The Tavistock Clinic and the University of East London

Safeguarding Adults: The impact emotional and unconscious factors have on decision making.

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A thesis submitted in partial fulfilment of the requirements of the University of East London for a Professional Doctorate in Social Work and Emotional Wellbeing.

Abstract

This research project examines unconscious and emotional factors that influence decision making in adult safeguarding work. The author builds upon research into child protection that highlights the complexities of 'rational decision making'. Adult safeguarding is relatively new compared to child protection, and academic research into the day-to-day practice of adult safeguarding professionals is limited. Intense levels of anxiety experienced by practitioners and organisations makes it an extremely challenging area of practice.

The author uses psychoanalytic theory as a way of understanding and making sense of adult safeguarding as a social work task. Over more than 12 months, data was collected through observation and free association narrative interviews in a local authority safeguarding team. The results show that numerous unconscious and emotional factors influence the decision-making process and practice decisions. This directly affects those tasked with protecting vulnerable people. Some are obvious, however many are hidden and the extent of their influence often passes unnoticed.

This study provides fresh insight into how practitioners make decisions. It demonstrates powerful ways in which unconscious and emotional dynamics affect practitioners' responses. Understanding this more fully can inform the support that practitioners require from their organisation in order to make better decisions. It concludes that specialist adult safeguarding teams ought to be reconsidered as operational arrangements. This is particularly due to the level of expertise and understanding required being grossly underestimated and the emotional and psychologically demanding aspects of the work.

Key words: adult safeguarding, decision making, unconscious, emotions, psychic defences, transference, projective identification, dynamics of abuse, containment, organisational environment.

Declaration

This thesis has not been previously submitted for any degree. This represents my own research and original work. It cannot be attributed to any other person or persons.

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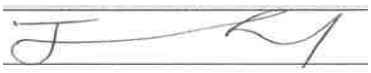
Signed: 

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The nature of safeguarding work can involve regular encounters with violence, cruelty and darkness. Despite this, I am constantly reminded by those doing this difficult work that there is always light and reason to stay hopeful.

I dedicate this to all the social workers who sacrifice so much to tend to the most vulnerable and the most violent in our society.

Introduction

> *"Generally, things get a bit stressful and tiring – that's social work. Always under pressure to make the right decisions and make sure you are doing the right thing. Making sure you are safeguarding people and minimising risks and all that – so you are constantly making decisions*."

(Serwa - Interviewee 6)

Eileen Munro (2011) wrote that the only certainty about social work decision making is the presence of a greater or lesser amount of uncertainty. Safeguarding and decision making in and amongst uncertainty is a central professional activity in health and social care services (Mason,1993; Taylor, 2013). Serious case reviews (SCRs), domestic homicide reviews and safeguarding adults' reviews (SARs) all highlight the challenges of decision making for professionals when it comes to dealing with abuse. Munro's (2011) review of child protection procedures talks about the role of anxiety in safeguarding work. Since that review, the body of knowledge seeking to understand emotional and unconscious factors affecting child protection workers has grown (Noyes, 2015; Smith, 2014; and Harvey, 2014).

Adult Safeguarding is a relatively new, challenging, and evolving area of social work practice. I became interested in this area because I had been working in care management and found this to be increasingly distant from what I had trained to do as a clinical social worker. I worked as an adult social worker and then managed a variety of teams who had responsibilities for safeguarding work. I then decided to focus on safeguarding, and for the past seven years have been a safeguarding lead and an independent safeguarding specialist and trainer. As head of safeguarding for a local authority, I have operated in statutory, health and voluntary services. The frequent lack of consideration of the psychological and emotional aspects of abuse work I saw in the statutory sector was remarkable. They were often missing from safeguarding training and approaches to intervention. Consequently, the impact this had on practice seemed to pass unrecognised.

The case that started it: ‘Amy’

About 8 years ago, I was asked to carry out a review of a safeguarding case following Amy’s death. Amy was 58-years old and suffered from motor neuron disease. As a consequence, she had lost her mobility and was reliant on a wheelchair. She was unable to manage her daily tasks without assistance and was dependent on others for meeting her essential needs, including eating, drinking, bathing, and taking medication. As a result of her condition, she gradually lost her ability to communicate and relied on a communication aid that helped her to spell out words. Her cognitive and decision-making abilities remained intact. She was living with her partner, who was also her main carer. Over time, we became aware that he was being violent toward her and coercive and controlling in his behaviour. He would physically assault her, often her face, and block access to visiting home carers, of whom he had become suspicious. He would prevent Amy from following professionals’ advice, including the use of appropriate equipment for transferring her safely and adhering to a soft diet to prevent aspiration due to her difficulties with swallowing. He stopped her from taking the prescribed medications required to treat her urinary tract and chest infections.

The social work staff had attempted many times to explore alternative options for her care arrangements, including other places she could live and be cared for properly. Amy would initially agree and then change her mind. After some time, Amy finally agreed to move into nursing care in a town where her family lived. Her partner was away, and the social work team seized the opportunity to transfer her out of the city before he returned and inevitably influence her or block her from leaving. A taxicab was booked, and she was hurriedly put into the vehicle. On arrival at the nursing home staff found her hypoxic, cold to the touch and semi-conscious. She was transferred to the nearest hospital and treated for aspirational pneumonia and a respiratory infection. Amy died a week later.

No one could understand why the social work team had put her in a taxi without thinking about how she would manage the six-hour journey without a carer supporting her. Amy should have been transferred in an ambulance, or at the very least with an escort, to ensure she would have something to eat and drink and could be properly assisted throughout the journey. The social worker and others involved said that they had simply not thought about it; their only concern was ensuring that

she got away from a violent man and into a place of safety. The fundamental oversight caused a death. I knew the practitioners in the case, they were all dedicated and the managers highly experienced. My desire to understand what had affected their decision making, led to this research.

Rationale for the study

There is a gap in existing research concerning how adult safeguarding practitioners go about their work, how they understand and make sense of the adult safeguarding task, and the factors that impact their decision making. In the absence of a credible culture of research and evaluation, social work has often been subjected to models drawn from other disciplines to "fulfil the criteria of those concerned with the governance of the profession, but not necessarily of practice values" (Frogett, 2002, p.170, in Briggs 2005). In recognition of this, in 2018, the Chief Social Worker at the Department of Health and Social Care (DHSC), Lyn Romeo, led the process of agreeing social work research priorities by consulting people using social work services and frontline practitioners instead of just hearing from research and high-level experts (Waterman and Manthorpe, 2022). These priorities included the impact of funding on decision making, and self-neglect as an area of adult safeguarding study. This did not however include other factors impacting adult safeguarding decision making. This study aims to address this gap. It explores the experiences of adult safeguarding practitioners within their organisational environment, with the aim of identifying the unconscious and emotional factors that may impact their decision making in the reality of practice.

Many people, including professionals in the social work sector, do not fully understand what the term 'safeguarding adults' means or what safeguarding for adults covers. Legislation has only relatively recently sought to impose a definition and provide criteria for when someone is considered an 'adult at risk' who requires 'safeguarding'.

The Care Act (2014) states an adult at risk is 18 years or older who

- has care and support needs,
- is experiencing or at risk of experiencing abuse or neglect, and
- as a result of their needs, is unable to protect themselves from the abuse or neglect or risk of it.

Previously referred to as ‘vulnerable adults’, these adults are likely to have an impairment or disability arising from a physical or mental health condition or old age. They are therefore more dependent on others to function and less able to protect themselves from harm. It is this vulnerability that leads to their increased risk of being neglected, exploited, or abused, whether in a hospital, care home, community service, their own homes or in public. It covers a wide range of people: old to young, from those with learning disabilities to those with physical disabilities or mental illnesses. Adult safeguarding can differ to other adult abuse models, such as domestic violence, because whilst it tries to hold principles of empowerment and choice, clear duties of care are placed on professionals working with them. Practitioners often find themselves in complex dilemmas, trying to balance an adult’s right to autonomy and choice with the duty to ensure that these same individuals who cannot protect themselves are kept safe (Braye et al., 2011). Trying to strike a balance becomes stressful and emotionally charged, particularly when working with adults who wish to remain in abusive situations and professionals can feel unable to fulfil their duty to protect them.

The topic of this study is an important issue for adult safeguarding practice. A review of available literature revealed little or no research into this specific area. As a safeguarding professional, I am interested in what influences practice and where effective approaches to dealing with complex adult safeguarding issues are evolving. My experience of the continued dominant rational-bureaucratic approach to decision making applied by policymakers is that it has a negative and unhelpful effect. In a highly emotive context, ignoring emotions, particularly anxiety, means distressing or emotionally charged work is marginalised. The result is a lack of real understanding of the difficulties practitioners face and how they need to be supported to be effective. It is hoped that having a clearer awareness of these factors will generate a deeper appreciation and understanding.

Research questions

My primary question for this research is: what impact do emotional and unconscious factors have on decision making in adult safeguarding?

The aims of my research are:

- To identify the key emotional and unconscious factors affecting decision making in safeguarding adults and how this understanding can support practitioners in their decision making
- To understand whether the nature of the work impacts decision making in adult safeguarding work
- To investigate how the stories of the people experiencing abuse or neglect impact practitioners and their practice, including decision making

My secondary questions (SQs) are:

SQ1: Can an attendance to the emotional factors in the work through an observational stance help us understand why and how decisions about safeguarding adults may go wrong?

SQ2: How can this understanding inform the support adult safeguarding practitioners require from their organisation to make good judgments about the people they work with?

SQ3: What types of emotions arise in adult safeguarding work and how does they impact practitioners personally?

SQ4: How does the emotionally charged nature of this work affect practitioners' professional decision making?

SQ5: How are emotional and unconscious dynamics of adult safeguarding cases transferred to the organisational environment?

SQ6: How does the way the organisational environment responds to adult safeguarding cases affect practitioners' ability to make decisions?

Summary of my research process

To properly explore the influence of unconscious factors, I applied psychoanalytic research methods. I combined psychoanalytic observation with free association narrative interviews. My research participants were adult social workers tasked with carrying out statutory adult safeguarding work. Following the approval of my research proposal, I submitted and received final ethical approval for the research in July 2017. My data collection commenced in January 2018, once I had obtained

agreement from a local authority to undertake my research within their adult safeguarding operational team. Once consent was obtained from all the team members, I undertook a ten-week observation of the team. During this period, I attended doctoral student seminar groups, where fellow students supported me to process and reflect on the observational research. I also engaged in research supervision sessions throughout.

I then undertook free association narrative interviews (FANI) with the same participants that were part of the observation. I completed seven initial interviews and six follow-up interviews (one person left the service before I could complete the follow-up) for a total of 13 interviews.

Research process reflections and findings

Researchers have undertaken studies to explore decision making in social work and safeguarding, offering new ideas about what influences decision making. In short, none of the studies that I have seen fully explain the impact that unconscious and emotional factors have on decision-making in adult safeguarding. This represents an important disparity in knowledge, given the evidence published through adult safeguarding reviews that current practice is not where it needs to be. This thesis attempts to offer a fresh perspective on these lesser-known influences in practice and to fully examine the phenomenon using psychoanalytic thinking and approaches.

Decision making was not always on show during the 10-week psychoanalytic observation, which was unexpected. However, there were several occasions where the observations of team discussions or individual members dealing with cases did reveal emotional factors and through them, how things could go wrong. Similarly unexpected, was that most participants described how useful they had found the interview space. It helped them share and reflect on their cases in ways they had not done before, they said. As a researcher, I was moved by the passion and dedication of each of the participants. Their commitment came out of their personal stories which led me to adapt some of my data analysis as a result.

“A defence mechanism is an unconscious psychological strategy, with or without resulting behaviour, which aims to reduce or eliminate anxiety arising from unacceptable or potentially harmful stimuli” (Walker and McCabe, 2021, p.42). The

research found that the emotionally charged nature of the work causes organisational defences. Similarly, psychological defences arise within individual practitioners in response to severe cases of abuse and the confusing contradictions that can arise in abuse work. These organisational and individual defences impact professional decision making as a whole because they can lead to unhelpful behaviours by both. I was surprised to learn that no examples were shared by the participants where the quality of decision making raised major concern or where decision making was called into question via statutory review. Many examples they shared were where practitioners were judging themselves harshly or were overly hopeful around what they could achieve.

These ideas might support a deeper appreciation of decision making in adult safeguarding work. I hope to encourage further conversation about how to apply them in practice and the way that practitioners are supported to carry out this type of work.

Structure of the thesis

The next chapter sets the background and context of adult abuse and adult safeguarding. Chapter 2 then examines the literature and theory that is relevant to adult safeguarding, emotions and decision making and psychoanalytic ideas around unconscious influencing factors. I identify the areas that make this research unique and important to further understanding in this area. Chapter 3 describes and explains the methodologies used in undertaking this qualitative study. Chapter 4 introduces the participants from the study by providing a brief summary of their background. Chapters 5 and 6 present the findings from the ten-week observation and the interviews respectively. Chapter 7 is a discussion of the findings where the research questions are answered. It sets out the main themes and patterns across both data sets and provides an analysis of the key unconscious and emotional factors identified from the research. The final chapter draws the conclusions from the research and makes practice recommendations.

Chapter 1: Understanding Adult Abuse

1.1 Definition and prevalence of adult abuse

Just like child abuse, adult abuse is often hidden, and its prevalence is greater than society wants to know. Hudson (2001) wrote that the perception of violence varies from society to society and culture to culture. She refers to original work of Sumner (1960), who describes the existence of family violence and elder mistreatment since the beginning of human history with early examples of elder neglect and abuse: adult sons killing their aged parents in Teutonic societies and Native American tribes abandoning their elders when they could no longer travel. Sumner (1960 in Hudson, 2001) argued that either honour or destruction underpins societies. When it is the former, older adults are respected and honoured, whilst the latter are viewed as societal burdens that sap the strength of the society. This negative view of older adults, he believed, set the stage for ageism and mistreatment (Hudson, 2001). This offers an interesting historical and sociological view on what may influence prevalence today in different contexts.

Today, the term ‘safeguarding adults’ is a response to all types of adult abuse, not just elderly abuse. Adult abuse spans a range of ages and takes many forms, such as physical, psychological, sexual, financial, or discriminatory. In recent legislation, neglect and self-neglect are also categorised as abuse, as is modern-day slavery. ‘Adult safeguarding’ is the term used when referring to the abuse of vulnerable adults with care and support needs, such as those with a learning disability or mental health problem, who are “unable to protect themselves from the abuse or neglect they may be experiencing because of their care and support needs” (Care Act, 2014).

In 2006, Action on Elder Abuse wrote to the government suggesting that the protection of vulnerable adults should be placed at a similar priority as child protection and domestic violence. Whilst the No Secrets guidance of the time provided clear steering for responses, they argued for national reporting requirements to support data collection and performance measures to lift the status of this work. This would enable a clearer understanding of prevalence across all demographics. O’Keefe et al. (2007) carried out the first real study on elder abuse in the UK, although the survey only included people aged 66 and over living in

private households and sheltered accommodation. The study identified physical abuse, neglect and financial abuse as among the top three reported forms of abuse in the elder population (Aylet, 2018). The prevalence of neglect and financial abuse went against the then still-common perception of abuse as physical violence.

Today, the understanding of the prevalence of adult abuse is significantly less ambiguous. Systems are well established for governments to collect adult safeguarding data, which is mandated as an annual submission by each local authority with clear reporting parameters. Adult safeguarding data for 2019-20 showed that in England, 475,560 concerns of adult abuse were raised (NHS Digital). This was an increase of 14.6% from the previous year, and the number of reported concerns has increased year on year. The most common type of adult abuse was neglect and acts of omission, which accounted for 31.8% of cases. The most common location was the person's home, at 43.8%. Of course, this data, only tells us about reported abuse where considerable abuse goes unreported and undetected.

1.2 Background of adult safeguarding in England

Child protection legislation was in place as early as 1933 in the Children and Young Person's Act. However, no comparable legislation specifically covered the abuse of adults. The likelihood is that the recognition of adult abuse as a phenomenon took longer for society to acknowledge.

After witnessing inadequate and inhumane treatment of one of her former patients and other elderly women during a visit to Friern Hospital, Barbara Robb, a professional psychotherapist, founded a pressure group called AEGIS (Aid for the Elderly in Government Institutions). AEGIS campaigned to improve the care of older people in long-stay wards of National Health Service (NHS) psychiatric hospitals. In 1967, Robb compiled a book titled *Sans Everything: A Case to Answer*, which detailed the inadequacies of care provided for older people in 'mental homes' including the practice of 'stripping', where new residents' possessions, including glasses, hearing aids, and dentures, were taken away (Pike, 2012). Such institutional abuse was implied to be the norm in the popular press in the late 1960s, contributing to governments' decisions to reduce hospital-based care and increase community care provision (Means, Richards & Smith, 2008).

A brief history shows societal focus on child abuse in the 1970s and domestic violence in the 1980s. Elderly abuse was recognised by doctors as early as the mid-1970s, however, later that decade, a reluctance to accept the notion of abuse was still widespread. In the 1980s it started to shift (Eastman, 1994). The Cleveland crisis of 1987 marked the beginning of society acknowledging the existence of widespread abuse (Cooper and Whitaker, 2014). Elder abuse however remained a low priority. "It was not until the late 1980s that the issue of elderly abuse was taken seriously in the UK following a national conference by the British Geriatric Society in London" (Penhale, 2008, p.1).

By the 1990s, abuse and neglect of older people began to elicit concern. A growing number of terms were used in an attempt to define and describe it. These included 'elder mistreatment', 'elder mis-care', 'old age abuse', 'non-accidental injury', 'granny bashing' and 'granny battering' (Mysyuka et al., 2012). Mervin Eastman (1984) pioneered the cause in the UK and challenged 'media terminology' as a reluctance on their parts, and that of the public, to admit that 'non-accidental injury' to the elderly can be next door or even in one's own home. Linda Aitken, a social worker working with the elderly in hospital care during this time had become increasingly aware of the presence of older people abuse. "On 1st April 1993, with the coming into force of the NHS National Health Service and Community Care Act 1991, she raised awareness about elderly abuse within health and social services" (Aitken and Griffin, 1996, p.3). In 1998, the Social Services Inspectorate (SSI) began work to broaden the guidance on adult protection to include other vulnerable adults (Penhale, 2008). In 2000, the Department of Health released the No Secrets statutory guidance. This set out the process, roles and responsibilities of different organisations and disciplines concerning the protection of vulnerable adults.

Since No Secrets, safeguarding adults has been gathering more momentum and is increasingly acknowledged as a critical issue for society (Mantell and Scragg, 2011). High-profile cases including the deaths of Stephen Hoskins (2006) and Fiona Pilkington and her daughter (2007) and the investigations into Ash Court (2011), Winterbourne View (2012), and other establishments have raised public awareness and given voice and context to the presence and types of adult abuse occurring in UK society and globally. The government and wider society are now much more aware of abuse and neglect occurring in institutions, people's homes and the

community. This is reflected in the Care Act 2014, which came into force on 1 April 2015 and includes a section on safeguarding adults. It is a landmark piece of legislation that placed statutory duties on local authorities to protect adults at risk from abuse and neglect.

1.3. Terminology

In this field, like many, terms and definitions are used interchangeably. First and foremost, this is a study about the influences in adult safeguarding decision making. To save from repetition, **'**adult safeguarding decision making' or 'practitioner professional decision making' are referred to and taken to mean the same throughout as 'decision making' or 'decisions'.

Similarly, the terms 'victim', 'adult at risk' and 'vulnerable adult' are used interchangeably as is 'adult protection' and 'safeguarding adults'. 'Perpetrator' is mostly used in the literature but this term is replaced with 'person thought to have caused harm' in adult safeguarding legislation. (Care Act statutory guidance, 2014). Vulnerable adult is a contested term and 'adult at risk' is now the correct legal term (Care Act statutory guidance, 2014). The synonyms 'professional' and 'practitioner' are used one in the same, as are 'clients', 'service users' and 'patients'.

'Judgment' and 'decision making' are used interchangeably throughout. This is because the terms overlap, particularly within the literature. I have not sought to define decision making beyond the natural and ordinary meaning of the words because my focus is on understanding the unconscious and emotional influences that contribute to decisions. It is less about sense- or decision-making processes. How the impact of these lesser-known influences on decision making can be deployed is specifically psychoanalytic and stresses the intimate relationship between emotional experiences and our capacity to make sense of, verbalise, and use such experiences to inform practice (Cooper, 2017, in Hingley-Jones et al., 2017).

As one key data collection method was carrying out an observation, any reference to 'the Observation' is referring to it.

Chapter 2: Literature Review

2.1 Introduction

Social work is a profession regulated by law, operating within a framework of legislation and government policy, with legal and ethical obligations to promote human rights and equality (Preston-Shoot, 2014). It involves many complexities around other people's lives, including decisions about whether to invoke statutory powers. "Social workers find themselves having to make decisions that are difficult, challenging and fraught with risk and a degree of uncertainty" (Stokes and Schmidt, 2012, p. 83). The response to this uncertainty and the media's frequent portrayal of social workers' 'catastrophic failures' has led to the government's demand for reform and a growing reliance on policy, procedures and risk-averse managerialism (Noyes, 2015). The work of Foster (2009), Spratt (2000), Stevens and Cox (2008), Munro (2011), Whitaker (2014), Noyes (2015), and Harvey (2017) challenge these ideas and suggest that types of reform are often defensive responses to highly emotive work. They often do not produce better outcomes for children, adults or families. The complexity of the safeguarding task demands a comprehensive understanding of the dilemmas that arise and a deep appreciation of the difficulty practitioners face in dealing with them.

This literature review summarises and evaluates research and theory relevant to my central research question about the emotional and unconscious factors in professionals' decision making within adult safeguarding. I attempt to outline the extent to which this has been addressed by adult safeguarding research, child protection research and wider social work research and literature. I go on to explore the literature on decision-making models relevant to my research. I look at the emotional factors specifically in decision making, which is important given that this too is a relatively new area of research. Some of this literature supports my findings or has informed aspects of my findings. I discuss the theory of decision making in organisations and the systemic influences and wider political context of the work. I set out key psychoanalytic ideas that link to the themes in my findings to explain unconscious behaviours that are at play and support my research questions. Finally, I explore other areas of theory related to adult abuse. Given that adult safeguarding

research is relatively limited, these can add to our understanding of what might affect unconscious and emotional factors in practice.

2.2 Literature review methodology

The two established forms of literary review are narrative and systematic, and I used both. A narrative review contains no defined approach to accessing and reviewing the literature (Aveyard, 2008, in Smith, 2021). I adopted a narrative review to gain combined insights from social care (statutory safeguarding) and psychoanalytic approaches. My study is a small one, so attempting to replicate, at least in part, the approaches other researchers have used in this area was an important means of corroborating the authenticity of my findings (Ridley, 2012, in Smith, 2021). I carried out practical searches of legislation and policy and a range of relevant journals, books, and articles pertinent to my area of research. This enabled me to identify relevant literature from other academics interested in the influence of emotions and the unconscious in decision making and/or safeguarding practice.

I also conducted a smaller theoretical literature review to incorporate existing theories and research concerning psychoanalytic thinking, domestic abuse/violence and the role of the unconscious within these areas. Carrying out a full systematic literature review was beyond the scope of this study. Instead, I employed a systematic review of peer-reviewed articles with an inclusion criterion to ensure transparency. Peer-reviewed articles are relatively easily searched for through online databases and the peer review process assures quality control by other academics in the field. Details of the search terms used, inclusion criteria, information sources, databases and journals accessed are listed in Appendix 1.

2.3 Adult safeguarding research history

The study of adult abuse received only minimal research interest after Baker (1975) first remarked on the phenomenon of ‘granny bashing’ (Northway et. al., 2005). Most early research data are drawn from studies in the USA, and research in the UK that focused on elder abuse was only beginning in the late 1970s (Biggs and Haapala, 2010, in Manthorpe and Stevens, 2014). Mervin Eastman is known for pioneering efforts in the UK to raise awareness. In 1984, he wrote the first book on the subject, *Old Age Abuse*. Organisations such as Action on Elder Abuse emerged

in the 1990s following activity and publications by the older people's campaigning and voluntary group Age Concern. This specifically drew attention to elder abuse as a social problem. Most of the adult protection research conducted since the late 1980s was associated with an impetus for the development of policy and practice initiatives (Aylet, 2010).

The practices in long-stay hospitals in the last century were analysed by Martin (1984), who investigated factors causing corruption. These would now be described as adult safeguarding concerns, as they relate to the influence of structural or organisational systems, routines or practices that result in abusive cultures. Martin (1982) outlined factors such as geographical isolation, a lack of support of people using services in terms of limited visits from family, friends, or advocates, failures of whistleblowing, leadership, administration and management and resource shortages (Aylet, 2018). The move from institutional to community care aimed to resolve some of these issues, but by the 1990s, it became apparent that the transition had been badly planned, and the quality of care people were receiving in some cases amounted, again, to abuse (Nolan, 1993). Nolan points out that in the 19th century, institutionalisation for the insane was hailed as a revolution in care but in reality, many of the attitudes from the previous system of workhouses, prisons and private institutions were absorbed into the new system (Aylet, 2010).

Some of the earliest research into adult abuse was carried out by Dr Elizabeth Hocking, who sought to understand what led those caring for older people to abuse them. At the time, the ethical committee suggested that the research might make carers who had not thought of abusing the person they cared for start doing it (Hocking, 1994, p.35). As astonishing as this is, it reflects how little was known at the time about what influenced people to abuse.

In another small study on elder abuse, Homer (1990) describes how she set out to discover how much abuse might exist in a community-based sample of old people in South London. The ethical committee for her study suggested that "*carers would be furtive and unwilling to talk about their feelings"* (Homer, 1990, in Eastman, 1994, p.35). Homer's study found quite the opposite: carers admitted to their abuse, and they were relieved to be able to discuss their difficulties. Understanding this would have expanded the narratives emerging around domestic abuse. It provided insight for the first time into what was happening within certain situations that caused people to abuse: often those committing the abuse knew it was wrong and wanted help.

In today's adult safeguarding work, seeking to understand the needs of an informal or family-member carer and how this may be influencing the abuse is integral to an adult safeguarding process. Carers who are identified as burning out and struggling to cope with the emotional and practical pressures are offered support. Such steps can result in the cessation of abuse. This reflects the impact of this original research and its influence on practice today. Adult safeguarding practice highlights the importance and difficulty of balancing different factors or imperatives (Preston-Shoot, 2014, p.32). However, while the literature on judgment and decision making is rich and diverse, most studies are not specific to the field of adult safeguarding (Aylet, 2018). The next section attempts to collate the existing literature on factors influencing decision making in adult safeguarding.

2.4 Factors influencing decision making in adult safeguarding

I was unable to locate specific research exploring unconscious or emotional factors influencing decision making in adult safeguarding. A systematic review of articles in The Journal of Adult Protection produced little in the way of helpful material. Much of the literature on decision-making in this journal explores decision making by those suffering from a brain injury or the challenges faced by professionals in the application of the Mental Capacity Act 2005 (MCA). The MCA is integral to adult safeguarding work, and Professor Hilary Brown (2011) conducted a review of the decision-making literature that touches on it. Her aim was to understand the role of emotion and challenged the rational model that underpins the MCA. Her findings support the argument that decisions are not made linearly but are influenced by "history and memory, motivation and drive, mood and stability, and openness to influence" (Brown 2011, p.194).

The message from Brown's research is that professionals need to expand their understanding of how those they are assessing come to decisions for themselves. It is an equally relevant message, however, for professionals making decisions for others. If we are to ensure that we are making best-interests' decisions in adult safeguarding work, understanding how emotion influences decisions is vital. A psychoanalytic approach is likely to support the type of emotional intelligence needed and is poignantly captured by Davenhill (2007) in her book *Looking into Later Life*. Whilst her work is about supporting those with depression and dementia,

the text outlines how a deeper emotional understanding can support decision making in practice.

Some adult safeguarding-specific research studies and some wider literature directly and indirectly explores different factors that may influence decisions. I have summarised those below. Several similar factors are found across key studies that influenced responses and/or decision making in adult safeguarding practice. A number of them might be considered 'unconscious or emotional factors' even if they are not named as such.

2.4.1 Factors influencing professional decision making in self-neglect cases

Self-neglect is considered a category under statutory adult safeguarding[1]. Three studies are summarised here. The first, by Lauder et al (2001), used factorial surveys to investigate the factors that influence nurses' judgments of self-neglect, studying three groups of nurses: psychiatric nurses, student nurses and general nurses. The second study was by Lauder et al. (2005) and used qualitative in-depth interviews with housing, healthcare, environmental health, and social workers to explore the ways different health and social care organisations responded to self-neglect. The third study was by Lauder et al. (2006), and here again registered nurses were presented with vignettes to investigate their judgments of capacity in self-neglect.

Lauder et al. (2001) found that psychiatric nurses, general nurses, and student nurses did not differ significantly in their views about self-neglect and all rated patients as choosing to lead many aspects of their lifestyle. This suggests that professional designation did not affect judgments. They also found that a person's ability to perform activities of daily living exerted influence on the nurses' perceptions of capacity, reflecting perhaps how they viewed what is now often referred to as 'executive capacity'[2].

[1] Whilst self-neglect has not always fallen under 'adult safeguarding', I have included it here given that is does now fall within adult safeguarding and often requires a statutory response.

[2] Executive capacity is about the ability to use or weigh information in order to make a decision (Braye et. al., 2011). It directly relates to 'executive functioning', a term used to describe disruptions in function in those who have sustained a brain injury and who are often unable to translate their thinking into meaningful action.

'Self-care status'[3] was found to have the biggest influence on judgments of self-neglect (Lauder et. al, 2001). Mental or psychiatric status was also found to influence professional judgments of self-neglect in a couple of studies (Lauder et al., 2001) with no psychiatric diagnosis: "the rationale for intervention was much less comprehensive" (Lauder et al., 2005, p.322).

"Understanding of self-neglect, and how to respond to it, are influenced by values and meanings that are the product of social and cultural practices and beliefs" (Lauder et al., 2005, p.47) and as such may be a social construct influenced by social, cultural, and professional values (Lauder et al., 2001, p. 601). Lauder et al. (2005) argued that cultural norms influence a context-specific view of self-neglect and, in a UK context, a preoccupation with hygiene and sanitation and a cultural tolerance of eccentricity contribute to an 'ambivalent and contrary attitude towards those who self-neglect' (Lauder et al., 2005, p.47). They also found that professional responses are likely the product of a range of factors, including professional socialisation and agency working practice. This points to the influence of organisational practice and culture on decision making.

Lauder et al.'s study (2006) revealed how conditions of squalor described in the vignettes given to nurses barely had any influence on their judgments. This was extraordinary, given that hygiene and squalor are the essence of self-neglect; however, for nurses not to utilise these in their judgments may highlight how complex and puzzling they found this issue. "When they find themselves facing self-neglect they resort to tried and tested cognitive schemata" (Lauder et. al, 2006, p. 285). They also found that nurses were more likely to decide on using statutory intervention with younger people experiencing self-neglect (Lauder et. al, 2006).

3 In this study, self-care was conceptualised and operationalised using Orem's Theory of Self-Care (Orem 1985). An AS-B scale was used to measure self-care agency levels and therefore a reduction in the capacity to engage in self-care activities.

2.4.2 Thresholds for decision making

Collins (2010) conducted a policy and practice review looking at thresholds for decision making in adult protection. He found that the decision-making difficulties facing adult safeguarding practitioners were "a result of insufficient clarity in threshold guidance and an absence of legislation to support adult protection decision making" (Collins, 2010, p.4).

2.4.3 Factors influencing social care professionals' decision making in elder abuse

Killick and Taylor (2012) researched the judgments of social care professionals on elder abuse referrals, also using factorial surveys. They found a reasonably high level of consensus in recognition and referral of cases featuring the most abuse but much less when there was ambiguity. They found that type of abuse was a factor in how professionals recognised abuse, and how it had a statistically significant effect on their decision-making.

