serial killers in history (Butcher, 2014; Thames Valley Police, n.d.).

a great deal of support on the part of husbands, health visitors, and physicians” (Kempe, 1971). Ideologies of social contamination supported abusive care in maternity homes, where the practice of confining young unwed mothers continued in BC until late 1970’s. Women’s accounts of being forced to give up their babies to BC social workers in exchange for care during pregnancy and labour were captured in the media review for this study. Women described being sedated for birth and told that their baby was stillborn to prevent them from attempting to find their baby later (Carlson, 2012a, 2012b, 2012c, 2012d; N. Hall, 2012).⁵³

An interview participant described her frustrations with how many young mothers are still held to unrealistic and oppressive middle-class expectations despite their social situations. Describing the social inequities faced in practice she discussed how the young mother in BC is,

very harshly judged because of the context of her life. And that context of her life was often resulting in her not being able to parent her children, or not being seen as safe to parent her child. And so, just sort of trying to advocate a little bit for the mother. Support the mother, even if the end outcome isn’t going to be parenting. To still see her as the mother ... [I] see a lot of ... discrimination and judgments still in health care settings when it comes to parents. (RN₃)

As shown in Chapter 4, the figuration of *The Responsible Family* denies the need for maternal safety, resources and support. Mothers are held accountable for the conditions in

⁵³ Similar accounts were recorded in Australia (e.g. Standing Committee on Social Issues, 2000).

which they raise their children, regardless of how they ended up in those conditions themselves.⁵⁴

The monsters hidden within: discourses of psychopathology

As I have alluded to in the introduction to this section, profiling activities constituting the monsters as ‘other’ are always incomplete because monsters are not the other (Shildrick, 2002, p. 4). Within discourses of psychopathology, *The Monstrous Perpetrator* takes a turn and becomes difficult to distinguish from the rest of society. In this iteration, *The Monstrous Perpetrator* is at once a perpetrator and a victim who suffers from his own out of control body, and thus both embodies and contains threat *and* vulnerability. “What we see mirrored in the monster are the leaks and flows, the vulnerabilities in our own embodied being. Monsters, then are deeply disturbing” (Shildrick, 2002, p. 4). Figurations of the perpetrator within discourses of monstrosity capture reflections that humans are not essentially good, nor evil but have the capacity for both (Shildrick, 2002). The most famous and perhaps the most monstrous pathologisation *The Monstrous Perpetrator* is male: *The Paedophile*. However, there also appears an iteration of *The Monstrous Mother* who deserves mention prior to tracing the production of *The Paedophile*.

The Monstrous Mother

As described above, women who violate social norms of motherhood by failing to protect or harming their children are figured as especially monstrous. Among these mothers are those with a projected somatisation disorder called Münchausen Syndrome by Proxy (MSBP),

⁵⁴ I have argued previously, using an Australian example, a young Aboriginal mother was constituted as monstrous when her child disappeared (Einboden et al., 2011).

which offers an extreme example of this figuration. This mother is monstrous but also victim of psychopathology. MSBP is described by the paediatric nursing textbook as a “*medical child abuse or factitious disorder by proxy ... a rare but serious form of child abuse in which caregivers deliberately exaggerate or fabricate histories and symptoms or induce symptoms. Health care providers can become easily misled*” (Hockenberry et al., 2017, p. 419). The profile of an MSBP mother is one who has health care knowledge and harms her child in ways to secure physician attention (Dye, Rondeau, Guido, Mason, & O'Brien, 2013). Compared with other forms of abuse, MSBP is exceedingly rare but is well known to paediatric health professionals who are instructed to remain on watch (e.g. Day & Moseley, 2010; Dye et al., 2013; Ferrara et al., 2013; Hockenberry et al., 2017; Stirling, 2007).⁵⁵ The paediatric textbook states that MSBP should be considered when: physicians fail to make sense of or treat the child’s clinical presentation; the illness is recurrent or protracted; or the child’s mother presents with ongoing concerns about the child that resolve when in the presence of caregivers (Hockenberry et al., 2017, p. 419). Thus, the diagnosis of MSBP repeats the pattern described earlier in this chapter of diagnosis by exception, where *all other possible known* causes of a child’s condition are ruled out.⁵⁶ If MSBP is suspected, covert video surveillance is considered (D. E. Hall et al., 2000; Southall, Plunkett, Banks, Falkov, & Samuels, 1997).

Children are especially vulnerable to violations at the hands of their mothers because maternal care has been naturalised and romantic notions of motherhood interfere with the ability to see the harm she causes to her child (Scheper-Hughes, 2002). These

⁵⁵ In my first position as a Registered Nurse, I worked on a unit in a paediatric hospital that had two rooms set up with covert close circuit video recording, reserved for suspected cases of MSBP.

⁵⁶ See discussion of this type of logic earlier in this chapter.

notions render the harm a mother may be causing. This is the case with MSBP; Scheper-Hughes (2002) reminds us that the performance of the sick role has existed within many cultures throughout history, and follows “a great deal of substitution (or projection) that goes on in perfectly ordinary and normative practices of mothering” (p. 157). Curiously, discussion of MSBP in the text and literature constitutes the health care professionals “as if they ... were the *real* victims” (Scheper-Hughes, 2002, p. 167). The role of the physician in the MSBP situation is rarely discussed in the literature, yet power is central to the physician-patient relationship, and within the context of isolation and oppression that comes along with motherhood an encounter with the benevolent authority can be perceived as “magical” and cherished (Lupton, 1995, p. 159). Lack of attention to relations of power sits at the foundation of this iteration of *The Monstrous Mother*, which justifies concentrated and intrusive interventions.

The Paedophile

The most famous iteration of *The Monstrous Perpetrator* is that of *The Paedophile*. This figuration is gendered, assembled from practices of psychometric testing and brain imaging, and tangled within webs of technobiopower. The most recent version of the *American Psychiatric Association's (APA) Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)* offers a more ambivalent pathologisation of *The Paedophile* than seen in previous editions (see Appendix 19). Instead of using the term paedophilia, the DSM-5 describes ‘Pedophilic Disorder’ as one of several ‘Paraphilic Disorders’ that include behaviours from sadomasochism to transvestism (American Psychiatric Association [APA], 2013b). Pedophilic Disorder is differentiated from “pedophilic sexual interest ... [and

diagnosed when] individuals ... complain that their sexual attractions or preferences for children are causing psychosocial difficulties” (APA, 2013b) or when they act on them.

However, if they report an absence of feelings of guilt, shame, or anxiety about these impulses and are not functionally limited by their paraphilic impulses (according to self-report, objective assessment, or both), and their self-reported and legally recorded histories indicate that they have never acted on their impulses, then these individuals have a pedophilic sexual interest but not pedophilic disorder. (APA, 2013b)

Thus, the text normalises “sexual attraction or preferences for children” (APA, 2013b) and pathologises them only when they are upsetting (for the individual who experiences them) or when they lead to action.

In the first release of the DSM-5, the APA described the “sexual attraction or preferences for children” as “pedophilic sexual *orientation*” (APA, 2013a, emphasis added). This description was met with offence and contestation because the term ‘*sexual orientation*’ has political significance in that it was used as a counter discourse to the pathologisation of homosexuality by psychiatrists and psychologists in previous versions of the DSM. In response to this contestation the APA offered a correction, which reads:

‘Sexual orientation’ is not a term used in the diagnostic criteria for pedophilic disorder and its use in the DSM-5 text discussion is an error and should read ‘sexual interest’. In fact, APA considers pedophilic disorder a ‘paraphilia’, not a ‘sexual

orientation.’ This error will be corrected in the electronic version of DSM-5 and the next printing of the manual.

APA stands firmly behind efforts to criminally prosecute those who sexually abuse and exploit children and adolescents. We also support continued efforts to develop treatments for those with pedophilic disorder with the goal of preventing future acts of abuse. (APA, 2013b)

Linguistically *sexual interest* and *sexual orientation* have a similar meaning. If meaning was the central concern, the correction to *sexual interest* should provoke similar contestation. This hints as to how the linguistic association between homosexuality and paedophilia was contested, while the discourse of sexual interest and normalisation of attraction to children remains unproblematised.

Legal and dominant social discourses describe sexual acts between adults and children as assault. Thus, normalising sexual attraction to children as a “*sexual attraction or preference*” also normalises a desire to sexually abuse a child, condoning the desire for violence as long as it is not enacted.⁵⁷ In the slippage between the language of sexual interest and orientation, there is a confusion between a desire for *power* with a desire for *sex*. A hegemonic idea that sexual violence originates from the out of control male sexual desire underpins this confusion. This idea is entangled within discourses that individualise and naturalise sexual desires as biological and psychological. Psychologisation of pedophilic interest, as seen in the DSM-5, alleges that ‘sexual attractions and preferences for children’

⁵⁷ My intent with this line of argument is not to entrench the social refusal of child sexuality, but to distinguish the desire for power from sexual desire. While children are sexual beings with desires these would be challenging for children to express within the context of unequal relations of power.

arise from an individual's body, rather than within the context of human sociality and relations, which is a much more likely place for them. This operation is akin to the long-fought feminist battle against constituting rape as originating in sexual desire rather than violence. Further, "psychologisation, in tandem with pathologising explanations and the disconnection of power-knowledge from violence, operates to deplete the theoretical resources for tackling sexual violence" (Nic Giolla Easpaig & Fryer, 2011, p. 168).

Reserving pathologisation of 'sexual attractions and preferences for children' for when they are acted on, the DSM-5 draws a fictitious line between normal and pathological (e.g. Canguilhem, 1989). From this line springs discourses of *The Ethical or Virtuous Paedophile*, an identity claimed by those who are *sexually attracted to children* but do not act on their desires. Rooted in the ontology of possessive individualism (see Chapter 2), when the individual maintains rational control over their body they can avoid a diagnosis of psychopathology. However, this discourse detracts from relations of power that infuse a sexual interest in children. From a critical perspective, power relations between adults and children are relevant, and this 'interest' is not neutral. While suffused with notions of 'loving children', a sexual interest in children is also an interest in wielding power and control over a child, raising questions about the idea that resisting such desire is virtuous.

The hegemony that constitutes *sexual* desire as motivation for abusive relations places out of view the *desire for power* that is insidious to sexual violence. This *desire for power* is further obscured by the discursive co-location of *sexual desire* in the perpetrator and victim of a sexual assault. A nurse participant illustrated this concealment within the discourse of a news media broadcast.

The news presenter was saying: 'the videos showed girls as young as five years old having sex'... and I was like ... huh? A girl who is five-years-old is not 'having sex'. She didn't say 'being exploited', she didn't say 'being sexually abused', you know? She said, 'having sex'. And I think that is very telling. Whether we like to admit it or not, as a society we still have our heads up our asses about child sexual abuse.

... we're not responding to it as if it's that prevalent. And there is still a 'well, we don't want to talk about that' and I think that on some level it speaks to our society thinking that it's okay. The little newscaster blurb is evidence of it being socially sanctioned. (RN₁₉)

By normalising and constituting 'sexual attraction to children', a desire for power and control remains cloaked in a discourse of love and sex. Constituting *The Paedophile* (who acts on their urges) as a disordered, dangerous and out of control body, contradicts grooming behaviours and strategic, patient and opportunistic ways child sexual assault is executed. Power is the aim of sexual violence. Challenging the discursive constitution of sexual violence as a "sexual interest" is therefore central to addressing CN&A.

Colonisation of the Child: effects of The Monstrous Perpetrator

Child sexual abuse, like other forms of CN&A, is underpinned by domination and rooted in a *colonial desire* not a *sexual desire*. Threats of sexual or other forms of violence support dominant and proprietary relations and are a means of social control, and hence a means of social ordering. The most obvious and extreme example of how sexual violence is about power and control rather than sexual desire is in the deployment of rape as a tactic of war. In combat, sexual violence is used to colonise by occupying and possessing the land and the

bodies on it. “[S]exual violence is not merely the action of rogue soldiers, but a deliberate tactic of warfare” (UN Development Fund for Women, n.d., p. 1). At this point in time, the use of sexual violence in combat is pervasive: *“It is perhaps more dangerous to be a woman than a soldier in an armed conflict”* (Cammaert as cited in UN Development Fund for Women, n.d., p. 1). Tracing the logic from this extreme example reveals how sexual violence is a tool of domination. It has long-lasting and far-reaching effects, leaving imprints on victims’ bodies. As embodied reminders of lack of safety, victims are subjected to exclusion.

Violence also dominates through the production of fear. Threats of sexual and other forms of violence can limit participation in community life and influence choices and behaviours of its targets, for example what neighbourhood to live in, or when, how and where to travel, attend work, school and other activities central to social life. Limitations vary according to social, geographical and cultural positions of potential victims. Violence perpetrated against children is so common within western society that it limits children’s activities, participation in social life and presence in public spaces in a way that is *accepted* instead of challenged. Further, threats govern the child’s parents (mothers), tying them tightly to the surveillance of their children. In turn, their surveillance opens parents to criticisms of hypervigilance (e.g. ‘the helicopter parent’).