Killick & Taylor's (2012) study found that frequency of abuse significantly influenced respondents' recognition of abuse and was the greatest influence on the decision to refer for an investigation. If the victim consented to an investigation, a high recognition of abuse and a decision to refer for an investigation appear to reveal the extent of influence of the person's wishes i.e., it was not recognised if the person did not want it to be. 'Practitioner autonomy' was referred to in vignettes where the recognition and reporting score was different, and analysis showed this was influenced by the wishes of the client. Professional training was also found to influence practitioner autonomy in decision making. Finally, the mental capacity of the older person influenced professionals' judgments.

Their study provided insight into practitioners' responses to complex ethical dilemmas, and they pointed out the need for further research.

2.4.4 Factors influencing other safeguarding professionals in financial abuse

Gilhooly et al. (2013) carried out research with banking and finance professionals which explored what decision cues raises suspicion of financial abuse, how such abuse comes to the attention of professionals who do not have a statutory responsibility for safeguarding older adults, and the barriers to intervention. Using

financial abuse scenarios, the subjects were asked “how certain they were that the older person was being abused and the likelihood of taking action” (Gilhooly et al., 2013, p.84). There were marked differences in the two responses. The study concluded that each professional group sees different aspects of an individual’s life and, consequently, “will notice some cues of financial abuse, but either (do) not have access to other cues or will just not notice the other cues” (Gilhooly et al., 2013, p.64). Dealing with a case involving family members who were suspected of committing the abuse was, however, problematic for both those in banking and health (Gilhooly et al., 2013).

The study made some more interesting discoveries. It found that mental capacity was an important factor influencing health professionals but less so the banking/finance cohort. Both groups indicated that decision-making was problematic when the older person had full mental capacity. They noticed that most referred cases involved other people reporting suspicions of abuse, suggesting that two people making the judgment enabled the social worker to feel more confident when making the referral.

Gilhooly et al. outlined different types of financial abuse and demonstrated that the banking professionals responded more to one type than another. For example, a suspicious third party was the most common type to be reported over misuse of power of attorney, likely because national banking protocol informs staff to be particularly attentive when an older customer is accompanied by someone unknown to the bank (Gilhooly et al., 2013).

Participants reported difficulty in identifying abuse but explained that even when they were sure an older person was being financially abused, they did not know what to do because of a lack of guidelines and training. Process issues around reporting also arose where banking professionals felt restricted by data protection legislation and health professionals by patient confidentiality. Health professionals reported a general lack of legislation concerning abuse and what to do in such circumstances (Gilhooly et al., 2013).

2.4.5 Factors influencing adult safeguarding designated officers' decision making

Trainor (2015) conducted a qualitative review of factors that potentially influence decisions in adult safeguarding investigations. She developed a file tool to examine recorded safeguarding documentation that looked at the personal characteristics of the vulnerable adult, the nature of the alleged abuse and the decisions and outcomes reached by safeguarding designated officers. She then used semi-structured interviews with the same staff members to explore their experience of training and understanding of the process in addition to the factors they believed were central to the adult safeguarding decision-making process.

Trainor's research found that threshold decisions to accept or reject referrals were influenced by the professional's designation, although she acknowledged her numbers were too small to draw firm conclusions. Findings were mixed concerning how the type of abuse influenced decision making. She noted that allegations of sexual abuse were always screened, and that financial abuse did not elicit the same response. This points to the way professionals determine what is considered abuse and the perception of more severe abuse justifying a response.

Trainor reported consent as often being recorded as the reason for not proceeding with a safeguarding investigation. This is pertinent because, in current adult safeguarding legislation, the statutory criteria for an enquiry do not require consent. Whilst consent is important if someone is considered an adult at risk and unable to protect themselves from harm, then taking steps to safeguard them can sometimes mean overriding their consent to do so, for example, calling the police if their life is at risk even if they have not consented to the police being involved.

Unlike Killick & Taylor's 2012 study, Trainor found that frequency of abuse did not influence decision making, although she commented on possible limitations in her data in this respect. She found a real lack of understanding around roles and outcomes at each stage of the process, including that a parallel process could occur in criminal and safeguarding investigations. Interviewees reported that workload issues did not influence the process; however, she suggests this was probably only at the initial stages when the risk of harm was potentially greatest and later other priorities did likely compete. Trainor's sample noted that out of the 50 cases she reviewed, the identity of the alleged abuser was known in 42. Family members accounted for half of these. She found, however, that consent appeared to play a

more significant role than perpetrator identity. No evidence was uncovered to suggest that training played a role in practitioners' decisions.

Referrals were more likely to meet adult safeguarding thresholds for older people than other client groups. This may not be surprising, given greater awareness around elder abuse than other types of vulnerable adult abuse. Findings from Trainor's research were used in Ireland, to redesign regional adult safeguarding documentation to ensure "designated officers have access to the information necessary to assist them in reaching decisions" and "reduce the potential for variation in practice" (Trainor, 2015, p. 51).

2.5 Other relevant adult safeguarding research or literature

Other adult safeguarding research has indirectly explored decision making, as some studies have identified similar or pertinent factors that influence adult safeguarding responses.

2.5.1 Impact of adult safeguarding policy

Northway et al. (2007) examined the implementation of policies relating to the protection of vulnerable adults from abuse in services for people with learning disabilities. The study involved a survey of service providers including social services, the NHS, private providers, and focus groups with direct care staff with responsibility for investigating alleged abuse. They found a potential for policy 'overload' and, despite awareness of the existence of vulnerable adults' policies, knowledge and understanding of their content may be more limited (IPC, 2013).

2.5.2 Impact of adult safeguarding training

Pike (2012) researched the effectiveness of adult safeguarding training. She states that training evaluation in the UK is generally not carried out in any depth. She emphasises the importance of considering the effect of the training culture and transfer climate on training effectiveness. Her research identified the level of confidence as a factor affecting decisions. Confidence might be considered an emotional factor. She noted that individual characteristics of a case can affect the recognition and reporting of child abuse and asked whether the same could be true

for adult abuse (Pike, 2012). She found that confidence in recognition and reporting increased by situational factors including more severe abuse, the alleged victim not liking the alleged perpetrator, and disclosure from the alleged victim. Previous involvement in safeguarding also positively affected confidence in decisions (Pike, 2012, p. 316). Pike (2012, p.44) points out that an additional challenge in adult safeguarding "stems from the consideration that must be given to people's capacity to decide how they would like abusive situations to be managed". Legal routes support someone who is being abused but cannot consent to accept help. However, the challenge arises when people have the capacity to consent but refuse professional help, despite the risk.

2.5.3 Adult safeguarding operational arrangements

Norrie et al. (2014) researched the best organisational arrangements for adult safeguarding. Their research compared models of carrying out adult safeguarding work that distinguished the benefits and disadvantages of having specialist teams or practitioners versus generic models (Norrie et al., 2014). The major reservations were that specialist roles dilute the message that 'safeguarding is everybody's business' and that 'generic models offered greater continuity' (Norrie et al., 2014, p.4). The strengths of specialist models include perceived objectivity, consistency in decision making and process, and a higher chance of substantiating abuse. Despite this, many local authorities chose to disband their adult safeguarding specialist-only teams and instead opt for the work to be carried out as part of social workers' workload across adult teams.

2.5.4 Practitioners' understanding of vulnerability

Aylet (2018) explored practitioners' understanding of vulnerability when assessing the risk of abuse or exploitation of adults. She chose a mixed qualitative methods design that included document analysis, semi-structured focus group discussion, semi-structured interviews, and observation. She identified factors that influenced practitioners' conceptualisation of vulnerability in adults at risk and subsequent responses. Aylet (2018) argued that to appreciate the findings of statutory reviews and implied criticism of practitioner understanding of vulnerability, an understanding of the context and other influences on decision making in practice is required. She

identified three main categories of characteristics that influence professional conceptualisation of vulnerability to abuse: an adult's personhood (character), their circumstance (context) and the conduct or condition of persons who exploit them (Aylet, 2018, p.1).

2.5.5 Factors identified from statutory reviews

Thacker et al. (2019) reviewed the lessons from both SCRs and SARs. Similarly, Preston-Shoot et al. (2020) undertook an analysis of SARs to collate the learning and inform sector-led improvement in adult safeguarding. The latter's research is substantial and serves as one of the most comprehensive (and recent) summaries of adult safeguarding practice. It collates findings from national safeguarding adult statutory reviews (each review was already a detailed case analysis often identifying a range of factors influencing decision making). The following is a summary of the relevant factors each study identified.

Individual characteristics

In the SARs analysis, Preston-Shoot et al. (2020) note an absence of professionals paying attention to individual characteristics such as gender, race and learning disability in this field and that reviewers did not consider these in their analyses, either. The National SARs analysis found that in many cases, professionals had had an insufficient understanding of deeply ingrained cultural values (Preston-Shoot et al., 2020). More widely, a theme from the SARs was a professional cultural perception by agencies of a limited value to multiagency safeguarding work, with mental health services in particular unable to see added value from even making a safeguarding referral (Preston-Shoot et. al, 2020, p.162).

Power and control

Another important finding from the SARs analysis was that practitioners reportedly showed reluctance challenging issues of power and control in cases involving Black, Asian and ethnic minority groups, reducing them to 'cultural issues'. SAR reviewers found deficits in knowledge and attitudes around different communities' complexities, leading to ill-informed responses. Leading to one recommendation: "Training should help to develop cultural confidence for staff working with clients who did not share their cultural background" (Preston-Shoot et. al, 2020, p.201).

Professional curiosity

The absence of professional curiosity is cited as a reason for poor decision making in several statutory SARs. Thacker et al.'s (2019) research showed that a lack of professional curiosity led to poor assessments and intervention measures, which failed to support those at risk of harm and abuse. Preston-Shoot et al. (2020) reflect on the large number of SARs relating to homeless people. A number of these findings relate to people's living situations and the location of abuse posing the question whether health, housing and social care practitioners express sufficient professional curiosity and authoritative doubt when they can intervene to prevent abuse and neglect.

Mental capacity

The MCA sets out to ensure that decisions cannot be made on behalf of someone capacitated (MCA Code of Practice, 2005). Issues arise, however, when 'unwise' decisions place individuals and the public at significant risk. The right decision may not be obvious; options may appear so unattractive that practitioners are left searching for the 'least wrong' answer (Preston-Shoot, 2014). Conversely, statutory SARs have flagged issues with health and social care professionals citing capacity as the reason for their decision not to take any further action to safeguard a person against the abuse or neglect they were experiencing.

Decision-making hierarchy

Poor management decisions and practices were found in some cases, and in one case, boundaries between senior and operational decision makers were blurred, with managers overriding staff decisions.

Organisational culture

Several SARs highlighted concerns relating to organisational practice and culture that did and could have a direct impact on decision making. For example, a disconnect and failure of collaboration between adult social care and other key stakeholders such as children's services in the local authority, mental health services, commissioners, and service providers (Preston-Shoot et al., 2020). This was also found earlier in Lauder et al.'s (2005) research, where "liaison between professions was often ad hoc and that knowledge of each other's roles was limited" (Lauder et al., 2005, p.322). In addition, some SARs referred to a negative culture

and examples of scary, chaotic, or fearful cultures (sometimes created by senior managers) that prevented staff from being able to speak out about poor conditions or periods of organisational structure change disrupting practice (Preston-Shoot et al., 2020). More concerning, Preston-Shoot et al. (2020, p.163) highlight:

"an observed management culture of praising the persistence of practitioners' efforts when experiencing hostile engagements with individuals, which normalised such behaviour and left staff tolerating unacceptable levels of abuse (themselves)."

Both practitioners and managers confirmed that engagement was a priority, revealing the absence of a protective and supportive organisational culture towards staff. SARs also found evidence of good practice facilitated by organisational structures, cultures and systems of the agencies involved. This is important because for a significant amount of safeguarding work, decision making is not called into question and good decision making is taking place. More evidence is needed, not just to ensure a balanced view of what is happening in practice but to identify the processes that enable it. Preston-Shoot et al. (2020) found only a single case where identifying positive practice was the reason for commissioning a SAR and suggest this could be utilised more to disseminate learning from positive practice.

Adult safeguarding policy and procedures

The SARs analysis (Preston-Shoot et al., 2020) reveals a wide range of evidence around issues with policy and procedure that includes some unhelpful policies within a safeguarding context, missing policies that would have been helpful, or clear examples of practice departing from policy and procedural expectations. The latter includes instances of safeguarding concerns being recorded but no action being taken, delays in responses, and lack of clarity over what action could be taken, with situations of "social work staff seeming to assume that without criminal court level evidence no safeguarding could be undertaken – not even a plan to support and protect someone could be put in place" (Preston-Shoot et al., 2020, p. 113). This suggests that a lack of understanding of statutory procedures can lead to perceptions of powerlessness around decision making.

It can also result in needs not being properly assessed or risk not being appropriately managed in adult safeguarding cases. One example of this was seen

in an SCR by Buckinghamshire's Safeguarding Vulnerable Adults Board (2011). This was a domestic homicide case of a 70-year-old Mr C by his son, who was a 22-year-old only child and Mr C's full-time carer. The review found insufficient assessment and provision of services, including insufficient monitoring of a father-son relationship, passive and remote social work oversight of the father's needs, and an absence of healthy scepticism (Preston-Shoot, 2014, p.32). Adult social care policy advocates for principles of independence, choice, autonomy, and self-determination; however, "unthinking promotion of these may result in inadequate consideration of safeguarding" (Fyson and Kitson, 2010, in Preston-Shoot, 2014, p.32).

2.6 M*aking Safeguarding Personal*

Inappropriate application or understanding of adult safeguarding policy and procedures has been a theme throughout SARs and other literature around adult safeguarding. In 2014, the Making Safeguarding Personal (MSP) agenda emerged following research that concluded no reliable evidence existed that the adult safeguarding processes at that time delivered outcomes valued by service users (Klee, 2009). Feedback from people who had used adult safeguarding services, stakeholders and practitioners highlighted that too much focus was on process and procedure (Lawson et al., 2014) and that the responses failed to consider sufficiently what the individual said they wanted. Decision making was not influenced by the wishes of the person but by practitioners trying to meet prescribed, procedural deadlines. The research findings were difficult to hear. Social workers had been working hard to implement the required procedures in response to safeguarding issues. It exposed the impact of rigid prescription within the existing procedure.

The MSP model now emphasises safeguarding *with* instead of *to* people. The process should be steered by 'supported decision making' so that decisions are made with the person's desired outcomes as the primary factor. Braye et al. (2012) note that, in the context of personalisation, the focus shifts from protective interventions determined by professionals to helping people engage in self-protection in the context of autonomous decisions. However, whilst this model rightly ensures that what the adult says they want to see happen takes priority, practitioners

often find themselves in complex dilemmas, trying to balance an adult's right to autonomy and choice with the duty to ensure that these same adults, who cannot protect themselves, are kept safe. This balance is susceptible to becoming stressful and emotionally charged, particularly when practitioners are working with adults who want to remain in abusive situations.

2.7 Summary and limitations of adult safeguarding research

The literature above identifies multiple factors that influence judgments, decision making and practice in adult safeguarding. It does not directly explore emotional or unconscious factors. I therefore turn to child protection, an area with significantly more research and literature exploring emotional and unconscious factors in practice. These are touched on in the next few sections. I have summarised some of the most relevant immediately below.

2.8 Factors influencing decision making in child protection

2.8.1 International review of child protection decision making

Keddell's (2014) international literature review looks at research literature about decision making in child protection work. It highlights factors including *policy context, cultural ideas*, group processes such as *groupthink* (described later) and 'good' or 'wicked' *organisational context* (in Harvey, 2017, p.15).

2.8.2 Variance in decision making

Platt and Turney (2013) explore the variance in decision making regarding the *threshold criteria* for social work intervention in child protection cases and suggest that decision making is not linear but a result of a combination of decision-making processes. They identify a range of factors affecting decision making, including the *nature of the welfare concerns for the child, the policy and organisational circumstances, the role of collaborative practice among a range of professionals*, and decision making of front-line staff (Platt & Turney, 2013). They do not mention unconscious processes but argue that a technical-rational approach is limited in effectiveness and a naturalistic approach to how front-line social workers make decisions should be adopted instead (Harvey, 2017).

2.8.3 Professional judgment, practitioner expertise and organisational culture

Whitaker (2014) describes the everyday realities of child protection professionals who must make difficult decisions in circumstances that often-involved limited knowledge, uncertainty, conflicting values, time pressures and high levels of emotion. His study is a comprehensive contribution to the field as he provides detailed descriptions of practitioners' reasoning processes and explains how these are “a dynamic interplay of intuitive and analytic processes with emotionally-informed intuitive processes as the primary driver” (Whitaker, 2013, p.2). He identifies that practitioner experience is a key factor in effective decision making because experienced practitioners have developed more sophisticated internal processes to analyse and evaluate complex information. However, he found practitioners of all experience levels were “vulnerable to the same predictable errors arising from cognitive vulnerabilities such as heuristics and bias (discussed below) that affect the whole population” (Whitaker, 2014, p.2).

2.8.4 Unconscious influence in child protection

Houston (2015) explores issues of the unconscious in his paper on reducing child protection error in social work, in which he proposes a holistic-rational perspective. He refers to the work of Rustin (2005), who suggests that practitioners need to become mindful of their propensity to identify and counter-identify with extreme pain. He suggests that this can be achieved by using different forms of rationality to process emotion psycho-dynamically. In these safeguarding contexts, “affective rationality enables the professional to stand back, create mental space and examine his (sic) emotional domain of experience” (Houston, 2015, p.387). His paper covers the irrational and highlights how unconscious processes can be thought about during good reflective supervision. The latter is a recommendation promoted by earlier social work researchers who have emphasised its critical importance to decision making (see Hughes and Pengelly, 1997, Rustin, 2005, and Fook, 2012). This is discussed in further sections below.

2.8.5 Emotional and unconscious factors involved in child protection work

Ferguson (2014) examines the emotional and unconscious factors involved in child protection work, although he does not look specifically at decision making. He identifies factors such as the intensity of the work, organisational factors such as too much paperwork, and the impact of aggression, both overt and covert, on a social worker's capacity to undertake their work. He notes the common abuse dynamic (explored further in Section 13) of covering up and the lengths some parents go to hide their abuse. He describes how ‘dissociation’ can occur, whereby “social workers become emotionally and spiritually absent in response to hostility, or bureaucratic pressures” (Harvey, 2017, p.37), flagging this as a particular defensive response that likely significantly impacts decision making.

2.8.6 Factors involved in child protection decision making

Harvey’s (2017) research found that social workers’ adult capacities and judgment can be destabilised by the emotional factors or unconscious processes involved in child protection work. She powerfully demonstrates, through case examples, the emotions transferred to social workers that cause intense feelings such as guilt and confusion or cause social workers to identify with the individual. She articulates the painful impact of the often-repeated experience of death and the negative impact on decision making if the relationship between the social worker and manager is strained. All these factors make it difficult for social workers to step back and gain a perspective for good decision making. She notes that “instead of these processes being recognised as an integral part of the process…they are denied by the organisation” (Harvey, 2017, p.157). She identifies the numerous unconscious factors affecting decision making, which include projection, projective identification, splitting, disconnection, transference and countertransference. These are explained in section 2.15 below.

2.9 Relevant decision-making models

"Common sense is a collection of prejudices acquired by age 18."
~ Albert Einstein ~

There are extensive decision-making theories and models contained in the literature on this subject. For this review, I have focused on decision-making models pertinent to my research questions and those featured in research papers. I have chosen psychological and social work models that concentrate on professional judgment and decision making. These seemed best placed since my research uses a psychoanalytical frame and is rooted in psychosocial-minded thinking.

Reason (2008) identified two approaches to studying human judgment and decision making. The first approach is the study of errors in judgment, which he calls the 'human as hazard' approach. The second focuses on skilled professional judgment, which he calls the 'human as hero' approach (Whitaker, 2014, p.29). The latter challenges the dominant narrative of social workers as poor decision makers, something Ferguson (2003) says is part of the wider tendency to adopt a deficit model of social work.

My motivation for this thesis stems from repeated experiences in practice of being faced with senior managers and politicians, among others, complaining about the absence of ‘common sense’ and ‘rational thinking’. Comments like those were prevalent when things became complicated or had ‘gone wrong’. Van de Luitgaaren (2009) shows the poor fit between rational choice decision making and the nature of the decision task in social work practice. It may be that attempts to improve decision making are influenced by the idea of what Van de Luitgaarden refers to as rational choice theory. The technical-rational model of decision making was questioned in the field of psychology in the 1950s (Hardman, 2009) by psychologist and economist Herbert Simon (1957). He challenged the notion that people attempt to evaluate all available response choices as called for in rational models of decision making. Research has since supported the proposition that “people adapt and change their decision-making strategies based on the task with which they are confronted and because of time pressure” (Kleespies, 2014, p.31).

Kleespies (2014) describes three broad categories of theoretical models for decision making: (a) *rational* and *normative* models, (b) *descriptive* models, and (c)

naturalistic decision-making models. The development of the study of decision making occurred in this order (Rasmussen, 1997). A summary follows:

2.9.1 *Normative models*

Often known as classical technical rationality models, are rational procedures based on probabilities. “In these models, there is an analysis of all possible choices and associated risks, and the risks are assigned weights” (Kleespies, 2014, p.32). These models assume that people behave as rational social actors (Klein, 1999). Simon (1956) argued that rational models of decision making do not consider real-life limitations, such as the limited capacity that people have to process information and time pressure. He proposed the concept of bounded rationality, which suggests that people use limited rationality when making decisions where they consider only as many alternatives as required to find one that satisfies them. Psychologists like Daniel Kahneman and Amos Tversky built upon this proposal by investigating and describing more closely the processes by which individuals arrive at decisions (Kahneman et al., 1982). This led to descriptive models of decision making.

2.9.2 *Descriptive models*

Those in the heuristics and biases approach explain that under conditions of uncertainty, people frequently rely on a limited number of heuristic principles or strategies that reduce the complex tasks of decision making to simpler judgmental operations (Tversky and Kahneman, 1974, in Kleespies, 2014). The term ‘heuristic’ is defined as “a simple procedure that helps find adequate, though often imperfect, answers to difficult questions” (Kahneman, 2011, p.98) and the term ‘bias’ refers to systematic and predictable errors. Heuristics range from reasonable prohibitions to more pernicious blinders (David, 2016). As noted above, the complexity and uncertainty in safeguarding work mean practitioners may default to both heuristics and biases when making decisions. The following are some of the key types relevant to consider for this study. They have been compiled from different sources, including David (2016), Taylor (2013), and Kahneman and Tversky (1982).

- *Affect heuristic* - judgments and decision making are guided primarily by feelings of liking or disliking, and little deliberation and reasoning are used.
- *Adjustment bias* – initial information unduly influences perspective so that when new information is provided, the decision does not change.

- *Confirmation bias* – the tendency for people to seek and pay attention to information that confirms their existing hypothesis, ignoring conflicting or inconsistent information.
- Optimism bias – in social work, often referred to as the "rule of optimism", is the tendency to focus on positive information and ignore other negative evidence.
- *Illusion of control* – underestimating future uncertainty because of the belief that they have more control over events than they do.
- *Representativeness heuristic* – people are likely to judge the probability that a person belongs to a category based on the resemblance with a typical stereotype.
- *Availability heuristic* – the tendency to estimate probability, based on how easy it is to think of examples, i.e., what comes to mind first.
- *Ethnic/racial and gender biases* – personal and sometimes unreasoned judgments made solely on an individual's race/ethnicity or sex.

A better understanding of heuristics and an awareness of the biases to which they can lead are seen as the means to improve decision making in situations of uncertainty (Kleespies, 2014, p.34) and thus are important considerations in safeguarding decision making. One of the criticisms of the descriptive models is that they are based on studies done "in the laboratory," and therefore may fail to consider the effects of the context that can accompany decision making in the real world (Whitaker, 2014). This is where naturalist decision making comes in.

2.9.3 Naturalistic decision-making (NDM)

These models attempt to understand how people make decisions in real-world contexts. NDM has been defined as the study of the way people use their experience to make decisions in field settings (Zsambok, 1997). Aylet (2018) explains that decision making in the context of safeguarding adults from abuse is complex and interdependent with real-world variables and that the research from the NDM field can assist in its understanding. Several NDM models have been proposed, such as the recognition-primed decision (RPD) model, a situation awareness (SA) model, and the hypervigilant decision-making strategy (Whitaker, 2014), all of which speak to phenomena that occur within adult safeguarding practice.

RPD making, also known as intuitive decision making, arises from studies of decision makers in high-pressure and high-stakes situations, such as firefighters and battlefield commanders (Zsambok and Klein, 1997 in Aylet, 2018). The RPD model asserts that people can use their experience to understand a current situation and make a decision on a course of action without generating large option sets (Whitaker, 2014, p.38). It also asserts that time pressure need not negatively affect the performance of experienced decision makers because they use pattern matching, which can occur quickly.

An *SA model* shows that individuals may make the correct decision given their perception of the situation, but their perception may be where the flaw is (Whitaker, 2014, p.38). Endsley's (1995) model of SA involves three levels: (1) perceiving critical factors in the environment, (2) understanding what those factors mean, and (3) understanding what is likely to happen soon in a dynamic or changing situation. "The experienced decision maker is typically capable of achieving Levels 2 and 3 of this model, but the novice decision maker may fall short at these higher levels" (Whitaker, 2014, p.39).

The *hypervigilant decision-making strategy* outlines how in many task settings, decisions must be made under time pressure with ambiguous and conflicting information. The person making the decision must conduct a less-than-exhaustive information search, do an accelerated evaluation of the data, consider a limited number of alternatives, and come to rapid closure on a decision. It is argued that this does not represent a defect in the decision-making process but rather an adaptive and effective response given the time-limited nature of the task (Whitaker, 2014*).*

2.9.4 Dual system model

In his book *Thinking, Fast and Slow*, Kahneman (2011) places the heuristics model within a larger, two-system framework for thinking and decision making. His model presents human thinking as characterised by two types or systems of thinking: System 1 and System 2.

System 1 consists of thinking and perceiving that operates automatically and quickly with little or no effort. Thoughts are typically fast, automatic, effortless, associative, and implicit, which means they are not available for immediate introspection (David, 2016). Unsurprisingly, heuristics are a function of this system (Kleespies, 2014). System 1 thinking, however, often carries emotional weight. It includes the innate abilities by which people recognise objects, see causality and think intuitively (Whitaker, 2014).

System 2 is controlled, effortful and analytical and can undertake complex computations that require considerable effort (Whitaker, 2014). System 2 thoughts are slower, more deliberate and require a deeper level of attention (David, 2016). System 2 runs in a low-effort mode much of the time and is activated when events are encountered that require analytical and logical reasoning. In everyday situations where judgment problems arise, System 1 provides intuitive answers that are rapid and associative. The quality of these proposals is monitored by System 2, which applies rules and uses deduction to endorse, correct or override them (Kahneman and Frederick, 2002; Kahneman, 2011). If the proposals are accepted without significant revision, we will likely regard them as intuitive. Whilst System 1 processes characterise much of our everyday thinking, our sense of agency, choice and identity is associated with System 2 (Kahneman, 2011). The dual process theory offers an interesting account of how we develop expertise. Kahneman and Frederick (2002) argue that as we gain proficiency and skill, the complex cognitive operations that originate in System 2 migrate into System 1.

2.9.5 Intuitive decision making

The use of intuition is often reported by social workers as a key part of their decision-making process. Hugh England (1986, in Wilson et al., 2011) first described how in social work the use of intuition is ever-present and yet unclear. Munro (2008) says that intuitive thinking is quick and effective as it enables practitioners to form judgments within short timescales in real-life situations. However, she acknowledged that these were difficult to articulate, which is problematic when practitioners must share knowledge or explain or justify decisions. David (2016) says that ‘gut responses’ often have a dark side because when heuristics dominate people’s thoughts and behaviour, they are less able to detect unusual distinctions

or new opportunities. Kahneman (2011) asserts that because of such biases the confidence people place in their intuitions is not a reliable guide to their validity and that intuition is nothing more and nothing less than recognition. This links to the RPD model outlined above.

The idea that 'gut feelings' are used as a source of knowledge generates scepticism and reflects the dominant view that responses must be based on rational and cognitive processes (Wilson et al., 2011). Sheppard (2006) describes the practice of social work as a creative art form, which requires personal capabilities linked to an individual's intuition. He argues, however, that practitioners also need to engage in a high level of analytic thinking (Sheppard, 2006). Whitaker (2014) says the benefits of analytic thinking are that it is formalised, explicit, can evidence the basis for decisions (Turney, 2009; O'Sullivan, 2011), is less subject to bias and other errors in thinking (Turney, 2009; Munro, 2008), and conforms to traditional conceptions of decontextualised and universalisable knowledge that can be generalised to a range of settings (Munro, 2008). The disadvantages are that it is slow, demanding, and cumbersome and sees emotion as a potential contaminant to thinking, so it can appear distanced from real-life situations (O'Sullivan, 2011).

Lerner et al. (2014) write that the best model for decision-making domains will depend on the decision-making context. In this respect, adult and child safeguarding contain similarities and differences. Galpin and Hughes (2011) draw on the experiences of social work practitioners involved in safeguarding activity and qualified social workers undertaking post-qualifying social work education. They report that practitioners find multi-agency decision-making in the adult safeguarding context professionally, intellectually, and emotionally challenging. They refer to the five-stage Harvard Business model: 1) establishing context, 2) framing the issue, 3) generating alternatives, 4) evaluating alternatives and 5) choosing the best option. The model stops here, and they propose that for most decisions a sixth step is required to identify actions and those responsible for implementing them. Thus, they offer a multi-agency decision-making model for safeguarding practice. Whilst their study acknowledges the emotional elements in typical adult safeguarding decision-making contexts, no stage supports the reflecting upon and processing of this emotion, or any unconscious influence.

In conclusion, the above range of decision-making models offers useful theoretical ideas and frameworks for applying more psychologically informed models from decision making research. I have included them here because they challenge the current dominant technical-rational decision-making model that is often the default within adult safeguarding practice. I think these alternative models provide a far more realistic and helpful approach to decision making and believe their application in an adult safeguarding context should be considered.

2.10 Emotions and emotional factors in decision making

As limited research exists on emotional factors influencing decision making in adult safeguarding, this next section looks at literature from other disciplines. In their paper titled 'Emotion and Decision Making', Lerner et al. (2014) present an analysis of the literature from the past 35 years. For most of the 20th century, research examining emotion in all fields of psychology was scant and "one almost needed to go back to Freud to find theoretical bases for emotion in decision making" (Lerner et al., 2014, p.5). Loewenstein (2003) explains that traditional theory focused on cognitive decision-making but largely ignored the importance of emotions in decision making until the late 1980s (in Loewenstein and Lerner, 2003). Many theorists such as Keltner and Lerner (2000), Loewenstein (2003) and Damasio (2006) posit that emotions are the dominant driver of most meaningful decisions in life. Collectively, they make at least two conclusions clear: emotions powerfully and pervasively influence decision making and the field of emotion research is in its infancy.

Lerner et al. (2014) summarise the key findings from a wide range of emotion researchers. Collectively they have shown how emotions guide choices to avoid or reduce feelings such as guilt, regret, or sadness. They also guide choices to increase or sustain feelings such as happiness, elation, pride, and even negative feelings like disgust and fear. This reportedly happens even when we lack awareness of their influence.

Once the outcomes of our decisions materialise, we often feel new emotions such as elation, surprise or regret (David, 2016). Robert Zajonc (1984) proposed the concept of 'affective primacy', suggesting that emotions operate independently, and in advance of, cognitive operations. Contemporary science now reveals a

considerable amount about the crucial role of emotion in interrupting and directing cognitive attention (Whitaker, 2014, p.3). According to Lowenstein (in Lowenstein and Lerner 2003, p.620), two main kinds of emotions influence decisions: expected emotions, which are expectations about future emotional consequences of a decision, and immediate emotions, which are emotions felt while making a decision.

Lerner et al. (2014) also refer to two distinct types of emotion that influence decision making: 'Integral' emotions are those arising from the judgment or choice at hand such as feeling anxious when contemplating the potential outcomes of a risky choice (Lerner et al, 2014, p.16). 'Incidental' emotions are those that are felt at the time of decision but are not normatively relevant for deciding.

The negative influence of emotions

Adult safeguarding is similar to child protection in that social workers deal with highly distressing situations involving abuse or neglect resulting in the professional experiencing intense emotions. Research has often focused on the negative influence of emotions, including how they degrade decision making or influence a course of action despite the presence of information that suggests a better alternative (Lerner et al., 2014). Lerner et al. (2014) also note emotions have been shown to carry over, e.g., those arising from one situation have been found to drive decisions unrelated to that situation, even when the individuals making the decisions consciously regard the situations as unrelated. Studies also show that when people must make risk-based judgments, they tend to show bias toward the familiar and give more credence to opinions that appear to be widely held (David, 2016). The latter is sometimes seen to manifest in a phenomenon known as *groupthink*, in which decisions are influenced by the group. The term was first coined by Irving Janis (1972), who described it as the tendency of group members to go along with the decisions of a group because members have come to value the group of which they are a part more highly than anything else. This occurs even when they do not agree with them, to minimise conflict and maximise harmony and conformity (Whitaker, 2014, p.35). Safeguarding adults' practice is conducted in a multi-agency, inter-professional work context and consequently, some but not all decisions will be reached in teams or inter-professional groups (Aylet, 2018). The vulnerability to groupthink is ever-present.

The positive influence of emotions

The generally accepted notion is that emotions negatively influence our thinking and responses and specifically that *all* strong emotions negatively affect decision making. More recent research has challenged this view reasoning that it has dominated much of Western thought (Keltner & Lerner, 2010). The work of Antonio Damasio (1994), a neuroscientist, generated insights into the relationship between emotions, judgments and decision making in particular. His research shows how emotions can inform intuitive judgments without conscious awareness. Damasio researched patients who had experienced brain damage in a specific area of the frontal lobe. These patients had normal IQs and no cognitive impairments or memory disturbances; however, their capacity to experience emotion was impaired. Patients had significant difficulty in thinking ahead and could only process the immediate present with clarity (Damasio, 2006). The emotions experienced by the control group guided their behaviour. The patient group, who could not draw upon their emotions to inform their choices, repeatedly made riskier or poorer choices, evidence that judgment devoid of emotion is poor. Emotion is an essential ingredient in successful decision making.

David (2016) explains that emotions such as anger, sadness, fear, surprise, contempt, and disgust are still with us because they have helped us survive millions of years of evolution. One only has to consider ‘fight or flight’ responses to see how in reaction to danger, we feel fear, which triggers a response that helps to protect us. More recent research has shown how the more negative or difficult emotions have a purpose and specific emotions carry specific “action tendencies” (Lowenstein and Lerner, 2003). Anger, for example, motivates one to act, respond to injustice, change the situation and move against another person or obstacle by fighting, harming, or conquering it (Lerner & Keltner, 2000). Negative emotions including sadness, anger, guilt or fear have positive consequences, including that they help us form arguments, improve memory, encourage perseverance, make us more polite and attentive, encourage generosity and make us less prone to confirmation bias (David, 2016).

2.11 The impact of difficult emotions on professionals

In the context of adult abuse work, decision making can be emotionally laborious, and practitioners' vulnerabilities to negative impacts heightened. Abuse is trauma and, as such, ongoing exposure to it means that professionals are always at risk of being vicariously traumatised, i.e., the professional starts to show trauma symptoms like those experienced by the helped person (British Psychological Society, 2002). The British Psychological Society published guidance (2020) on reducing the likelihood of secondary or vicarious trauma, specifically referring to safeguarding roles as being at risk of being exposed to trauma.

Employees in these types of roles need to be empathetic, but empathy can increase the risk of secondary trauma for them. Craig and Sprang (2010) report that when people view their jobs as a calling, compassion satisfaction increases and helps levels of compassion fatigue and burnout. Social work is often linked with activism, and research by Metin Basogulu (2009) found that activists had less psychological trauma than non-activists; that is, the experience of trauma is contextual.

Several SARs found that support for staff dealing with difficult situations had been lacking. Staff had not been supported to manage the personal experience of their work, were traumatised and struggling to deal with the emotional impact, and recognition of the emotional impact by managers was lacking (Preston-Shoot et al., 2020). Preston-Shoot et al. (2020, p.155) quote from one SAR that describes how:

"In the face of his mother's relentlessly aggressive and racist behaviour towards care workers and professionals, a number of staff described feelings of burn-out and powerlessness which they found difficult to cope with. Senior managers praised the efforts of staff to engage with hostile service users whilst giving little consideration of the emotional impact of managing aggression and violence."

This draws attention to the need for emotional support for professionals in safeguarding roles. In particular, practitioners require complimentary protection to those that they are protecting from abuse.

2.12 The importance of supervision

Workers need opportunities not just for reflection but for refining and rebuilding their internal resources (Bower, 2003). Huffington et al. (2004, p.88) say that because the capacity to process personal distress cannot be taught and social work has no tradition of personal therapy as a way of developing professional skills, the role of a supervisor in processing emotional experiences becomes particularly important. Many SARs emphasise the critical role of supervision and it is increasingly becoming a hot topic in this field. In a paper on restorative supervision in safeguarding, Wallbank and Wonnacott (2015) offer an integrated model for supervision suggesting that to be effective it needs to combine reflective practice and critical thinking with a restorative experience. The restorative element is how professionals feel emotionally supported and maintain their capacity to think. Effective supervision should also support social workers to develop critical 'reflective capacities' that consider unconscious processes - possibly the most important element (Harvey, 2017).

Literature on the supervision of professionals who counsel victims of abuse can be useful to consider and in many ways is more developed than adult safeguarding supervision. The literature highlights the importance of supervisors needing to be emotionally robust to contain and manage often the most difficult and nastiest of material (Walker, 2005). Safeguarding work can induce feelings of hopelessness and despair and often the most appalling details of the abuse are encountered. Supervisors need to be trained effectively so that they have internal capacities to hold despair, tolerate not knowing and manage extreme anxiety as part of the supervisory task (Walker, 2005). This perhaps deepens the model proposed by Wallbank and Wonnacott and suggests that it is not sufficient for a supervisor to support reflective practice in adult safeguarding. The supervisor will need to develop their emotional capacities to cope with the work.

2.13 Decision making in organisations

The political nature of statutory safeguarding work means that organisations can be publicly exposed and scrutinised when things go wrong, such as a vulnerable adult being killed or dying where safeguarding concerns existed. The rise of managerialism and audit culture was a response to high-profile child tragedies over the past 20 years. It was introduced to social work as a way of controlling what social

workers did and how (Rogowski, 2011). Managerialism was first developed during the industrial revolution in factories and drove production and outputs, later known as Taylorism. It is driven by principles of efficiency, calculability, and predictability. Whilst this approach worked in profit-driven organisations, the same cannot be said for public sector organisations, where outcomes require intangibles such as professional relationships (Dustin, 2007). Workers had less contact with clients, reducing opportunities for real connection and relationship building.

Howe (1999) described the consequent shift as being shallower and increasingly performance orientated. Interest declined in developing knowledge to make independent professional judgments and the emphasis was on following protocol (Howe, 1999). The impact of managerialism on safeguarding practice was exposed when Professor Eileen Munro reviewed child protection in England in 2011. She described how a system needs 'requisite variety' to respond to the varied needs of children and young people but notes that; "…many professionals describe themselves as working in an over-standardised framework that makes it difficult for them to tailor their responses…" (Munro, 2011, p.37).

Managerialism within organisational culture leaked from child to adult safeguarding practice. Adult safeguarding policy mostly echoed child protection policy with the language and many of the professional processes being the same. Adult safeguarding response timeframes matched the ones used in child protection procedures. It was later discovered that these timescales had not been based on real evidence. The pressure to arrange strategy meetings or write investigation reports within these set timeframes often meant essential information could not be obtained or became a barrier to responding to case-specific dynamics.

The Munro report (2011, p.63) pointed out that besides over-standardising practice, having timescales leads to undervaluing other key practice principles. Performance data on timescales continue to be routinely collected. They have been used by inspecting agencies to make judgments about good practices; however, without examining actual local practices, such judgments are of limited value and questionable validity (Broadhurst et al., 2010). Quantitative data reporting will always be at odds with the primary task of safeguarding. Whilst it can be helpful to have information that provides a snapshot of safeguarding activity, if it only focuses

on whether targets are achieved then it becomes the main measure of 'good' adult safeguarding work, and the complexity of the decision making, i.e., the work, is lost. The Probation Association (2011) captured these types of measures as: 'hitting the target but missing the point' (UK Parliament). The target system has institutionalised getting it wrong, leading to mistrust of the people who work in public institutions (Bower, 2005).

Wilson et al. (2011, p.37) explain that when the organisation becomes subject to being 'named and shamed', it must cope with the anxiety of 'failing in performance'. The organisational response to this anxiety is often to focus on target-driven and tick box work (Bower, 2005). Rigid adult safeguarding procedures and managerialism are likely signals of an institutional defence against the anxiety that arises within safeguarding work and an attempt to manage this anxiety. In most statutory safeguarding settings, adult safeguarding cases must be overseen by a manager. Policy and procedure imply that social workers cannot be trusted to make autonomous decisions. This dynamic of mistrust deskills and disempowers practitioners' confidence in knowing how to navigate independently. Whitaker (2019, p.131) found that it "was commonplace during the observations to hear practitioners talking on the phone to family members or other professionals and to state that they would first have to 'speak to their manager' about a decision."

Noyes (2015) outlines how managerialism has resulted in a split: practitioners must serve and meet the needs of both the clients and the organisation. Tension between the two is frequent, and a practitioner's decision about what is in the client's best interests can be in direct conflict with that of the organisation (Noyes, 2015). Aylet (2018, p.76) notes that: "discretion around decision making is usually shaped by how much freedom in decision making is permitted".

Studies from around the UK indicate the gap between policy and implementation concerning adult safeguarding (IPC, 2013) demonstrating the disconnect between what policymakers intend and what happens in practice. Ash (2013) observed that SCRs and other inquiries rarely explore the work environment and its impact on decision making in practice. Often the focus is on whether the practice was compliant with policy and provides little insight into how the 'rules' are experienced by the frontline worker. Cooper and Wren (2012, p.208) suggest that policy may

generate more confusion than it clears up and can have unintended consequences. In the face of complexity, social workers are left confused by the often-rational linear perspective of policy, upon which they have come to rely, but which is inadequate in guiding them on how to respond effectively. Cooper's (2009) view helps to explain this when he describes that:

"Traditional policy analysis still relies upon a machine metaphor to 'diagnose' social ills, and 'treat' them to effect a 'cure'; but societies are not machines, and are better conceptualised as complex adaptive systems, or social ecologies, in which the relationship between causes and effects are non-linear, and never fully predictable" (Cooper, 2009 p.8).

Clients of services are not straightforward rational beings, so policy denies the complexity of the human condition and the uniqueness of the social work task (Ruch et al. 2014).

Safeguarding decision making in organisations might therefore often be what happens in the space between where the policy stops, and the reality of practice starts. This connects to the concept of 'street-level bureaucracy', a term coined by Lipsky (1980, p.xii), who used it to describe how "the decisions of street-level bureaucrats, the routines they establish and the devices they invent to cope with uncertainties and work pressures, effectively become the public policies they carry out" (in Evans and Harris, 2004, p.874). In *Street-Level Bureaucracy*, Lipsky (1980, p.xii) asserts that the operation of this discretionary decision making makes street-level bureaucrats the ultimate policymakers. He saw deviations from policy not as failures but as creative responses to impossible mandates (Aylet, 2018). This is relevant when considering the adult safeguarding practice context where high volumes of referrals and workloads often mean regular managerial or supervisory oversight and support are not possible and frontline practitioners face emotionally charged complex scenarios that do not have simple solutions. Direct contact with the public, whether fleeting or sustained, is the personal encounters that expose the emotional lives of both client and worker, giving rise to a mixture of emotions (Aylet, 2018). As such is it unlikely that the "bureaucratic ideal of impersonal detachment in decision making" is occurring (Lipsky, 1980, p.9).

Ruch (2005) and Ruch, Turney and Ward (2010) strongly influenced the discussions in addressing the need to re-think the task of social work in the light of the obvious deficiencies, dominated by managerialism and risk-averse functioning. Munro's (2011) recommendations were centred on freeing services from 'the grip of managerialism' by enabling less central prescription and greater emphasis on professional judgment (Munro, 2011a, 2011b). Ruch et al.'s (2010) views serve as a helpful reminder that despite these structural pressures, relationship-based work can still be at the heart of good social work practice because all work starts with a human encounter (Rogowski, 2011). The Munro Review also highlighted that earlier reforms had pursued technical solutions at the expense of giving sufficient attention to organisational support. This is necessary to enable practitioners to manage the emotional aspects of the work without it harming them or their judgment (Munro, 2010). Froggett (2002) argues that the failure to provide a containing environment leads to fragmentation in thinking. The integration of thought and feeling is fundamental to reflection so thinking in social workers and their organisations can only be achieved with the right quality of environment (Harvey, 2017).

2.14 Race, power, and diversity as a factor influencing decision making

Critical race theory (CRT) starts from the premise that race and racism are central, endemic, permanent and a fundamental part of defining and explaining how UK society functions. The CRT framework enables us to see the insidious ways that racism impacts social structures, practices, and discourses (Yosso, 2005). I knew it was important for my research to consider how race, power, and diversity as factors that influence decision making in adult safeguarding. Evidence already exists that minority ethnic groups face significant disparities in mental health care. They are more likely to be admitted to the hospital under a section of the Mental Health Act and more likely to be readmitted once discharged, and it is more probable that they will be assessed as violent (CQC 2011; Davies 2014). The Race Equality Foundation highlighted that this evidence indicated ethnic bias (Thornton, 2020) and demonstrates how decision making by professionals is influenced by this bias. The National Analysis of Safeguarding Adults Reviews states that whilst some review

examples referred to the Equality Act 2010, they failed to consider what impact race, culture, religion, language, and ethnic origin might have had on the events being analysed (Preston-Shoot et al., 2020). It reveals that none of these key characteristics was considered as a factor influencing risk or having any impact on vulnerable people. One SAR referred to the “possibility of unconscious bias in how agencies respond” (Preston-Shoot et al., 2020, p.103) and reflects how little connection has been made concerning how this unconscious factor influences practitioner decision making in adult safeguarding.

Several SCRs and SARs highlight the poor quality of information about the ethnic identity of the individual and their family members. In *Safeguarding Children Across Services: Messages from Research* (Davies & Ward, 2012), virtually no mention is made of race or ethnicity as a factor. Both SARs and SCRs highlight that an understanding of the family in terms of their ethnic or cultural identities was not seen as a priority. This means that opportunities have been missed to identify how ethnic bias and racism have affected and do affect decision making in safeguarding practice. The collection of adult safeguarding data on demographics to show how these might influence responses in practice is still in its infancy, and even the wider performance system has failed to recognise the importance of this until recently.

The widely reported cases of Stephen Lawrence and Victoria Climbié sharply drew into focus how institutional racism directly affected decision making and responses with devastating consequences. Fundamental to addressing institutional racism is the need for professionals to understand the effect of racism on service users and communities. People regularly speak or behave in discriminatory ways, often unaware of or disconnected from this fact. Wilson et al. (2008) note that people understand racism, whether it is personal, institutional, or societal, but the idea that it is a site of complex personal, emotional pain for those who experience it is less common. This might explain the disconnect between people’s awareness, real understanding, and willingness to identify their required behaviour change. Lowe (2013) uses psychoanalytic ideas to explore institutional racism, arguing that it is an example of an unconscious organisational process that occurs due to unexamined discrimination arising from the needs and interests of the dominant group in the organisation. He describes how Black people are objects for White projection by virtue of the historical role and lack of power of the former. This, he explains, can result in Black and minority ethnic people unconsciously internalising White people’s

projected feelings of inadequacy and inferiority. “Black and minority ethnic staff can then feel demoralised, helpless, and hopeless, without fully comprehending how it happened” (Lowe, 2013, p.156). The next section expands on the concept of projection and other psychoanalytic concepts relevant to this study.

2.15 Psychoanalytic theory and concepts

My research is placed within a psychoanalytic frame, and I have chosen to draw upon psychoanalytic concepts because they support the premise of unconscious and emotional influence. As previously noted, earlier researchers have utilised these, within a child protection context, to demonstrate the power of unconscious dynamics on practice. Bower (2005) highlighted that social work practitioners are often not taught or provided with theoretical frameworks that enable them to understand human disturbance and problems. Having this for an adult safeguarding context seems critical if practitioners are to understand how people come to find themselves in abusive situations and how powerful abuse dynamics can affect the professional relationship.

I have summarised the key psychoanalytic concepts described by Freud, Bion and Klein. I have referred to Bower (2003, 2005), who used psychoanalytic ideas to explore and improve understanding of abuse and its impact. My aim is to propose the usefulness of their application to adult safeguarding work and the context of adult abuse. I discuss the concepts of defence mechanisms, transference, countertransference, projection, projective identification, splitting and containment. I have found these particularly useful in my own safeguarding practice when considering the unconscious dynamics that may be affecting professional relationships or professional intervention. These are useful concepts for understanding how internal psychological processes become externalised, how unconscious factors affect the relationships around us and how defences against anxiety can impact professional judgment (Harvey, 2017).

Defence mechanisms

Psychoanalytic theory is the theory of personality organisation and the dynamics of personality development. Central to psychoanalytic theory is the idea that much of

our mental life is unconscious. It offers a developmental perspective emphasising the formative effect of early relationships (Milton et al., 2004). First laid out by Sigmund Freud in the late 19th century and then built upon by subsequent theorists such as Melanie Klein (1946), Bion (1961) and Winnicott (1965), the development of psychoanalysis and practice was driven by two goals; “One was to understand why and how people developed psychological symptoms and the other was how to help them become free of them” (Bower, 2005, p.6). Freud (1923) introduced the structural model of the mind that describes three elements, namely the id, ego, and superego (Davenhill, 2007). He believed that ‘the Id is the unconscious instinctual impulses that drive us; the Ego is the element that sits between the Id and Superego, acting as an intermediary; and the Superego is formed over time, based on the internalising of parental figures and forms the basis of the conscience’ (Davenhill, 2007, p.12). It is the ego, whilst mediating between the demands of the id, superego, and external reality, that deploys what Freud (1923) describes as defence mechanisms (Milton et al., 2004). These are also devices that the ego uses to ward off anxiety aroused by the individual’s reactions to situational occurrences. The inherently human wish to avoid the experience of pain and anxiety is often dealt with by various mechanisms of defence (Trevithick, 2011).

Some of the common defence mechanisms include denial (refusal to acknowledge to self and others, the existence of a thought or feeling), projection (attributing one’s thoughts and feelings to others), displacement (where feelings and thoughts that refer to one person are transferred to a different one), and avoidance (pains are taken to avoid a potentially arousing situation) (Trevithick, 2011). Preston-Shoot and Agass (1990) explain that these defences can sometimes be re-enacted by the professional system.

Social or psychic defences

Menzies-Lyth’s (1960) study of nursing practices in a hospital in the 1950’s identified how anxieties arose for nurses, when caring for seriously ill people and led to the establishment of particular ‘psychic defences’ to help them cope. These so-called ‘psychic defences’ were observed in certain behaviours, splits and conflict in the nursing hierarchy (Noyes, 2015). Jaques (1955) had already described the concept of social defences in organisations. He initially described them as unconscious

agreements or collusions that deny or distort aspects of experience that provoked unwanted emotion. Later, he attributed these 'social defences' as being the result of poor organisational structures (Long, 2006). A number of social work academics have referred to and/or built upon these concepts and drawn attention to how these apply and can be seen in statutory safeguarding settings (Lees and Rafferty, 2011; Cooper et al. 2011).

Transference and countertransference

Freud first described the concept of transference in 1895. It is the process in which one person 'transfers' feelings from their own inner life to someone else (Wilson et al., 2008), and Freud experienced this when treating his clients. It is a powerful unconscious process that will occur in most if not all 'helping' relationships including safeguarding professionals. Transference is the idea that in our current relationships and interactions we may unconsciously 'transfer' feelings that belong in our previous relationship into the here and now. "Understanding of these unconscious processes supports practitioners to differentiate between their own personal responses and those aroused by the service user" (Wilson et al., 2011, p.116). By developing the ability to identify transference, practitioners in a safeguarding context can use this as information about what might be happening with their clients and adjust their responses accordingly. For example, someone from an abusive background may experience the social worker as punitive, harsh, and abusive or view them with hostility and huge distrust. Even when the social worker considers themselves to be benign and is trying to be helpful, this help can be rejected as controlling (Bower, 2005). This is useful to recognise, given how many people experiencing abuse often reject offers of help despite being at significant risk and in real need.

Ruch (2010) suggests that social workers need to be aware of the presence of transference, both in terms of what they carry within themselves and how they are affected by service users' transference onto them. 'Such reactions to the transference are known as counter-transference' (Ruch 2010, p.35) and can help workers to understand the 'psychological happenings of the patient' (Racker, 1953, p.159). Little (1951), however, saw countertransference as a disturbance to understanding and interpretation in that it influenced the therapist's behaviour to unknowingly repeat behaviour of the patient's past resulting in a re-experience of

their) childhood (in Racker, 1953). This has important considerations for those working with the abused; powerful transference might unknowingly elicit harsh or abusive responses by social workers. Awareness of these issues can give us a more realistic perspective on what we can expect from our clients and the difficulties they have in making change (Bower, 2005).

Projection and projective identification

Melanie Klein (1946) first proposed that the establishment of one's internal world comes through complex interactions of projection and introjection. This process starts at the beginning of life with a baby's feeding (introjection) and defecating (projection). Davenhill (2007) explains that this includes how a baby starts to navigate emotional states by learning how to take in and release feelings such as hate and love, frustration, and reparation. Mastering this process sets an individual up for how they manage their experience of loss throughout life. Projection in adult life is seen when people place their unwanted feelings, like fear, anger, or confusion, in another person. This happens so that individuals can get rid of the unwanted anxieties they are experiencing in situations (Ruch, 2010). Understanding this response allows identification of what the person is experiencing or 'projecting' onto them, which is called 'projective identification' (Bower, 2005). As a defence mechanism, it means the person's unwanted aspects are disowned in their own mind and lodged in others, who then are often "influenced in such a way that they come to feel what has been disowned and to behave accordingly" (Skogstad, 2004, p.67).

Ruch (2010) highlights that these unconscious aspects of communication reveal the tensions between the feelings associated with the past and present and how these tensions can influence or distort our behaviour and experience. Clients who have experienced neglect in childhood or are experiencing it in their current circumstances might present as feeling that no matter what the social worker does, it is not good enough or even perceive it as not any good at all. Those who have experienced or are experiencing abuse might project an overwhelming sense of anger, hatred, or disgust onto the worker. The theory of projective identification can be illuminating in these circumstances and is an important unconscious and

emotional factor present in practitioner-client relationships and therefore in adult safeguarding work. Both Rustin (2005) and Bower (2003, 2005) highlight the emotional pressure placed on social workers who are bombarded by these clients' projections.

Bower (2005) describes how clients who need to get rid of unwanted feelings and states of mind will use this to make others feel them instead. This can affect the worker's state of mind and, in turn, workers can identify with these feelings, believing that they are helpless, inadequate, cruel or whatever is being projected. Those who have been abused use a range of schizoid types of defences, from those that are rigid and differ in quality to more flexible projective processes whereby the client unconsciously wants to communicate and seek containment of their feelings for the worker to understand and bring to light. Bower (2005) describes the problems inherent in child protection work, which often involves seriously disturbed individuals with chronic pathological problems. "Relationships with social workers can be hostile and suspicious or superficially friendly" (Bower, 2005, p.161).

In safeguarding work, practitioners often encounter clients who are either the abuser or the abused. Those working in health and social care settings will often need to face and deal with people they know to be potentially violent or extremely dangerous (Smith, 2004, p. 45). Professionals have to work with and within this reality and with difficult behaviour often caused by pathological defence mechanisms. Pathological defences are commonly seen in adults who have grown up in abusive familial systems. The presence of a cruel or sadistic superego is common because children have internalised projections of aggressive or abusive parental figures. Bower (2005) explains that this type of superego makes it exceedingly difficult for the individual to face guilt and responsibility. Guilt is defended against by its outward projection, paralysing the worker who feels the guilt instead, through projective identification (Harvey, 2017). The effects of projective identification are strong and can produce intense countertransference reactions. These are likely unconscious factors that influence their subsequent decisions on the case.

Splitting, paranoid-schizoid and depressive positions

The ‘splitting’ between ‘good’ (person(s)) and ‘bad’ (person(s)) is what Klein (1946) explains as the paranoid-schizoid position, an emotional state we seek to organise our psychic experience when faced with extreme fear or anxiety (Waddell, 1998). It is ruled by the principles of self-preservation (Milton et al., 2004). Klein’s (1940) depressive position, which comes after the paranoid-schizoid position, is where a healthier emotional state is achieved. The capacity to tolerate ambivalence and conflict and to understand ‘the other’ perspective or experience is increased. That humans and situations have both good and bad aspects is recognised, which enables a fuller picture to be seen and an ability to integrate opposing perceptions and/or emotions inherent in the situation.

Huffington et al. (2004) describe how this can also be seen as part of organisational life. For example, a version of the paranoid-schizoid split is often seen in response to organisational change (Huffington et al., 2004, p.108). In these situations, professionals can feel anxious and fearful of the future, so, understandably, they attempt to protect themselves psychologically. Splitting behaviour can also be seen within teams, where individual workers scapegoat certain colleagues for not pulling their weight or making mistakes. Smaller groups can form within the team, with other members seen as ‘the bad ones’. Many people in the face of intolerable stress turn to coping strategies (Preston-Shoot and Agass, 1990) and the in-group, out-group dynamic, avoidance, and splitting can all be seen as ways that individuals try to manage their anxieties. It is not uncommon to see binary ‘black and white’ positions taken by those in leadership positions, particularly when situations become highly political or reputational risks are at stake.

The paranoid-schizoid position can then be reflected in organisational culture. Whilst this may contain anxiety, it does not enable holistic thinking and good practice. To achieve ‘a depressive position’, leaders need to be able to tolerate the uncertainty and anxiety integral to adult safeguarding work. This would likely enable the culture of ‘professional curiosity’ so often referred to in SARs as missing. It could be argued that the notion of professional curiosity requires a culture where the depressive position can be the norm because practitioners need to have the capacity to tolerate difficult scenarios and feelings of ‘not knowing’ to maintain curiosity.

Anxiety and nameless dread

We all have some awareness of the primitive, ever-present, all-pervasive anxiety that is part of the human condition (Dartington, 2010). Winnicott (1965) referred to this as unthinkable anxiety and Britton (1998) suggests this is not just about a fear of dying but a more undeveloped, basic anxiety. It is a dread of the unknown, the child's fear of the dark and a fear of annihilation (Dartington, 2010). Later, as an adult, fear of annihilation takes on different forms such as anxiety around one's identity and tends to come back during crisis periods. Bower (2005, p.107) explains that nameless dread is present to some degree in all human minds and ultimately derived, in Bion's view, "from a failure in a mother's capacity to contain her infant's terrifying states of mind". These uncontained states are often then what social workers experience when they encounter clients in crisis. Bion's (1962) theory of containment is immensely valuable in providing a model for social work practitioners on how to manage emotional states when dealing with distressed individuals.

Containment and reverie

The concept of 'containment' is derived from the work of Bion (1962). The model for this is the way a mother or primary carer responds to an infant's first experiences of hunger, discomfort, or fear. Through the actions of holding, feeding, and changing an infant, the mother or primary carer "acts as a container for these feelings and returns them to an infant in a manageable form" (Preston-Shoot and Agass, 1990, p.42). The infant learns to tolerate and make sense of the experiences rather than becoming overwhelmed. Bion (1962) suggested that if the mother (sic) is not accessible to her child, if she is not able to receive and take in the child's experiences and to help take care of them, then the child will be left with the feeling that they were not possible to understand and the child is left 'in a state of nameless dread' (Symington & Symington 1996, p.54). Waddell (2013, p.35) explains Bion's (1962) concept of containment as 'being able to make sense of one's feelings as a consequence of having had sense made of them by a thinking other'. In social work terms, it is the capacity to be emotionally receptive to the client's feelings and to reflect on them before making decisions about action (Bower, 2012, in Harvey, 2017). This can be particularly difficult to do in safeguarding work because the nature of abuse elicits difficult and often unbearable emotions. Working with abuse survivors can be draining and exhausting, and professionals have to manage their own emotions whilst still needing to contain equally difficult emotions in their clients (Walker, 2005).

"The mother's capacity to hold her baby's anxiety and her own, to go on thinking in the face of puzzling and increasing intense protest and distress, drawing on and offering her inner resources, beautifully exemplifies what Bion (1962b) called 'reverie'." (Waddell, 2013, p.33)

Reverie is the state of mind of the mother concerning her baby's communications and is related to the process of containment. It is the idea that the mother can take in the baby's communications and think about what the baby is communicating in a way that makes the baby feel understood (Harvey, 2017). It is a type of 'mental holding' that supports the integration of thought and feeling. In social work and safeguarding practice, containment provided by reflective supervision can lead to the process of 'reverie' (Harvey, 2017). This, in turn, supports clearer thought and perspective, essential for effective decision making.

Mirroring

Boyd (2007, in Ruch, 2010) states that within systemic theoretical frameworks, the process of mirroring has a similar role to play as transference. It helps professionals understand the experience of the service user more fully and accurately. It occurs when the dynamics of a situation are replicated in a different but related context and are acted out in an adjacent area as though they belong there, being carried from one area to the other by a player common to both (Hughes and Pengelly, 1997).

The similarity between mirroring and countertransference is that both are a response to what is being transferred or projected onto the social worker by the service user. Mirroring, however, is a secondary effect of countertransference that is not fully known about but enacted; the practitioner, like the service user, is compelled to act rather than feel or think (Hughes and Pengelly, 1997). Mirroring can be seen by the conveying 'upward' of dynamics from service users to workers (Hughes and Pengelly, 1997) or by how dynamics originating within the supervisory relationship may be mirrored in a worker's behaviour with an individual or family (Mattinson, 1976 in Hughes and Pengelly, 1997). It might also include mirroring dynamics that originate in the worker's other relationships.

Evidence exists of both social workers and organisations turning a blind eye to children's suffering or the suffering of parents (Harvey, 2017). As noted earlier, managers and organisations turn a blind eye to the suffering of social workers, whom they expect to continue to engage in often abusive, violent behaviour as part of their

safeguarding responsibilities (Preston-Shoot et al., 2020). The phenomenon of mirroring is unconscious and therefore can easily be missed if practitioners are not alive to it. Noticing it requires awareness of and a capacity to use the insight this awareness offers (Ruch, 2010).

2.16 The abused and the abuser: understanding abuse dynamics

The complex dynamics of abuse can be predictable, common patterns, within abusive situations. They are often the forces or motivation behind the act of abuse and the way indicators may be observed or determined. Many can powerfully occur unconsciously and with strong emotional impact. Knowing them could support awareness and recognition. Social workers carrying out safeguarding procedures must work with adults in a personalised way (as described above in Making Safeguarding Personal) to respond to concerns about abuse. Understanding how the behaviour and mindset of those who may be perpetrating abuse impact the adult is critical because it affects how the adult can or will engage with the social worker. Social workers are the lead decision makers, so failures by them to recognise these unique features means they could be misunderstood (Yorke, 2016). Through the psychological processes known as projection and mirroring, these dynamics are also known to be powerfully transferred into the professional system and unconsciously re-enacted in the professional network. The literature on this is extensive and I have summarised relevant studies below.