As other, the figuration of *The Monstrous Perpetrator* masks and contains violence. In a similar way, *The Vulnerable Child* contains violence by emphasising the victim’s social marginality and vulnerability. These figurations work in tandem to obscure the everyday colonisation of children and to constitute violence as a problem of marginalised populations. This process is illustrated in Thielen-Wilson’s (2012) analysis of the criminal sentencing of Arthur Henry Plint (*R v. Plint* 1995). A notorious Canadian paedophile, Plint “plead guilty to charges of indecent assault against 27 male Indigenous claimants when they

were children residing at AIRS [Alberni Indian Residential School]" (Thielen-Wilson, 2012, p. 22). During his trial, state policies of residential schools slid into view exposing the objective violence of the state. Historically, these policies were legitimised by paternalistic discourses but in contemporary times, they no longer had the support of public opinion.⁵⁸ In order to contain the exposure of the structural violence within state policies, the curator of state legitimacy, Judge Hogarth labelled Plint a "paedophile" and "sexual terrorist" pathologising and racializing him (Thielen-Wilson, 2012, p. 121). Hogarth also others Plint by "wield[ing] the ontology of possessive individualism ('the rational individual') to evict ... Plint ... from membership in the white settler collective (of property owners)" (Thielen-Wilson, 2012, p. 22). Hogarth displayed "much emotion when he mention[ed] the type of sexual violence Plint committed against Indigenous boys. The forced sodomy/rape counts ... are of 'grave concern'" (Thielen-Wilson, 2012, p. 136). However, Thielen-Wilson (2012) questions whether it is

the sexual propensity of pedophilia or the sexual propensity of homosexuality which is of grave moral concern to Hogarth. ... [Further, she reminds us that in] Western medical and popular discourse, a pedophile is a person who ... cannot control their sexual desire for children. (Historically, in Western thought, the same has been feared of homosexuals.) (p. 138)

In this text, the out of control male body was used to figure *The Paedophile* as other (outside rationality). This figuration is as fictitious as the out of control body of the

⁵⁸ Yet a parallel and paternalistic argument that justifies the appropriation of Indigenous children into MCFD care arrangements currently has support of public opinion.

homosexual, and as the out of control body of any man. Those who perpetrate violence against children, sexual or otherwise, do it under a distorted guise of out of control sexual desire that stands in for and conceals a colonial desire that is *very much in, and all about, control*.

Thielen-Wilson argues that Hogart's pathologisation and racialisation of Plint is politically useful. It denies the need for violence to sustain the occupation of Aboriginal Peoples' land, yet "[u]sing sexual violence against Indigenous bodies is one thing Plint has in common with generations of settler colonizers" (Thielen-Wilson, 2012, p. 139). Further, it denies the long tradition of familial heterosexual violence in the European family, where women and children are considered property.

[S]exual violence against children by their fathers, and sexual violence against women by their husbands, was and is a common *heterosexual* practice within European patriarchal societies ... made possible through various European institutions which defined women and children as the property of heterosexual men ... [and i]mportantly, for our purposes, sexual violence as a means of enforcing property relations, was a skill transferable to the context of European colonization of Indigenous people. (Thielen-Wilson, 2012, pp. 138-139)

The family is where most CN&A, including child sexual assault occurs. From their experiences within or outside of their family, Canadian children learn to use sexual and other forms of violence in their relationships, as a means developing and maintaining social positions and hierarchies. One nurse interview participant explained:

We see it here a lot, sibling abuse. A particularly difficult situation where you have parents dealing with both the offender and the victim at home. And that divided love for both their children and how do you support one and the other? To me it's the most horrific situation there can be, because even if you have say, a husband, offending the children that is sort of some person you can take out of your home.

(RN₁₂)

Cases of sibling abuse troubles the othering and complicates containment or excising *The Monstrous Perpetrator*. These cases also illustrate how humans are not essentially good (not even children), nor are they essentially evil but have the capacity for both (Shildrick, 2002). Sexual abuse perpetrated by one sibling onto another is a common form of abuse, not captured by the figuration of *The Paedophile*. According the RCY (2016),

2015/16 statistics show that sexualized violence is the most common type of critical injury involving children and youth in care, at 21 per cent. ... A quarter of the reported incidents of sexualized violence that occurred in care placements were perpetrated by the child or youth's foster parent. More than one-third were perpetrated by another child or youth in the same placement. (p. 2)

The paediatric nursing textbook also acknowledges sibling abuse, it reads: "Anyone, including siblings and mothers, can be sexual abusers, but a typical abuser is a man whom the victim knows" (Hockenberry et al., 2017, p. 420).

The Paedophile is figured as external to the family, supported by the hegemony of 'stranger danger'. Contemporary research and the discourse of grooming have moved him

strategically close to the family with the aim of abusing a child. The textbook avers: “Offenders often are employed (or volunteers) in positions such as teaching or coaching that bring them into contact with young girls and boys” (Hockenberry et al., 2017, p. 420). Hogarth’s judicial rationale works within these discourses, reinforcing the fantasy that residential schools “tragically attracted only pathological *individual* perpetrators” (Thielen-Wilson, 2012, p. 22, emphasis in original). Individualising and othering *The Paedophile* conceals how sexual violence operates as a mode of social ordering, and how the social order beckons individuals into violent behaviours. Figured as *The Paedophile*, Plint is sacrificed to obscure the objective violence of ongoing colonial relations. The “law constructs Plint as exceptional, as only a sadistic and especially vicious monster and *not both* especially vicious and very much like other Canadians. The white collective is cleansed” (Thielen-Wilson, 2012, p. 139, emphasis in original). Racialisations and pathologisations play key and complex roles in the figuration of *The Monstrous Perpetrator*, which in turn reinforce the fantasy that there are a few bad apples in our midst, whose moral depravity bears responsibility for the violent conditions children face within society.

I believe Hogarth’s discursive moves are typical and Thielen-Wilson’s argument is relevant far beyond the violence directed onto Aboriginal Peoples. The objective violence of social structures and systems supported CN&A in residential schools (subjective violence), and continues to support CN&A across western society today. To see this violence, our gaze must shift sideways and down toward this “obscene underground” (Žižek, 2009, p. 143). Explaining this idea, Žižek (2009) uses the example of the Catholic Church:

The paedophilia of Catholic priests is not something that concerns merely the persons who ... happened to choose the priesthood as a profession. It is a

phenomenon that concerns the Catholic Church as such, that it is inscribed into its very functioning as a socio-symbolic institution. It does not concern the 'private' unconscious of individuals, but the 'unconscious' of the institution itself: it is not something that happens because the institution has to accommodate itself to the pathological reality of libidinal life in order to survive, but something that the institution itself needs in order to reproduce itself. One can well imagine a 'straight' (not paedophiliac) priest who, after years of service, gets involved in paedophilia because the very logic of the institution seduces him into it. ... The Church as an institution should *itself* be investigated with regard to the way it systematically creates condition for such crimes.

This obscene underground, the unconscious terrain of habits, is what is really difficult to change. (pp. 142-143)

The persistent reduction of women and children to property within the family in contemporary society is part of this terrain of habits. *The Paedophile* calls attention away from the family, and participates in isolating the child within it. While investigations of the Church and the way it systematically perpetuated child sexual abuse are underway (e.g. Australia, Ireland), a systematic investigation of the institution of the family continues to escape critical attention.

An ontology of possessive individualism and its underlying proprietary relations have created an identity for the child (and all other forms of human dependency) that is inherently violent in Žižek's objective sense. Notions of the sovereign self whereby the body is controlled, positions children and their out of control bodies vulnerable in the first instance. Within possessive individualism certain bodies are constituted with more social

worth than others. Bodies that are constituted with low levels of sovereignty over their functioning have less social worth and are more vulnerable to spectacular forms of violence than bodies constituted with high levels of sovereignty. Despite variations of vulnerability at different intersections of social positioning, within this ontology the first relation with one's own body as property is violent – and no-one escapes this violation.

A nurse participant described how relations of domination usurp children's power, leaving them open to abuse. She argued that perpetrators,

... see children as property. Without a voice, that they overpower ... they figure they can do it because the child is beneath them in terms of emotional, physical and all sorts of development. That is the problem. They are powerless in our society that way. And you get somebody that [needs]... power and control, lacks self-esteem. ... What is a sexual pervert? Seriously? Why kids, why not a woman? Is that your sexual orientation? I don't believe so. It's because they don't have the self-esteem to be who they are ... with an adult.

When I turned 14, I had a family friend who was trying to get funny with me ... and I picked up on that immediately. And he asked me to go fishing with him to the creek. ... And I said 'No, no, no.' ... I stayed away from him and there was nothing he could do to me at that point, except forcibly rape me, that would make me go to him because that wasn't going to happen. I had boundaries from a young age ... [my father] said, 'They have issues. Not you. They have problems.' Not me. It was never me. It was always them. I was well grounded. ... [He could have been] a priest. Yeah, I see you. A cop. Yeah, I see you. Kids need to see behind that uniform. ... they need to be grounded in terms of who they are and what they allow around them. ... they

need to feel good about themselves and not think that adults are going to make them feel good about themselves. (RN₉)

This narrative describes how children are set up for exploitation in two central ways. First, as property, children are robbed of voice and self-worth. Second, lack of acceptance and self-worth set children up to seek approval. Everyday exploitive relations of possessive individualism set the foundations for further exploitation. Children are vulnerable to adults, especially those with social power and approval (e.g. those who wear uniforms). These adults are trusted by children's parents and hold promise of validation that children seek, protection from other forms of violence, and the keys to future opportunities.⁵⁹ This narrative also described personal power, self-worth and boundaries as protective against abuse. Personal power and self-worth allowed this nurse to navigate away from potentially abusive people and situations. Her parents' role-modelled these protections and did not erode her boundaries.

Following Thielen-Wilson's argument of the need for violence to sustain the occupation of Aboriginal Peoples' land, there is a parallel ongoing need for violence (or the threat of violence) to be perpetrated against both women and children in order to preserve

⁵⁹ This point is illustrated in the film *Doubt*, when a boy's mother described how homophobia, poverty and violence in the family home posed a more acute danger to her son than sexual abuse by the Priest. This complexity was missed by the nun who challenged: "What kind of mother are you?" The mother responded: "Sister you ain't going against a man in a robe to win, he's got the position. ... You accept what you gotta accept and you work with it. ... My boy came to your school 'cause they were gonna kill him in the public school. His father don't like him. He come to your school, kids don't like him. One man is good to him, this Priest. Then does a man have his reasons, yes. Everybody does. You have your reasons. But do I ask the man why he's good to my son? No. I don't care why. My son needs some man to care about him and to see him through to where he wants to go. And thank God this educated man with some kindness in him wants to do just that. ... It's just until June ... Please leave my son out of this. My husband will kill that child over a thing like this" (Shanley & Rudin, 2008).

patriarchal relations within western society, and within the family. It might be argued that some women have enjoyed some level of emancipation from patriarchy, however the prevalence and seriousness of domestic violence as a gendered form of violence that permeates across all socioeconomic domains of western society limits this argument. The seemingly contradictory discourses of children as precious and the family as happy and loving amidst the perpetration of violence in the home can be reconciled: domestic violence is needed to preserve the family. Like the Church, the family as an institution itself requires investigation “with regard to the way it systematically creates conditions for such crimes” (Žižek, 2009, p. 143), and perhaps even ‘seduces’ men to perpetrate violence against their own beloved women and children.

The Monstrous Perpetrator is used to preserve illusions of a safe and caring society amongst layers of hierarchal and intimidating relations. Drawing on Hannah Arendt’s thesis of the banality of evil, Bauman (2011) surmises,

How safe and comfortable, cozy and friendly the world would feel if it were monsters and monsters alone who perpetrated monstrous deeds. Against monsters we are fairly well protected, and so we can rest assured that we are insured against the evil deeds that monsters are capable of and threaten to perpetrate. (Bauman, 2011, p. 134)

Citing examples from the Holocaust to Abu Ghraib, Bauman argues that what is bone-chilling is how, across time and place, unexceptional persons “are capable of acting in a perverted and sadistic way” (Bauman, 2011, p. 136). Bauman concludes that our efforts to strain out “the carriers of inhumanity from the rest of the human species are either botched

in execution or misconceived from the start – and most certainly ineffective” (Bauman, 2011, p. 136). Thus, we all are both suspect and vulnerable, monstrosity does not need a monster, and inhumanity is human.

A radical reconsideration is needed, of our understandings of the:
binaries setting out the good and the evil, the self and the other, normal and abnormal, the permissible and the prohibited ... [And] embrace instead the ambiguity and unpredictability of an openness towards the monstrous other. It is a move that acknowledges both vulnerability to the other, and the vulnerability of the self. (Shildrick, 2002, p. 3)

This includes embracing the vulnerabilities of both victims and perpetrators. Of course, they are not so different as dominant discourses would have us believe. To transition from *The Vulnerable Child* to *The Monstrous Perpetrator* is to cross a fine line, constituted by a few years, a difference in gender, or any other small increment on any axis of marginalisation.

The promise that *The Monstrous Perpetrators* are only a small number of wayward individuals who act in discordance with society, is the hegemony of this figuration. Instead, *The Monstrous Perpetrator* acts in accordance with and extends the violence that is socially perpetrated and condoned by the objective violence within the structures. In concert with the figurations of *The Vulnerable Child* and *The Responsible Family*, *The Monstrous Perpetrator* turns our gaze away from the proprietary relations that form the fabric of family life. The discourse of pathology deflects responsibility onto the perpetrator and refuses to acknowledge how extreme violent acts are extensions of, and even incited by, these types of social structures and values that support them.

Conclusion

As I have argued throughout this chapter, responses that focus on spectacular violations of children and spectacular figurations of their abusers concentrate attention away from most CN&A. Concentrations on subjective forms of violence articulate into deferrals of objective violence and a disavowal of the relation between these forms. This technique allows the cause of spectacular violence to be attributed to an identifiable agent: *The Monstrous Perpetrator*. It is this figuration that legitimises the contemporary medico-legal responses within CPSs.