Cover-up dynamics

The Freudian Cover-up is a theory first introduced by social worker Florence Rush in the 1970s. It asserts that Sigmund Freud intentionally ignored evidence that his patients were victims of sexual abuse. The fact that Freud and many of his fellow early analysts were sexually abused as children did not stop mainstream psychoanalysis from de-emphasising the reality of childhood sexual abuse (Middleton, Sachs and Dorahy, 2017). Covering up and denying the abuse is often a natural and immediate response. This reflex denial seen by society is also the denial voiced loudly by many abusers, the abused and those who witness or know of it (Middleton, Sachs and Dorahy, 2017). It is easier to turn a blind eye or to cover up than to face the disturbing reality of the abuse. It explains why so many failed to

report the decades of child sex abuses perpetrated by prominent TV personality Jimmy Savile. Similarly, it was easier for the Catholic Church and other churches to cover up the abuse of children by priests and ministers. The frequent default response to the presence, extent, or severity of abuse is to cover it up. This dynamic is likely an unconscious factor at play that must be addressed within adult safeguarding work.

Often, perpetrators of abuse are loved by those they abuse, which is the case whether the victim is a child or an adult. Adults may conceal the truth by covering up the abuse to protect the person causing them harm. The key objectives of an adult safeguarding enquiry are to establish the facts and to ascertain the adult's wishes (Care Act, 2014). If practitioners must navigate situations where the truth is hidden or denied, achieving these objectives becomes difficult in practice. Practitioners need to be cognisant of the potential for abuse to be minimised not only by the victim but the wider professional system.

Fear, shame and powerlessness

These three potent and overwhelming emotions are inherent in abuse dynamics. Victims feel fearful, powerless, and shamed by their weakness, and are “too contaminated with the evil done to them to come out from the shadows” (Middleton, Sachs and Dorahy, 2017, p.251). The shame of speaking about what was done to them can be paralysing and cause victims not to do so. Also, the nature of shame and its capacity to erode selfhood leads to dutiful compliance (Middleton, Sachs and Dorahy, 2017). For perpetrators of the abuse, shame manifests as minimisation and denial of their behaviour and its effects on their partners or children (Yorke, 2016).

For survivors of abuse, successful separation and entry into new relationships is an emotional obstacle course (Walker, 2005). Whilst practical help such as a safe passage to escape can be lifesaving, many victims are psychologically enslaved, an emotional factor inherent in abuse dynamics. Abusers often justify their abuse by blaming it on the abused, whilst victims tend to take more responsibility for the abuse. This often creates confusion in the professional system and is why proper training is so important for decision makers (Yorke, 2016).

Secrets and silence

Abuse situations are bound up in secrets and silence. This is one of the most common abuse dynamics. Multiple reasons for this include that abuse victims, if very young, may have repressed the memories, and details of their abuse are "buried behind a dissociative amnestic barrier" (Middleton, Sachs and Dorahy, 2017, p.252.). Patterns seen in abusive families include denying the abuse and instilling their children with a sense of the external world as being a dangerous place. The danger and viciousness that lie within the home are projected outwards, and any risk of the child speaking is effectively minimised (Walker, 2005, p.109).

Perpetrators are often charming to others and can keep their actions a secret. Often the victim is told by their abuser not to tell anyone about the abuse. Sometimes this is accompanied by a threat of consequences, including that they will not be believed. As such, reporting the abuse may have worse repercussions than remaining silent (Yorke, 2016). Society has come to better accept the prevalence of abuse; however, victims often continue to experience poor responses, including from police, when they report abuse, rendering them hopeless and silenced. Some victims are essentially captives or slaves and have little or no opportunity to tell anyone and no one to protect them (Middleton, Sachs and Dorahy, 2017, p.251). Many abusers live among us hiding in plain sight, never publicly identified, despite abusing multiple victims over decades. This points to the existence of powerful long-term dynamics that cause the victims to remain silent. Silence from perpetrators, witnesses, and victims creates and perpetuates the hidden nature of abuse and human rights violations. This was never seen more devastatingly than in the Catholic Church.

Identification with the abuser

In 1932, Ferenczi, engaging with the complexity of the dynamic involving the abused and the abuser, introduced the concept of introjection of, or identification with the aggressor (Howell, 2014). As mentioned above, children who are abused by principal attachment figures use dissociation to cope, which enables them to remain attached to those they rely on to survive. Middleton, Sachs and Dorahy (2017, p.256) highlight that:

Those who abuse long term, frequently extend their abusive activities to include fellow abusers, who in turn exert additional pressures on their victims to maintain

silence. Such structures, whether they be familial, multigenerational networks or based around work mates, churches or other institutions, paedophile rings or child prostitution businesses, may be difficult to fully document, let alone disassemble, due in part to the victim's strong attachment to their principal perpetrator.

The dynamic whereby a captive identifies and sympathises with their captor is known as Stockholm syndrome. However, those not physically imprisoned but being abused often also feel deeply connected to their abusers. This apparent loyalty speaks to the real need to understand this complex dynamic in adult safeguarding work. For example, when trying to support people to leave abusive relationships, it must be recognised that disentangling their relationship from the harm done through it is as painful as the harm itself (Middleton, Sachs and Dorahy, 2017, p.251). Often the victim's attachment to their perpetrator is such that police and child protection authorities are stymied in their actions. This attachment can be confusing and frustrating and lead to professionals feeling helpless and angry that the person is 'choosing' to remain in an abusive situation when the reality is far more complex.

Collusion

Research by Neale (2018) into abused women's perceptions of professionals' responses found that abused women felt staff had colluded with the perpetrator, albeit inadvertently. One woman describes how she was discredited as hysterical, selfish and attention-seeking, whilst he was cast as a heroic carer (Thiara et al., 2012) and remained in complete control (in Neale, 2018). Common myths and misconceptions associated with intimate partner violence include "both men and women batter", "domestic violence is anger out of control", "if it was really happening others would know about it" or "the woman must want it or be crazy, or she would leave" (Yorke, 2016, p.577).

This tendency to hold victims responsible for their circumstances is not uncommon. By ignoring the source of women's difficulties, frontline workers could effectively distil the problem into something more manageable (Neale, 2018, p. 8). This reveals how believing in these myths or making the victim responsible by denying their reality becomes a defence mechanism that workers deploy when overwhelmed by what they are encountering. Unfortunately, this means that for professional decision

makers, the likely result is a misrepresentation of the facts or real picture and is how collusion with the abuser can occur.

Many abuse survivors will be quite used to meeting the emotional needs of others whilst their own are entirely disregarded (Walker, 2005, p.109). All these dynamics can all too easily be repeated within the professional relationship. Therefore in 'working with the person thought to be causing harm', practitioners need to be cautious so they do not unintentionally end up colluding and making the perpetrator's needs more important. Abusers often present themselves as the "true" victim, even though they are unequivocally the actual perpetrator of the abuse (Yorke, 2016, p.573).

Inexperience and a lack of awareness of this powerful and manipulative behaviour can cause professionals to default to optimism bias, described earlier and a well-known phenomenon in safeguarding that affects professionals' judgment and decision making (Dingwall et al., 2014). Good judgment, sensitivity and caution are needed to discern when professional responses may be colluding with the abuser (Perel-Levin, 2008). Many professionals today do make concerted efforts to avoid colluding, aware of the fact that this can result in jeopardising the safety of the adult and their children. We now know that the majority of abuse is carried out by people known to the person, such as their partner or family member, not by a stranger or 'monster' that jumps out from behind the bushes. Understanding abuse dynamics is critical if practitioners are to be able to recognise the disconnect between what adults at risk say they want (what outcome) and what might be going on, which they are either unable to acknowledge due to the pain of facing it or do not feel safe enough to disclose.

2.17 Summary and conclusion

In this chapter, I have examined relevant studies that have explored decision making. I have examined how researchers from both social work and psychological traditions have explored the role of emotion and/or the unconscious influence in decision making, and where possible, how this has been researched or considered within a safeguarding context. I have included different decision-making models that I think are useful to consider for my study and adult safeguarding practice. I have covered relevant research that covers decision making in organisations and the

importance of considering race, power, and diversity as a factor influencing decision making, particularly with safeguarding work. Much of this has been presented within a psychoanalytic frame because this is the research paradigm.

The final section focuses on specific psychoanalytic theories and concepts that are used to support this study because they support the premise of unconscious and emotional influence. I have included literature on abuse dynamics because of their powerfully unconscious nature and the strong belief that this influences adult safeguarding practice. I believe that this study will contribute to the research literature because by examining everyday adult safeguarding practice and using the above literature, I will identify lesser-known factors that affect practice.

Having set out my theoretical framework, the next chapter will outline my methodology, research approach and study design. It will explain my data collection process, method of analysis and researcher reflexivity and how each of these is compatible with my theoretical framework.

Chapter 3: Methodology

3.1 Introduction

In the last chapter, I contextualised this study within wider literature on safeguarding and decision making. I set out why I believe this study is necessary. This chapter sets out the methodological choices I made to engage with the issues that surround decision making by social workers when carrying out adult safeguarding. The guiding objective of the study was to uncover unconscious and emotional influences and their impact on decision making. First, I explain my overall methodology and approach, including my philosophical position and framework for exploring the concept of reality within the study parameters. I then outline my research design and explain the use of a psychoanalytic research method, a less established method and one that can be controversial. I seek to address these and outline the usefulness of this approach in answering my research questions. I detail how I set up my research and went about my data collection.

I aimed to obtain a good variety of participants reflecting different ethnicities and cultures that exist in the metropolitan city and client group with whom these professionals worked. A researcher's own culture can reinforce misunderstanding because of the complex cultural matrix that imposes meanings on contents (Giami, 2001). I knew I would need to be aware of how my ideas and values influenced both the research process and how I interpreted the data I gathered. Finally, I explore the ethical considerations and issues that arose at the beginning, during data collection and later when writing up my findings. I describe my process of analysing and triangulating the data. The last section discusses reflexivity and how I used my own experiences as a researcher as a data source.

3.2 Research philosophy position

To ensure a strong framework, my chosen research paradigm had to fit with the epistemological and methodological positions determined by the stated aims of the study (Crotty, 1998). The following components framed my study: epistemology, ontology, theoretical perspective, methodology and methods. Outlining my epistemological and ontological positions requires the interrogation of how I

determine what knowledge is ('epistemology') and my relationship with the concept of 'reality' ('ontology'). My intention to explore practitioners' experiences in practice and to capture the complex reality of decision making in adult safeguarding practice drew me towards a qualitative approach and an interpretivist epistemological position. The traditional epistemological debate in social science research has been between positivism and interpretivism (Sarantakos, 2005). The underlying principle for positivism is a scientific outlook on knowledge and the world. It involves statistical data collection based on large numbers of participants (Gray, 2014) and is considered quantitative research. Interpretivism, in contrast, is a group of approaches that challenge positivism (Whitaker, 2014) and is qualitative. With interpretivism, the researcher is considered part of the research and is viewed as never being fully objective. Interpretivists are interested in specific, contextualised environments and acknowledge that reality and knowledge are not objective but influenced by people within that environment (Gray, 2014).

In the qualitative research tradition, reality is contested ground and "constructed prioritising the perspective attained and validated through practice" (Harvey, 2017, p.45). Most professional doctorates in social work hone in on the reality of practice to make it authentic, relevant to other practitioners or to inform best practice. I aimed to obtain the perspectives of frontline practitioners to construct a picture of their reality. However, I acknowledge that my construction of their reality was influenced by my existing knowledge about this work. Psychoanalytic studies in social work practice have used critical realism (see Harvey, 2017; Whitaker, 2014; Briggs, 1997; Rustin, 1991) as their ontological position because it sits within a sociological framework and explores structural and organisational influences (Archer et al., 1998). This is compatible with my study as it allows me to make statements about people's experiences within the social world (Finlay and Ballinger, 2006) and to postulate about open systems and non-linear causality (Smith, 2021).

I also applied a psychoanalytically informed paradigm (Hollway, 2009) that sits within a psychosocial research framework and therefore considers both psychological and sociological influences of reality. The psychosocial approach respects subjective knowledge and argues that we can only know anything from a subjective point of view (Harvey, 2017, p.45). This supports my interpretivist epistemological position and gives weight to my pre-existing understanding and subjective view of the truth about adult safeguarding practice. The interaction

between researcher and researched is also seen as where knowledge is created (Mehra, 2002). Hollway (2009, p. 464) states:

> *"Epistemologically the psychoanalytically informed paradigm can help the use of researcher subjectivity as an instrument of knowing. Ontologically it can inform an understanding of participant subjectivity. Of course, these are intimately linked because a psychoanalytic emphasis on unconscious dynamic intersubjectivity ensures that the focus of both epistemology and ontology is on the affective traffic within relationships, be it the relationship between researcher and researched or those of the participants in their life, past, present and anticipated future."*

The recognition of this intersubjectivity is the benefit of a psychoanalytically informed paradigm. As such, and as noted earlier, using myself as a vessel for obtaining information was inherent in my approach, particularly to identify otherwise unconscious influences at play.

3.3 Research design

Using a psychoanalytical research method

The development of British psychosocial studies has provided avenues for a more critical and reflexive engagement with psychoanalysis in social work (Archard, 2020). Using a psychoanalytically informed research method seemed the most likely to answer my research questions (Bryman, 2012 in Whitaker, 2014). This approach recognises the role the unconscious plays in the construction of reality and the way people perceive themselves and others. Clarke and Hoggett (2009) state that the unconscious plays a part in the generation of research data and the construction of the research environment. A psychoanalytic researcher uses "particular capacities of mind to observe, record and make sense of the unconscious processes in the field of enquiry" (Cooper, 2014, p.1). Cooper (2014) explains that these 'psychoanalytic capacities' can be developed through a psychoanalytically trained 'thinking mind' that enables researchers to study unconscious processes using clinically derived methods. Exploring the role of the unconscious has been a central part of my social work doctoral programme, and my years of clinical experience and training placed me in a good position to use a psychoanalytic research method.

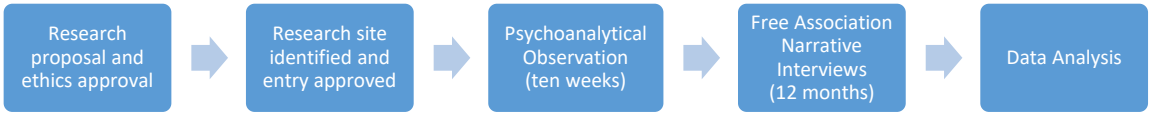
I relied on Hollway and Jefferson's (2013) explanation of this method of research. They explore the widespread assumption in the tradition of research, that their participants are telling it like it is. The psychoanalytic framework challenges this and draws on psychoanalytical thinking around defences inherent in the human psyche and behaviour that can conceal the truth and reality of what is happening. Hollway and Jefferson (2013) go into how the research interview produces both the 'defended subject' and the 'defended researcher'. "The affective dynamics of the research encounter are also influenced by what each person brings to it, some of which will not be accessible to conscious thought" (Clarke & Hogget, 2009, p.12). Being alert to both the interviewees and my own unconscious influences was central to the approach. Cooper (2019, p.8) outlines what the researcher should pay attention to whilst undertaking psychoanalytic research, summarised as:

1. The subjects' overt behaviours, interactions, and communications
2. The fluctuations in the 'emotional atmosphere'
3. The researcher's changes in their emotional state
4. The researcher's conscious (but difficult to name) responses in the encounter
5. The researcher's awareness of being non-verbally 'recruited' into a particular role in the subject's position
6. The researcher's awareness of their countertransference response to the subject's material

Several of the above steps involve reflecting on the researcher's experience and emotional responses. Countertransference should be taken into account, given the subjective influence of the researcher (Giami, 2001). Understanding the countertransference, as described in the literature review, of both the participants and researcher gives access to what is being hidden or defended against (Hollway & Jefferson, 2013).

3.4 Research process

Flowchart 1:



Following ethical and research approval (appendix 2), I sought an appropriate research site and gained approval to conduct the research. Access is an important issue when considering research design, especially because for social workers, "anxiety is often heightened by a fear that outsiders will come in and scrutinise their practice in a highly critical way" (Whitaker, 2012, p.83). I needed to be sensitive, consent carefully sought, and reassurance about anonymity provided. Once I had managed to do this, I carried out a 10-week psychoanalytic observation and then carried out free association narrative interviews (FANI) and follow up interviews over 12 months. These methods and my process of data analysis are described in detail below.

3.5 Research methods

Methods are "the techniques or procedures used to gather and collect data related to some research question or hypothesis" (Crotty, 2003, p.3). Much of the research in adult safeguarding to date has been qualitative, engaging the views of practitioners through interviews, focus groups and case study reports (Aylet, 2018). Conducting an observation meant that my research was a type of ethnographic study, a qualitative method where researchers immerse themselves in the lives, cultures, or situations they study (Reeves et al., 2013). In my case, it entailed immersion in practitioners' day-to-day lived experience of adult safeguarding practice. The combination of interviews and observation has been successfully applied in other ethnographic studies in social work (see Whitaker, 2014, and Scourfield, 1999). I opted for this blend of psychoanalytic methods in order to effectively explore unconscious factors.

Psychoanalytic observation

Psychoanalytic observation is rooted in the practice of psychoanalysis itself (Hinshelwood and Skogstad, 2002). Esther Bick (1964) introduced the method of infant observation as a training exercise for child psychotherapists and psychoanalysts. It was later introduced to social work qualifying programmes as a response to child death inquiries and "criticism of social workers for failing to 'see' children they were supposed to be safeguarding" (Tanner, 1998; Trowell and Miles, 1991, in Hingley-Jones et. al., 2017, p.1). Observation as a type of research represents a good counterbalance to overly positivistic methodologies, often criticised for failing to pick up on the nuances of human experience and emotions (Briggs, 2005). This method has also been adapted for observing the dynamics within institutions (Hinshelwood and Skogstad, 2002). It involves using the mind as 'a research instrument' (Skogstad, 2004) to gather data about the emotional, relational, and unconscious dimensions of other people's subjectivities, relationships or organisational environments (Cooper, 2017).

Psychoanalytic observation is considered non-participant observation because the observer is simply observing and does not engage in the activity being observed. This fulfils the psychoanalytic approach of quiet presence and free-floating attention (Hollway & Jefferson, 2013). A criticism of the observation method is that generalisations made are not reliable because of the relativeness of the social phenomena and the personal bias of the observer. My experience of undertaking psychoanalytic observations during the doctoral programme showed me how these exposed what would otherwise not be 'seen' or obvious. Emotional experiences are difficult to access. I knew that an observational stance informed by psychoanalytic theory could help me discover the hidden, more unknown unconscious, and emotional factors in decision making. As this is an established method of research, I could rely on the mechanisms within the approach such as the reflective seminar groups to identify my own unconscious emotions, influences, and biases.

Free association narrative interviews

The strength of qualitative research is how it can address questions of meaning and causality (Hollway & Jefferson, 2013). By conducting interviews, I would be able to obtain respondents' explanations and feelings about safeguarding adults' work and decision making. Traditional structured interviews and most aspects of semi-structured interviews are question-and-answer type, where the interviewer "sets the agenda and remains in control of what information is produced" (Hollway and Jefferson, 2013, p.31). In the context of statutory safeguarding work, industry 'language' around how things 'should' be done exists. I knew any type of structured or semi-structured interview would have questions that would inevitably lead back to this type of language. Consequently, I was drawn to a narrative approach to steer away from the usual statutory setting rhetoric. It could support me to find original and personal narratives from safeguarding practitioners.

I chose the psychoanalytic FANI method so adult safeguarding practitioners could share, in their own words, their experiences of the work. This method is discussed by Hollway and Jefferson (2013) in their book *Doing Qualitative Research Differently (DQRD)*. Archard (2020, p.2) states:

"This method is inspired by the practice of psychoanalysis, grounded in a theorisation of the research subject as a 'defended psycho- social subject' and a combination of Kleinian psychoanalytic and discursive psychology."

The researcher starts with an open question and then allows the respondent to talk freely about their experiences of the research topic. This enables participants to lead the direction of interviews (Archard, 2020). If breaks in the narrative occur, the researcher can pick up on a recent point within the narrative and prompt with an open question. Using the same language used by the respondent, the researcher asks them to say more about this point. This prevents interruption of the respondent's production of the information and encourages the continuation of their, possibly unconscious, thought process.

I chose to ask a single question to all participants in the first interview to initiate the process: "*Tell me about a case that has stayed with you…"* By asking an open question, I was able to get participants to access some of the more painful parts of their work. I believe this exposed some of the emotional and unconscious factors at

play. It allowed participants to share, in their way and at their pace, their feelings about the cases they had worked on. I knew it would be important to listen and learn from the experiences of practitioners about what supports or hinders their ability to make good decisions about adults who may be experiencing abuse or neglect.

This method has tended to be inconsistent in social work research (Archard, 2020). I relied on Hollway and Jefferson's book DQRD, as little other literature on FANI was available at the time. I turned to my clinical experience, guidance from supervisors and interviewing techniques from other psychoanalytic interview methods such as the Biographical Narrative Interview Method (BNIM) to support its application. Archard (2020) provides a critique of FANI and captured the challenges I experienced using this method. These include the risk that the role of researcher and therapist become conflated. I, for example, naturally wanted to express empathy in response to the difficult feelings' participants were sharing, which, however, then placed me in a therapist role.

In this method, second or follow-up interviews are recommended because the first interview ideally lowers the participants' defences. This makes participants more open to talking about hidden issues. The first follow-up interview question asked respondents to reflect on the thoughts their previous interview had left them with. This allowed for their previous narrative to continue or expand. The initial interview flagged certain themes or areas of interest about individual participants. For the follow-up interviews, I then asked additional specific questions to extricate further information. The follow-up questions included:
What do you think it is about those two cases that has made them stick in your mind?
What do you think was the hardest part of the decision making in these cases?

3.6 Setting up the research

I approached my professional network to enquire whether anyone might be interested in accommodating me as a researcher. I was mindful of colleagues coming forward who may know me. I iterated commitment to confidentiality and professional boundaries. Most local authorities have adult safeguarding work carried out by care management teams. To effectively observe adult safeguarding (only) decision making and what was influencing this, I needed a local authority with a safeguarding adult's operational team. This presented a challenge as there were very few. Many responded to say they were already accommodating researchers.

The Association of Directors of Adult Social Services (ADASS) eventually contacted a local authority safeguarding manager with such a team and enquired; '*why they would not accommodate this research'.* They subsequently agreed.

Participants and sampling: The participants I sought for this research were social work practitioners who were undertaking adult safeguarding work or who had at least two years of experience in the area. Given I was accepted into an operational safeguarding team in a metropolitan city, I was fortunate to find it. The sample of the team was mixed background, mostly female, with some male practitioners. There were up to eight staff members present whilst I undertook the observation. My intention was to interview up to eight practitioners however this was always contingent on their consent. I managed to interview seven. Those interviewed were the same participants from the observation. This enabled me to triangulate and further validate the findings.

Observation: Each member of the team was provided with an information sheet about the research (appendix 4) and given a face-to-face opportunity to question me directly about the research. Team members were reassured that my role was exclusively about researching. The information sheet set out advantages and disadvantages of participation. It was important to articulate that the participants might find it strange not to be able to engage with the researcher and that it also could feel hard to be observed whilst trying to do their work. By outlining my overall aim of the research, I hoped to try to normalise the experience of the research process for them. The consent forms (appendix 5) reinforced confidentiality and clarified how the data would be used.

Interviews: An information sheet about the interview process (appendix 6) and a separate consent form were provided (appendix 7). Participants could ask questions before they consented to the interviews. The consent form set out the limits to confidentiality. It also outlined what to expect from the interview process, clarified how the information they shared would be used, and reassured them of their anonymity.

The potential impact of the research on participants was acknowledged. At the end of both the observation and interviews, debriefing forms were provided (appendix 5

and 8) which contained a list of support resources available to participants following their participation.

3.7 Data collection: Fieldwork undertaken

Figure 1: OBSERVATION PERIOD

Date	Week
7th November 2017	Pre-observation: Team Meeting
4th January 2018	Week 1
11th January 2018	Week 2
18th January 2018	Week 3
25th January 2018	Week 4
1st February 2018	Week 5
8th February 2018	Week 6
15th February 2018	Week 7
22nd February 2018	Week 8
1st March 2018	Week 9
8th March 2018	Week 10

Figure 2: INTERVIEWS PERIOD

April 2018 – September 2018	First interviews
October 2018 - April 2019	Follow-up interviews

3.7.1 Observation research process

I observed the team for an hour at the same time every week for ten weeks. This involved me sitting with the team whilst they carried out their day-to-day duties, taking in what was happening in and around them. I was able to tune in to what was being said in conversations. I was able to notice the interactions and reactions to colleagues, telephone calls or casework that were taking place. I spoke to members of the team only if approached but attempted to maintain the silent stance of a non-threatening observer. It did seem that, over time, the team got used to me being there and were able to behave as they normally would. I did not write down anything during the observation but later wrote up a recording of that day's observation, capturing as much as I was able to remember about not just what I had seen but also what I had felt or noticed myself thinking. I had ten written observation records which formed the data.

Seminar group input

Cooper (2017, in Hingley-Jones, 2017) explains that an observer needs support to make sense of their observational material, particularly because of the often-emotional demands of the process. "Usually this takes the form of a weekly, facilitated, small seminar group at which observers present detailed, descriptive presentations of their observational experiences" (Cooper, 2017, in Hingley-Jones, 2017, p.179). My colleagues in the doctoral programme and the facilitators of the programme formed my seminar group and were able to meet at least fortnightly. I took my written-up observations to this group. I read out the written account and together we tried to make sense of the observations and observational experience. By processing the observational data as I progressed in this way, I was supported to reflect upon and identify what might have been less obvious to my immediate mind about what I had observed. This helped me to name some of the potential unconscious processes and emotional elements at play. The group also supported me to make sense of the countertransference so that I could distinguish it from my own emotional and cognitive responses.

3.7.2 Interview research process

Most interviews took place in a quiet room. I voice recorded each interview in addition to making written notes during them. Participants were advised of this in advance and as part of the consent process. At the end of the first interview, I discussed the follow-up interview and, where possible, secured a date for it. I completed follow-up interviews with all participants except for one, who left the department and did not respond to my attempts to meet with him separately outside of the original research site. A total of 13 interviews were completed.

Supervision

In addition to the group seminar sessions, I had formal research supervision where I met one or both of my supervisors to discuss progress, challenges and to receive guidance and support. I shared my research data, discussed the content and worked through what it might be telling me. This process assisted in teasing out unanswered dynamics, such as what might be happening within the team or among individuals. It influenced the follow-up questions I used to unpack potentially underlying unconscious factors identified from the first interview. The questions in the follow-up interviews were sometimes different for each participant. Emerging themes included the influence of social workers' personal backgrounds, their unconscious motives for going into social work and how this influenced their decision making. As a result, I added certain follow-up questions to elicit more information. It was not within the scope of this research to examine in detail the motives for becoming social workers. However, given that it emerged through the data gathering process so strongly, it seemed likely that this would provide an understanding of background underlying factors.

3.8 Ethical considerations

Ethical considerations for this type of research and ethical issues arose during the observation, interviews and in writing up the findings. The relationship between the researcher and participants is complex; the researcher should reflect on this and factors such as gender, race, ethnicity, class, status, and age (Allan & Skinner, 1991). Coming in as a researcher presented a power dynamic and possible intrusion. Reflecting on this and how it might influence the research was important. It also ensured I was aware of the ethical issues both before and during the research

process. Researcher reflexivity was an ongoing process (discussed further below), as was revisiting the ethical elements of the research in dialogue with my supervisors.

Psychoanalytic observation – ethical issues

Cooper (2017, in Hingley-Jones et al., 2017, p.179) outlines that for both ethical and methodological reasons, the observer must:

7 Negotiate access to the subjects and/or setting being observed openly and transparently;
8 Be prepared and able to honour their 'contract' with the observed subjects, e.g., agreed day and times; and
9 Be prepared to tolerate intense, sometimes disturbing, and unexpected emotional impacts arising from the observational experience.

The office was open plan, so the team under observation was physically next to another team. It was difficult not to observe the neighbouring team. I became aware of unintentionally observing members of the neighbouring team without permission. I carefully kept my observational focus and recordings on the safeguarding team that I was permitted to observe.

FANI – ethical issues

"The very idea of taking psychoanalysis outside of the consulting room and into social research remains controversial" (Jervis, 2013, p.151). Wren (2012) points out that using psychoanalytic processes in research can be interventive because they may construct a new account for an individual, which will have effects. This can pose ethical dilemmas to a researcher and differentiating between my approach as a clinical practitioner and a psychoanalytic researcher was therefore important. Preparation for the interview mitigated this. I ensured that my attention was on following the narrative and keeping it flowing rather than using typical therapeutic responses such as reflection or paraphrasing.

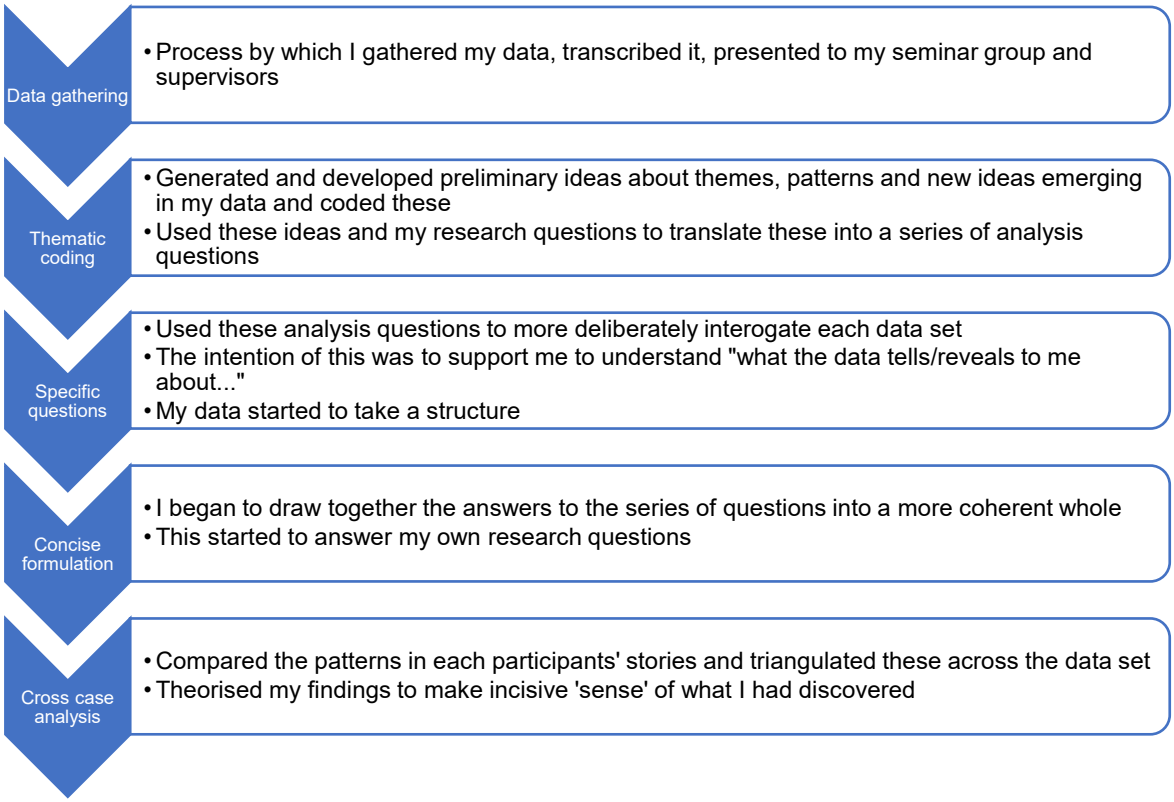
Presenting findings from the interviews – ethical issues

I present a summary of each participant in the findings that follow. A strong theme emerged concerning the participants' biographical histories and how these shaped their responses. Examples of personal disclosure about the participants' history deepened the understanding of unconscious factors at play and helped to inform the research findings. However, it raised an ethical question about whether providing these details might mean participants could be identified. The way this information was presented needed to be carefully thought through. One participant requested that I not include a particular personal disclosure. I mentioned in the follow-up interview that other participants had also made personal disclosures and that I was finding a connection to the research. I sent this participant a copy of her transcript, so she could see how it had been written up and anonymised. This seemed to alleviate her concerns as she then agreed for me to include her disclosure. These ethical elements of the research were navigated in consultation with participants when required and with careful consideration and supervisory guidance. By normalising the disclosures and identifying ways to reinforce safety and anonymity, I was able to obtain permission to include these powerful stories and demonstrate how these affect decisions.

3.9 Data analysis

My initial intention was to use thematic analysis (TA) for identifying and analysing patterns in my data (Braun and Clarke, 2006). Hollway (2013), however, warns of the risks around detailed transcription conventions that attempt to capture layers of meaning but which may lose the meaning of the whole. "The atomization of the data runs counter to some inherent principles of a psychoanalytic or ethnographically informed approach" (Cooper, 2014, p.1). To prevent the risk of decontextualising and losing meaning, I used the analysis method as outlined by Cooper (2014) in his working paper 'From raw data to theorisation'. Here he outlines how the social work doctoral programme sees students seeking to address research questions that are generated by practice experience.

The following flowchart 2 below outlines a summary of my analysis process as per Cooper (2014):



My data analysis commenced from the start and as part of the data collection process. The psychoanalytic interpretive nature of my method meant that I was analysing each observation, interview, and follow-up data as these were received. The process of gathering, transcribing, and reading through data generates preliminary ideas about themes or patterns of interest to the researcher (Cooper, 2014). I transcribed all interview data myself, ensuring verbatim text. The cases discussed represented rich holistic examples of practice experience. My transcription included all nonverbal communication, such as deep breaths, gasps, sighs, speed of speaking, changes in tone (e.g., whispering) or other unusual aspects of speech. Noyes (2015) highlights the importance of nonverbal communication as it draws attention to possible unprocessed emotions of the participant. Several examples of these in the transcript include pauses, changes of tone, and silences, all of which provided ‘communications’ that were at least as important as the articulated thoughts and views (Harvey, 2015).

Whilst doing the transcription myself was laborious and time-consuming, it meant I fully immersed myself in each data set. I ended up highlighting statements made by

the participants or adding comments alongside the texts to capture my thoughts and responses. I carried out thematic coding on all my data, which helped me process their volume. I quickly learnt that pulling out codes without retaining reference to the original text meant I lost some of the original meaning. I reverted to ensuring reference links to where in the data the codes had come from. I 'pulled out' participants from within each observation and analysed them alongside their interviews and any other data that were relevant to them.

I used initial codes and research questions to generate a series of analysis questions to draw out specific answers more systematically. These questions included:

1. *What was learnt about the participant's history and background, and does it help us understand or shed any light on their professional practice and decision making?*
2. *What sorts of cases did the participant discuss and what might be the reason for this?*
3. *What did the cases the participant discussed reveal about the difficulties in decision making?*
4. *What did it tell us about the emotions that influenced their decision making?*

The process of answering these questions allowed me to start formulating what the data was saying concerning my research questions. I wrote up the observation and interview findings separately to capture the key themes for each of these data sets. As part of the final stage of cross-case analysis, I interrogated the data to see if similar themes were occurring elsewhere across the data set. This allowed me to triangulate my findings by making meaningful linkages and comparing patterns of similarities and differences. I was able to make inferences and develop generalisations of the findings to support me in answering the final questions. The key themes across the data set are presented in my discussion chapter, where I connect them to relevant theories, particularly those discussed in the literature review.

3.10 Researcher reflexivity

As outlined above, the influence of the researcher on the research was inherent in my methodology and as such, I recognised the importance of engaging in reflexivity and recognising how my defences might arise in response to the research content.

I made notes of my feelings, thoughts, and emotional reactions after each observation, during and after each interview. My clinical training enabled me to understand the potential defensive responses by both a research participant and researcher when confronted with something that provoked anxiety during the research process. These defences arise in the relationship between the interviewees and researcher or are related to personal or work life. Identifying countertransference requires reflecting on the emotional charge of the interview and the different feelings and intensities evoked in the researcher and the person being researched (Harvey, 2014).

I recorded and reflected on my emotional reactions and behaviour. My supervision group and supervisors supported me to consider what they may be telling me. This support was important because of the "difficulty the researcher can have in clearly distinguishing material that comes from outside (the subject or field) and from the inside (his/her own emotional reactions)" (Giami, 2001, p.6). Through my reflexivity, I became acutely aware of certain unconscious dynamics at play. This gave me insight into patterns of behaviour that were being mirrored in the wider system or insight into unconscious, unnamed issues that I could then bring to the fore.

I felt uncomfortable about how I had unintentionally managed to use the power and authority of a respected body to 'gain entry' for my research. I knew the manager and worried that she had been pushed into doing it because of the power dynamic. Through reflexivity, I was able to start recognising how abuse dynamics unknowingly become mirrored in the system set up to respond to it. Before starting the observation, I met with the team to discuss my research. I recorded how the presence of a practice educator, sitting in the corner of the room to observe a social worker, affected me. I was acutely aware of her and felt her gaze heavily. I felt judged and started doubting whether I could do the research. Reflecting on these feelings of both anxiety and vulnerability helped me to plug in to what participants might feel about my presence as an observer and their feelings about their abilities. The practice educator also represented 'the knower' as an educator, and I was there suggesting 'we do not know' (given the role of the unconscious).

Through reflexivity, I was able to notice my own emotional reaction to team members' uncertainty. The uncertainty practitioners felt going about this work (and what the right decision may be), began emerging as an ongoing dilemma. It showed

up in many ways throughout the observation particularly through team internal day to day discussions. Here is one example taken from an observation recording I presented to my seminar group:

"They (the team being observed) were having a debate about whether a safeguarding enquiry should be undertaken for someone who had developed a pressure sore. This is an issue that has been debated extensively within my own workplace and we had developed clear guidance to help with the decision making. I wanted to say this but stopped myself. I noticed myself wondering if I could send this to them."

Members of my seminar group reflected that I seemed to be struggling to 'give up' the safeguarding manager role and be a researcher. It was difficult not to direct or advise as 'the knowing' one. I regularly recorded feeling annoyed by what was being said by team members, particularly around team members not knowing the process. Reflecting helped me recognise my underlying anxiety. It flagged how decision making was tied to a process and the anxiety that was generated when the process was not clear.

3.11 Summary and conclusion

In this chapter, I have explained my overall methodology and approach, including my philosophical position and framework for exploring the concept of reality within the study parameters. Adopting a critical realism ontological position and psychoanalytically informed paradigm that sits within a psychosocial research framework allows me to consider both psychological and sociological influences of reality. It supports my interpretivist epistemological position and gives weight to my pre-existing understanding (given I am already an adult safeguarding professional) and subjective view of the truth about adult safeguarding practice.

I justify my decision to use psychoanalytic research and data analysis methods, highlighting how this supports my hope to name lesser-known unconscious and emotional processes that pertain to adult safeguarding practice. I describe how I found an operational adult safeguarding team where I could complete my observations and interviews and highlight the ethical issues that arose through the research process. Research reflexivity and supervision supported me in deepening

my ability to notice what might be happening (and therefore gather useful data), reflect on the issues arising, and be cognisant of the power of my presence and role as a researcher.

Chapter 4: Introduction to the participants

The following participant summaries are included to support the understanding of the data presented and the analysis of the findings. Pseudo-names have been used. The summary is limited to what was disclosed by each participant about their background. The cases they discussed are outlined in appendix 9 and are referenced throughout the next chapters.

Participant 1: Sameera

Sameera was the manager of the team, a woman in her fifties and of Asian British (either Pakistani or Indian) heritage. She was married with two children. She had come to work in adult services as a manager after working in children's services. She had been working as the manager of the safeguarding team for over five years.

Participant 2: Sam

Sam was a White British man in his thirties. He spoke with a regional accent that suggested he was not from London but possibly Northwest England. He disclosed that he lost his mother when he was a teenager and reflected on this throughout the interview.

He explained that he was from a family of at least three siblings. He referred to his brothers but did not say anything more about them. He talked about his sister as being a bit of a gossiper, and therefore 'not like him' although he still seemed to be accepting of her. He felt that he could not talk to her about his work because she tended to gossip. He disclosed that he has drifted apart from family members but still seemed to have a respectful attitude toward them.

Participant 3: Isabela

Isabela was a White woman in her late thirties from Romania. She described being from a Latin culture. She reported that she had no siblings but that both her parents were alive. She was close to them and spoke to them daily. She supported them financially.

Before becoming a social worker, Isabela worked for the Romanian embassy. She came to England because she got a bursary for a political science master's degree.

After graduating, she was offered a job at the embassy. Here she met a prominent royal figure (anonymised). He offered her a job in one of his charity organisations that worked with vulnerable people like orphans and people with disabilities in Romania. She did that for eight years and it involved her travelling back to Romania frequently. The charity built orphanages for children from poor backgrounds or the Roma community. This work made her realise "*that I kind of like doing social workery stuff with those kids. And then people have said to me, why don't you go and get a degree in social work anyway, because you doing it already you know? So I said, why not? Why not? I'll get another degree."*

She found out about the NHS bursary and realised she could afford to quit her job. Doing this, however, meant leaving her incredible job: "*Imagine working with xx, come on, who does that? I feel like, seriously, it was amazing*!" However, she felt adamant that she wanted to follow this new path in her life and described how this decision left people shocked: (They said): "*Are you mad? You're gonna leave that job to become a social worker? You know, like, pay-wise and everything. Why would you do that?"* She described that becoming a social worker 'became more like an obsession type thing' and that she 'wanted to prove to everyone that I can do it'. Her first placement was in a semi-independent unit with children, which she didn't like as she felt afraid: *"I was really afraid because those kids, they had very high needs, they were teenagers. So their voice was more powerful, let's say. And they were quite rude as well and I didn't feel comfortable working with children at all."*

However, she loved the placement in safeguarding and liked the pace and rhythm (how fast everything was) of the job, "*because (of) my personality*".

Participant 4: Andria

Andria was the senior social worker in the team and had worked for the local authority for 19 years. She was a White woman in her early fifties. She had come to London at a young age and referred to the hardship of being a young person with no family support. She described her earlier years at school as being about having fun. In the observation, I noted she had faded tattoos and wondered whether this reflected this earlier rebellious period of her life.

She disclosed that she became pregnant and was a single mother. She had her daughter when she was 25 years old. Whilst raising her daughter, she started

studying. She described how she was not academically minded when she was at school but found herself more focused as an adult learner.

She referred to a tutor in her access course who was extremely passionate about anti-discriminatory practices and standing up to oppression. In both her interviews, she described the influence he had on her and even thought about looking him up as she spoke about him; such was his continued impact on her 20 years after her training. Having to survive from a young age with no family support coupled with possible discrimination due to being a single mother may have left her feeling isolated and oppressed. It seemed that her experience with the tutor may have liberated her from this state and meant she remained passionate about doing this for others. She described herself as not diplomatic and someone who 'speaks her mind'. However, she also admitted that to cope emotionally, she takes long walks and talks to her dog.

Participant 5: Vivienne

Vivienne was a British woman in her late thirties. She had a child when she was 18 years old who was diagnosed with Asperger's syndrome. She was working as a senior middle secretary for clinical psychologists in a hospital. She explained that thanks to these psychologists her son was diagnosed quite quickly. Her employment there, however, ended due to funding cuts. She decided to train to be a social worker after this job, having seen the struggle for services, her grandmother having Alzheimer's, and that she liked social workers. She also said, ''*Maybe subconsciously, I've always kind of taken on a role of supporting others. And being someone like the person who (you) talked to, go to for advice, I think I naturally potentially have that personality then coupled with going through that.*''

As a result of her son's condition, she described how she always had to fight for him, whether this was ensuring he got what he needed from the educational and social care systems or protecting him from the mean behaviour of other children. Her professional practice was propelled by a drive for justice.

Participant 6: Serwa

Serwa was a Ghanaian woman in her sixties. She described how she came from a culture that did not have care homes because families looked after the older generation. She said that her upbringing and her involvement with her siblings and parents motivated her to be a social worker. She described herself as a childcare

practitioner because most of her social work background was in children and families. She disclosed that she was unwell and would be taking time off work. She was unsure what she would do next but said it would not be safeguarding.

Participant 7: Cynthia

Cynthia was a senior social worker in the team. She was a Black woman in her late fifties, originally from the Caribbean. She talked about her partner and that this person was someone she had been able to turn to for advice when she felt concerned about a case. She took deep breaths and pauses throughout the interview. She disclosed a previous personal experience of domestic violence and how this had motivated her to move into safeguarding work. She said she continued to enjoy being a social worker and found ongoing satisfaction and pride in the work she did.

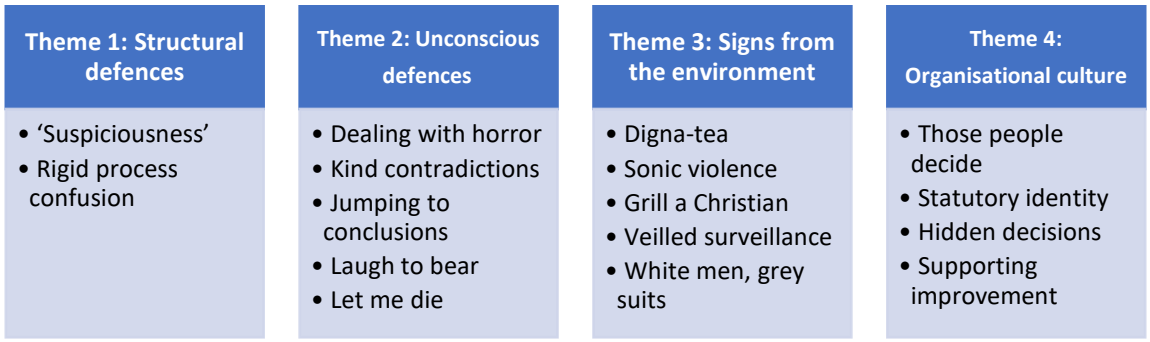
Chapter 5: Findings from the institutional observation

This chapter focuses on the key themes that emerged from the ten-week observational research. As outlined in the methodology chapter, observation as a method of psychoanalytic research has become an established method for gathering data indirectly from participants in their natural setting. My research question was about the unconscious and emotional factors within an adult safeguarding context, and I used the observational method to help me identify the more hidden, unconscious factors involved in decision making.

In this section, I provide snapshots of observations that were relevant to my research questions. One of the secondary questions of my research was whether attendance to the emotional factors in the work through an observational stance could help to understand why and how decisions about safeguarding adults may go wrong. By the end of the observation, I found that I had observed less decision making about direct casework than I thought I would. However, what I did observe in detail was the working environment, the relationship dynamics between team members and overall team functioning, and the wider system and organisational culture. Through these, I could identify unconscious defences at play in both the organisation's structures and participants' and others' behaviours.

I was supported by my seminar group to analyse and postulate how these might be influencing decision making, and I include their reflections and input in these findings. The environment gave insight into what it might feel like emotionally to work there and the context of their decision-making processes. My presence as an observer and the responses to me whilst I was there illuminated the pervasive anxiety that existed within every layer of the organisation. Signs of power, racial segregation, political influences, and the absence of containing safe spaces provided insight into the organisational culture. I present these findings and then explore more thoroughly how they may influence decision making in the discussion chapter.

Table 1: Observational themes



Theme 1: Structural defences

Negotiating entry to carry out my research was a challenge with this organisation. In the end, an assertive suggestion by a higher external authority opened the door, suggesting that the team manager should support the research. Once I got through the door, I found myself throughout the ten-week observation having to negotiate my entry and explain my presence. This never got easier. It seemed to me that controlling access to what went on in the organisation may have been central to how this organisation managed its anxiety. The existence and extent of 'structural anxiety' was exposed through the structural defences I encountered. Some of these are set out below.

1.1 Suspiciousness

Once I received approval to carry out the research, I still had to negotiate with the team. I attended a team meeting to discuss my research and the team members were suspicious about what precisely I would be observing: one team member asked how I could observe the unconscious if it were unconscious. The team manager asked how I would be observing decision making, explaining that "clearly their decisions would all be based on what the policy and procedures told them it should be".

Team members asked about what I intended to do with the information I gathered and whether other local authorities were doing this. They wanted to know whether their identities would be known by those reading the research. They asked the manager whether the research had been authorised by the local authority, and she confirmed it had. One team member described a case that had reminded him of a family member and how he thought this had influenced his decisions. He asked me if that might be an example of how his emotions influenced his decision making. His

willingness to share this openly with his team members contrasted with the dominant feeling of cautiousness over my presence.

After this first encounter with the team, gatekeeping continued and each time I entered the building for the observation I had to answer searching questions before being allowed through. After a few weeks, Sameera suggested that a team member did not need to come down to collect me, and I could just let myself up. When I subsequently tried, the security guard and receptionist prevented it.

1.2. Rigid process confusion

In Week 1, I overheard Andria becoming somewhat passive-aggressive to someone on the phone, saying: “This has been the process for five years and now you have a problem with it.” Once she was done, she turned to her colleague Isabela to express her frustration over this person not knowing this ‘by now’. Other professionals ‘not knowing the process’ was witnessed when I observed a conversation between a nursing home and Vivienne, regarding a nurse who was at the centre of a safeguarding enquiry. The nurse had been suspended pending the investigation and the care home was calling the social worker to ask what they needed to do next. Vivienne told the person from the nursing home, that it was not for her (the social worker) to decide whether the nurse should be dismissed. This decision should be determined by the care home’s disciplinary procedures. Vivienne struggled to convince the caller and said that she would discuss it with the team manager and call her back.

In Week 8, Serwa was on the phone dealing with a case with issues about a person’s payment for their care in a care home. She was saying: “They can’t make you leave. It needs to come to a panel for approval of the funding. The care home knows this and that there is a process that must be followed.” In this example, Serwa used ‘the process’ to reduce the anxiety of a vulnerable adult who felt threatened and the process itself safeguarded a decision around someone’s care arrangements.

In several examples, ‘the process’ was debated to seek clarity. In Week 2, I caught a conversation between the team manager Sameera and the senior practitioner Andria regarding a case about pressure ulcers. They were discussing whether an investigation should be undertaken for someone who had developed one. Andria argued that an investigation was not necessary and challenged Sameera. Sameera

remained calm but said that they would still need action it. She did not explain the rationale behind her decision.

Rigid processes showed up throughout the professional system. In one observation, Vivienne was speaking with the receptionist of a mental health team and calmly saying that she '*understood the process and that he needed a new referral through the GP'*. She explained that the process through the GP was always slow and she was '*hoping for more flexibility*', given the person had been known to the team recently. Navigating these rigid processes was likely something all practitioners had to learn to do.

Theme 2: Unconscious defences

I was aware that if I wanted to identify unconscious factors influencing decision making in adult safeguarding work, I would need to be alert to 'defensive' reactions and behaviours. As I outlined in the literature review, psychoanalytic thinking states that we deploy defence mechanisms to conceal and protect ourselves from what is going on emotionally and psychologically beneath the surface. I would also need to use established psychoanalytic indicators such as transference and countertransference. I recognised the importance of noticing my responses, both thoughts and emotions, to what I was observing. These might provide me with clues to what was happening unconsciously with practitioners and the team. The following observations seemed to me to powerfully reflect unconscious defences in response to the daily reality of the work, environment, and individual practitioners' vulnerabilities.

2.1 Dealing with horror

In my first observation, I heard Cynthia talking to her colleague about an establishment where a man had been so neglected that his tongue had gone black. I noticed myself cringe. I watched how others responded to it: with an almost manic determination. I reflected on how the emotions triggered by encountering this situation channelled practitioners into action. Nobody said anything further, other than to identify who would need to do what in their response.

In Week 3, Vivienne talked about one of the cases she was dealing with. A son with cerebral palsy and mental health problems. He was regularly violent toward his mother but she wanted to remain his carer. He then attempted suicide in front of her by slicing his wrist open.

She described to the team what happened:

"I spoke to the mother, and she said that his blood had sprayed everywhere - all over the floors, all over the walls and the table. She said that he had cut through all the veins, tendons or arteries in his wrist and so they (medical team) had had to surgically repair each one – he can't use his left hand normally now."

Vivienne went on to say that the son's behaviour was extremely confusing because he was well known. I watched her search for him online. She found a picture of him with the Queen, receiving an MBE award and announced it to everyone. She then read out the difference between MBE, OBE, and knighthood. As she explained that a knighthood can only be awarded to men, her colleagues complained about the continued sexism in the system. What was striking was how no team member showed any emotional reaction to hearing the gruesome scenario. From their lack of response, it appeared as though they had heard this kind of 'bloody' narrative so many times before that they minimised it. However, their angry responses to structural inequality that followed suggested practitioners were affected by the description and used displacement (as outlined in the literature review) as a defence mechanism to protect themselves from it.

During the gruesome description, I noticed that I felt physically ill and quite overwhelmed. I had to move away from the desk and went to get a glass of water. This same sort of physical response ('my stomach crunched') occurred in Week 7 when Andria described a case of a very young woman, known to be a rough sleeper, who had been found pregnant and living with a much older man, causing concerns about sexual exploitation.

I observed the 'dealing with horror' as a daily reality for safeguarding practitioners but was also struck by how team members and clients found ways to sustain through it and maintain compassion. This was simply captured when I observed Andria speaking to someone on the phone regarding a domestic abuse case. The woman's husband had dementia and had started to be abusive toward her.

"I understand it is difficult when it gets to this stage. I'm going to open up what's called a safeguarding concern and we will contact you in a couple of weeks to discuss this again so you can see how things go over the next couple of weeks…yes I do see it…the sun is shining through the windows on me now…it is lovely."

Andria was able to acknowledge the reality of the situation, show kindness and validate her resilience. The woman who was suffering not only from the 'loss' of her husband to dementia but now from his violence toward her, finds ways to focus on the sunlight despite the dark and difficult reality of her situation.

2.2 Kind contradictions

Vivienne seemed to have a role that involved her working with carers of people with mental health issues which was atypical safeguarding work. This may have been a role that was in place pre-Care Act when safeguarding carers were part of adult safeguarding policy[4]. I regularly observed Vivienne having conversations that had kind but contradictory elements. She would over-empathise with the carer and take a hard line about the person they were caring for. An example of this was her response to a case where a man with mental health issues had been violent towards his mother who was his carer: "Well, he was at the hospital yesterday and could have spoken to the doctor about what he was feeling but didn't". She came across as harsh toward someone mentally unstable but then later was seen showing great tenderness toward the mother over the difficulty she had experienced with her son's behaviour and offered to be contacted anytime for emotional support.

This contradictory dynamic was seen in a discussion between senior managers and Serwa about a domestic abuse case the team were dealing with. Serwa explained that the perpetrator was an activist who often marched on behalf of Iran. The police, however, regularly arrested him for assaulting his partner. This kept occurring, but he would deny ever hitting his partner. Serwa raised concern that this same man regularly called the team and Isabela would speak to him for long periods, often empathising with him. The team felt Isabela was being too nice to him and that she seemed to believe his side of the story.

I observed a discussion between the senior social worker and a social worker. It was about a case where the social worker explained that '*the carer no longer wanted a*

[4] The Care Act has since changed this as carers were not considered to be 'adults at risk' with care and support needs but should be offered a carers assessment and supported in a different way.

care package'. The senior was surprised to hear this, especially as this carer 'had demanded the care', saying she was not coping. Both practitioners concluded that this carer '*had exaggerated how severe things were'* to get what she wanted at the time. Their interpretation of what might be happening with the carer presents as harsh and contradicts the initial response of providing support. No other explanation for the care cancellation or what might have been happening for the person is explored as part of their joint decision-making process.

2.3 Jumping to conclusions

Vivienne was talking to the senior about a case she was dealing with where the daughter who was the full-time carer for her mother had been accused of neglecting her mother. The safeguarding concern had reported that the elderly mother had a severe pressure sore, and her daughter was refusing pressure-relieving equipment to assist. Vivienne had then spoken to the district nurses, who explained that the mother was extremely difficult and often unkind to the daughter. It was the mother who was refusing the equipment and any formal care. Vivienne repeated the story. She was frustrated that the initial concern had been so incorrect and felt sorry for the daughter's difficulty; "*she is basically stuck there 24 hours a day".* Vivienne is annoyed by the injustice of the false allegation; she is seen siding with the carer again, as she has in other examples above. She appeared unable to consider a more detailed or wider explanation for what might be going on.

I observed Andria as the senior and more experienced social worker, urging Vivienne to expand her perspective. She did this by offering her view of the situation: that things might be difficult for the mother too. She is elderly and in her final stages, so it was understandable that she did not want strangers in her house and wanted to be left alone; it was also understandable that she may not want to be moved if her sore was too painful. They then talked about the possible options around equipment such as a pressure-relieving mattress, which gently turns the person itself without someone having to physically turn them. Vivienne agreed to give the daughter a ring. She was exceptionally skilled in the way she approached the call and explained a referral had been received about 'the situation' instead of being accusatory. She was empathic toward the daughter, saying things like "this must be very difficult for you." She was able to clarify some information and asked if she could speak with the mother, which was not possible. After the call, Vivienne

explained she would visit next week and said that the mother was on morphine so now she could understand why she would be unable to speak.

I observed a discussion between Isabela and Andria involving concerns about a son's behaviour toward his elderly mother. When they explored the information further, the son was 72 years old, and his mother was 92 years old. Andria pointed out that Isabela needed to understand the circumstances more before forming a judgment about what was happening. She reminded her of the case above, involving the mother and daughter where information referred by the district nurses had been based on their initial observations and turned out to be incorrect. Isabela was not able to recall it, so Andria explained that this situation could be similar and that it might be the mother and not the son that was the problem. The son might be someone with learning difficulties for whom the mother had been the carer her whole life but who now was too elderly to care. This was another example of Andria as the senior social worker encouraging a less experienced practitioner to consider all the possible explanations for what might be going on, to avoid jumping to conclusions.

2.4 Laugh to bear

"Sameera laughs at Andria's suggestion that people may be dying due to the care home's do not resuscitate (DNAR) policy and says she won't take that seriously. They both then laugh together".

I later observed Andria obtaining evidence that supported her hypothesis as correct, with a high number of unexplained deaths at the home and concerns raised by London Ambulance Service about care home staff not performing CPR. As an experienced senior member of the team, Andria had noted a pattern in the home. However, when she presented this to the team manager, the immediate response to the possibility of Andria's suggestion being true was that it was laughed off, perhaps because it was so shocking. Andria joined in on the laughter, but it did not affect her judgment as to whether it might be true, and she continued to take action in order to ascertain the facts.

Laughter was ever-present in this team throughout my observation. On one occasion, I was confronted by a neighbouring team worker asking me if I was ok as I 'seemed to be looking around for something'. She had seen me observing the team

and perhaps, unintendedly, also her team. As she did not know who I was, Andria stepped in to reassure her, acknowledged my presence was ‘weird’ and then laughed about it, enabling the tension to dissipate. Another example was seen when Vivienne spoke about a man with Korsakoff’s dementia who alleged that he was sexually abused when he was in the hospital. Vivienne respectfully described that, despite evidence that he had an enema whilst in hospital, which likely accounted for what happened, they had still reported the incident to the police. She added that the man told the police that he had ‘reported it to Jeremy Kyle’. Team members burst into laughter.

Another more administrative work example was seen when tensions arose between a senior and social worker about casework, based on what had been recorded on their technology platform. This was my observation:

Cynthia asked Serwa why she was dealing with a case if the person was now in hospital. Serwa tried to explain, and they both became increasingly confused and frustrated. Eventually, Cynthia realised that someone had put a case note on the wrong file. They laughed together and simultaneously agreed to contact the IT team to remove it.

The regular presence of laughter illuminated a positive team culture. Team members could lighten the load using laughter with one another about cases.

2.5 “Let me die”

During the last observation, Vivienne came into the office following a visit and started talking to Andria about what had happened: “*It was awful. The whole thing and I shouldn’t really have been there*”. Vivienne explained how the patient was in bed in the nursing home and barely able to talk. Family members were whispering around him, and the patient kept saying “keep it down”. She pointed out that despite being half-conscious, his senses were extremely heightened. She repeated herself saying the family were barely whispering, and she had ‘basically been lip reading’ what the daughter was saying. The family were upset with the nursing staff and had put pressure on them to make things better. However, he was not going to get better, due to his condition. Andria reflected to Vivienne that it was hard for families to accept when someone was dying.

Vivienne found it painful with all the family members in the same room whilst he was there dying. They had even brought in their children. The nursing home had suggested that this was perhaps not a good idea. The patient kept saying, “Please just let me die, please just let me die.” The daughter intermittently kept trying to put a wet sponge in his mouth to moisten it, but he did not want it. As Vivienne spoke about the situation, I started to piece together what I understood to be happening: two different safeguarding concerns had been raised, one by the family about the home, and one by the home about the family. Vivienne concluded that the home had become ‘a bit reactive’ in implying the family ‘wanted to kill him’ when, by what she had seen, they had been extremely distressed by watching him die. Family members may have asked nursing staff about assisting him to die and this is when the home raised the concern about them. Vivienne explained that it was a big family, quite chaotic at times, intermittently shouting at each other. The family had raised a concern about a palliative patient in the next room. They kept assisting this patient back to bed because ‘there were no nursing staff attending to her’. The staff explained that this patient only got up out of bed to go and see where the shouting was coming from. Vivienne said that she understood that the family ‘just wanted what was best for their granddad’.

This scenario captured the intense emotions surrounding death and the difficulty that both the family and care provider had in containing them. The safeguarding concerns raised by each party show how easily misunderstandings can occur, particularly in painful situations where family members have to face the death of a loved one. Vivienne quickly decided that no cause for concern existed about the family’s intentions with the dying father/grandfather. She empathised with their pain and why they might want to reduce his suffering. She seemed less able to empathise with staff and to acknowledge that the family members’ behaviour was negatively impacting staff and other residents. She did not seem to determine that these issues might need to be addressed too.

Theme 3: Signs from the environment

During the ten weeks of observation, I logged a considerable amount of information about the physical environment, e.g., light streaming in (or not), dirty flooring, green colour permeating everything, the sounds, books lying around, and the type of trinkets practitioners tended to keep on their desks (e.g., fluffy small bear). Several observations in my data flagged how gender and racial dynamics showed up in the physical environment. In my analysis of this part of the data, I came to believe that these represented what might be happening within this organisation, the nature of the work and the decision-making context. I have captured those that I think give possible insight into unconscious or emotional decision-making factors.

3.1 Digna-tea

Vivienne arrived and greeted everyone in a friendly way. She went over to her desk and as she did, looked at the table behind her desk. She picked up a poster that was handmade and addressed everyone saying, “Why has no one done anything on this? What have you all been doing since yesterday?”

I observed Vivienne telling her team off and was confused by what this was about. I then saw a large paper poster in her hand which had ‘Safeguarding’ written at the top of it. Lying loosely on top of it were small cut-out speech bubbles, which were all blank. Vivienne started handing out these bubbles, saying team members needed to complete them as a priority. Isabela asked her what they were supposed to write, and she explained that it was part of the ‘dignity in care’ campaign. She told Isabela to write out what she thought ‘dignity in care’ was and how this was connected to safeguarding. I watched Isabela google something and then write on the bubble. She handed it back to Vivienne, who told her it was perfect.