By tracing the history of these medico-legal responses, I have shown how they were produced within advances in technoscience, specifically in imaging technologies that promised to address uncertainty and the threat CN&A posed. Technobiopower influenced the practices of early CN&A experts, figured *The Battered Child* and *The Shaken Baby*, and redefined CN&A as subjective forms of violence. In turn, these figurations evoked urgent responses confounded by the paradoxical ways images operate within a visual culture. In many instances, the overreliance on imaging technologies and diagnostics has had a disruptive effect on child protection and has undermined children's voices. Their promise to identify and excise an identifiable agent (*The Monstrous Perpetrator*) offers a mechanism to preserve an understanding of society as safe despite expanding objective violence. However, I have also demonstrated how *The Monstrous Perpetrator* operates as a technique of power, maintaining social order and inequity. Thus, illustrating again how investigation and substantiation of CN&A operate and are paradoxical to the overall aim to protect children. Images, while improving in quality and digitalisation, continue to mediate responses and entrench the *game of origins*. These highly visual responses are shown to

operate paradoxically in relation to child protection forming the action of inaction rather than meaningful responses to C&NA. Amongst these responses, nurses work to mitigate the harm of the medico-legal system, and navigate compromised relationships with children and their families. Fractured relations interfere with nurses' possible contributions to child protection and leave them even more powerless to assess and intervene on behalf of the child.

Justified by discourses of risk and safety, *The Monstrous Perpetrator* is produced within gendered, racialised and classed discourses as well as through ambivalent discourses of psychopathology. Through the threat of its existence and horrors, this figuration participates in a colonisation of the child justifying the erasure of children from public spaces and sequestering them in the privacy of the family home, the place where they are most likely to experience violence. This chapter demonstrates that concentrations on spectacular forms of CN&A facilitate another turning away from most children who are neglected or abused. Limited understandings of violence allow these concentrations, support individualised responses that disavow social responsibility, distract from its prevalence, and render invisible the everyday violations that children experience.

Chapter 6: Conclusion

The original inquiry of this thesis was concerned with how nurses respond to CN&A and what guides these responses. While nursing practice remains the focus of this research, a critical analysis of nursing responses to CN&A required I step back, at times a long way back, to better understand these responses as they are situated within the social. Thus, I journeyed through the politics of contemporary responses to CN&A, in which nurses are enrolled. Reflecting on this journey, I returned to Castañeda's analysis of *The Developing Child*, which I discovered during my literature review of childhood. Merging the sociology of childhood with critical cultural studies of technoscience, bodies and worlds, Castañeda's analysis exemplified how technobiopower constitutes categories of difference and erases children (Castañeda, 1997, 2002). Through Castañeda's work, I was introduced to Donna Haraway's conceptualisations of technoscience and figuration. Attuned to dialectical relations, these conceptualisations aligned well with DRCDA and reconciled the contradiction of social constructionism of discourse and the materiality of the body, a contradiction that was foregrounded by the child.

After working with these ideas (e.g. Einboden et al., 2013a; 2013b), I followed Haraway's (1997) methodology and Castañeda's (2002) examples, tracing the outline of the figuration of *The Vulnerable Child* in the corpus texts, and later *The Responsible Family* and *The Monstrous Perpetrator*. Haraway's methodology supported an analysis that appreciates the intersections of the personal, social and cultural, and was able to "turn dominant world-making over, and open up an alternative vision of how things can be done and can be

understood” (Latimer, 2016, September 26). Castañeda (2002) offered further direction with the analysis of *The Vulnerable Child*, through her insistence that:

It is critically important to understand and respond both to the ways in which the child (as one among a number of categories of difference) comes to *accrue significant cultural value*, as well as the work that it does along the way. ... Asking *how and why* the child as a figure has been made a resource for wider cultural projects brings the child into the foreground of analysis regarding its uses and value for adult discourses, and provides the groundwork for imagining an alternative order of things. (p. 1, emphasis in original)

Throughout the thesis, I have considered how the figurations of *The Vulnerable Child*, *The Responsible Family* and *The Monstrous Perpetrator* are produced, distributed and consumed, and how they operate as cultural resources and techniques of power. From a DRCDA perspective, these figurations form obstacles to addressing CN&A by grounding contemporary child protection responses in their hegemonic animations.

Produced as far back as the Enlightenment era, *The Vulnerable Child* justifies oppressive proprietary relations and surveillance over children in contemporary society. This figuration sets the child’s body as the site of vulnerability rather than questioning the social context in which their vulnerability is produced. Paternalisms are justified and enforced by legal discourses, requiring the subjugation of children by their parents and other adults, including nurses. Children’s views are considered contingent on adult definitions and interpretations of their capacity. Thus, everyday social structures and

practices participate in the production of children's vulnerability and undermine children's agency and power.

The figuration of *The Responsible Family* took form with the division between public and private labour during the Industrial Revolution, and was further entrenched during the post-World War II era with the privatisation of domestic and reproductive work. This figuration continues to operate in a way that contains and defers the problem of CN&A to one of parental and especially maternal responsibility, regardless of parental resources or capacities. Although saturated with discourses of love and affection, *The Responsible Family* is a technology of the liberal state. Denial of social responsibility for children allows marginalisation and inequity to be preserved and reproduced through *The Responsible Family*. This figuration also institutionalises paternalisms and isolates children in the privacy of the home, where they are most likely to experience abuse. Parents who fail to keep their children safe are constituted as irresponsible, or figured as *The Monstrous Perpetrator*, irrespective of their distress and powerlessness.

The Monstrous Perpetrator is a shadowy figuration, produced within anxieties about human capacity for monstrous behaviour and the use of violence to maintain social order. The magnitude of the problem of CN&A reminds us of the human capacity for violence, a capacity that is cultivated in certain social situations. As the identifiable agent of CN&A, *The Monstrous Perpetrator* contains and externalises CN&A, supporting the story that it is perpetrated by a few wayward individuals. The culpability of *The Monstrous Perpetrator* is emphasised in a way that contains violence and legitimises a medico-legal focus on the child. This figuration works in tandem with *The Vulnerable Child* and *The Responsible Family*, intensifying the surveillance of children within their isolation. *The Monstrous Perpetrator* diverts attention away from poor social conditions for children and preserves ignorance

about how violence escalates, and how this context incites more spectacular forms of CN&A.

Following Žižek's analysis of violence, and by tracing the lines between subjective (spectacular) and objective (structural) forms of violence, the findings from this study point to how CN&A operates as a contemporary mechanism of power that generates and maintains social hierarchies. The figurations of *The Vulnerable Child*, *The Responsible Family* and *The Monstrous Perpetrator* coordinate responses to CN&A that remain actions of inaction. Thus, the figurations ensure the smooth running of the social. It is in this way that "the social order 'needs' the social wrong" (Fairclough, 2009, p. 170). The production and maintenance of social hierarchies and inequity requires violence. This thesis demonstrates how CN&A is a technique of power and an integral mechanism of social ordering.

Social ordering starts early in our lives. Analysis of *The Vulnerable Child* allows the cultural use and value of this figuration for projects of social ordering to come into focus. While this project is not in full view, its imprints are everywhere. For example, Ahmed recounts the Brothers' Grimm fairy tale of *The Willful Child* (Ahmed, 2014, p. 1; 2017, p. 67).⁶⁰ In this tale, the child who disobeys her mother is rejected by God and struck with disease and death. At the child's burial, her arm rises up through the earth in a display of defiance. Replaced and reburied, the child repeatedly raises her arm up until her mother strikes it with a rod, after which the arm is drawn in and rests in the ground. Ahmed (2017b) argues:

⁶⁰ Ahmed (2017a) explains her deliberate use of an American spelling of 'willful' to preserve 'will' within the text and her choice to gender *The Willful Child* as a girl (who is non-gendered in the original German text, and gendered as boy and but more often as girl, depending on the English translation) (see explanation, p. 68).

If authority assumes the right to turn a wish into a command, then willfulness is a diagnosis of the failure to comply with those whose authority is given. The story is thus about how authority is given. It is part of a tradition Alice Miller (1989) called “poisonous pedagogy,” a tradition of educational writing that assumes the child as soiled and spoiled by sin; and which *insists on violence as moral correction, as being for the child*. ... the rod becomes a technique for the elimination of willfulness ... It offers a warning: *be willing or you will be beaten*. It offers an invitation: *identify with the rod and you will be spared*. So much violence is abbreviated here: *so much silence about violence is explained here, as if by not bringing ... violence up, not noticing it, not mentioning it, you might be spared*. No wonder: whenever someone [brings] violence up, the willful child quickly comes after her. She is a way of coming after her: as if to say, speak up and her fate will be yours. The figure of the willful child is a container; a way of containing snap⁶¹; making her refusal appear lonely and unsupported: her protest becoming babble; her voice scrambled, a stray, faint, so faint, becoming fainter, *until she disappears*. (Ahmed, 2017, May 21, emphasis added)

The fairy tale offers a lesson: resisting authority will result in being beaten; and compliance is a condition upon which social acceptance may be granted. It is about how authority is given and preserved, and how each of us come to ‘*identify with the rod*’. Quiet acceptance of violence is matter of survival. We must bury our willfulness to survive within society; our

⁶¹ Ahmed (2014, 2017a) uses ‘snap’ to define a breaking point, a moment with history that evokes a crisis or a conflict. Snap is a response to being threatened and pushed too far; it “can also be an opening, a new way of proceeding, depending on how we do or do not resolve that crisis; depending on whether we think of a crisis as something that needs to be resolved” (Ahmed, 2017, p. 187).

compliance is ensured by our drive to be (conatus) and our sociality. Ahmed urges us to resist the violence of the social order by keeping the arm of *The Willful Child* up, to prevent her, and our own, erasure.

Engaging critical methodology to study responses to CN&A within the social resists the '*silence about violence*'. The figurations found within the texts embody obstacles but also point to possibilities for resistance, social change, and an ethical place for nurses to stand. Acknowledging that technoscience intensifies our perception of threatening 'facts' about our contemporary world, Haraway (1997) counsels: "Changing the stories, in both material and semiotic senses, is a modest intervention worth making" (pp. 44-45). The compelling nature of narratives open possibilities for finding an ethical place to stand, and guide the recommendations presented below. First steps include attending to social justice and inclusion, by recognising how children are marginalised within society.⁶² Next steps include recognition of how spectacular forms of CN&A erupt from this structural violence, and of how collective social responsibility and willfulness are needed for change.

Recommendation 1 – Respect children as equal persons within society

1.1 Break the silence about CN&A

Dominant hierarchical social relations require silence about violence or its threat, therefore naming it, or 'bringing it up', is an important strategy to decrease its power (Ahmed, 2017). Opportunities to name the violence children experience abound. These opportunities range

⁶² Children's marginalisation was recently illustrated by a case where a sole-parent family living in downtown Vancouver was investigated by the MCFD's due to the children (aged seven to 11) using public transport without their parent. The MCFD decided that children under 10 years of age are not eligible ride public transport without an adult, regardless of the child's capacity to safely navigate their way (see Brend, 2017).

from noticing when children are excluded to challenging discursive constitutions of sexual violence, as one of the participants of this study argued, children are not “*having sex*” (RN₁₉) when being assaulted. Considering the tropic qualities of figurations of *The Vulnerable Child*, *The Responsible Family* and *The Monstrous Perpetrator* and challenging their operations are other central ways to bring up violence and open a dialogue about CN&A.

1.2 Include children in public social life

The erasure of children is one of the most important findings in this thesis. Although rhetorically children are valued as the most precious members of society, they are among the most marginalised. The inclusion of children in public social life, ensuring safe spaces for children to be, and for their voices to be heard, resists their erasure. While there has been much effort by domestic violence scholars and activists to challenge the sanctity and privacy of the family home and expose it as a site of violence for many women and children, these efforts need to be recognised and prioritised within public health agendas. Recognition and prioritisation of children’s inclusion could be initiated by engaging in critical considerations of how public and private social spaces could be made safer and more accessible to children. Designing inclusive, child friendly cities, towns, workplaces, schools and homes is not impossible but begs imagination, as well as the contributions of children.

1.3 Abolish corporal punishment

Highlighting the relationship between everyday and extreme violations points to the need to challenge the proprietary parent-child relations and the use of violence in child-rearing. During the hearing when Canada’s Supreme Court reified corporal punishment by delimiting ‘reasonable force’, dissenting Justice Binnie aptly argued,

To deny protection against physical force to children at the hands of their parents and teachers is not only disrespectful of a child's dignity but turns the child, for the purpose of the Criminal Code, into a second class citizen. (*Canadian Foundation for Children Youth and the Law v. Canada [Attorney General]*, 2004)

In abolishing corporal punishment, Canada would join an international movement, in the company of 52 nation states that have progressed this legislation in compliance with the directives of the *UNCRC* (Global Initiative to End All Corporal Punishment of Children, n.d.). Further, children need support to develop a sense of personal power, self-worth and boundaries that are expected and respected in all relationships. Activities and programs that foster these attributes hold potential for protecting children from violence.

1.4 Critically analyse practices that measure and monitor children

Homogenising children using technologies of normalisation is another mechanism that contributes to the child's erasure. Critical analyses of practices of measurement and surveillance of children, how these are used, and learning about their implications for children are needed. Developmental assessments orient nurses to focus on the child's body and maternal behaviours, de-emphasising social deprivations, which are constituted as too difficult to change and constitute children who are 'developmentally delayed' as of either less social worth or social liability (Einboden et al., 2013a, 2013b). Similarly, the technocratisation of child rights into indicators has led to a dilution of rights as an emancipating legal instrument. A child rights framework offers an important way to lever change in extreme violations, yet it entrenches individualism and reinforces the figuration of *The Vulnerable Child*. Moving away from standardisation toward a flexible approach that

values the individuality of children and supports them to develop skills to contribute to society in various ways aligned with their strengths, is recommended (Duff, 2010).