The next week, I noticed that on the walls alongside the inside of the walkway were different teams’ ‘dignity in care’ posters. It looked like a school hallway or classroom. I learnt this was for ‘Dignity Week’. One poster had written ‘Digna-tea’ with a drawing of a teacup within a teacup with different layers of ideas. I noticed myself thinking ‘maintaining dignity one cup of tea at a time’ and thought about the meaning of a cup of tea in British culture. A ‘stiff upper lip’ and not talking about emotions are sometimes considered intrinsic parts of British culture. However, suggesting a cup

of tea is also a cultural tradition, used to soothe in distressing moments such as a loss of one's dignity.

By Week 8, the dignity in care posters on the wall had been moved and rearranged. A star attached to one had the number three on it. It struck me as odd that this complex issue had been dealt with like a school project. The use of written posters seemed to me to reflect an 'out of touch' or 'old fashioned' approach as did the awarding of the 'best poster'. It raised the question about how this organisation approached complex issues and whether more appropriate mechanisms or spaces to hold difficult discussions existed.

3.2 Sonic violence

"My first thought was that a lot was happening around the team's work area. It was an open-plan office with different types of barriers such as cupboards or glass meeting room doors that served to 'corner off' the different teams. These, however, did not block out any noise and I noticed myself constantly drawn to a telephone ringing in the next team, behind the cupboard, or distracted by another type of loud noise."

The above extract was one of many I recorded during my ten-week observation. The intensity of the noise for me was ever-present. I noted that even when no one was talking, the sound of typing was loud, like people were taking their frustrations out on the keys.

During one observation, I was startled by a loud noise from behind me. It sounded like someone had dropped a glass, except the crashing sound continued. I realised it was the hand-drier in the bathroom.

When the noise levels were high, I found myself unable to hear what team members were saying. I struggled to concentrate and noticed myself worrying that I might be distracted from the observation. I wondered about the extent to which these noise levels around workers interfered with their ability to concentrate on the issues they were dealing with. I wondered how they could make safeguarding decisions with clarity with this backdrop.

3.3 Grill a Christian

I scanned the room and noticed a box on the corner of the window ledge. I glared at it for a while, not sure if I had read it properly. The label on the side of the box said 'Guilt 180675' in red.

In another observation, I noticed a book sitting on the cupboard directly behind me. It was titled *Grill a Christian*. I initially thought that I had read it wrong. I could not work out who it might have belonged to because its location appeared to be generic like it belonged to the team. I later looked this book up online and discovered it was sold on Amazon. The book is about sitting down with a Christian and questioning them about Christian beliefs.

Persecutory heuristics appeared in both these observations. I could not help but wonder whether the box on the window ledge had something had to do with the primary task of the service, to form a view on who is being abusive or neglectful. The box seemed to symbolise a judgment being handed down and perhaps reflected how social workers themselves might feel. The *Grill a Christian* book seemed to me to link to phantasies around social workers being saviours who often get 'burnt to death' or burned out, that despite their best efforts, they are always blamed and 'found guilty' when things go wrong.

3.4. Veiled surveillance

I had worked in this local authority myself years before. As I walked around, I did not recognise the layout of the office and it felt more crammed than I had remembered. They seemed to have added twice the number of desks and people within the same area. Walkways circled the teams on each side.

From the first week of the observation, I became aware of the number of people moving past me. The team sat up against the window, and alongside it was the corridor where people moved from one side of the large room to the other. It was like the team was stationary whilst people moved past and peered in. I wondered how this felt for team members.

This layout meant one could see across the entire floor from all points. In seminar group reflections, one member pointed out that this was quite like a panopticon, most often seen in prisons and designed specifically to make it possible to see what

was happening in all directions. In this setup, workers can be observed, assisted by bright lighting.

Another version of structural-style surveillance was seen in Week 2 when I observed how the team needed to prove their existence:

"A man arrived from the performance team. He asked Sameera about a 33% drop in 'their numbers'. An anxious ripple of discussion erupted in the team. "But we have not had less work," said one team member. Sameera pointed out that it had been the Christmas period, so it was likely that this was because the work had yet to be recorded on the system. The performance man showed little empathy and expressed concern that they could not demonstrate what work was being completed. He said that this made it difficult to justify their continued need as a team."

The team's work was under intense scrutiny to such an extent that its very existence was called into question and threatened by the lack of performance data for a relatively brief period of time. Sameera looked over at me, seemingly anxious, and said to the man from the performance team: "*Careful, we have a researcher here*". I desperately wanted to reassure her that I was not spying on her and yet simultaneously realised the irony: the critical performance monitoring was intrusive. The team's experience of this was seen again in Week 6 when I overheard one of the seniors complaining and saying, pointing her eyes towards me, '*we have an observer here today'*, urging caution to the person talking.

3.5 "White men, grey suits"

I noticed, one at a time, two older White men walking around the corner alongside the team and then disappearing further down the corridor. They both seemed to be wearing the same grey suit and glasses and had strikingly similar features. I had noticed 'White men in grey suits' before.

A member of my reflective group for this observation described these men as cameras watching, highlighting further signs of veiled surveillance. However, an additional dynamic was that it was being carried out by White senior people. In another observation session, I realised that the hot desking system that meant different staff must rotate the days they came into the office seemed to translate into

‘White staff days’ and ‘Black staff days’. Desks inhabited by White staff members on some days were then occupied by Black staff members on another.

In Week 3, I noted a ‘White senior manager’ in a grey suit approaching the senior social worker Andria, asking her if she was coming to the event that afternoon. She said she was. He responded by saying, “Ok great, you will do then…” I was unable to hear what he asked her but watched him pull out his wallet and give her £20. She appeared very taken aback by the request and awkward in taking the money. I heard her asking him, ‘What type of coffee?’

She looked visibly shaken by this request and I found myself upset too, perhaps having identified with her as a woman and a senior social worker. He was condescending and she seemed unable to say no to him.

Theme 4: Organisational culture

My secondary research questions include understanding how the organisational environment responds to adult safeguarding cases and how it affects the practitioner’s ability to make decisions in this area of work. They also include how the emotional and unconscious dynamics of adult safeguarding cases might be transferred into the organisational environment. Through the observations a number of key themes emerged including; a dynamic exposed by team members about senior people making decisions; and that people seemed to stay working for this local authority for long periods, with a real sense of ‘statutory identity’ and perhaps allegiance to this workplace. It was difficult to observe decisions in practice and this suggested that they were ‘hidden’ or happening elsewhere. On the whole, the signs were clear that the organisation wanted to make improvements and was trying to apply a supportive approach. These are discussed below and begin to answer some of the key research questions.

4.1 “Those people decide”

The team discussed the referral process for ‘self-neglect cases’[5]. Fire services wanted to refer a hoarding case. Andria stated that the referral went through the

[5] The Care Act 2014 added self-neglect/hoarding as a ‘category of abuse’ under adult safeguarding legislation.

service centre in the first instance and then would be passed to their team. Cynthia, however, disagreed, saying that a decision had been made that self-neglect cases should no longer be dealt with under safeguarding. She gestured towards the manager Sameera's desk and stated, "Those people, senior management, decided on this". Cynthia's comment captured a sense that decisions were made by those hierarchically 'above' them. Sameera was not in the office that day so she could not clarify the agreed process. I observed that the conversation kept looping back to this issue and within the hour, they had still not agreed on how to respond. I was unsure whether the team felt able to make clear decisions without the manager.

In Week 6, I learnt that Sameera kept a log of the number of safeguarding concerns for each care provider. No one else had access to this information. When a commissioner visited the team and asked for it, they could not help her in Sameera's absence. Sameera's control of such information may have meant she had a fuller picture than her team. The team received new referrals related to provider concerns regularly. It seemed that this setup meant they did not have the necessary information to make accurate judgments to determine risk regarding these new incoming concerns.

In Week 3, I overheard a conversation Andria was having with Isabela about 'feedback to referrers' and how someone had made a complaint. She said the man was just complaining because he did not receive information about the safeguarding case following his referral. He had not, however, contacted Andria to ask for it. In any case, she felt it was inappropriate to share the information given his limited involvement. Andria was annoyed by the criticism as she felt her decision not to share information was valid. Both scenarios flagged how controlling safeguarding information created a power dynamic.

4.2 Statutory identity

Sameera was on the phone having a conversation and I overheard common phrases in social work statutory settings such as '*we will get on that*' or '*we can bang that out'*. Practitioners' responses seemed to have become automated.

In Week 7, I noticed one of the administrators walking around the office and recognised her. I realised that she would have been working for this local authority for a very long time, at least 20 years. It struck me that Sameera had also been working for this local authority for some time, as had several other members of the

team. People seemed to stay working here. It appeared that not only were people still passionate and committed to the work, but they were also deeply connected to the place. During my observations, I became acutely aware of the council 'branding': everyone's laptop screensaver was of the Council's Town Hall, a strong and striking image representing the area's history and heritage. The colour of the council logo was then used to match the boarding that framed the back of the desks and across all the rooms. The statutory setting and context perhaps provided a clear framework for practice, which then became linked to professionals' sense of identity, connection and belonging. It may have engendered an allegiance to the organisation and became why people stayed for so long.

4.3 Hidden decisions

For the first few weeks, I was often querying what work people were doing. At one point, the observation seminar lead asked whether the team was doing safeguarding work. My observations were often of team members not engaged with their primary task.

In fact, throughout the ten-week observation, only a few decisions were made on safeguarding cases. Which decisions should or should not be made was discussed, and the process for decision making was debated. Sameera was keen for me to observe a 'team huddle' to see how it worked. However, this too may not have provided clear examples of decision making, given it was a space for sharing thoughts and ideas. In the second week, one of the team members asked if I would go out on a visit with them. It seemed they were keen for me to observe them elsewhere or differently from how the observation had been set up. I thanked them but explained my observation was of the team within the organisational setting.

There were only two rows of seats in the team and no more than seven practitioners present at each observation. I sat at the end of one row most (observation) days and regardless of where I was seated, I was able to see and (over)hear conversations majority of the time. During the observations, I noticed long periods of silence. My seminar group also noticed that many people were often not in the office as they were 'working from home' (WFH). It seemed that decisions about cases were happening elsewhere, perhaps somewhere not visible to the organisation.

4.4 Supporting improvement

In my first week, Sameera introduced me to the head of service. She said it was great that research was being carried out by social workers and was pleased I was doing it. She told me that they had brought in a consultant to trial some new ways of working in the team such as motivational interviewing skills, in line with some of the changes made by children and families. She felt that they were “getting back to traditional social work”. This training was aimed at supporting more relationship-based and therapeutic approaches to social work. It suggested the organisation wanted practitioners to improve upon their practice.

Throughout the observation, Sameera kept referring to the ‘team huddles’ and was disappointed that I kept ‘missing the opportunity’ to observe them taking place. She seemed to feel that they were a positive and dynamic new addition to the team’s way of working and decision making on complex cases.

During a few observations, I noted that some practitioners struggled with technology. Accountability for decisions in practice lay with practitioners who had to ensure these were recorded on the relevant digital platforms. As such, any difficulties in this respect could interfere with practitioners’ ability to do their jobs. An IT support desk was set up by the canteen area for staff. It was a bit of a ‘hub’, so having an easily accessible place to speak to a tech person about any IT issues seemed sensible. A sign with a list of services offered included technology improvement sessions. The presence of an IT support desk seemed to reflect that the organisation was aware of the need to support practitioners.

These are examples of efforts made by the organisation to support the smooth running of practice.

5.5 Summary of observation findings

The observation provided fascinating insights into hidden dynamics within the organisation. At the start, I encountered structural defences through high levels of suspicion. Once I could observe the team, I found that when the right decision was unclear or perhaps provoked anxiety, the trend was to debate the process. In the manager’s case, she may have reverted to rigid procedures, even if these did not make sense. Unconscious defences revealed more difficult realities of the work.

These included how practitioners dealt with horror and death, using laughter as one method. It revealed practitioners' responses to the contradictions that arose such as taking sides (even with a clear perpetrator) or harshly judging a situation when help was rejected. It also highlighted the real risk of jumping to conclusions with minimal information.

The signs from the environment showed hidden structural factors that that revealed the likely wider influences on decision making. The poster competition for teams tasked with exploring the concept of dignity questions how the organisation dealt with complex issues. The working environment, with high levels of noise, appeared to exacerbate an already high-pressured decision-making context. Finally, the racial and gendered dynamics observed inferred systemic prejudice and a hidden influence within this organisation.

A hierarchy of decision making is not surprising in a local authority. When confusion and disagreement arose around what process to follow, team members referred to senior ("those") people as the ones who had made the final decision.. There were indications that the team were unable to make decisions without the presence of the manager. People seemed to work for this local authority for extended periods, with a real sense of 'statutory identity' and allegiance to the workplace. However, very few decisions were observed in practice, and this prompted whether decisions were obscured or happening elsewhere. There were signs that the organisation wanted to make improvements and was trying to apply a supportive approach. The regular team huddles, for instance, provided a peer space that could support and explore decision-making options.

The next chapter presents the interview findings, where some similar themes emerge. A deeper analysis of these observations alongside the interview data is then explored in the discussion chapter which identifies the key unconscious and emotional factors found overall to be impacting decisions in adult safeguarding practice.

Chapter 6: Interview findings

This chapter outlines the findings from the individual and follow-up interviews. It collates patterns identified across the interview data set and explores them under key themes. As outlined in the methodology chapter, participants were asked very few questions. Only one question was asked at the start of the FANI: "*Tell me about a case that has stayed with you – one you still think about."* The participant was then left to free flow in their responses and allowed to share, in their way and at their pace, their feelings about the cases they had worked on.

In the follow-up interview, the starting question all participants were asked was: '*What thoughts did our last interview leave you with?'* It allowed respondents to reflect on what they were left thinking and feeling. This permitted their narrative to continue and the participants to expand further on what they had previously shared. The initial interview had flagged certain themes or areas of interest about individual participants. Follow-up interviews then included additional specific questions (asked when this flowed into the conversation easily), to elicit further information relating to them. The follow-up questions included: '*What do you think it is about those two cases that has made it stick in your mind?'* and *'What do you think was the hardest part of the decision making in these cases?'*

In this chapter, the three main themes that emerged from the interviews are discussed using the participants' background, the specific cases they chose to discuss, and the said and the unsaid narratives they shared. Each case meant something to the individual participant. This helped to reveal some of the unconscious and emotional influences in decision making in practice. An in-depth analysis and discussion is carried out in Chapter Six.

Table 2: Interview themes

Theme 1: Participants' biographies	• Personal history • 'Failure to help' • Cultural differences
Theme 2: Emotional factors	• Severity of abuse • (In)experience • Responsibility
Theme 3: Practice Culture	• Perception of competence • Statutory anxiety • Practice environment

Theme 1: Participants' biographies

When considering which analysis questions to put to the interview data as part of the data analysis stage, the most obvious one was to ask what was learnt about the participant's history and background. This is because participants were disclosing their personal information during the interviews unprompted. A pattern emerged of how the cases chosen for discussion each had a significant personal meaning for the participant. Participants were seen identifying with the individual in the case or the participant's personal history, which appeared to strongly influence their motivations in practice. These personal motivations made a difference in the way the participants made decisions about cases and how they perceived and experienced the success of their and others' interventions. They often seemed to perceive failure where there was none. Participants' cultural backgrounds also appeared to affect their perceptions and expectations, and these differences affected the emotional impact of the cases.

1.1 Personal history

Sam

"What if this was my mum? What if she was being starved by a son who was abusive?"

Sam described a case (2.1) involving abuse by the son of an elderly woman. In the interview, he discussed what went through his mind in deciding how to respond. The son was taking all his mother's money due to a drug problem and consequently, she was being starved of food. Sam lost his mother when he was a teenager. It was a painful experience that he reflected on throughout the interview. It seemed he felt guilty about how he had behaved then as he stated he was a '*completely different person then'*, '*rebellious*' and '*didn't have time for academic study'*. He hoped that his mother would be proud of him now that he was a social worker.

This seemed to drive him in professional practice. His childhood experience of losing his mother was central to his interview and Sam discussed only this case. Safeguarding concerns about this abusive situation had repeatedly been raised by concerned family members and the case file was closed. Each previous social worker had decided to close the case on the justification that the elderly woman had the mental capacity to make decisions and was denying any abuse. Sam decided to visit the family home repeatedly, gathered evidence from other family members, navigated the son's aggression, and challenged him specifically in relation to food for the mother. He decided to enlist the support of the local police, who gave him background information about the son and consulted the local authority's legal department about his legal options in this scenario. He wrote to the son to tell him that court proceedings would be initiated against him unless he left the home. This was enough to result in the son moving out. Shortly afterwards, the elderly woman was admitted to hospital. In the safety of a new environment, she admitted to staff that she had been starving and was terrified of her son.

Sam's close personal identification with the case appeared to be the main factor influencing his decision making and persistence. His personal experience drove him to respond in ways other practitioners including his team members had not. He exposed the situation and probably saved a vulnerable woman's life. He may have chosen the case because he had identified so closely with the mother-and-son dynamic. The mother was vulnerable, someone who 'could have been my mother'. Her daughter was pleading with him to help; she, similarly, could have been his sister. The case was the first that came to mind when he was asked because it had significant personal meaning for him and a long-lasting impact. He described feelings of *'abhorrence'* and *'disgust'* about the son's behaviour toward his elderly mother. The impact of the case left him "*emotionally rattled…such that when you ask me which case has stayed with me, this is the one I first think of".*

Andria

Andria's first case involved a young woman, just over 18, who had moved to adult safeguarding from children and family services. She talked about how she identified with the case:

"…you build relationships up with these vulnerable people because you have to build relationships but then you're still left with…..because it's a two-way relationship. Plus, she was the same age as my daughter…so I was oooeeerrrr…this could be my child and I want to do what's right for her."

The young woman came to the hospital with bruising and alleged sexual abuse by her father. The safeguarding enquiry process was not able to establish whether she had been the victim of abuse, with suggestions that she was making it up and self-harming to cause the bruising. Andria said this was the first case she '*did take home'* and that she had to talk to her partner about it to '*just try and get clear in my head.*' She described the case as causing her '*a lot of stress'* and its impact seemed to have stayed with her for some time. She explained that she had never had another case of its kind as the safeguarding team mostly dealt with older people.

Andria also felt let down by the professionals involved. She took a considerable amount of time to connect with this young woman to develop trust. She felt sure that she was telling the truth. One reported incident was unproven and Andria's view was that this brought into question the veracity of the other incidents. Andria's close personal identification with the case appeared to be the main factor in her decision to believe the young woman's account and not concede to other involved professionals' views. Whilst Andria was not satisfied with how things ended, she managed to get the young woman support from mental health services.

Separately, Andria referred to how her experience working in mental health enabled her to have a certain view of risk. She took a personal perspective, stating: *"…if it was me, I would want to be allowed to take risks*." She said she tried to see things from that person's perspective. She seemed to pride herself on this as an example of how she is anti-oppressive in her practice by 'allowing people to take risks'. Her approach informed her decision making, revealed in her comment: "At the end of the day we are all humans, we all have human rights…so I try to make my decisions

rounded." Andria's sense of purpose appeared to be strongly linked to her need for fairness and justice. Throughout her interviews, she referred to herself as someone who was unafraid to say what she thought and therefore 'not diplomatic'. She believed that the most important part of a social work role was to challenge the system and to prevent discrimination or oppression. She was frustrated by the lack of action by her colleagues as social workers, for not standing up against the new organisational demands on social workers such as keeping spreadsheets of how much they were 'spending'[6], which she felt strongly were against the values and ethics of social work.

She believed in standing up to societal injustice and so felt that if social workers could not stand up to the unjust way they were being treated by their organisation, they could not do so for their clients. Her pushing back against the dominant unjust system is seen in the decisions she makes in her cases. This is explored in the discussion chapter.

Vivienne

Vivienne's experience of having a young child who had Asperger's syndrome meant she found herself always having to fight for him, whether ensuring he got what he needed from the system or protecting him from the mean behaviour of other children. In her interview, she described how she hated bullying, nastiness or when *"people try to get ahead by stepping on someone else*". She found certain types of abuse more difficult (or emotional) than others and that "*premeditated abuse is a real bugbear for me"* compared to where the abuse was related to situational family stress or struggle.

All the cases Vivienne spoke of were cases where she had fought hard to get justice or where she felt unhappy that she had not achieved justice in the way she wanted. She often took on cases where she perceived that the person had no one else and believed she had to advocate for them. She admitted that in one case she was down as the next of kin and later realised this was not appropriate. She also admitted to taking cases that were not safeguarding ones and not within her team's remit. She

[6] Adult social care departments within local authorities, will pay for certain care services for adults in need. It appears that this local authority expected social workers to keep a record of what services they were arranging and the cost of these. Andria suggests that social workers were being scrutinised on these and were being held individually responsible for this spending.

built close relationships with each of the cases she worked with, kept them on her caseload for long periods and came to know personal details about their lives.

She formed strong attachments with the person, couple, or family. An example was when Vivienne visited one of her clients and found her covered in bruises, half-naked, heavily intoxicated and hallucinating (case 5.1). She became even more determined to remedy the abusive and exploitative situation her client was in. This determination appeared to have a direct link to her personal history and her sense of purpose as a social worker. She talked about the case proudly because her perception was that she had secured a positive outcome: she had helped the client to fight a legal case and managed to get her house back from the scammer. The woman moved to sheltered housing, had friends and was happy. However, Vivienne later admitted she had doubts about what she had done:

"I don't know if it was worth it, the cost of how much it took, she had to go through in terms of video evidence and all that. I think she felt empowered by doing it. She's certainly came across like she felt empowered and that she had accomplished, she was very happy. She wasn't happy with the solicitors' costs, but I think she felt she gained some control back so maybe I am overthinking it. But for me, I remember thinking, even if you break even, it is better than him having it. But it wasn't me going through it, do you know what I mean? So I thought maybe it's a bit of a personal…because it's a bugbear for me. Because of the injustice of it and maybe I lost sight a little bit. It could have really lost sight if she ended up not breaking up (even) in terms of finances or lost sight of who you're safeguarding and the priority of safeguarding someone because you need to leave them in a place that was better than when you started."

Vivienne reflected on whether her determination to achieve justice may have caused her to 'lose sight a little bit'. She admitted that it was 'lucky' that the client did get a good outcome. Her unconscious motives may have interfered with her decision making. It may have driven her with conviction to proceed with what she perceived as the right approach and hindered her ability to consider whether this was what the person wanted. At the same time, however, her client had been unwell and may not have had the energy or ability to seek justice for herself. In this sense, Vivienne's actions are remarkable.

Cynthia

Cynthia described a domestic violence case (OC7) where the neighbours had provided a statement to the police about the perpetrator. She did not believe the neighbours because they had "been there when the assault happened but had not done anything to intervene". She took their lack of action as evidence of them being unreliable or not credible witnesses. Throughout her interviews, and during the observation too, Cynthia voiced disappointment and frustration about others' faliure to get the police involved sooner and the lack of action by the police themselves once involved. She later disclosed that she had experienced domestic violence herself. She did not disclose the details around this personal experience however there were indicators that this influenced her perceptions and judgments of case situations.

Isabela

Isabela left a well-paid, high-profile job to become a social worker. She described becoming a social worker 'became more like an obsession type thing' and that she 'wanted to prove to everyone that I can do it', which perhaps reflected deep insecurity about herself. She found that the safeguarding role was like 'properly helping people' and described it: *"Wow, I can't believe that actually, because of me, this person today will eat something. You know, it was that feeling of 'Ah!' (deep breath in). I did something for someone you know? – it was that sense of satisfaction."* This tangible example made her feel good but contrasts with the difficulty she described in her first placement with children, where she felt afraid of them. It is also a simple example of social work and might explain why when she encountered more complex safeguarding work (described later), she felt so afraid.

The above examples demonstrate how client-identification influenced participants' decisions in both positive and controversial ways. This was likely down to the influence of each participant's individual biographical history. All participants disclosed details from their past that were alive in what motivated them in their practice and why they became social workers.

1.2 ‘Failure’ to help

“*nothing happened to her, it’s still the same…*”.

Andria described how let down she felt by the professionals involved in the case (4.1). She had a real sense that they had failed to help. The perceived failure appeared to have stayed with her as she admitted that she still thinks about this young woman. However, she then disclosed that the young woman no longer came into the hospital with injuries like before. She had also moved in with her grandparents and was going to university. This was a clear improvement in the situation and the young woman seemed safer with her grandparents, however Andria still felt very disappointed by the outcome as she perceived it.

Andria’s second case, a hoarder who died, similarly appeared to leave her with a sense of ‘failure’ or powerlessness. She talked about the ‘lack of legal power’ with hoarding cases. She described feeling limited in what she could do to help despite regularly visiting and trying to convince the client to engage. She was also working with a ‘hoarding case’ at the time who presented in the same way. She admitted that she had kept her current hoarding case open for over two years and continued to visit him secretly. She did his shopping even though she knew she should not. She did not want to ‘fail’ this time by letting what happened to her last hoarder happen again.

The outcome of one of Vivienne’s cases (5.2) similarly left her feeling like she had failed to help. She admitted to becoming very attached to the couple. She worked extremely hard to keep them together despite interference from family members to separate them. She explained that this case was particularly difficult as she later discovered the family had Lasting Power of Attorney. They used this power to remove their mother from her partner. Their power over this decision shocked and enraged her. It was what they wanted, and not what their mother would have wanted. Vivienne tried to find ways to reunite them but was unsuccessful. The outcome appeared to leave her feeling she had failed them. She admitted to regular feelings of guilt and thought this might be why these cases stayed with her. She was unable to reconcile the feelings of guilt and said she did not fully understand what caused them. Quite like Andria, she found it very difficult to walk away because it made her feel *“quite deflated and quite frustrated and wish that I could do more”.*

In two of the cases Serwa discussed, it was evident that she was unable to do anything about them herself. One had to go to court for a decision. She was unable to resolve the other due to the person's refusal to engage with her. This saddened her and the emotional impact on her was palpable. She said, *"Sometimes it's difficult. It can really make you upset…depending on why you didn't get the outcome."*

Likewise, Cynthia described getting *'a lot of satisfaction out of it, like especially if there was a positive outcome',* which for her seemed specific to if she was "*able to assist police to put perpetrators in prison or there was justice served*". However, for both cases Cynthia spoke about, she felt very strongly that they '*should not have ended this way*'. Both people received support and care, but she remained puzzled by the police's explanation and by what she perceived as a lack of action against the perpetrators: "*He never got prosecuted for what he did, he got away with it*." She felt the police did not give either perpetrator a caution or 'put the fear into him' so he would not do it again.

Each participant wanted to find the best way to resolve the abusive situation, and this seemed strongly linked to their personal views and desires. When they found themselves unable to achieve a positive outcome in their minds, it was perceived as a failure. This had a personal impact and may well be why these cases stayed with them.

1.3 Cultural differences

Isabela

"So, in my culture, I am Latin – in my culture, people care a lot for their families...And when I see other people, other families doing all these nasty things - physically assaulting them or tying them up to the bed… I compare them, their reality, their situations with my own family. I talk to my parents three times a day making sure they are ok. Half of the wages I make here I have to send back to Romania just to help them out and making sure that they have the best possible back there. I love them so much seriously. I respect them so much. I would never imagine myself, doing all these atrocious things that I hear in this country – everything that is happening here, I would never in my life do such things to my own family."

Through both interviews, Isabela presented as highly anxious and spoke at a rapid pace. She repeatedly took deep breaths. She remained distressed about the way events in the two cases she discussed unfolded despite having received considerable supervision and support for both. Whilst she was an ASYE (Assessed and Supported Year in Employment) at the time and therefore inexperienced, her description showed a naivety of how social work should be: *"because for me going to work, it has to be a pleasure, I have to learn something. Of course, you have to challenge yourself, but I shouldn't be dealing with such a huge amount of stress."*

It seemed that her view of the world was shattered through the cases she encountered. She was shocked by her experiences and the reality of abuse in families, believing that these did not exist in her background. Her cultural expectations over 'how people should behave' conflicted with what she encountered. She presented as traumatised by these case experiences, and that may have left her feeling unable to make decisions without support. Notably, she had stayed as the duty worker within the team. When attempts were made to change this arrangement, she vehemently opposed them. The duty role meant less direct contact with cases and fewer decision-making responsibilities. The role was always based in the office with support available.

Serwa

"*If you are the eldest, you look after your siblings. So, the caring nature, it comes out of, where…it can be cultural, it can be self-motivation or something like that you want to do."*

Serwa is Ghanaian and described how she came from a culture with a hierarchy of roles in the family, where family members care for one another. It is unclear whether she was the firstborn, but she admitted that her upbringing and *'my involvement with my siblings and my parents, motivated me to be a social worker'.* She said she always wanted to do the best for people and to *'make sure they're protected...and safe'.*

Interestingly, all the cases Serwa discussed were about financial abuse and strained family relationships. In the first case (6.1), she described how it became "*like a battle between the local authority and the family*". The two siblings tried to remove their mother from the care home and intimidated the staff. For her, this was *'a really big case.'* Solicitors got involved and the case went to court. Serwa's professional views

were upheld by the judge, so her decision making was not called into question. It took a High Court judge to intervene and make the final decision.

She reflected on the difficulty of decision making for a vulnerable family member when other family members are fighting: *"it was all about them. You know, the mother's welfare wasn't their paramount decision, which was very, very sad looking back."* Her sadness was palpable during the interview. It seemed likely that these scenarios stayed with her because of the personal link to her cultural upbringing and her model or idea about what family systems or behaviour should look like. It was unclear when and at what age she left her home country, however, like Isabela, she described her upbringing in an idealistic manner.

Her sadness may have been about seeing families not behaving in ways that she was raised to believe they should, coupled with not being able to mediate the family conflict as the social worker despite her best efforts. If caring and ensuring protection and safety is so core to her nature and upbringing as she described it, then the inability to enact it professionally would understandably leave her feeling a sense of hopelessness. This may be particularly because she tried so hard to work with families to support them to make their own decisions whilst recognising her role as the social worker in safeguarding: *"It's a huge impact on you because you are trying to intervene on behalf of your client as well as…. you want to make sure that…hee…. you are not in conflict with a family. You want to work together. But sometimes it's a bit difficult."*

She also asserted that 'pure family issues' could be resolved without involvement from a social worker, as a family. This underlined her opinion that certain issues should not be dealt with by social services. It reveals her ideas of responsibility around decision making and the likely influence of her family background.

Cynthia

> *"I'm originally from Bermuda, you know, it's in the Caribbean. And then later my family moved to Dominica, but in Dominica, you know, elderly people are respected. And I just find here in England, the way they're treated like shoved on (under) the bus…"*

Both the cases that Cynthia spoke about were elderly people experiencing domestic violence. Cultural differences in the way that older people in the UK were viewed and treated were a shock to her. Her anger at the police, as described earlier,

included the notion that they seemed to disregard elderly people's experience of violence and not take action to prosecute. The presence of this injustice did not appear to deter her in any way. Quite the opposite, she described being passionate about her job. Her cultural background appeared to influence her motivations and enabled her to advocate against injustices in the system.

Cultural differences affected how practitioners experienced their cases and influenced their responses. It links to value frameworks and will be explored further in the discussion as an unconscious factor influencing decision making.

Theme 2: Emotional factors

The second strongest theme emerging from the interviews are the emotional factors. These arose through the case examples and in the reflections shared by participants. Some echoed what exists in the literature. What was evident in each interview was how quickly each participant responded to the question asked at the start. From a psychoanalytic perspective, this shows how close to the surface 'case memories' were, revealing how much each of them meant to the participants and their emotional impact. These emotional factors included the severity of abuse, (in)experience, and responsibility.

2.1 Severity of abuse

Safeguarding work mostly involves complex and emotionally intense cases. However, the cases raised by each participant featured significant abuse or death.