Recommendation 2 – Develop an infrastructure of support for parents

2.1 Ensure resources to support families' basic needs

Accessible, integrated and flexible resources are needed for supporting families. The nurse participants in this study *all* identified the importance of material and relational provisions for family sustenance, safety and sociality. *“[F]inances have a huge role in it. ... we all need to have a roof over our head, we all need to eat, and it sure as heck would be nice to go to a movie once in a while”* (RN₁₁). *“Anything you do for families to support them at a very broad-based level is what you need to do”* (RN₇). Participants identified how vulnerabilities ensued with material deprivations, and how the nurse's ability to support child safety required the provision of basic needs to families.

2.2 Address the exploitation of reproductive labour

Since Industrialisation and the public and private divide of labour, reproduction and child rearing has been exploited and devalued. Positioning mothers with full responsibility for children without resources is a serious issue of social inequity, and increases women's and children's vulnerability to other forms of violence. Ensuring financial emancipation through fair compensation for mother's social contributions is essential to child protection.

Strategies could build on existing initiatives such as mother's allowance, shifts in taxation structures for young families, as well as quality childcare programs that are flexible, accessible and free of charge.

2.3 Address isolation of women and children in the privacy of the home

This thesis has shown how the figuration of *The Responsible Family* has preserved spaces where many children and their mothers are not safe, or where their safety is contingent on the values, beliefs and actions of fathers or partners. Domestic violence is an issue for children's safety *beyond* being exposed to the abuse of their mothers. Supporting nurses to build relationships with new mothers is urgent. Nurses can "eyeball" (RN₂₀) the family living situation, which as CPWs well know, can be more informative than diagnostic imaging. Further, an ongoing relationship with the nurse provides multiple opportunities to intervene before violence escalates.

Nursing responses need to be part of a coordinated social response to domestic violence. Social attention to domestic violence is increasing and a social response is developing around a similar pattern of spectacularisation seen in relation to CN&A responses. Instead, a response that includes gendered analysis of domestic violence is needed, as it encourages attention to the ways which unequal relations of power support conditions for coercion and control, and counters the construction of women as victims thus undermining women's agency (valentine & Breckenridge, 2016). In particular women and children require,

long-term and flexible support, rather than that which is time limited; and for services that meet economic and financial needs as well as psychological and mental health needs. There is also a need for increased access to legal responses, because courts are a key part of supporting women's capacity for choice and independence. (valentine & Breckenridge, 2016, p. 42)

Recommendation 3 – Increase nurses’ roles and autonomy in responding to CN&A

3.1 Redistribute funding to increase nursing presence with children and families

Narrow understandings of what constitutes CN&A has led to inadequate resource allocation for child protection. While BC’s current CPS is underfunded for its mandate (RCY, 2015), the findings from this study illustrate how simply pouring more resources into responses that prioritise investigations and substantiation of individual CN&A cases, at the expense of family support, would be unethical. Using the example of the state of Connecticut, Leventhal (2005) illustrates the trends in allocation of resources across developed countries and suggests that we could do so much more with a *redistribution* of current funding:

[T]he 2004 budget for home visiting and related preventive services was \$7.2 million per year for the 31 sites. This is in contrast to the budget for the state’s child protective service agency, which was \$650 million. The ratio of child protection to prevention was 90 to 1. Imagine how much more prevention could be accomplished if in every community the ratio were closer to 10 to 1. (p. 209)

Evaluations from Australia support refocusing child protection initiatives on family support, but caution that the success of these initiatives requires ensuring that the family’s basic needs are also met (Churchill & Fawcett, 2016). The intent of the child protection reform in the state of New South Wales has been to use a public health approach and this has supported a shift towards holistic services, however tensions in relation to early intervention, discursive categorisation of families in relation to risk, what services should be offered, whether these services should be mandated or voluntary, and what agencies

should be responsible for service provision remain (valentine & Katz, 2015). Attention to these issues is required in working towards prevention oriented child protection in Canada.

The nature of nursing work means that nurses gain important insights from spending more time with families than other health professionals. Nurses have a unique position that sets them up in an ideal way to address child protection collaboratively with families. The nature of nursing work allows nurses to *“sit back and listen ... ask some of the right questions”* (RN7). Presence and trust are central to nurses' CN&A prevention efforts. Thus, it is concerning that community nurses in BC, who could take a lead in CN&A prevention, have been spread thinly across schools, required to prioritise immunisation agendas over other aspects of their roles, and shifted from universal to targeted home-visiting for new mothers. The findings of this thesis call into question the erosion of the community and primary care role for nurses in BC, and emphasise the opportunity for nurses to integrate child protection into health and community services. As demonstrated with the Nurse Family Partnership (NFP), when nurses are well supported, they are effective in *preventing* CN&A (Olds, 2006; Olds et al., 2002; Olds et al., 2014). Thus, nurses could play a key role in reorienting the CPS to interrupt rather than respond to violence.

3.2 Challenge mandatory reporting legislation

As demonstrated throughout Chapter 4, BC's mandatory reporting legislation launches a coordinated set of deferrals that undermine the role and responsibility of nurses to intervene on behalf of a child. This study confirmed findings by Crisp and Lister (2004); Land and Barclay (2008); Nayda (2002) that nurses' poor reporting compliance was related to their prioritisation of relationships with families, rather than an inability to recognise CN&A

or lack of understanding of legislation. *Nurses intervened through their relationship with the family.* As Gilbert et al (2009) suggests:

Professionals who have continuous contact with children ... can have a leading role in recognising, responding to, and supporting maltreated children. Their scarce reporting to child-protection agencies is a cause for concern, and we need to find out whether maltreatment is being recognised and dealt with in other ways. (Gilbert, Kemp, et al., 2009, p. 176)

Mandatory reporting compromises nurses' ability to address abuse. Children, especially those who mistrust the MCFD, are further isolated because this law makes it risky for them to disclose abuse, even to adults they trust. Nurses described feeling like they were betraying children's trust: *"their little worlds just fall apart once they have disclosed"* (RN₆); *"as soon as you report that, they are never going to talk about their abusive experience again. And they are trying to"* (RN₂₁). Mandated reporting is legitimised by the assumption that the state can provide better conditions for children. Yet, McTavish et al. (2017) found that while mandatory reporting has resulted in the identification of more cases of CN&A, in line with the findings from this thesis, they also found that

negative experiences seem to involve the reporting process itself and the associated responses (or lack of response). A key issue is the number of children identified by MRs [mandatory reporters] who receive either no service or of greater concern – inappropriate, ineffective or harmful responses. (p. 11)

Amidst a failing CPS, BC's abused and neglected children are set up for *"the ultimate betrayal"* (RN₇). *"There needs to be some leeway there with clinicians"* (RN₂₁) because current structures limit nurses' autonomy and undermine their ability to collaborate with families to address violence.

3.3 Decentralise decision-making power regarding child protection

Decision-making authority is centralised with the MCFD. The CPWs are gatekeepers to services, set rules for families, and decide when to escalate matters to the courts. Once a report is made, the reporter and family have no control over the outcome. Despite inadequate staffing, poor retention and lack of training and experience of CPWs, centralisation of their authority is rarely challenged. Findings demonstrate how nurses' abilities to work effectively with families is related to *their lack of authority*. Thus, an essential caveat to increasing nursing autonomy and participation in CN&A responses would be to preserve current relations of power between nurses and families. What could be shifted is the way that decision-making is enacted, to include a more collaborative model that encourages contributions of children, their families and service providers in relation to child protection decisions.⁶³

⁶³ 'Open Dialogue' is an example of a model for decision-making with persons in mental health services that could be applied to child protection. Principles of this model include: an immediate response; inclusivity of the person's social network; flexibility, mobility, responsibility and continuity of care providers; tolerance of uncertainty; and dialogism (Seikkula et al., 2003, p. 163). Responsiveness, continuity of relationships, engagement of the child's social networks, and the mobilisation of family resources align well with child protection. Creative strategies to include children's voices, regardless of their linguistic ability would be needed.

Finding an ethical place to stand

Networked into the community, nurses are well positioned to ‘bring up’ violence, and doing so can support meaningful responses to CN&A. Nurses can support communities to engage in dialogue that encourages taking a step back to appreciate the complexities of violence and operations of power. Findings from this study point to five strategies that can support nurses to find a place to stand, each of which I will briefly discuss below with an example of how it might be applied in practice.

1. *Develop critical understandings of the connection between everyday and extreme violence.*

It is well understood that violence concentrates on the bodies of society’s most marginalised persons. Yet, the dominant social discourse continues to constitute spectacles of violence as coming from nowhere amidst an otherwise peaceful society. Thus, this concentration of violence is more often understood as incidental rather than an integral part of the way violence flows. Worse, it is also constituted as if marginalised persons are responsible for their own suffering. Deprivation, social ordering and exclusion ground spectacular violence. Making explicit links between structural and spectacular forms of violence provides an alternate discourse, and thus an opportunity to reframe accountability from individual to social, and shift responses towards social inclusion and equity.

An example of how this strategy could be enacted in practice and in education for nurses is to offer complex scenarios about family violence for small groups to work through with some discussion and reflection questions. The cases of Matthew Vaudreil (Gove, 1995), the girl from the *Lost in the Shadows* report (RCY, 2014), or the girl with a disability and her ill mother (RCY, 2011), all have distinctive links between structural and spectacular violence.

Each case includes a background of multiple intersecting poverties, social isolation and exclusion, stigmatisation and lack of support for parents with mental and physical health problems, which constituted the everyday violence of these children's family lives.

Discussion of these cases could include questions about how the ideologies of vulnerability (the figuration of *The Vulnerable Child*) and of parental responsibility (the figuration of *The Responsible Family*) guided care providers to make decisions, and take some actions and not others? In addition, each case cumulates in extreme spectacular violence (homicide, suicide, and dehydration/starvation). Discussion questions might work to bring into view forms of everyday violence, the social beliefs and values contributed to the isolation and invisibility of these particular children, and how these beliefs and values might be challenged.

2. *Historicise child protection across the social-cultural landscape of BC, including the discriminatory legacies of colonial relations with Aboriginal Peoples.*

Child protection practices are grounded in and influenced by dominant social beliefs about families and children, which have shifted over time. Attending to the history and the ways in which responses have formed in various socio-cultural contexts encourages a reflexive approach. While historical accounts of the system exist in the literature (Foster & Wharf, 2007), transparency about how child protection has operated in the past, and on what assumptions it operates today, could support the decentralisation of decision-making power and offer a way to address the ongoing colonialism within the system. As de Leeuw (2014) suggests, a practical and urgent approach would be to contextualise child safety concerns within ontological realities of colonialism for Indigenous families and communities. Thus, instead of removing children, serious attention to reparations and resources are needed in collaboration between families, communities and service providers (John, 2016).

Further, to understand these contexts, service providers (health care, education, child care, CPWs) need to learn about the specific regional context where they practice, including details of the colonial past and present (e.g. ongoing unsettled land title or sovereignty over aspects of community and family life). Institutions could support their staff to develop these understandings by connecting with the Indigenous community in the area, and by creating reports or other materials that capture information about the region's relations, legislations, and agreements since the first contact between the Indigenous community with white settlers up to present day. For example, as part of the *EQUIP Healthcare: Research to Equip Primary Healthcare for Equity Project*, regional histories were compiled for each primary healthcare clinic to ensure contextualised interventions were developed that were appropriately oriented to enhance equity-oriented services (see Varcoe et al., 2014).

3. Consider how our affections and sociality operate to cultivate suspicion.

Suspicion sits at the crux of legal response to CN&A and thus requires careful consideration. Instead of directly guiding practices this study has described how suspicion is better considered as a sign, which requires further interpretation that attends to our sociality. Ignoring affective experiences has led to oversimplifications and inappropriate responses. In practice, this would mean suspicions and affective experiences (such as fear, disgust, pain) are considered carefully in effort to support understandings of the context and social relations. Encouraging dialogue about suspicion among health providers would be one way to engage in this strategy. Nurses and other care providers could be invited to bring to a seminar or small group discussion an example of when they felt suspicious about safety concerns for the child, and share details of their experiences and actions. Focusing on the cases where suspicions were complicated and unclear would likely be the most productive.

Further, structuring a dialogue around the care providers' affective experience, context, previous experiences, values and beliefs about the appropriate treatment of children, and expectations of families might also be fruitful. In this way, care providers would have the opportunity to share different perspectives about the experience and appreciate the complex nature of suspicion and uncover ideological assumptions and power relations that underpin affections.

4. *Expose the tropic nature and operations the figurations of The Vulnerable Child, The Responsible Family and The Monstrous Perpetrator.*

How the figurations operate to preserve conditions for CN&A have been articulated throughout this thesis. Conceptually, they can be understood as obstacles to addressing this social wrong or an integral part of the structural violence that sets the conditions for spectacular forms. Engaging in public dialogue about the tropic nature of these figurations holds potential for initiating significant change. They are easily recognised and revealing their tropic qualities erodes their power. In practice, disrupting dominant hegemonic discourses of children's vulnerability, parental responsibility and perpetrators' monstrosity might be accomplished by offering further context to these figurations, including describing their production, distribution and consumption within contemporary society, and CN&A discourses. Encouraging dialogue and critique about the ways in which children's vulnerability is socially constructed, rather than solely biologically determined is needed. Offering examples and identifying the ways that the definitions of children and childhood have shifted over time offers an important starting place. Similarly, common-sense notions of parental responsibility can be challenged by examining the economic situations for many young families in BC, including challenges related to the cost of housing and child care. As

suggested above (see point 1), discussion of cases could include questions about how the ideologies of children's vulnerability and parental responsibility guide responses. Finally, disrupting the notion of perpetrators as monstrous might begin with a discussion about why perpetrators are identified and monitored in the community, and how it is that seemingly 'normal' people perpetrate violence. Following Arendt's (Arendt, 1963/2006) notion that monstrous deeds do not require monsters, dialogue should aim to disrupt the ideology that individual people are essentially 'good' or 'evil', and build an appreciation for human vulnerability to behave in line with the situations they find themselves in.