Sameera spoke about three cases, all of which featured serious abuse or neglect, and in all three cases the person had died. None of the cases had called into question her or her team members' decision making and yet they had still 'stayed with her.' It may be because these were the more traumatic cases so their emotional impact on her and the team was greater. She carried a real sense of horror and worry about each of these cases.

The cases Andria discussed seemed more severe than some of the other participants' cases. This may be because she was the senior social worker in the team and had worked in this area for over a decade. The final case Andria described

was of a known rapist discussed at a Multi-Agency Public Protection Arrangements (MAPPA) conference, a high-risk forensic case panel, in which she was the adult services representative. This person would dress bizarrely and post videos of himself dancing online. Andria's daughter, who owned a hair salon, sent a video of this man in her salon and later told Andria she had exchanged emails with him. Andria was unable to say anything to her daughter but said that she no longer attended MAPPA as the representative, because of it.

Cynthia described one case (7.2) where a son assaulted and strangled his elderly mother, leaving black bruised finger marks all over her neck. She explained how the team *"got really, really worried because for us this was like attempted murder."* She felt angry about the case because despite the evidence of finger marks and the woman "*told the doctors what her son had done…they didn't believe her. They just assumed she had dementia*". The hospital did not raise a safeguarding concern to social services. It was only later, once she was home and told the district nurse about what happened, that a safeguarding concern was raised. The police visited her home and collected evidence of blood on her pillow. The police arrested the son, who told them his mother had dementia and suffered from hallucinations. It seemed to Cynthia that the police appeared to favour the son's version and spoke with the paramedics who had brought her to the hospital. The paramedics said she had changed her story a few times. Despite the social work team providing evidence that the woman did not have dementia, the police took no further action, citing a lack of 'public interest' and that the woman herself did not wish to pursue it any further. The team eventually moved her into a care home permanently. Cynthia explained:

"In the end, it was agreed for her to stay permanently in the care home, you know, because it didn't make sense for her to go (home). Because we felt by sending her back, she would still be at risk because even though this thing happened to her, she still wanted her relationship with her son. And she would have still allowed him to visit her and who knows when he would, you know, get annoyed or irritated and do something again."

The lack of police intervention may have meant that she could not remain in her own home safely. There is also clearly a difficulty in ensuring someone's safety in situations where they want to continue to have a relationship with the perpetrator. Cynthia goes on to describe that *"while she was in the care home, her health deteriorated…while she was living in her flat, she was able to move about on her*

own...for some reason whilst she was in the care home, she stopped walking, so her needs actually increased." There was an unintended negative outcome from this decision. It is unclear whether the decision to move her into a care home was what she wanted or whether it was felt necessary by the social work team because of the risk.

2.2 (In)experience

Most of the participants described cases they had encountered either whilst they were newly qualified or new to their role. Sameera's cases occurred when she had just started as the manager of the team, a point when she felt ill-equipped *"because I was really new into this job…and (so) I was really quite intimidated by it…"*

Isabela's case (3.1) was when she was a newly qualified social worker. An elderly woman was allegedly being financially abused by her friend and informal carer. When Isabela visited the elderly woman, she was confronted by this carer, who had been told about the allegation: "*She started crying, she started threatening me – how dare you accuse me of these things, are you aware that my son is a police officer, this and that... She left the house; she slammed the door. I was shaking, I was so disturbed by this, you know."*

Isabela returned to the office crying and described feeling 'low' and 'hurt'. The impact was such that a year later, when this interview took place, she still vividly remembered the experience and its impact: "*Like I went there with good intentions, even now – look at me I'm even shaking when I think about it.".* During her follow-up interview, she repeated the entire account several times, almost word for word. She felt the impact influenced her responses today: "*from a personal point of view, because I've experienced that, I would say that I am more cautious... being more careful how you speak with the alleged perpetrator and explaining the role and maybe why you're doing that. Understanding that you're not doing anything wrong only because you're investigating the matter…" also '*not taking it so personally'.

2.3 Responsibility

"Social work is not simple. It's very rewarding, don't get me wrong. But the decision-making process involving this work, it's very challenging. It's very challenging in the sense that, at the time you are making the (a) decision which can break or make the person."

Serwa's comment above reflects the weight of responsibility that decision making carries from her perspective. Whilst she found the work rewarding, her comments also reveal that she had seen negative impacts, perhaps both hers and others.

Sameera had come to work in adult safeguarding after working in child safeguarding and seemed to carry over the same anxieties from her previous role. When describing a case where the person had died, she said: *"If it was children's (services), heads would be rolling*". Feelings of not knowing whether she was doing the 'right thing' were accompanied by a seemingly distorted perception of responsibility for what happened. She appeared to fight this off by pushing the responsibility away. She would complain about the '*incompetence*' of workers or declare that the '*organisation should be carrying more responsibility'*. This may have been because she felt the burden of carrying it alone or with the responsibility came guilt. She says, *"The cases that stay with you the most are the ones where you think you could have possibly done more*."

Isabela's second case (3.2) was of a 97-year-old woman who was a severe hoarder, "*piles of trash up to the ceiling, food from 2001, rats…there were bottles of urine around the house, there were faeces on the walls…*". She described how unsafe the environment was and that the woman could barely walk. Isabela visited her with the police, fire services, and an environmental health officer. She '*prepared the papers for the panel'* to arrange for a deep clean of the property. Once it was cleaned, she *'would have been thinking of arranging a care package'*, which would have meant care workers visiting to support her within her home. She had managed to contact a nephew in Scotland to discuss the concerns. The woman herself, rejected all offers of help and Isabela explained: *"There was no diagnosis of dementia, her cognition was really good – like super sharp. She could understand all the risks, she did explain to me – it's none of my business- it is the way she has been living for the past 60-something years. Why am I interfering? What is my job here? She doesn't*

want to pay for anything." The woman was taken to hospital and died days later. This left Isabela questioning whether she had done the right thing or done enough.

"So I started having all these thoughts and questions – oh my god, have I done something wrong? Did she die because of me? Could I have done something better?... *Should I have forced her to go – to take her into hospital. I started having all these, you know, dilemmas. And obviously, they were addressed in supervision, and I knew that I didn't do anything wrong, because a person who has capacity and has these sorts of decisions, they have to be respected as these are the person's decisions."*

Isabela, however, was not able to resolve it within herself and the case stayed with her because when "*I received the email about that lady dying, I immediately felt it was my fault - she died because of me."* She admitted that she found having to make "*all these types of judgments in social work, tiring and draining*".

Andria's hoarder also died, and his death left her questioning herself, too, whether she should have done more and about her level of responsibility for what happened. "*So, there was some reflecting then whether I could have done more or not? Does that responsibility lie with me? Um, you know….I tried to engage the other agencies again, the GP and other agencies and that, and they hadn't gone to see him or hadn't tried to engage him…. So, but still, it's like – could I have done more to prevent…? It didn't go to the coroner's or anything..."* Similar to Sameera, her decision making was not called into question, but she was still left feeling guilty and responsible.

Vivienne spoke about cases where the person had died or where the outcome was not what she had hoped for. This pointed to the sense of responsibility she felt for her cases. One of her cases (5.4) was a man who was being drugged, exploited, and scammed by a woman trying to get him to change his will, to give her all his money and assets. He was discharged from the hospital and later found dead. She knew she did her best but still questioned whether she could have done more. She explained, *'I engineered the plan'* (for his discharge) and so was left with feelings of responsibility for what happened.

“I find that instead of being supported by other professionals, I feel attacked at times, and always been made to feel like, um…. I don't know how to explain it, like I'm the lead.”

Cynthia’s describes her experience with other professionals above. The absence of support within the professional system while being attacked by those who also have responsibilities to contribute to safeguarding, may have caused Cynthia to feel alone and resist her own leadership role.

In high-risk situations, not knowing what the right decision is might cause practitioners to want to avoid making them. This was seen when the elderly woman in Cynthia’s case (7.2) refused police involvement because she did not want to get her son in trouble. The team felt they could not override her personal wishes. Cynthia took the dilemma home and discussed it with her partner who said: “*You've got to do something. Because what if you don't do anything, this son comes and murders her. And then this ends up on the news? And do you want your name in the paper to say: ‘these social workers from [X Local Authority] knew the risks, they didn't do anything?’”.* An external perspective was a reminder of the consequences that can occur where someone’s personal wishes are not overridden when there is a threat to someone’s life. It allowed Cynthia to see the risk to the individual, as well as herself, and she subsequently took responsibility for the decision to report to the police.

Theme 3: Practice Culture

The culture of safeguarding practice was revealed through common patterns throughout the data. These appeared to be some of the unconscious factors within the environment and their influence on decision making is explored. Repeated examples of hostilities experienced by social workers and the continuous questioning of their abilities, exposed an unconscious dominant narrative that suggested social workers were incompetent and could not be trusted with decisions. This was likely exacerbated by the presence of organisational or statutory anxiety linked to the need to demonstrate good performance and the fear of consequences when it was perceived this was not happening. The safeguarding practice environment included evidence of both punitive and progressive approaches by the organisation. Evidence shows that practitioners struggled to reflect on their own

decision making. The (positive) experience of the interview space is described and the possible reasons for this, more fully explored in the discussion.

3.1 Perception of competence

"*And this job can, like I think the social workers will say that it can really wear you down. Sometimes you can be made to feel as if you are not really the expert."*

Sameera is talking about 'expertise' and being an 'expert' within this area of practice. Most interviewees described various scenarios where they felt their expertise or competence was being questioned. There was a culture of questioning or undermining adult safeguarding practitioners' competence. Cynthia explained that this came across in the way other professionals treated her: *"When you meet with other professionals if they have that negative viewpoint, like you feel that, I don't know how to explain it - sometimes it's attitudes or hostilities."*

The hostility that Isabela experienced from the neighbour was outlined earlier. Isabela later received a letter apologising and saying they did understand that *"I actually did a good job by going there dealing (with it) and asking questions".*

Participants described examples of where their competence was called into question when they attempted to advocate for the adult's wishes. This tended to happen when individual wishes were not in line with other professionals' 'clinical judgment'. The hostility by other professionals, meant safeguarding practitioners found themselves having to regularly defend their views or approaches. Sameera reflected on how she tried to manage it: *"And you get to this defensive…well I think this, because of this…and then you think…aah hang on a minute, I don't need to be this defensive. But there are days you are so…where you are like constantly battling..."* Negative perceptions of competence appeared to result in practitioners' decisions constantly being questioned and them unfairly having to defend their position.

Sameera, as the team manager, admitted that she questioned the competency of some of her team members. After discussing one of the team's complex cases where someone had died, she reflected that: "…*it left me feeling, kind of, do I actually trust people going out there and doing the assessments?"* Despite no questions being raised about the quality of the decision making, or 'failure' in the case she was referring to here, Sameera's reaction suggested that following a

death, the surrounding anxiety may lead to questions around competence. She goes on to admit that at times she felt incompetent herself: *"sometimes I feel it really comes down to me – and I'm not necessarily equipped or the right resource for all that.."* This left her feeling vulnerable as the manager: *"it's made me kind of think about how… I can safeguard myself, and the work I do.."* Sameera denied that the cases she had discussed in her interview had impacted her decision making. However, in her follow-up interview, she talked about wanting to be '*surrounded by experts'* and that she felt she needed further development and training.

"They believe that when they report it to social services, we can do something about it."

Serwa was talking about one of her cases (6.2) which left her feeling powerless to help someone in a terrible situation. When she described it, her feelings of helplessness were clear and overwhelming. I was left wondering whether the impact of this strong emotion led her to give up. She almost laughed at the expectation that social services would be able to do anything when these types of safeguarding referrals were sent to the team. She also defended against helplessness by suggesting that social services are not or should not be responsible. *"We get dragged into the conflict but can't really help*: *we try our best to point them to the right direction…but sometimes it doesn't work. It doesn't work, sometimes it doesn't work".* This was followed by silence and a sense of futility.

"Discrimination – it is just a reality"

In both interviews, Sameera spoke about prejudice and discrimination. She described how the presence of (the policy) 'equal opportunities' meant that these issues were never discussed but that "*whilst we are clear we can't discriminate, we actually do do that unconsciously."* She asserted that this '*was not all negative'* and referred to 'positive discrimination' and laughed, saying other professionals often assumed she was a doctor. She exhibited difficulty in finding a way to explain this to me which reflected her cautiousness in sharing this opinion with me and simultaneously her courage to do so:

"I approached things very, kind of, almost, kind of, I approach the subject, and I'll let the person know that I know what's going… say if it's a worker or somebody's been

quite, kind of, um, possibly could have, you know, there has been a comment before, but how come they got services, they're from overseas? And I think, wait hang on a minute…. You know, you have to be very careful…"

She reveals how challenging it is to respond to team members who hold discriminatory views and, in her follow up interview expressed: *'I work with a lot of people who won't admit they have fixed views. And that's a challenge'.* She also indicated that she was aware of how these views might affect her team members' responses: *"your economic status and your, where you live impacts on how you're received".* She talked about social work training around equality but questioned what this meant if '*you get the talk but after that….do you actually walk the walk (laughs), I don't know? I don't know*'. She doubted whether training addressed the reality of discriminatory views and behaviour effectively.

3.2 Statutory anxiety

The Care Act says…you hold the overall responsibility for safeguarding and you have to be robust, and you have to be….and that's a big kind of task – that's a big ask, and actually do we have enough resources to really fulfil that responsibility?

Sameera asked whether the statutory expectations to safeguard can be achieved. What was evident is that when things went wrong, everyone felt criticised, including the manager: *"And people say, I'm always criticised, I'm always criticised. But I feel it too – on a different level."* The criticism may reveal an organisational culture punitive in its reactions to anxiety-provoking situations.

Vivienne described a scenario where one of her clients dies and panic ripples through the organisation:

So, people all around were running back and forth, deputy head of service was being phoned... I could see on the floor, people walking backwards and forwards, people, like, saying the manager was off that day, so we had no manager and then I walked out of that room. I calmly called the police officer I had been working with and learnt it was not suspicious…I was able to do a summary of the safeguarding, a summary

of what we know about him passing away. And I sent it to everyone, and I sat back – and I still saw everyone else stressed out by it, but it was my safeguarding enquiry.

She remained calm but told me it was an 'an uncompleted case' – referring to a case still 'on the case recording system'. She was mindful that she might be accused of wrongdoing. She calmly responded by speaking to the police involved and clarifying the facts of the situation to the senior members of the organisation. She explained that normally she would get support from her manager, but the manager was away. Vivienne had to deal with the shock of losing one of her clients, whilst simultaneously needing to contain senior people within the organisation about the death. She also had to contain her own anxiety around being held responsible for the handling of the case.

When the manager returns, she described the scenario as a crisis and that Vivienne had 'shielded her' (the manager) by the way she handled it. Vivienne believed her years of safeguarding experience had enabled her to respond differently to these kinds of scenarios: previously she '*would have been that person out there going "OMG",'* but now she felt she had developed in a way: '*to keep a level head shall we say? And not to kind of join in with that – "anxiety", and just think, this is what you need to do, in that order'.* Her experience with life and death cases meant she was more able to step back, see the organisational anxiety, and seek to de-escalate it.

Responses by team members included them trying to cope with or even manage the organisation's reaction. This contributed to what appeared to be an 'organisation versus team' dynamic. Team members seemed to stick together against the wider organisation which supported internal team cohesion against the perceived outside threat. The case described by Sameera (1.3) highlighted the emotional impact of this 'statutory anxiety'. The following longer clip captures Sameera's nervousness as she anxiously described the situation, the response by her team, and her reflections on what happened.

"…it took a lot of hard work because this lady – the mother had complete capacity. She wasn't being put under undue duress – she loved her daughter. She'd always lived with her daughter. She said she's always been like this – they'd live their whole life like this but as she was getting frailer and frailer, her daughter was causing her more significant harm. It didn't go to the Court of Protection because she had capacity but also um, a compromise was reached where it was agreed that the

daughter would go and live in a care home. But she lasted two days in the care home and went to live with a friend. So it – that was (laugh) so it well it was a non-starter – but…the daughter kind of kept boomeranging back home – the worries continued, the daughter kept going into hospital because of her own condition, and so just constant like to and froing and on the last occasion, the local authority was kind of digging its heels in saying 'we don't want her to return home because she's a risk to her mother' and you had like the hospital saying well 'we can't keep this daughter in hospital so what do you want us to do with her? – you know, she's well now. She needs to go.'

And – then a compromise was reached that you know, the mother would be given some support at home and the daughter would be given some care at home and, um, so she, the mother would have to get up at night to tend to this daughter who was actually mobile, but would have these dropping seizures, or something like that anyway, what happened was – she went home on a Friday. On the Monday, the social workers were asked, you know, there is nothing we can do, we can't prevent her from going home and the mother is saying I want her home –and I can't prevent this. So she's gone (went) home and it's agreed that we will have some sort of rapid response kind of support over the weekend, to check in on her but to check on what? Because the police were saying: "We're not going. This is not a high risk – we respond to 999's – we're not going to do a welfare, so over to you guys". (Takes a deep breath).

Anyway, so a social worker would go out and start their assessment again, and just check touch base with them, see how things were going, see how the weekend had been. (She starts to whisper). Anyway, when the social workers arrive there, she sees a body is being carried out. And the social worker just fell to pieces. Because her immediate thought was that this daughter has killed her mother. She thought my god what has happened and she literally, she aged there and then – she started thinking "OMG, OMG this poor woman….OMG OMG, we let somebody go home and she's gone home and killed her mother. Anyway – I'm talking about this is the reaction, but actually what had happened, her daughter had died. I'm saying this confidentiality cos it's still…kind of like, um, the daughter had died – she died in her sleep. She was ill. She was unwell. Natural causes. But what had gone through these two social workers' head as they were both holding each other's hands, going: "We are done for". This woman is dead. We allowed for this to happen." But it wasn't!

So, when the social workers came back, I was explaining to them – but you don't, this was a collective decision. It wasn't a decision of yours. It was a decision that went all the way up and all the way back down and we collectively made this decision together. You were not carrying risk on your own. But we were carrying it together. And it's about that kind of, having that, sometimes you want that having that unifying people to feel more confident, by saying actually…because I have had people who can't make decisions. And that's why you've got decision makers."

The start of the clip (again) summarises the difficulty practitioners face when an individual can make their own decisions and chooses to put themselves at risk. The notion that 'there is nothing we can do' reflects feelings of helplessness in the context of abuse. However, despite the difficulty of 'not having the power' to make decisions on behalf of the person, practitioners were able to take a range of actions. A compromise was reached - the daughter agreed to go and live elsewhere. Sameera considered this a 'non-starter' given it was not successful. The decision however demonstrated proactive attempts to reduce the risk. A mother's desire to keep caring for her daughter appeared to be appreciated, but there was perhaps less understanding of the reasons for the dynamics of their relationship. The mother had been caring for and living with her daughter for some time. The daughter had been dependent on her mother. Any separation would have difficulties.

Sameera referred to the daughter's undiagnosed mental health needs and how they affected the situation. She did not, however, reflect on why they were not addressed. She brushed over the daughter having 'drop seizures', a significant care need. It seemed that the daughter's abusive behaviour toward her mother and the anxiety around the risk this presented to an elderly woman, may have interfered with practitioners' abilities to recognise the extent of the daughter's own needs. This in turn seemed to impact their ability to identify ways to address the complexity of the situation. Despite going 'out to start their assessment again', which suggests practitioners had visited on a few occasions, their assessment did not appear to change.

Sameera was encouraging and supportive to her team members. She had worked hard to foster a team culture that was perhaps (even if perceptively) kinder than the wider organisational culture. Team members expressed feeling 'able to vent' their

frustrations. She showed an awareness of her team's emotional needs and proactively tried her best to reassure them. In the above scenario, we see her move to reassure her team members about what happened by trying to remove their idea of individual responsibility around decision making and replace it with one of collective decision making and a clear 'chain of command'. Initially, it appears to be a supportive approach to make team members feel like they do not carry risk alone, to unify them and restore confidence. However, it is then contradicted when she moves on to suggest that 'some people' cannot be left to make decisions and therefore their responsibility should be removed through a hierarchy of decision makers.

3.3 Practice environment

Punitive processes:

Cynthia described an experience with the organisation as something that "really hurt me". She had just started in the safeguarding team as a senior. A certain university had been brought into the local authority to discuss how social workers deal with cases. Her case was selected, and she was told that it was because it was 'complex'. She described the experience:

So I went there (clears throats) with everybody from the safeguarding team. And at that time, I didn't really know people in the safeguarding team, because I had just joined. And then basically, these people from xxx um, brought up my case, the circumstances and...they just basically criticised me, like for the whole hour – saying that, that I hadn't handled the case properly, that um, I didn't give the husband any support, that he was under stress, because he was caring for his wife with dementia, and why didn't we get involved sooner and, you know, I didn't give him any support. And my focus was on the wife and all this. And because I was new to being confronted like that, (clears throat) because I had just gotten into the post as a senior social worker. So I wasn't used to that kind of challenge. I got really, really angry. Because I felt that I had worked really well with this case. And it was really challenging. And I got so angry at being criticised, and everybody could see it on my face, I actually left, that I just walked out. And I was like crying in the bathroom. And the manager came to find me, and was trying to explain that these people are called critical friends, that they criticise social work cases, for learning purposes, but the

way that they did, it was not constructive, I found that it was very destructive because I was ready to give up social work, to be honest, after that.

This experience left her 'demoralised' especially painful and unfair given she was a new senior and one of the few Black members of the team. The example exposed how the organisation had attempted to provide a reflective learning space that ended up becoming yet another example of persecutory criticism. For Cynthia, it was not well-handled, and the negative impact was so severe that she wanted to leave the job.

Andria's view of the organisation was that it was applying a business model (instead of a human one). The focus had become about saving money instead of caring for people. She described intense scrutiny of their work and unfair expectations of social workers such as keeping spreadsheets on 'their spending' (described earlier). She whispered when describing how the independent 'consultants' brought in had no social work training, and so none of their recommendations were effective. She referred to the organisation's current restructure happening without consultation with staff. One member of her team was told by email that she was moving teams. Poor communication and decision making by senior management led to rumours, distrust, and fear. In her view, the nature of the work was challenging and the volume of the work '*physically impossible'* without enough staff. She felt that when things 'went wrong', the response was interrogation, not support. She relayed the impact of heavy or horrific cases and the lack of emotional support such as debriefing or counselling: "*no one ever asks you if you are ok".* She described one manager telling her to at least be happy she had a job.

New processes:

Examples show the organisation trying to improve. This included openness to trial new ways of working and different approaches to decision making. Training on motivational interviewing had been rolled out. 'Team huddles' were implemented and Sameera felt that they supported team members by providing opportunities to come together 'almost like group supervision'. It challenged practitioners to think about whether they were coming from a too risk-averse or too zealous approach: *"Whereas actually, when you look at it together, you might say, we're going to keep going back…look at a case, and think about it, and somebody, may bring a problem and say, Look, I think I've tried everything, has anyone got another idea? And it's a*

really good brainstorming approach….it's a really good way of, being able to talk about that case quite openly…And people will say well I've had something quite similar – and this is what I did in that situation, or have you thought about…?" It seemed that the provision of a group reflective space may have enabled team members to explore different decisions with support from their peers.

Sameera reflected that some of what the organisation had trained her staff to do, often did not help them in safeguarding due to 'hidden abuse': "*My team was saying you dealing with, day in and day out quite complicated situations, complicated situations with families that don't always tell you the truth. You can't use them dynamic, motivation or systemic kind of interviewing techniques because people are all/might be trying to cover up in certain situations or not be true to themselves*." She argued that 'even recommended techniques' did not help practitioners obtain all the information required to make effective decisions.

3.4 Space for reflection

3.4.1 Experience of the interviews

The following theme was unplanned and unexpected. Each participant commented about the experience of the interview to such an extent, that it was important to consider the reasons. I describe what participants shared and then analyse possible reasons in the discussion chapter.

Sameera

In the first interview, after 35 minutes of talking non-stop, Sameera said she felt 'talked-out' and invited me to ask her something. Her initial experience of the interview perhaps felt strange. In the second interview, when asked what thoughts the first interview had left her with, she did not talk about the cases or content of what she had discussed but described the experience of the interview. The first interview was not 'too traumatic' which perhaps emphasised her feelings of anticipation. The interview space may have been difficult and helpful. She said she was used to having a 'two-way conversation' and found it difficult to talk about something without getting a response. This may have left her feeling vulnerable, particularly in front of someone she viewed as a peer – and the silence made her

'want some sort of professional reassurance' to what she was saying. After the interview she had thought about getting a mentor. However, this was because she felt that "*(it) would be good to be able to speak openly about cases without fear of judgment."* The interview space to talk freely with no interruptions may have felt good; however, with no feedback or response, may have left her feeling judged and insecure. As a manager, who must be seen as knowing more than others, she perhaps had no space to admit feelings of 'not knowing' and to obtain reassurance and support.

Cynthia

After her first interview, Cynthia said she felt '*happy that I was able to express how I feel' and to be 'able to talk about some of these issues'* particularly because she found the job stressful and that '*social workers don't get much understanding from other professionals'.* Both signalled that she felt the interview space provided those.

Sam

Sam had been keen to be a part of the research from the beginning and spoke candidly in the interview about the case that had impacted him. It seemed that once he felt safe in the space (he took a great deal of time to read the confidentiality statement and asked me to only use his first name when referring to him in my write-up), he felt able to talk about the impact of the case in a way he had not allowed himself to do with others: *"I haven't um. Like for example, I haven't spoken to my family about it, or even my friends" and that "I don't have, like, in-depth conversations like now…"* He believed his emotions should be *'kept under wraps'.* At moments during the interview, he took deep breaths in and out, suggesting there were painful feelings that were hard to talk about.

At the end of the interview, he reminded me that whilst he had spoken openly with me, he did not talk to others and 'understood confidentiality'. He asserted that he knew the rules around confidentiality and did not break them. The reason he did not talk about his experiences was that he was tired, wanted to relax after work and on the weekend: *"I want to think about something else something different".* It seemed he wanted to show that he knew how to cope; however, his anxiety suggested

otherwise. He left the team and did not respond to the request for a follow-up interview. It may have been that opening up in the space felt difficult afterwards.

Isabela

Isabela used the interview and follow-up interview to talk through the cases that had had an emotional impact. She was very open about it. She did not seem to be sharing anything she had not shared elsewhere. Her account in the follow-up interview was almost word for word, to the extent that it sounded rehearsed. She seemed unable to move forward emotionally despite having been provided with supervision and support. She struggled with the silences in both interviews and prompted for questions.

Vivienne

Vivienne spoke about the inadequacy of supervision, and she reflected how her supervisor always immediately moved to reassure her when issues arose e.g., her client dying. She explained that whilst she found this complimentary and made her feel better in the moment, she was not '*given that time to process that yourself and to genuinely feel whether you've, that guilt is valid or not – do you know what I mean? And so, I think sometimes just silence – and letting someone talk, that you can validate feeling – if you process that feeling – you can't just have someone say to you: "No you did everything" and that fixes it.*"'

She also explained that supervision was '*still a professional space'*. If a supervisor asked if you were stressed, Vivienne felt she would have to put on a front: *'how you feeling? Stressed?' "Noooo", you know but really you are, um and you say, No, everything's fine. And you develop a culture, where you don't want to be seen as the stressed-out one. And I think when I had that interview with you, I didn't feel the need to have that front".*

She found that she had not '*reflected on the situation I've just spoken about until kind of now really and reflected on how I've changed as a practitioner until right now – which is crazy'.* She felt that she had said more in the interview space than she had ever really before and said, *"I suppose it's just being given the space – so I hope you've got a lot out of it cos I know I have."*

Andria

Andria said she found the interview space '*like a counselling session where I'm offloading'* and concluded she would like to offer something similar in her supervision with others.

Serwa

Serwa was an anomaly. She agreed to be interviewed however cancelled or did not show up for the interviews despite confirming. This was an interesting contrast and I wondered whether there was a part of her that wanted to participate however as the time came closer, the prospect felt unnerving. The cases she discussed elicited tremendous sadness and 'heartbreak' and perhaps revisiting this was too painful for her.

3.4.2 Ability to reflect on decision making

In the follow-up interviews, each participant was asked how the cases they discussed (in the first interview) influenced the way they responded to cases now. Participants' responses provided some insight into how able they were to reflect on their decision making and practice.

Sameera

Sameera was able to reflect on decision making in general but seemed more guarded about her own. She talked about cases she was indirectly involved with, so included the wider team's decision making. This may be why at times she came across as rejecting responsibility for some of the decisions or questioning the capability of her staff. It was difficult to know where she had made final decisions herself; certainly, she had not for the domestic homicide review case (1.2). She pondered the dilemma of decision making in the case (1.1) where the man with dementia was found tied to a bed and later died in hospital. She appeared to suggest that the dilemma was over the presenting risk and wondered whether her team should have done more. She talked about creating "*space for the family to try and resolve some of the issues"* and this part of her account may have been her trying

to reinforce that she (her team) had made the right decision to withdraw when they did. The family had been actively involved, refused the support offered and so she felt they should be held responsible for the outcome.

She stated that decision making was *"about risk and the need for a good risk assessment".* She viewed decision making as a skill and about having an inquisitive mind, which involved spotting the 'unsaid stuff' and getting a full history. She claimed it was the part of the work she enjoyed: "*I like that. I like that about this work*." This, however, seemed to contradict an earlier comment about abuse being hidden, and why the work was so difficult, implying that practitioners should not be held responsible for when things go wrong. In response to the question of how the domestic homicide case might influence the way she responded to cases today, she said: *"I think very, is exactly as not being really well, but I think it's kind of, there's a risk of you being absolutely too productive or too – sort of, you know what I mean?"* This excerpt is hard to make sense of. In the recording, you can hear her struggling to find the words to respond. It is unclear what she meant by the risk of being too productive. She went on to talk about how she had to explain to someone demanding a certain response (on a different type of case), that a specific process had to be followed.

Andria

In her first interview, Andria reflected on her decision making after the hoarding case died and recognised that she had held onto another hoarding case for two years 'because of that case'. However, when asked in the follow-up questions about whether the case(s) affected the way she responded to cases now, she became almost offended, as though her ability to offer the same level of support to the next person was being questioned: "*I would have thought that the way that I worked with her I would be consistent regardless of what the concern was, I would always want to be giving the best of me, regardless of what effects it might have on me or if it's something that presses a nerve sometimes which sometimes they do".*

Andria repeatedly came back to the question and denied it had changed anything. She reflected on her decision-making responsibilities as the safeguarding adults manager (SAM) in that "*when things go wrong, the buck stops with me*". However, her reflections were about the decision-making issues of the wider system and about others' failures. She also admitted that she had felt forced to think about how to

sustain herself in the work. This may have revealed her true feelings around the lack of emotional support and perhaps her acknowledgement of its potential to affect practice.

Andria referred to the positive team culture and the liveliness of the atmosphere however said that there was still a wider culture of believing one is weak if you admit you're struggling. She concluded that she would raise this in team meetings and in her supervision to check if anyone may be feeling unable to say what they were feeling. Quite like Sameera, she thought about the emotional well-being of her team and wanted to create safe spaces for them too. This might have been particularly poignant at this point in the interview as she came to express how she did not have enough of it for herself.

Isabela

Isabela demonstrated an ability to reflect on her cases; however, she moved from conclusively saying she could not have done much differently, to asserting the importance of risk assessment and working with family. Nothing suggested she had not risk-assessed or worked with family (case 3.2), quite the opposite. As such, her account seemed superficial and lacked a depth of self-understanding.