5. Encourage collective community responsibility for addressing CN&A.

Together these findings and recommendations offer possibilities to reconsider and disrupt contemporary responses to CN&A. The idea of cultivating collective responsibility may be open to critique as being too big, difficult, or utopian. However, I am reminded that an overwhelming sense of powerlessness to effect change, characteristic within modernity, allows the reproduction of dominant relations of power (Chouliaraki & Fairclough, 1999). I am also reminded that it is much easier to be swept up in pseudo-activity than to pause, think, and act carefully (Žižek, 2009). This study had demonstrated that many contemporary child protection responses are misaimed. Not only are these responses uneven in their ability to address violence against children, this study has also shown they operate paradoxically, preserving inequitable relations of power and allowing the violence children and their families experience to continue. The resistance of CN&A to change, despite considerable effort over the last century, highlights a significant change of tack is required to meaningfully address the violence children experience. Responses need to pay close attention not to reproduce CN&A directly, or indirectly by creating the conditions for it.

Recommendations from this study offer a challenge for nurses, families, communities, and nations to rethink how we engage with children, and to move away from paternalisms of protection towards a discourse of respect. Within these initiatives, there is room for nurses to redefine their role, contribute to a collaborative and socially just child protection response, and in so doing find an ethical place to stand.

Appendices

Appendix 1: Publications relevant to this study

Peer-reviewed Journals

1. **Einboden, R.**, Rudge, T. & Varcoe, C. (2013). Image, measure, figure: a critical discourse analysis of nursing practices that develop children. *Nursing Philosophy*, 14(3), 212-222. DOI: 10.1111/nup.12023
2. **Einboden, R.**, Rudge, T. & Varcoe, C. (2013). Producing children in the 21st century: a critical discourse analysis of the science and techniques of monitoring early child development. *Health: an interdisciplinary journal*, 17(6), 549-566. DOI: 10.1177/1363459312472081
3. **Einboden, R.**, Rudge, T. & Varcoe, C. (2011). Battling the passions: the birth of a conceptual understanding of suspicion for child abuse and neglect. *Aporia*, 3(2), 5-14.

Conference Presentations (with peer-reviewed abstracts, presenter underlined)

4. **Einboden, R.** (November 1, 2016). *The spectacularisation of child abuse and neglect*, Concurrent Session, The 2nd Critical Perspectives in Nursing and Health Care International Conference, The University of Sydney, Sydney, Australia.
5. **Einboden, R.** & Rudge, T. (October 27, 2016). *A Freudian slip: de-legitimising the discourse of paedophilia*, Poster Session, The 21st Nursing Network on Violence Against Women International Conference, La Trobe University, Melbourne, Australia.
6. **Einboden, R.** & Rudge, T. (June 11, 2015) '*Children of the Recession*': critical policy analysis of a report card on child poverty. 6th International In Sickness and In Health Conference, The University of the Balearic Islands, Mallorca, Spain.
7. **Einboden, R.** & Rudge, T. (September 2, 2014). *Child rights in the context of child abuse and neglect, innovation or family isolation? A critical discourse analysis*. Concurrent Session, 5th International Conference Critical Approaches to Discourse Analysis across Disciplines, Elte University, Budapest, Hungary.
8. **Einboden, R.** (May 27, 2014). *Shifting accountability beyond 'a game of origins', a critical discourse analysis of practices that address child abuse and neglect in BC, Canada*. Concurrent Session, Philosophy in the Nurse's World 2014: Troubling Practice, University of Alberta, Banff, Canada.
9. **Einboden R.**, Rudge, T. & Varcoe, C. (January 30, 2014). *Figuring the ideal child: critical considerations for early child development theory and practice*. Poster Session, Early Years Conference 2014: Shaping Childhoods that Matter, Vancouver, Canada.

10. **Einboden, R.** & Rudge, T. (December 4, 2013). *Action on child abuse and neglect? Discourse analysis on legal guidelines in British Columbia, Canada*. Concurrent Session, 4th Biennial New Zealand Discourse Conference, Institute of Culture, Discourse & Communication, Auckland University of Technology, Auckland, New Zealand.
11. **Einboden, R.**, Rudge, T. & Varcoe, C. (July 20, 2013). *Shaken and stirred: an analysis of media discourses in the Shaken Baby Syndrome debate*. Concurrent Session, 5th International In Sickness and In Health Conference, University of Ottawa, Montréal, Canada.
12. **Einboden R.**, Rudge, T. & Varcoe, C. (June 19, 2013). *Shaky foundations: reconsidering knowing and responding to Shaken Baby Syndrome*. Concurrent Session, 1st Critical Perspectives in Nursing and Health Care International, University of British Columbia, Vancouver, Canada.
13. **Einboden, R.** & Rudge, T. (June 16-18, 2013). *Suspicion: A paradox of objectivity*. Poster Presentation, The 19th Nursing Network on Violence Against Women International Conference, University of British Columbia, Vancouver, Canada.
14. **Einboden, R.** & Rudge, T. (September 10, 2012). *An untapped resource: engaging nurses as active partners in preventing child abuse and neglect*. Concurrent Session, XIXth ISPCAN International Congress on Child Abuse and Neglect, Every Child Matters: Promoting Local, National and International Partnerships for Protecting Children, Istanbul, Turkey.
15. **Einboden, R.** & Rudge, T. (September 9-12, 2012). *Suspicion: a paradox of objectivity*. Poster Presentation, XIXth ISPCAN International Congress on Child Abuse and Neglect, Every Child Matters: Promoting Local, National and International Partnerships for Protecting Children, Istanbul, Turkey.
16. **Einboden, R.**, Rudge, T. & Varcoe, C. (May 14, 2012). *Commodity and cost: implications of figurations of 'the developing child'*. Concurrent Session, Philosophy in the Nurse's World: Politics of Nursing Practice II, University of Alberta, Banff, Canada.
17. **Einboden, R.**, Rudge, T. & Varcoe, C. (May 6, 2011). *Producing children: healthy development, risk and human capital*. Concurrent Session, 4th International In Sickness and In Health Conference, University of Southern Denmark, Odense, Denmark.
18. **Einboden, R.** (September 21, 2010). *Suspicion as a human experience: the particular case of child abuse and neglect*. Concurrent Session, 14th International Philosophy of Nursing Conference, 'Philosophizing Social Justice in Nursing? International Philosophy of Nursing Society (IPONS), University of British Columbia, Vancouver, Canada.

Appendix 2: Data Corpus

Genre	Text and Source	
Legislation	Provincial	<i>Family Law Act (2011)</i> <i>Child, Family and Community Service Act (1996)</i> <i>Representative for Children and Youth Act (2006)</i>
	National	<i>Criminal Code of Canada (1985)</i>
	International	<i>United Nations Convention on the Rights of the Child (1989)</i>
Professional Obligations	College of RNs of BC	<i>Professional Standard 1: Professional Responsibility and Accountability</i>
		<i>Legislation Relevant to Nurses' Practice</i>
		<i>What were the warning signs? Case study about a nurse's legal obligation to disclose</i>
		<i>Practice Standard: Privacy and Confidentiality</i> and online module
	Ministry of Children and Family Development	<i>*The BC Handbook for Action on child abuse and neglect: for service providers (2007) (n=6)</i>
	Canadian Nurses' Association	<i>*Code of Ethics for RNs (2008) (n=1)</i>
News Media	<i>National Post (National Edition)</i>	
	<i>Canadian Broadcast Corporation News Online (British Columbia)</i>	
	<i>The Province</i>	
	<i>The Vancouver Sun</i>	
Report	Representative for Children and Youth	<i>Lost in the Shadows: How a Lack of Help Meant a Loss of Hope for One First Nations Girl (2014)</i>
Interviews	Audio-recorded interviews with practicing BC RNs (n=21)	
Institutional Policies	Children & Women's Health Centre of BC	<i>*Guideline: Children's & Youth at risk for abuse and neglect (n=1)</i>
	Fraser Health	<i>*Child Physical Abuse: Assessment in the Emergency Department Guideline (n=3)</i>
	Authority Clinical Practice Guidelines (2010)	<i>*Child Sexual Abuse: Assessment in the Emergency Department Guideline (n=3)</i>
		<i>*Fraser Health & Fraser Region: MCFD Child Welfare Alerts Protocol and Guidelines (n=3)</i>
Nursing Literature	Hockenberry, M., Wilson, D. & Rodgers, C. (2017). <i>Wong's Essentials of Pediatric Nursing 10th ed.</i> St. Louis: Elsevier.	
	<i>*Adams, J et al (2007) Guidelines for medical care of children who may have been sexually abused. Journal of Pediatric Gynecology, 20, 163-172. (n=1)</i>	
	<i>*Proceeds from: Annual San Diego International Conference on Child and Family Maltreatment (2012) (n=1)</i>	
	<i>*Early Childhood Educators of BC, Let's Talk About Touching (n=1)</i>	

* indicates texts identified by nurse participants; n=number of participants

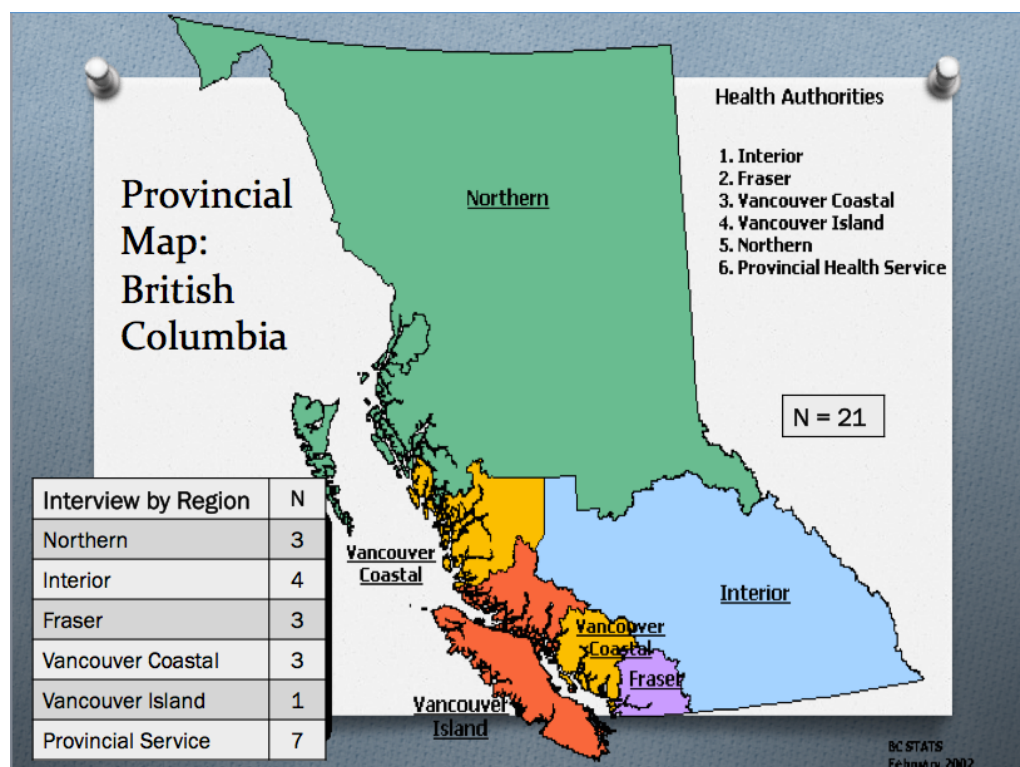
Appendix 3: Participant Selection Criteria

Inclusion Criteria	Exclusion Criteria
<i>At the time of the interview, the participant:</i>	<i>At the time of the interview, the participant:</i>
1) was over 18 years of age	1) was under 18 years of age
2) was licensed as a RN with the CRNBC	2) was not licensed as a RN with the CRNBC
3) was working with infants, children, youth and their families in any setting	3) was not working with infants, children, youth and their families
4) had experienced one or more situations of suspected or known child abuse or neglect in the context of nursing practice	4) had not experienced a situation of suspected or known child abuse or neglect in the context of nursing practice
5) had access to the Employee and Family Assistance Program	5) did not have access to the Employee and Family Assistance Program

Appendix 4: Participants' Practice Setting

Geographical setting	<i>Rural</i>	<i>Suburban/Urban</i>	
	n=4	n=17	
Practice setting	<i>Hospital</i>	<i>Community/Clinic</i>	
	n=12	n=9	
Type of health care service	<i>Primary Care</i>	<i>Secondary Care</i>	<i>Tertiary Care</i>
	n=6	n=8	n=7

Figure 8 Participant's Geographical Setting of Practice by Health Authority



Appendix 5: Participant Information and Consent Form



ABN 15 211 513 464

TRUDY RUDGE
PROFESSOR

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Suspect Practices:

An analysis of the discourses and nursing responses surrounding child abuse and neglect.

PARTICIPANT INFORMATION STATEMENT

(1) What is the study about?

Child abuse and neglect is increasingly recognized as a critical issue for population health. Due to the nature of nursing work, nurses are well placed to identify and address issues of child safety. This study will examine nursing responses to child abuse and neglect, and what guides nurses in these responses. It will use a critical discourse approach to examine this practice issue within the complexities of the social context. This study aims to generate knowledge to support a better understanding of current practices and evidence to guide strategic changes in practice and policy in development of more effective and ethical interventions.

(2) Who is carrying out the study?

The study is being conducted by Rochelle Einboden, Doctoral Research Student and will form the basis for the degree of Doctor of Philosophy, Nursing at The University of Sydney under the supervision of Professor Trudy Rudge and Professor Colleen Varcoe (University of British Columbia, School of Nursing).

(3) What does the study involve?

This study involves one semi-structured audio-taped interview. The researcher will invite you bring with you to the interview any resource which you draw on to support your practice when working with issue of child abuse and/or neglect, or suspicions of child abuse or neglect (this could be anything that supports your practice i.e. a document, article, book reference, online reference). The interview will take place in a location which is mutually agreed upon and determined by participant and interviewer prior to the time of the interview.

(4) How much time will the study take?

The interview is expected to take approximately one to one and a half hours.

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Version 1 13/04/11

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(5) Can I withdraw from the study?

Being in this study is completely voluntary - you are not under any obligation to consent and - if you do consent - you can withdraw at any time without providing any reason to and without affecting your relationship with The University of Sydney or the researchers. You may stop the interview at any time if you do not wish to continue, the audio recording will be erased and the information provided will not be included in the study.

(6) Will anyone else know the results?

All aspects of the study, including results, will be strictly confidential and only the researchers will have access to information on participants. Audiotapes and files will be securely locked and stored by the Research Support Unit at the University of Sydney, Sydney Nursing School for a period of seven years, as is required by University Policy. After that time audiotapes will be erased and files shredded. Transcriptions of the interviews will remove identifiers at the time of transcription. These also will be digitally stored in a password protected file, and shared only with the researchers and the original participants for verification/feedback purposes. Items brought to the interview will be stored and destroyed in the same manner. A report of the study may be submitted for publication, but individual participants will not be identifiable in such a report.

(7) Will the study benefit me?

This research aims to support nursing practice by examining guidelines and obligations which challenge or support nurses in responding to child abuse and neglect, and developing evidence to support strategic changes in nursing practices and policy.

(8) Can I tell other people about the study?

You are welcome to share any information about this study with others.

(9) What if I require further information?

When you have read this information, Rochelle Einboden will discuss it with you further and answer any questions you may have. If you would like to know more at any stage, please feel free to contact either Rochelle Einboden, Doctoral Research Student, University of Sydney, Sydney Nursing School, at rochelle.einboden@sydney.edu.au, Professor Trudy Rudge, University of Sydney, Sydney Nursing School at +61 2 9351 0700 or trudy.rudge@sydney.edu.au; or Professor Colleen Varcoe, University of British Columbia, School of Nursing at 604-822-7748 colleen.varcoe@nursing.ubc.ca.

(10) What if I have a complaint or concerns?

Any person with concerns or complaints about the conduct of a research study can contact The Manager, Human Ethics Administration, University of Sydney on +61 2 8627 8176 (Telephone); +61 2 8627 8177 (Facsimile) or ro.humanethics@sydney.edu.au (Email).

This information sheet is for you to keep



THE UNIVERSITY OF
SYDNEY



Consent Form

*Suspect Practices: An analysis of the discourses
and nursing responses surrounding child abuse and neglect*

Principal Investigator:

Professor Colleen Varcoe, RN, Ph.D. (Director Pro Tem)
School of Nursing, University of British Columbia, 604-822-7748

Co-Investigators:

Professor Trudy Rudge, RN, Ph.D.
Sydney Nursing School, The University of Sydney, +61 2 9351 0700

Rochelle Einboden, RN, MN, Doctoral Research Student
Sydney Nursing School, The University of Sydney, 604-329-4309

This study is being conducted by Rochelle Einboden, and will form the basis for the thesis for the degree of Doctor of Philosophy, Nursing at The University of Sydney under the supervision of Professor Trudy Rudge and Professor Colleen Varcoe.

Purpose:

Child abuse and neglect is increasingly recognized as a critical issue for population health. Due to the nature of nursing work, nurses are well placed to identify and address issues of child safety. This study will examine nursing responses to child abuse and neglect, and what guides nurses in these responses. It will use a critical discourse approach to examine this practice issue within the complexities of the social context. This study aims to generate knowledge to support a better understanding of current practices and evidence to guide strategic changes in practice and policy in development of more effective and ethical interventions.

Study Procedures:

This study involves one semi-structured audio-taped interview, expected to take approximately one to one and one-half hours. The researcher will invite you bring with you to the interview any resource which you draw on to support your practice when

working with issue of child abuse and/or neglect, or suspicions of child abuse or neglect (this could be anything that supports your practice i.e. a document, article, book reference, online reference). The interview will take place in a location which is mutually agreed upon and determined by you and interviewer prior to the time of the interview.

Confidentiality and Study Data:

Your identity will be kept strictly confidential by the separation of consent forms and data, coding and removing identifiers from data at the time of transcription, password protecting files and locking hard copies of information in storage. Audiotapes and files will be securely locked and stored by the Research Support Unit at the University of Sydney, Sydney Nursing School for a period of seven years, as is required by University Policy. After that time audiotapes will be erased and files shredded. Data will be shared between the research team and the original participants for verification and feedback purposes. A report of the study may be submitted for publication, but individual participants will not be identifiable in such a report.

Potential Risks:

Due to the sensitive nature of discussing situations of suspected or known child abuse or neglect, it is possible that the interview process could be emotionally upsetting. At the same time, the interview might create space for nurses to discuss practice challenges or distressing incidents in a constructive way, given the limited forums for these type discussions and limited invitations for nurses to share their perspectives. In order to minimize the risk of distress, the interview questions intend to generate a general discussion of practice and what informs practice, rather than explicit details of any specific case. In addition, it is important that the discussion in the interview is in accordance with your confidentiality obligations towards clients; therefore, if you discuss a case, please ensure all identifiers are omitted and use pseudonyms. Further, it is important to note that the researcher is also under legal obligation to report according to the British Columbia's Child, Family and Community Service Act in the case where there is a disclosure of the identify a child who has been, or is likely to be harmed, and that child continues to be in need of protection. However, your identity as a research participant would remain confidential, because the researcher must protect the identity of a participant as the source of information. If this were to happen, the researcher will discuss with you her reporting obligation and intended actions so you are aware prior to reporting, and will remove all identifiers from the transcripts.

You may pass over any interview questions or end the interview at any time. The researcher facilitating the interview may identify if they feel your distress is escalating, and manage this by discussing the presence of distress with you, offering either a break, to end the interview, or to facilitate your access to appropriate counseling services. All participants must be able to access their "Employee and Family Assistance Program" (EFAP). This service is confidential, free of charge, and accessible on an

urgent (24hours/day, 7 days/week) or routine basis for either personal or professional issues. All participants must have access to the EFAP as a requirement of enrolment in the study.

Contact for information about the study:

If you would like to know more at any stage, please feel free to contact either Rochelle Einboden, Doctoral Research Student, University of Sydney, Sydney Nursing School, at rochelle.einboden@sydney.edu.au; Professor Trudy Rudge, University of Sydney, Sydney Nursing School at +61 2 9351 0700 or trudy.rudge@sydney.edu.au; or Professor Colleen Varcoe, University of British Columbia, School of Nursing at 604-822-7748 or colleen.varcoe@nursing.ubc.ca.

Consent:

Your participation in this study is entirely voluntary and you may refuse to participate or withdraw from the study at any time. In giving my consent I acknowledge that:

1. The procedures required for the project and the time involved, have been explained to me, and any questions I have about the project have been answered to my satisfaction.
2. I have read this consent form and have been given the opportunity to discuss the information and my involvement in the project with the researchers.
3. I can withdraw from the study at any time, without affecting my relationship with the researchers or the University of Sydney, University of British Columbia or British Columbia's Institute of Technology, now or in the future.
4. My involvement is strictly confidential and no information about me will be used in any way that reveals my identity.
5. I am not under any obligation to consent my participation in this study is completely voluntary.
6. I can stop the interview at any time if I do not wish to continue, the audio recording will be erased and the information provided will not be included in the study.
7. I consent to

i) Audio-taping	YES	☐	NO	☐
ii) Receiving Feedback	YES	☐	NO	☐
- You will receive a copy of the transcribed interview and are welcome to comment and verify the transcribed version of the interview.

- At the end of the study you will receive a 5-page report summarising the results of the study (hard copy or pdf form). You will also be offered copies of any publications generated from the study and a copy of the dissertation, if desired (in pdf form).
- If you answered YES to the "Receiving Feedback Question (ii)", please provide your email address.

Feedback Option

Email: _____ **and/or**

Address: _____

Your signature below indicates that you have received a copy of this consent form for your own records. Your signature indicates that you consent to participate in this study.

Participant Signature

Date

Printed Name of the Participant signing above

Signature of Witness/Person obtaining consent

Date

Printed Name of Witness/Person obtaining consent

Contact for concerns about the rights of research participants:

If you have any concerns about your treatment or rights as a research participants, you may contact the:

1. Research Participant Information Line in the UBC Office of Research Services at 604-822-8598 or if long distance e-mail to RSIL@ors.ubc.ca.
2. The Manager, Human Ethics Administration, University of Sydney on +61 2 8627 8176 (Telephone); +61 2 8627 8177 (Facsimile) or ro.humanethics@sydney.edu.au.
3. The Research Ethics Review Board at BCIT research_ethics@bcit.ca or 604-456-1048.

Appendix 6: Interview Questions and Preamble

Semi-structured Interview Questions

1. Which area do you work in, and how do you come in contact with children?
 2. Could you outline your educational preparation in relation to children/paediatric nursing? And in relation to CN&A?
 3. Can you explain how this document (or resource) supports your nursing care for a child and family in situations where you or your colleagues have suspected or known that a child was being abused and/or neglected?
 4. Are there other documents or guidelines for practice that you know of and use?
 5. Are there aspects of these situations that you find especially challenging? How do you manage these challenges?
 6. What do you think nurses bring to these situations?
 7. Do you have any thoughts about what might contribute to violence towards children within our society?
 8. Is there anything you would like to add? Or anything you feel is important to discuss that we didn't have the opportunity to talk about?
-

Interview Preamble for Safety and Confidentiality

"Discussing the topic of CN&A has the potential to elicit psychological distress, either during or after the interview. You are welcome at any time, and without explanation, to pass over any interview questions you would rather not respond, end the interview, and/or withdraw from the study. As the interviewer, I may do the same. If at any point I am concerned about distress I will discuss it with you, offer a break, or offer to end the interview. I also would like to remind you about your "Employee and Family Assistance Program" (give pamphlet), and to confirm that you feel comfortable accessing this service?"

"Also, before we begin, I'd like to remind you that the objectives of the interview are to hear your perspectives about nursing practice when responding to CN&A. The focus of the interview is a discussion of your practice and what informs your practice, rather than details of any specific cases in practice. However, if there are important examples or salient issues directly related to actual cases in practice, please ensure you leave out any identifying information in accordance with confidentiality obligations (for example, you might use pseudonyms and change any identifying details)."

Appendix 7: Ethics Approvals

The University of Sydney, Human Research Ethics Committee



RESEARCH INTEGRITY Human Research Ethics Committee

Web: http://sydney.edu.au/research_support/ethics/human/

Email: ro.humanethics@sydney.edu.au

Address for all correspondence:
Level 6, Jane Foss Russell Building - G02
The University of Sydney
NSW 2006 AUSTRALIA

Ref: IM/KR

1 August 2011

Professor Trudy Rudge
Sydney Nursing School
The University of Sydney
Email: trudy.rudge@sydney.edu.au

Dear Professor Rudge

Title: Suspect Practices: A critical discourse analysis of the legal, ethical, health and social welfare policies, and nurse interview texts constituting social and nursing responses to child abuse and neglect [Protocol No. 13993]

PhD Student: Ms Rochelle Einboden

The Executive of the Human Research Ethics Committee (HREC), has reviewed your study to include the PhD student – Ms Rochelle Einboden and acknowledges your right to proceed under the authority of University of British Columbia Behavioural Research Ethics Board & British Columbia Institute of Technology Research Ethics Review Board.

The Human Research Ethics Committee advises that you consult with The University of Sydney **Audit and Risk Management Office** (http://sydney.edu.au/audit_risk/) to ensure that University of staff/students and premises are adequately covered for the purpose of conducting this research project.

Any modifications to the study must be approved by the University of British Columbia Behavioural Research Ethics Board & British Columbia Institute of Technology Research Ethics Review Board. A copy of the approved modification, approved progress report and any new approved documents must be provided to The University of Sydney HREC for our records.

Please do not hesitate to contact Research Integrity (Human Ethics) should you require further information or clarification.

Yours sincerely

Dr Margaret Faedo
Manager
Human Research Ethics Committee

cc: Ms Rochelle Einboden [Email: rochelle.einboden@sydney.edu.au]

Professor Colleen Varcoe [Email: colleen.varcoe@nursing.ubc.ca]

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CRICOS 00026A

The University of British Columbia, Behavioural Research Ethics Board

<https://rise.ubc.ca/rise/Doc/0/HLV52SHD80H4PDUJUUS...>



The University of British Columbia
Office of Research Services
Behavioural Research Ethics Board
Suite 102, 6190 Agronomy Road, Vancouver, B.C. V6T 1Z3

CERTIFICATE OF APPROVAL - FULL BOARD

PRINCIPAL INVESTIGATOR: Colleen Varcoe	INSTITUTION / DEPARTMENT: UBC/Applied Science/Nursing	UBC BREB NUMBER: H11-00834
INSTITUTION(S) WHERE RESEARCH WILL BE CARRIED OUT:		
Institution UBC		Site Vancouver (excludes UBC Hospital)
CO-INVESTIGATOR(S): Trudy Rudge		
SPONSORING AGENCIES: N/A		
PROJECT TITLE: Suspect Practices: A critical discourse analysis of the legal, ethical, health and social welfare policies, and nurse interview texts constituting social and nursing responses to child abuse and neglect.		
REB MEETING DATE: April 28, 2011	CERTIFICATE EXPIRY DATE: April 28, 2012	
DOCUMENTS INCLUDED IN THIS APPROVAL:		DATE APPROVED: May 17, 2011
Document Name	Version	Date
Protocol: Research Proposal	1	April 13, 2011
Consent Forms: Consent Form	1	April 13, 2011
Consent Form	2	May 14, 2011
Advertisements: Advertisement_CanadianNurse	1	April 13, 2011
Advertisement_ColleagueLetter	1	April 13, 2011
Advertisement_Poster (if needed for UBC)	1	April 13, 2011
Advertisement_Email (UBC, BCIT, Colleagues)	1	April 13, 2011
Questionnaire, Questionnaire Cover Letter, Tests: Interview Guide	1	April 13, 2011
Other Documents: Employee and Family Assistance Program Information	1	April 13, 2011
Other: n/a		
The application for ethical review and the document(s) listed above have been reviewed and the procedures were found to be acceptable on ethical grounds for research involving human subjects.		
<i>This study has been approved either by the full Behavioural REB or by an authorized delegated reviewer</i>		

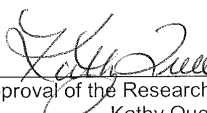
British Columbia Institute of Technology, Research Ethics Board



BRITISH COLUMBIA
INSTITUTE OF TECHNOLOGY
3700 WILLINGDON AVENUE
BURNABY, BRITISH COLUMBIA
CANADA V5G 3H2

bcit.ca

Certificate of Approval

PRINCIPAL INVESTIGATOR Rochelle Einboden	INSTITUTION University of Sydney	NUMBER 2011-01
INSTITUTION/LOCATION WHERE RESEARCH WILL BE CARRIED OUT Research will take place throughout British Columbia.		
CO-INVESTIGATORS: Trudy Rudge, Colleen Varcoe, Cheryl Isaak		
SPONSORING AGENCIES : N/A		
TITLE: Suspect Practices: A critical discourse analysis of the legal, ethical, health and social welfare policies, and nurse interview texts constituting social and nursing responses to child abuse and neglect.		
APPROVAL DATE May 17, 2011	TERM (YEARS) 1	DOCUMENTS INCLUDED IN THIS APPROVAL:
CERTIFICATION: The protocol and consent form for the above-named project have been reviewed by the BCIT Research Ethics Board and were found to be acceptable on ethical grounds for research involving human subjects. Any variations/changes to the protocol or consent form which are not approved by the BCIT REB will render this Certificate of Approval null and void.  Approval of the Research Ethics Review Board: Kathy Quee, Chair This Certificate of Approval is valid for the above term provided there are no changes in the experimental procedures, protocol or consent form.		

Appendix 8: Recruitment Strategies

Site	Description
<i>The Canadian Nurse Journal</i> (n=0)	An advertisement was placed in the classified section of the September 2011 edition of <i>The Canadian Nurse</i> . This journal is the publication of the national Canadian Nursing Association, and is widely available to and read by nurses in Canada.
<i>School of Health Sciences, British Columbia's Institute of Technology (BCIT)</i> (n=2)	Distribution of a study advertisement to nursing faculty and students involved in various specialty programs at BCIT through the usual school process (list-serve emails). BCIT offers three courses for practising registered nurses who want to specialise in paediatric practice: Paediatric Nursing Specialty (Standard & Critical Care Options) and Neonatal Nursing Specialty. Permission was later expanded to include a study notice to all BSN faculty, via email though faculty mailing lists and by providing an information session about the study at a clinical faculty meeting.
<i>The School of Nursing, University of British Columbia (UBC)</i> (n=7)	Distribution of a study advertisement to Master and Doctoral students through the list-serve email from the Graduate Programs Office, UBC. UBC has a large cohort of graduate students who are registered nurses. The list-serve email via the Graduate Programs Office is the usual mechanism for distribution of research initiatives.
<i>Passive Snowball Recruitment</i> a)(n=6) b)(n=6)	Used in two ways: a) the researcher's colleagues were asked by email to share the study advertisement and researcher's contact details with their networks of colleagues who might be eligible and interested in participating b) participants were invited to share information about the study with colleagues who they believe might be eligible and interested in participating.
<i>Emergency Nurses Association of BC Newsletter</i> (n=0)	An advertisement was placed in the June 2012 edition of this newsletter to support the final stages of recruitment.

The Canadian Nurse Journal September 2011 Classified Section Advertisement

ATTENTION RNs in BC! Are you a nurse currently registered in BC and working with infants, children and/or youth? Have you experienced one or more practice situations where **child abuse or neglect** was suspected or had occurred? Are you interested in sharing your nursing perspective by participating in a research study that aims to support a better understanding of current nursing responses to child abuse and neglect, and generate evidence for strategic changes in practice and policy? If so, please contact: rochelle.einboden@sydney.edu.au or 604-329-4309.

Passive Snowball Recruitment

Letter to Colleague

Dear _____, [insert name of colleague]

As you may know, I am undertaking research training at the University of Sydney. I am currently in the data collection phase of the research. This research aims to better understand how, given complex moral, legal, and professional obligations, nurses respond to concerns of child abuse and neglect in practice. As a part of this research, we are looking for nurses across a variety practice contexts and regions, who might be interested in volunteering for interviews.

Participants must:

- be currently registered as a nurse with the CRNBC
- be working in an area of practice with infants, children, and/or youth and/or their families (i.e. community settings, paediatric settings, emergency departments, etc.)

and

- have experienced one or more practice situations where child abuse or neglect was suspected or had occurred.

If you believe that any of your colleagues might be eligible and interested in sharing their ideas about nursing practice (in the context of suspected or known child abuse and neglect) by participating in an interview, could you please share the attached advertisement with them? A similar advertisement is also published in the classified section of the *Canadian Nurse*, September 2011 issue. Thank you for your support in getting the word out about this study to interested nurses!

Kind regards,

Rochelle Einboden RN, MN

Doctoral Research Student, University of Sydney

Email Attachment

**School of Health Sciences, British Columbia's Institute of Technology
The School of Nursing, University of British Columbia**



ATTENTION:

Registered Nurses

IF YOU:

- are a nurse currently registered in BC and working with infants, children and/or youth

and

- have experienced one or more practice situations where child abuse or neglect was suspected or had occurred

and

- are interested in sharing your nursing perspective by participating in a research study that aims to support a better understanding of current nursing responses to child abuse and neglect, and generate evidence for strategic changes in practice and policy

WE WANT TO HEAR FROM YOU!

Note: Commitment includes one face-to-face interview (approximately one hour). Researcher will travel within BC.

Please contact Rochelle Einboden RN, MN
Doctoral Research Student (University of Sydney) at:
rochelle.einboden@sydney.edu.au or 604-329-4309

Suspect Practices
Version 3 03/03/11

*Note: This was Version 3, which includes all the text in the original versions, and the UBC and BCIT logos, as well as the additional highlighted text.

Emergency Nurses Association of BC Newsletter



THE UNIVERSITY OF
SYDNEY



ATTENTION:

Registered Nurses

IF YOU:

- are a nurse currently registered in BC and working with infants, children and/or youth

and

- have experienced one or more practice situations where child abuse or neglect was suspected or had occurred

and

- are interested in sharing your nursing perspective by participating in a research study that aims to support a better understanding of current nursing responses to child abuse and neglect, and generate evidence for strategic changes in practice and policy

WE WANT TO HEAR FROM YOU!

**Commitment requires a face-to-face interview, of approximately one hour. Researcher will travel within BC.*

**We are particularly interested in hearing from nurses who have experience practicing in northern or rural areas of BC, as this voice is underrepresented in the study sample to date.*

Please contact Rochelle Einboden RN, MN
Doctoral Research Student (University of Sydney) at:
rochelle.einboden@sydney.edu.au or 604-329-4309

Suspect Practices
Version 1 18/05/12

*Note: This version was specifically added for the Emergency Nurses Association of BC Newsletter. It includes all the text in the original versions, the UBC and BCIT logos, as well as the additional highlighted text.

Appendix 9: Study Business Card

Suspect Practices Study

Commitment requires one face-to-face interview of approximately one hour.
Researcher will travel throughout BC.



THE UNIVERSITY OF
SYDNEY




Please contact:
 Rochelle Einboden RN, MN, PhD (c)
 rochelle.einboden@sydney.edu.au
 1-604-329-4309

If you:

- are a nurse currently registered in BC and working with infants, children, and/or youth
- have experienced one or more practice situations where child abuse and neglect was suspected or had occurred
- are interested in sharing your nursing perspective by participating in a research study that aims to support a better understanding of current nursing responses to child abuse and neglect, and generate evidence for strategic changes in practice and policy

We want to hear from you!

Appendix 10: Media Review

Source	Number of Articles
<i>CBC News Online, BC</i>	271
<i>The Vancouver Sun</i>	873
<i>The Province</i>	737
<i>The National Post</i>	577
Total	2458

Appendix 11: Excerpts from BC's *Child, Family and Community Services Act* 1996

CFCS Act Part 1, Introductory Provisions, Guiding principles

-
- 2** This Act must be interpreted and administered so that the safety and well-being of children are the paramount considerations and in accordance with the following principles:
- (a) children are entitled to be protected from abuse, neglect and harm or threat of harm;
 - (b) a family is the preferred environment for the care and upbringing of children and the responsibility for the protection of children rests primarily with the parents;
 - (c) if, with available support services, a family can provide a safe and nurturing environment for a child, support services should be provided;
 - (d) the child's views should be taken into account when decisions relating to a child are made;
 - (e) kinship ties and a child's attachment to the extended family should be preserved if possible;
 - (f) the cultural identity of aboriginal children should be preserved;
 - (g) decisions relating to children should be made and implemented in a timely manner.
-

(CFCS Act, 1996)

CFCS Act Part 3, Section 13

13 (1) When protection is needed

- a) if the child has been, or is likely to be, physically harmed by the child's parent;
 - b) if the child has been, or is likely to be, sexually abused or exploited by the child's parent;
 - c) if the child has been, or is likely to be, physically harmed, sexually abused or sexually exploited by another person and if the child's parent is unwilling or unable to protect the child;
 - d) if the child has been, or is likely to be, physically harmed because of neglect by the child's parent;
 - e) if the child is emotionally harmed by the parent's conduct;
 - f) if the child is deprived of necessary health care;
 - g) if the child's development is likely to be seriously impaired by a treatable condition and the child's parent refuses to provide or consent to treatment;
-

... **(2)** For the purpose of subsection (1) (e), a child is emotionally harmed if the child demonstrates severe

- a) anxiety,
 - b) depression,
 - c) withdrawal, or
 - d) self-destructive or aggressive behaviour.
-

(CFCS Act, 1996)

CFCS Act Part 1, Section 4, Best interest of the child

4 (1) Where there is a reference in this Act to the best interests of a child, all relevant factors must be considered **in determining the child's best interests**, including for example:

- (a) the child's safety;
- (b) the child's physical and emotional needs and level of development;
- (c) the importance of continuity in the child's care;
- (d) the quality of the relationship the child has with a parent or other person and the effect of maintaining that relationship;
- (e) the child's cultural, racial, linguistic and religious heritage;
- (f) **the child's views**;
- (g) the effect on the child if there is delay in making a decision.

(2) If the child is an aboriginal child, the importance of preserving the child's cultural identity must be considered in determining the child's best interests.

(CFCS Act, 1996, emphasis added)

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Appendix 12: Excerpt from the CRNBC's Practice Resource

Legislation Relevant to Nurses' Practice

"Anyone **who believes** that a child needs protection is obligated to report this information to the director. The circumstances that require such a report include the following:

- If the child has been, or is likely to be, physically harmed, sexually abused or sexually exploited by a parent or other person
- If the child needs protection because he or she has been, or is likely to be, physically harmed because of neglect by the parent
- If the child is emotionally harmed by the parent's conduct
- If the child is not receiving necessary health care
- If the child's development is likely to be seriously impaired by a treatable condition and the parent refuses to provide or consent to treatment
- If adequate provision has not been made for the child's care in cases where the child has been abandoned, or if the parent is dead or is unable or unwilling to care for the child
- If the child is or has been absent from home in circumstances that endanger his or her safety or well-being

The Act protects a person from legal liability for reporting information about a child in need of protection, unless that person has acted in bad faith (e.g., by knowingly giving false information). In addition, the identity of anyone who makes a report is protected under the Act, unless that person agrees to be identified."

(CRNBC, 2015, pp. 9-10, emphasis added)

Appendix 13: CRNBC Practice Resource, *Case Study*

What were the warning signs? Case study about a nurse's legal obligation to disclose

“Two-month-old Brandon sees a public health nurse at a child health clinic for his first immunizations. His mom reports he is fussy, spits up frequently and is difficult to feed. She mentions that she tried a different formula without success. The nurse notes that while Brandon's weight gain is adequate and his development appropriate, the mom is concerned. The nurse advises the mom to take Brandon to see his family doctor. She also discusses strategies for managing fussiness and gives Brandon his immunizations. She arranges to follow up with the mom and Brandon in two weeks.

A follow up visit

At the next visit, the nurse notes that Brandon has a dime-sized bruise on his left cheek. The mom says Brandon's three-year-old brother hit him with a toy. The mom also says that she and the dad find Brandon's crying stressful. She admits that yesterday the dad became quite angry and pushed her. When the nurse questions her further, the mom states that the dad gets angry but has never threatened or hurt her. The dad loves Brandon and she's sure he would never hurt him. They take turns with Brandon when he is crying so they each get a break. The nurse is concerned and gives the mom a domestic violence resource card. They talk about having a safe place to go. Brandon looks well and the mom seems confident. She advises the mom to more closely watch the three-year-old with the baby. She discusses strategies for managing a crying baby. Then she arranges a home visit in two weeks.

When the nurse arrives for the scheduled visit, no one is home. The nurse leaves her card with a note for the mom to call. She also calls the mom's cell phone and leaves a message.

An emergency department visit

Three weeks later, the mom brings Brandon to a nearby emergency department. His mouth is bleeding. He is weighed, briefly assessed by the triage nurse and seen by the physician. Brandon's upper frenulum is torn. The mom explains that Brandon accidentally bumped heads with the dad while feeding. The physician says this should heal with no problem. Brandon looks well – his bruise has disappeared and the mom doesn't mention it. Because it is late on a Friday night, a social worker is not available. Brandon is discharged. A few days later, the public health nurse tries again to follow up with Brandon and his mom. She leaves a message on the mom's cell phone.

Back in emergency

Brandon is four months old when he arrives at the emergency department by ambulance. His mom says she found him unresponsive and seizing earlier that morning. His condition is serious. He has severe abusive head trauma, including bilateral subdural hematomas, retinal hemorrhages and four old rib fractures of two different ages. Brandon survives but is left with permanent neurological damage.

What are your thoughts?

What red flags should give health professionals “reason to believe” there is a risk of abuse?

What other questions would you have asked the mom?

What else could have been done to help Brandon?

Your legal obligation: Early detection and reporting is critical

If you have reason to believe a child is (or is likely to be) at risk of being abused or neglected, **you must report your concern to your local child welfare worker**. If you’re in doubt about whether to report, consult with someone who has experience in this area. You can report a concern any time day or night by calling the **Helpline for Children at 310-1234** (area code not required). The person answering the phone will direct your concerns appropriately.

What does "reason to believe" mean?

Source: The Handbook for Action on Child Abuse and Neglect

In British Columbia, anyone with reason to believe a child has been or is likely to be abused or neglected – and the child’s parent is unwilling or unable to protect them – has a legal duty to report that concern to a child welfare worker. “Reason to believe” simply means that, based on what you have seen or information you have received, you believe a child has been or is likely to be at risk. You do not need to be certain. It is the child welfare worker’s job to determine whether abuse or neglect has occurred or is likely to occur.

Additional support

There are five specialty teams across the province that offer additional support and guidance. Note that **contacting them does not replace reporting to a child welfare worker**.

Child Protection Service Unit, BC Children’s Hospital, 604-875-3270

Northern Health SCAN Clinic, Prince George, 250-565-2120

Health Evaluation, Assessment and Liaison (HEAL) Team, Surrey Memorial Hospital, 694-585-5634

Vancouver Island Suspected Child Abuse and Neglect Team, Nanaimo, 250-755-7945

Kamloops Suspected Child Abuse and Neglect Clinic, Royal Inland Hospital, 250-314-2775”

(CRNBC, 2014, March 7)

Appendix 14: Excerpt from the *Family Law Act*, 2011

Family Law Act, Division 1, Section 37

37 (1) In making an agreement or order under this Part respecting guardianship, parenting arrangements or contact with a child, the parties and the courts must consider the best interests of the child only.

(2) To determine what is in the best interests of a child, all of the child's needs and circumstances must be considered, including the following:

- (a) the child's health and emotional well-being;
- (b) the child's views, unless it would be inappropriate to consider them;**
- (c) the nature and strength of the relationships between the child and significant persons in the child's life;
- (d) the history of the child's care;
- (e) the child's need for stability, given the child's age and stage of development;**
- (f) the ability of each person who is a guardian or seeks guardianship of the child, or who has or seeks parental responsibilities, parenting time or contact with the child, to exercise his or her responsibilities;
- (g) the impact of any family violence on the child's safety, security or well-being, whether the family violence is directed toward the child or another family member;
- (h) whether the actions of a person responsible for family violence indicate that the person may be impaired in his or her ability to care for the child and meet the child's needs;
- (i) the appropriateness of an arrangement that would require the child's guardians to cooperate on issues affecting the child, including whether requiring cooperation would increase any risks to the safety, security or well-being of the child or other family members;
- (j) any civil or criminal proceeding relevant to the child's safety, security or well-being.

(3) An agreement or order is not in the best interests of a child unless it protects, to the greatest extent possible, the child's physical, psychological and emotional safety, security and well-being.

(Family Law Act, 2011)

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Appendix 15: Excerpts from the *UN Convention on the Rights of the Child*

Preamble

“Considering that, in accordance with the principles proclaimed in the Charter of the United Nations, recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world,

Bearing in mind that **the peoples of the United Nations have**, in the Charter, reaffirmed their faith in fundamental human rights and in the dignity and worth of the human person, and **have determined to promote social progress and better standards of life in larger freedom**,

Recognizing that the United Nations has, in the Universal Declaration of Human Rights and in the International Covenants on Human Rights, proclaimed and agreed that everyone is entitled to all the rights and freedoms set forth therein, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status,

Recalling that, in the Universal Declaration of Human Rights, the United Nations has proclaimed that **childhood is entitled to special care and assistance**,
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,

Recognizing that **the child, for the full and harmonious development of his or her personality**, should grow up in a family environment, in an atmosphere of happiness, love and understanding,

Considering that **the child should be fully prepared to live an individual life** in society, and brought up in the spirit of the ideals proclaimed in the Charter of the United Nations, and in particular in the spirit of peace, dignity, tolerance, freedom, equality and solidarity,
Bearing in mind that **the need to extend particular care to the child has been stated** in the Geneva Declaration of the Rights of the Child of 1924 and in the Declaration of the Rights of the Child adopted by the General Assembly on 20 November 1959 and recognized in the Universal Declaration of Human Rights, in the International Covenant on Civil and Political Rights (in particular in articles 23 and 24), in the International Covenant on Economic, Social and Cultural Rights (in particular in article 10) and in the statutes and relevant instruments of specialized agencies and international organizations concerned with the welfare of children,

Bearing in mind that, as indicated in the Declaration of the Rights of the Child, **"the child, by reason of his physical and mental immaturity, needs special safeguards and care, including appropriate legal protection, before as well as after birth"**,
Recalling the provisions of the Declaration on Social and Legal Principles relating to the

Protection and Welfare of Children, with Special Reference to Foster Placement and Adoption Nationally and Internationally; the United Nations Standard Minimum Rules for the Administration of Juvenile Justice (The Beijing Rules); and the Declaration on the Protection of Women and Children in Emergency and Armed Conflict, Recognizing that, in all countries in the world, there are children living in exceptionally difficult conditions, and that such children need special consideration,

Taking due account of the importance of the traditions and cultural values of each people for the protection and harmonious development of the child, Recognizing the importance of international co-operation for improving the living conditions of children in every country, in particular in the developing countries.”

(*UNCRC, 1989*, emphasis added)

UNCRC, Article 3, 9 & 43

Article 3

1. In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, **the best interests of the child shall be a primary consideration.**

Article 9

1. States Parties shall ensure that **a child shall not be separated from his or her parents against their will, except when competent authorities** subject to judicial review **determine**, in accordance with applicable law and procedures, **that such separation is necessary for the best interests of the child.** Such determination may be necessary in a particular case such as one involving abuse or neglect of the child by the parents, or one where the parents are living separately and a decision must be made as to the child's place of residence.
2. In any proceedings pursuant to paragraph 1 of the present article, **all interested parties shall be given an opportunity to participate in the proceedings and make their views known.**
3. States Parties shall **respect the right of the child** who is separated from one or both parents **to maintain personal relations** and direct contact with both parents on a regular basis, **except if it is contrary to the child's best interests.**

Article 12

1. 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.
 2. For this purpose, **the child shall in particular be provided the opportunity to be heard in any judicial and administrative proceedings affecting the child**, either directly, or through a representative or an appropriate body, in a manner consistent with the procedural rules of national law.
-

Article 43

1. **The Committee shall consist of ten experts of high moral standing and recognized competence in the field** covered by this Convention. The members of the Committee shall be elected by States Parties from among their nationals and shall serve in their personal capacity, consideration being given to equitable geographical distribution, as well as to the principal legal systems.

(UNCRC, 1989, emphasis added)

UNCRC, General Comment 7 Indicators

General Comment 7: Early Childhood Rights Indicators

Indicators

1. Dissemination of GC7
2. A Positive Agenda
3. Human Rights Training
4. Data Collection Systems
5. Birth Registration
6. Participation in Family Decision-Making
7. Violence Against Young Children
8. Basic Material Needs
- 9a. Breastfeeding and Complementary Feeding,
- & 9b. Access to and use of Health Services
10. Age-Appropriate Health Education
11. Provision of Early Childhood Education and Care Services
12. Educational Provision for Vulnerable Young Children
13. Knowledge of Rights and Capacity to Support Their Realization
14. Play, Leisure and Rest Opportunities for Young Children
15. Inclusive Policy and Provisions for Vulnerable Groups

(Human Early Learning Partnership, 2012)

Appendix 16: Excerpt from the *Criminal Code (1985)*

Criminal Code of Canada Section 215 Duty of persons to provide necessities

215 (1) Every one is under a legal duty: (a) as a parent, foster parent, guardian or head of a family, to provide necessities of life for a child under the age of sixteen ...

(2) Every one commits an offence who, ... fails without lawful excuse ... to perform that duty if, (a) with respect to the duty imposed by paragraph 1 (a) ... (i) the person to whom the duty is owed is in destitute or necessitous circumstances or, (ii) the failure to perform the duty endangers the life of the person to whom the duty is owed, or causes or is likely to cause the health of that person to be endangered permanently;

(3) Every one who commits an offence under subsection (2): (a) is guilty of an indictable offence and liable to imprisonment for a term not exceeding five years; or (b) is guilty of an offence punishable on summary conviction and liable to imprisonment for a term not exceeding eighteen months.

(Criminal Code, 1985)

Appendix 17: Child Protection Services Unit (BC's Provincial CN&A Clinic)

Child Protection Service Unit, BC Children's Hospital

The Child Protection Service Unit provides expert medical assessments for children in cases of suspected physical abuse, sexual abuse, emotional abuse and serious neglect.

The **Child Protection Service Unit** is committed to evaluating the most complex and serious cases of child abuse from around the province. We evaluate most of the children we see in the **Child & Family Clinic**, a specially designed confidential clinic area on the hospital site.

The unit is staffed by a multidisciplinary team consisting of pediatricians, social workers, clerical staff, a nurse, psychologists and a part-time psychiatrist.

The Child Protection Service Unit pediatricians provide a medical consultation and assessment for the most serious cases in BC Children's Hospital. In this capacity, the unit pediatricians also consult with other physicians faced with emergency cases of child abuse throughout the province.

Before a clinical referral, the unit social worker gathers relevant information. During the clinic visit, the specialists take a full medical and social history. The child is examined by the unit pediatrician and a medical report is prepared. The unit social worker provides crisis counseling to the parents and may refer the child and family for appropriate services in the community.

In the most serious cases, a child may be referred to one of our unit psychologists or psychiatrist for further assessment. They prepare a report with recommendations for ongoing treatment in the community. The Child Protection Service Unit social workers consult with professionals throughout the province on child protection issues. These professionals include police, social workers, physicians, community health nurses and therapists.

REFERRALS

You need a referral from a physician, the police, the Ministry of Children and Family Development, or a delegated Aboriginal child protection agency to use this service.

(British Columbia's Children's Hospital, 2017)

Appendix 18: Risk Factors for Physical Abuse

Parental Characteristics	Child Characteristics	Environmental Characteristics
Younger age Low socioeconomic status Single parent Social isolation Substance use Low self-esteem Poor parental role-models and little parenting knowledge	Age (< 1 year old) Prematurity The unwanted child The brain-damaged child The hyperactive child The physically disabled child due to: dependency, overwhelming needs, bonding failures, irritability	Chronic stress Poverty (though more concealed cases may occur across classes) Divorce Unemployment Poor housing Frequent relocation Alcoholism Drug addiction

(Hockenberry et al., 2017, p. 420)

Appendix 19: DSM5 Diagnostic Criteria and Features, Pedophilic Disorder

Pedophilic Disorder	
Diagnostic Criteria	e) Over a period of at least 6 months, recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving sexual activity with a prepubescent child or children (generally 13 years or younger). f) The individual has acted on these sexual urges, or the sexual urges or fantasies cause marked distress or interpersonal difficulty. g) The individual is at least age 16 years and at least 5 years older than the child or children in Criterion A. Note: Do not include an individual in late adolescence involved in an ongoing sexual relationship with a 12- or 13-year-old. Specify whether: Exclusive type (attracted only to children) Nonexclusive type Specify if: Sexually attracted to males Sexually attracted to females Sexually attracted to both Specify if: Limited to incest
Diagnostic Features	<i>Pedophilic Disorder vs. Pedophilic Sexual Interest</i> “The diagnostic criteria for pedophilic disorder are intended to apply to both individuals who freely disclose this paraphilia and to individuals who deny any sexual attraction to prepubertal children (generally 13 years or younger), despite substantial objective evidence to the contrary. Examples of disclosing this paraphilia include candidly acknowledging an intense sexual interest in children and indicating that sexual interest in children is greater than or equal to sexual interest in physically mature individuals. If individuals also complain that their sexual attractions or preferences for children are causing psychosocial difficulties, they may be diagnosed with pedophilic disorder. However, if they report an absence of feelings of guilt, shame, or anxiety about these impulses and are not functionally limited by their paraphilic impulses (according to self-report, objective assessment, or both), and their self-reported and legally recorded histories indicate that they have never acted on their impulses, then these individuals have a pedophilic sexual interest but not pedophilic disorder.”

(APA, 2013b, emphasis in original)

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