Serwa

"*So some decisions might go well. Some decisions will not go well, and you can, and you can like me, I carry the cases with me when I go home, I don't want to be holding onto things thinking: 'Oh I should have done this? Or what can I do better? Or I haven't done this, I should have...'*"

Serwa describes her experience of decision making. The impact of decisions not going well seemed to cause her to reject having to reflect on her decision-making process and possibly accept responsibility for some of her poor decisions. Serwa talked about having to 'keep emotions separate'. Deeper reflection of her cases and own decision making may have been too difficult because it elicited difficult emotions. This was apparent in her reluctance to be interviewed and repeatedly cancelling or rescheduling her interviews. In the case of the scammer (6.2), she

attributed poor case outcomes to others placing the responsibility on the incapacitated man or the police.

Vivienne

"I don't think there is a victim and a perpetrator in 90% of those safeguarding cases...I feel that you scratch beneath the surface, and you find out what is going on for people, and that is how you make proper change – it's understanding how we got to the point that we got to."

Vivienne remarks on the complexities of the primary task. It demonstrated her understanding and how she considered it in her decision-making process. She did not know why she became a social worker. She suggested a possible personal link, given the experience with her son but had only thought about that during the interview. She knew what motivated her but did not seem to be able to say why. She recognised her passion for justice and her 'bug bear' of premeditated abuse, but she was unable to say why she had these specific views and feelings. She talked about the journey of becoming a social worker at the turning point when you realise, '*you're not the only saviour'* and acknowledged that she started out trying to save the world. She felt that she was more aware now. However, despite recognising the advice she had been given about burnout, learning to have boundaries and that she 'can't save everyone', she continued to struggle with all these things. Her reflections exhibited a disconnect, with part of her knowing her behaviours were 'against' good practice, but unable to stop them. This was illustrated when she described one case:

"it was always quite a lot of like fighting in his corner because he didn't have anyone else. And I was a bit concerned (deep breath), I was kinda overstepping the mark. The strangest thing is that there were never any safeguarding for him. And I ended up having him for nearly 18 months, 2 years…so probably that is something I need to, um, reflect on and look at."

She said something 'within me' kept some cases open and that she did not understand why she felt so much responsibility when things went wrong. She continued to overwork and take on more than she should including taking on a student. She pushed against the limits set by the organisation or did not comply with the rules although the benefits of the organisational (financial) restraints meant: *"I can't do exactly what I want to do…which is probably a good thing for me because I would have..."*

She seemed to teach the student the very thing she struggled with: *"I say: you don't go straight to 'fix it stuff' – there's a process you go through".* She admitted that taking on a student meant she was being forced to look at herself more deeply than usual and admitted that following the death of one of her clients, she had felt stressed and anxious that the student was watching her. She showed an awareness of reflection and recognised its importance; however, she was not yet able to integrate how some of her values and possibly unresolved personal history, affected her motivations and judgments.

Cynthia

In response to the question of whether the experiences of the cases she discussed influenced the way she responded to cases now, Cynthia described:

"*Hmmmmmm…..hmmmm….No. I, I tried to give other professionals the benefit of the doubt. But, um, (breathes out) it was difficult for me in [LA name] when I was a senior because I, I found that I just wasn't getting support from professionals that I needed…You know, I had the support of my team, my colleagues, but trying to get other professionals on board. I always found it was, it was a battle sometimes…"*

Not unlike Serwa, Cynthia's reflections on the case centre around other people not taking responsibility. She felt unsupported and attributed the difficulties of the case to other professionals outside of her team (usually the police). The first case Cynthia described was also the first domestic abuse case she had dealt with. She described it in detail and articulated the complex dynamics that she felt she '*recognised at the time*'. Despite her inexperience then, she offered no reflections on what she had learnt since. She did not accept that she could have done anything differently. She went through each aspect of it to justify this. As described earlier, this same case was subjected to scrutiny by an outside professional, who believed that lessons could be learned about what could have been done differently. She admitted her own experience of domestic violence was *"why I was also very disappointed that with these two cases, that the police didn't do much",* and as such, was able to an extent, to reflect on how her personal history affected her feelings. She was less able to consider how this may have affected her decisions or judgments on the domestic abuse cases she dealt with in her work.

3.5 Summary of Interview Findings

The cases discussed in the interview process revealed several powerful patterns which helped to identify potential emotional and unconscious factors that influenced decision making. Some of these were overt whilst others shone a light on the wider context. These affected practice and the ways and reasons in which decisions made. The influence of the social worker's personal history was perhaps both an emotional and unconscious factor. Sam's close personal identification with his case of a woman who he saw as someone who could have been his mother, personalised his decision making. This resulted in him persisting where others had not, and he saved a vulnerable woman's life. Similarly, Andria's identification with the case of a young woman who she saw as someone who could have been her daughter, personalised her response and meant the young woman received compassionate support, whereas others had perhaps interpreted her distress as lies. Interestingly, this identification also appeared to prevent her from succumbing to the dominant view held by other professionals. This indicates that it prevents the influence of the often-seen cognitive bias - 'groupthink'.

Some participants shared experiences relating to struggles of being a single mother, dealing with discrimination against their child who had a disability, or experiencing domestic violence. These experiences had very specific impacts and they clearly affected their decisions. The examples revealed their positive influence such as how the passion for injustice drove them to get the best for their clients or to challenge discriminatory practices or systems. Some revealed how these same passions may have inadvertently caused them to lose sight, misjudge a situation or push them to take certain actions. The latter included trying to safeguard a client, which was not expressly wanted. Several participants had underlying motivations and seemed to imagine they had more power than they did. This led to their perceived failure to help and 'achieve a positive outcome'.

The impact emotionally of not being able to help in the way they wished to, also conjured up strong feelings like guilt, anger, and sadness. These emotions were further elicited due to cultural differences with some participants' own identity being tied to helping or their experience of the perceived contrasts between their own culture and the one in which they were practising. This influenced perceptions of or

suitability to take, responsibility over decision making, i.e., the family's responsibility versus the social worker's.

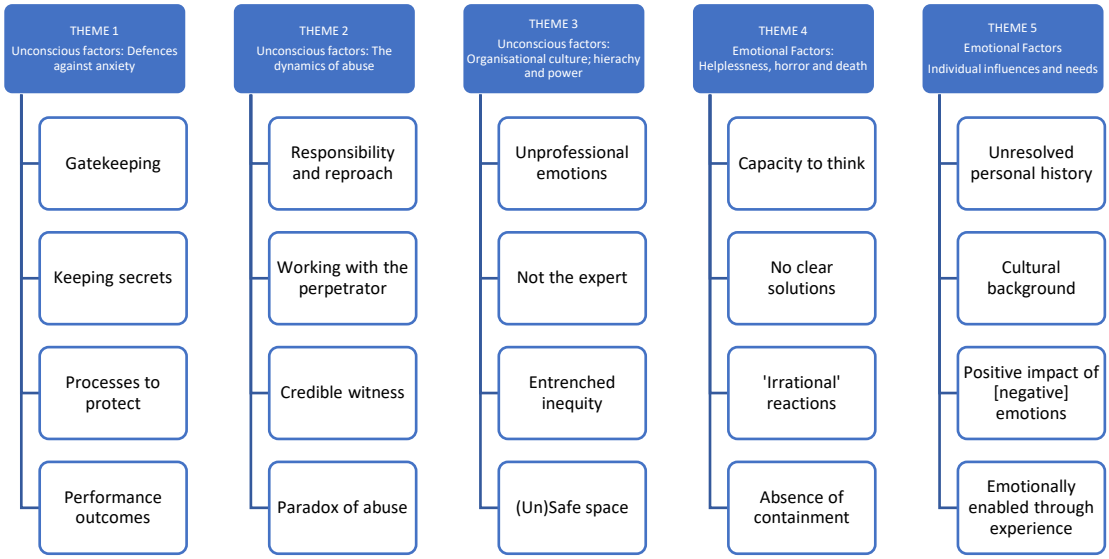
Further emotional factors were revealed through cases where severe abuse or death had occurred, participants who were inexperienced and from the burden (felt) of responsibility. The impact of all of these factors revealed how anxiety-provoking making decisions was; how the right decision to make was often not known or decisions were questioned or undermined by other professionals which in turn made it difficult to make them. It revealed how practitioners often felt unsupported in their decision making or attacked. This caused them to feel they had to defend their position or to resist their leadership responsibilities. The culture of safeguarding practice exposed both punitive and progressive processes. There was evidence that social workers struggled to deeply reflect on their decision making and that current methods of supervision were not effective in providing a safe space for meaningful reflection including on the quality of decisions being made within their cases.

Chapter 7: Discussion of findings

In the last two chapters, I presented the findings from the Observation and Interview data sets. This chapter sees me triangulate the key themes from across the entire data set. It seeks to provide a reflective critique of the findings and discuss other points of interest that may have been revealed.

The triangulation process allows me to collate data from both data sets more confidently. I have presented my findings using headings and sub-headings to show the data in relation to published literature. As I set out in the Methodology chapter, by triangulating this information, I hope to ratify my findings.

Table 3 below is the themes from the overall findings:



These have been divided into inter-related clusters to address the main research aims:

1. identifying the unconscious and emotional factors that impact practitioners' decision-making.
2. whether the nature of the work impacts on decision-making; and
3. how the stories of the people experiencing abuse or neglect impact on practitioners, their practice, and decision-making.

In the discussion that follows below, I answer the secondary research questions (SQs). I have not answered these sequentially (eg SQ1, SQ2, SQ3 etc), but preferred to refer to each of them in brackets within the body of the text (eg *The manager's own anxiety was notable throughout the Observation and interviews, which provided an insight into how the work impacted her personally (SQ3)*).

SQ1: Can an attendance to the emotional factors in the work through an observational stance help us understand why and how decisions about safeguarding adults may go wrong?

SQ2: How can this understanding inform the support adult safeguarding practitioners require from their organisation in order to make good judgments about the people they work with?

SQ3: What types of emotions arise in adult safeguarding work and how does this impact on practitioners personally?

SQ4: How does the emotionally charged nature of this work affect practitioners' decision-making?

SQ5: How are the emotional and unconscious dynamics of the adult safeguarding cases transferred into the organisational environment?

SQ6: How does the way in which the organisational environment responds to adult safeguarding cases, affect practitioners' ability to make decisions in this area of work?

THEME 1: Unconscious Factors: Defences against Anxiety

Psychoanalysis teaches that much of what happens is driven by unconscious defences against anxieties that we do not wish to consciously face. In my research, anxiety was ubiquitous and exposed repeatedly through psychic and social defences deployed by individual safeguarding practitioners and the wider organisation's behaviour.

Safeguarding work provokes a range of involuntary and unwanted emotions. Even anticipation as 'expected emotion' generates anxieties that individuals and organisations find difficult to manage (Lowenstein and Lerner, 2003).

Structural anxiety seen in this organisation was exposed through Observation themes of veiled surveillance, rigid process confusion, statutory identity, and hidden decisions. Through the Interview data themes, it was seen in statutory anxiety and negative perceptions of incompetence.

Personal anxiety was unearthed through the Observation sub-themes of suspiciousness and the use of 'laughter to bear' (the difficult emotion). Through the Interview data it was seen in 'failures to help', and the emotional factors.

These combine to make up specific behaviours that fit Menzies-Lyth's psychic defences or Jacques' social defences. The ways in which these unconscious factors presented, and impacted decision making are explored in more detail, below.

1.1 Gatekeeping

Entering the research site frequently was not straightforward. Before starting my research in earnest, I had to go through numerous hurdles to enter the building and the team area. Team members were very suspicious of me and I was at one point challenged by a member of a neighbouring team about the purpose of my presence. Some of this was entirely understandable owing to the confidential nature of the work and setting. However, my sense was that bureaucratic gatekeeping was embedded in the organisation as a controlling function. Perhaps social workers were expected to gatekeep on its behalf or protect the organisation from outsiders.

This links with Bion's (1962) theory around groups and specifically fight-flight basic assumption in groups, where behaviour is focused on protecting one's survival from external threat. Gathering information through research could be comparable to an adult safeguarding enquiry. Issues of consent arise. Those being abused or being accused of abusing, can experience the safeguarding process as intrusive and may refuse to engage. This is also especially relevant if someone has not consented to an enquiry, or the facts are yet to be established about whether the accused is really an abuser.

The fortress mentality was likely a defence against anxiety stimulated by an external visitor observing internal organisational and practice realities. This finding concurs with safeguarding literature which shows gatekeeping as a psychological defence used to protect professionals from feeling overwhelmed (Ash 2013, Whitaker 2014, and Aylet, 2019). Aylet (2019) suggests that the very adherence to criteria-driven decision-making means that abuse or risk of abuse acts as the first gatekeeper to safeguarding services. Gatekeeping within safeguarding has also been seen when incoming referrals are deflected by disputing responsibility (Ash, 2013). The gatekeeping seen was clearly a response to the anxiety generated by the emotionally charged nature of the work (SQ4). It was a social defence and the way the organisation attempted to contain anxiety. Gatekeeping can control how, when and by whom decisions are made. It can limit how much decision-making is required and who potentially witnesses decision making processes.

1.2 Keeping secrets

Sameera's enquiry of exactly what I was hoping to observe in the team, and her comment that their team made decisions according to agreed policy, suggested that even my proposed observation felt threatening. It suggested that the team were worried I might see something in their decisions or decision-making process. 'Hidden decisions' emerged as a theme because at points during the Observation, I was not witnessing any decision-making. The seminar group postulated that as most practitioners were working from home, most decision-making might not be visible. Foster (2009) refers to research which shows that social workers flourish with autonomy to make decisions and often wilt under autocratic regimes. Practitioners undertaking adult safeguarding work may have felt they had more freedom and autonomy over their decision-making at home, without the watchful 'eye' of the

organisation. The way in which the organisational environment responded may have affected practitioners' ability to make decisions, especially when in the office (SQ6).

Andria decided to continue working with her hoarder case in secret. Keeping cases open long term was contrary to the organisation's agreed practice. Her approach is the "antithesis of the 'assess, review and close' process that dominates current care management" (Braye et al., 2011, p.188). Andria believed that the organisation's stance was political, in place to manage high case volumes and limited resources. Research literature on self-neglect has, in fact, reiterated that to work effectively with people who hoard requires time (Preston-Shoot, 2019). A relationship must be built slowly, and change can only happen in this context. SARs across London show that self-neglect was one of the leading causes of death in its reviews. These have exposed the extent of the tragedy caused by poor responses to cases of self-neglect (Preston-Shoot, 2020). Andria would usually be prepared to follow procedural guidance but, when faced with this complex ethical dilemma, she acted more autonomously, using her assessment and relationship skills to weigh up the available information (Taylor, 2012).

Her response also fits with Lipsky's (1980) description of street-level bureaucrats (see literature review) where the operation of this type of discretionary decision-making can be seen. By effectively defying the system and deciding to continue to work with the case to build up trust, Andria was secretly trying (and more likely to achieve) a better outcome for her client. Her continuous engagement with the client mitigated his risk of worsening - including death. By keeping it secret, she protected the organisation. Noyes (2015) notes that very often there is tension because a practitioner's decision about what is in the client's best interests can be in direct conflict with those of the organisation. The challenges of decision-making are perhaps kept hidden because decisions are not in line with some aspects of the policy. This raises ethical dilemmas for practitioners like 'this person may die if I do not help' (SQ2). Values and ethics are core to social work practice (Banks, 2021) and these safeguarding ethical dilemmas highlight how practitioner decision making can be influenced by them.

The team seemed to want to show me their decision-making outside of the organisation, or 'usual context', which is why the manager hoped I would see their 'team huddle' or that I might go out on a visit with a practitioner. Sameera's anxiety, revealed in her regular apology to me at the end of sessions, suggested she did not want me to see the team's decision-making difficulties within the organisational environment and perhaps wanted to keep them from the organisation itself. The team may have unconsciously wanted to show me their decisions outside of the organisational context so that I could understand or vindicate them. Obholzer (1986) wrote extensively about how unconscious factors interfere with the functioning of an institution. Organisational (structural) anxiety causes practitioners to feel they need to hide their safeguarding decision making, because the organisation itself cannot cope with this anxiety generating activity.

The organisation did not function in ways that supported practitioners. This might explain the team versus organisation dynamic highlighted in the findings. Team members felt safer in their team than the wider organisation. Practitioners' suspiciousness and curiosity reflected the nature of the primary task: adult safeguarding enquiry demands that a practitioner hold a healthy level of suspicion but maintain a non-accusatory approach – a type of 'professional curiosity'**.** The nature of the work is transferred into the team environment (SQ5). Similarly, the way practitioners felt they must keep decisions hidden to protect themselves, and possibly the organisation too, mirrored the well-known abuse dynamic around protecting the abuser and concealing the truth (see literature review).

Keeping decisions secret from an organisation that responds as this one did, is not only easier, but less threatening, and enables autonomous decision-making. It also enables evidence-based decision-making, suggesting that better decisions and outcomes are more likely (SQ6).

1.3 Processes to protect

The confusion and debates around process, is worth exploring. The literature review discussed managerialism, which is a well-known phenomenon within social care settings. Debates around processes that were observed reveal the impact of managerialism. The need for process rules became intermingled with practitioners'

‘statutory identity’ (see Observation chapter) and their responses sounded robotic. The affective transfer of anxiety around decision making, may have meant that common language, often referred to in the industry as ‘statutory speak’, was found to de-escalate and manage demand, despite sounding monotone. It seemed to reflect that practitioners were unable to think independently anymore, regurgitating a stock response.

The team, and the organisation, appeared preoccupied with asserting, following, or using correct processes. The manager’s own anxiety was notable throughout the Observation and interviews, which provided an insight into how the work impacted her personally (SQ3). She perhaps relied on having routine systems and rules to manage it.

The data shows several clear examples where processes were fallen back on or caused confusion. I witnessed several discussions about process: what it was and how to apply it. It occupied a great deal of team members’ time and seemed to be a popular topic. Serwa, for example, sought to reassure her client by pointing to the ‘process that must be followed’ in relation to her care home fees. The process itself acted as a security blanket and informed Serwa in her safeguarding response around the client’s care arrangements. In this case, ‘the panel’ made decisions around payments. Serwa could rely on the process in seeking to allay the client’s concerns. Processes are therefore seen here as the social defences against the difficulty of weighing up or responding to difficult decisions (SQ6). They serve to protect against the anxiety generated and to contain it (Whitaker, 2014).

Team members frequently expressed annoyance when others did not appear to know procedure. This may have been an unconscious defence to being questioned or being unclear about the correct or most effective process themselves. There were several occasions during the Observation where ‘the correct process’ was debated amongst team members with demonstrable emotional annoyance. On a day that the manager was out of the office, the team appeared unable to make clear decisions about self-neglect referrals. It raises the question of the extent to which the team were able to make decisions on their own. The system may have inadvertently ‘infantilised’ them and therefore their decision-making abilities. The seminar group members reflected that adult safeguarding did not seem to be as developed as child protection and that the team under observation seemed to be in its’ infancy in terms

of understanding the primary task: those referring were confused and leadership direction was either unclear or absent.

Another example was seen when Sameera was annoyed and did not want to think through the process around pressure sores so asserted that the same process continue. There was no obvious rationale for her decision. She may not have been clear about what to do with these cases. Processes that became unnecessarily bureaucratic may have been borne out of not knowing and the anxiety accompanying it. Decisions are taken based on a 'just in case' rationale, rather than on actual information related to the safeguarding issue. This was discovered by Whitaker (2014) who remarked that familiar ways of working were clung to by social work practitioners, even when it was clear that they were no longer relevant or appropriate. The manager here adopted prescriptive and inflexible ways of working because it reduced the need for active decision making (Menzies-Lyth, 1989). The above scenarios also demonstrated how much time was wasted debating the process – a consequence of which was delayed decision-making in potentially urgent safeguarding situations. The 'not knowing what to do' may reflect how victims of abuse feel and how this gets transferred into the practitioner and projected into the wider system (SQ5).

The impact of managerialism appeared to bleed into external organisations in relation to the adult safeguarding processes. Other non-social work professionals with safeguarding responsibilities appeared to not know what to do. This was observed when the hospital contacted social care to ask if it should report a crime to the Police. Also, where the care home wanted to be told what to do about their suspended staff member and could not accept the reply when told it was their decision. Emotional annoyance expressed by Serwa during the call revealed that she too may not have been certain and perhaps why she agreed to speak with her manager. Wanting to be told what to do, and confusion around who the decision-maker is, and procedural uncertainty highlights a culture where professionals may have become disempowered in their responses to safeguarding issues.

1.4 Performance outcomes

Performance, 'failures to help' and outcomes were consistent themes throughout the data. Munro discussed how hindsight bias in Serious Case Reviews led to a

tendency towards human error becoming the explanation for bad outcomes (Aylet, 2018). It may have reinforced a culture of negative perceptions of competence. It is particularly unfair given that "social workers may follow a sound decision-making process but fail to secure a beneficial outcome for those with whom they are working" (Preston-Shoot, 2014, p.8). Preston-Shoot (2014, p.26) cites a legal case which shows how two reasonable social workers could reach opposite conclusions on the same set of facts, without being regarded as unreasonable ('*Re W (an infant)',* 1971).

Decision-making is not straightforward so neither can measuring performance around it be. The literature review identifies inadequacies in performance data. For the most part, these do not provide a picture of the complexity of safeguarding work. The data flows from the implicit use of instrumental rationality based on a 'means-end' logic which have been overused, limiting discretion and other modes of rational inquiry (Houston, 2015). The representative from the Performance Team threatened practitioners by suggesting there was insufficient evidence to legitimise their existence as a team. This scenario paints a stark picture of how the team were expected to account for their time but according to faulty or disconnected parameters which did not capture the realities of practice. The pervasive culture of accountability is well known in statutory settings (Lees et al., 2011) and the experience of constantly being scrutinised would have been anxiety provoking. Sameera's anxious look over at me when saying: "*careful we have a researcher here*" further revealed the fearful impact of being constantly scrutinised. How could the challenges of the work and decision making be known in this context?

On the other hand, accurate and timely recording of all decisions, and the reasons behind them, is important in case of challenge (Braye et al., 2012). When following the death of one of her clients Vivienne anxiously admitted that she had not properly closed the case file, she must have known that she may not have been sufficiently recording her decision-making. Both Vivienne and Andria were seen to be making decisions that were outside of the remit of the team or not in line with policy. The manager(s) may have trusted team members too much. Or there was an over-reliance on performance systems to monitor team activity. Team members' day to day decision-making may have been carried out without a reasonable level of oversight or accountability.

THEME 2: Unconscious Factors: Dynamics of Abuse

One of the central research questions surrounds how emotional and unconscious dynamics of the adult safeguarding cases are transferred into the organisational environment. The literature review considered the distinction between the abused and the abuser and the common dynamics which occur in abuse situations. These include typical patterns of behaviour which can powerfully influence those interacting with the abuse situation through psychological 'transfer mechanisms' such as countertransference and mirroring. It can cause professionals to unwittingly respond in pernicious ways. The literature demonstrates how abuse dynamics are known to transfer into and be seen mirrored within the professional system. "The crucial significance for the dynamics of an institution is that such projective processes do not remain on the psychic level but become a reality within the organisation" (Hinshelwood and Skogstad, 2002, p.6). Lack of awareness around this becomes a reality, can mean their influence over professional responses including decision-making, is lost. Themes around negative perceptions of competence and (burden of) responsibility, as well as participants' behaviour, reveal the dynamics of abuse.

2.1 Responsibility and Reproach

It was clear that each participant carried the responsibilities of the safeguarding task differently. Some practitioners, like Vivienne and Sameera, took on the totality of the situations as being their personal responsibility. At times, Serwa and Cynthia resisted aspects of case responsibility. Cynthia felt that decisions that should not be made by social workers were being foisted on them. Serwa similarly felt that some decisions should be made by families and not involve the social worker at all.

The local authority is the lead for safeguarding work, however the person leading will often need to contain the anxieties of others. The adult safeguarding process might not be capable of stopping the abuse or resolving the situation. Negative perceptions of competence may arise. Practitioners did not feel supported or respected by other professionals who, at times, behaved aggressively toward them. Questioning or undermining social workers' decision-making processes became an added layer of difficulty (SQ4). Certain behaviour by others could be explained as projection and occurs due to these professionals' own difficulties in dealing with the

intensity of the emotions elicited from the work. Social workers are repeatedly scapegoated and held responsible for situations which should be firmly placed on those who did the harming (Ruch et al., 2014). As previously noted, abusers often present themselves as the "true victim", even though they are unequivocally the actual perpetrator of the abuse (York, 2016, p.573). Twisting and distorting who is responsible is a feature of abuse dynamics. As safeguarding work elicits such strong feelings, other professionals and the public can, somewhat cruelly, displace them onto the social worker. The social worker is then wrongly held responsible (SQ5).

Interviewees' responses seemed to accentuate how those strong feelings were often wrongly attributed to incompetence or a lack of action by the social worker. The experience of both the team manager and team members was that they "*always feel criticised"*. Practitioners were left feeling victimised despite doing their best to manage difficult and complex situations. The pervasiveness of scapegoating is often described as "*an insidious process carried out by the collective unconscious, almost mechanically*" (Shenassa, 2001, in Ruch et al. p.4) and from a psychoanalytic perspective, has the purpose of relieving psychic discomfort (Cooke, 2007 in Ruch et. al., 2014).

2.2 Working with the Perpetrator

Working with the person thought to be causing harm or perpetrator is required as part of an adult safeguarding enquiry and the principle of natural justice must be upheld through the process[7]. Engaging with the person thought to be causing harm or particularly once it is known that they have caused harm, is very challenging in practice. Foster (2009) describes how practitioners are often rendered professionally powerless by legislation. Since adult safeguarding legislation provides very few powers beyond those of assessment, frustrations about its limitations were (and are) expressed. This was particularly the case when other legal powers were not used when social workers felt that they should be. Cynthia described the powerlessness she and the social worker felt when the son strangled his mother, and a decision was made not to charge him (case 7.2). The social worker complained that she was left having to work with the perpetrator despite knowing what he did. Neale (2018) points out that the reluctance of social workers to work

[7] highlighted in Davis v West Sussex County Council [2012] EWHC 2152 (QB)

with perpetrators is noted by several authors (Featherstone 2003; Littlechild 2008; Maxwell et al. 2012). It can be particularly difficult for practitioners when they know the types of crimes possibly committed (SQ2).

As the older woman wanted to continue a relationship with her son (case 7.2), the team felt, given the risks to her, that they “were unable to send her back there” (to her home). Decisions about what should happen, were made for this individual, although Cynthia reported that the woman had agreed to the plan. The powerlessness in relation to the (criminal) charging decision, plus the mother’s decision to continue a relationship with her violent son, may have caused the team to assert the little power they felt they did have: future living and care arrangements. Cynthia stated: “we decided that it was in her best interests to stay in the care home permanently.” However, she had previously reiterated the woman did not have dementia (or anything wrong with her memory) so a best interests decision-making process under the Mental Capacity Act would not have been legal. The team may not have had the power to make this decision on her behalf. Their desperation to make her safe had the best of intentions, however we later learn the unintended impact of this decision: the woman deteriorated significantly, raising questions about whether this was the right or best decision for her (SQ4). This difficult dynamic has led to challenges brought before court. The case of Local Authority X v MM & Anor (No. 1) (2007) is well known by safeguarding professionals because of how it addressed the way social workers need to consider ‘safety’. Lord Justice Munby famously concludes: “What's the point of making someone safe if in doing so you just make them miserable?”

Collusion is a common dynamic in abusive relationships and situations (see literature review). Collusion can occur within the professional relationship (Walker, 2005). The Observation and Interview data revealed collusion where practitioners struggled to work with the perpetrator. Isabela was seen to be colluding with the man known to be violent to his wife (case 6). She may have felt afraid of him or was too inexperienced to recognise she was being manipulated. Vivienne appeared to collude with whoever she decided was the real victim deserving justice. This was apparent when she took the side of the man whose wife’s family members had accused of controlling her (5.2) or when she took the side of the family where the

father was dying (case 10) instead of supporting both. The care provider was struggling with the family's inappropriate behaviour.

In the case described by Sameera (1.2), the daughter's abusive behaviour toward her mother, and the anxiety around the risk this presented to an elderly woman, may have interfered with practitioners' abilities to recognise the extent of the daughter's own needs. It may have also impacted their ability to identify ways to address the complexity of the situation. Munro (1999) found that (child protection) practitioners seemed unwilling to change their mind despite growing evidence that their original assessment was no longer accurate. This might equate to adjustment bias (outlined in the literature review). Despite going 'out to start their assessment again', which suggested that practitioners had visited to assess on a few occasions, their assessment did not change.

These all reflect the challenges of working with a person thought to be causing harm and its effect on decision making.

2.3 Credible Witness

One of the key objectives of an adult safeguarding enquiry is to establish the facts (Care Act 2014). The difficulty achieving this was revealed in how often practitioners had to navigate situations where the truth was hidden or denied. Abuse literature shows the common 'reflex denial' of abuse by society, abusers, by the abused and those who witness or know of it (Middleton, Sachs and Dorahy, 2017). Sameera commented about the difficulty of safeguarding work because practitioners are confronted with '*families that don't always tell you the truth."* Cynthia's first case, where the husband tried to strangle his wife (7.1) (and it was suggested this was the first and only time it happened), flagged how difficult it can be to establish the truth in intimate relationships. Social workers often hear from the adult at risk that the abuse was a 'one-off' or the situation is minimised by the adult victim who is either unable to face the truth of their situation or is so terrified of the person causing harm, they deny the abuse (see Sam's case 2.1). As such, practitioners find themselves trying to make decisions often based on incomplete or unknown information because of the difficulty of getting straightforward evidence to find or prove the abuse.

Cynthia was horrified that despite clear physical evidence of injury (black finger marks around her neck) and the detail with which the individual described what had happened to her, the entire professional system appeared to ignore it (case 7.1). The son claimed his mother was making it up as she had dementia and suffered with hallucinations. Cynthia pointed out that hospital professionals did not seem to take any steps to verify whether she did have dementia. Professionals may have defaulted to an optimism bias, a phenomenon well known in safeguarding as affecting professionals' judgment and decision-making (Dingwall et al., 1983). It is always hard for professionals to imagine that a family member is uncaring and abusive. The horror of the truth may cause professionals to deny or minimise the credibility of physical evidence (SQ4). Police rationalise non-intervention (Middleton, Sachs and Dorahy, 2017) and the victim's perception of the perpetrator may govern the professional assessment of vulnerability (Aylet, 2018). Cynthia felt that other professionals, especially the police, were hesitant to make decisions when it came to abuse. 'Covering up' the prevalence, extent, or severity of abuse, is a common dynamic (as discussed in the literature review). The above examples illuminate covering up, denial, optimism bias and turning a blind eye as unconscious factors. Here they negatively influence decision-making by safeguarding professionals (SQ4).

2.4 Paradox of Abuse

Many adults experiencing abuse or neglect wish to remain in relationships with their abuser. Often an attachment to the perpetrator means attempts by professionals to mitigate risk is compromised. Attachment to the perpetrator can be confusing, frustrating and lead to professionals feeling helpless and angry (SQ3). It can come across that the individual is 'choosing' to remain in an abusive situation when the situation is far more complex. The theme of kind contradictions in the Observation, captures some contradictions in the work. The requirement to 'work with the perpetrator', also means practitioners will experience internal emotional and moral conflict. Inexperience and a lack of awareness of the unconscious influence of abuse dynamics can unintentionally lead to collusion. It explains occasionally strange behaviour by professionals when strong emotions arise. These may compromise professional responses, as seen in the example above.

Practitioners can be challenged by extreme fear or anxiety (Waddell, 1998) and this is only intensified by the paradox of abuse. Professionals find ways to cope psychologically and emotionally in response to the presence of these confusing contradictions. The phenomenon of splitting and paranoid schizoid positions (see literature review) is seen occurring (SQ3). These psychological defences can result in practitioners 'taking sides' instead of 'seeing all sides'. Isabella is seen splitting so that in her mind, there are only 'good people like her and her parents in Romania' and 'bad people in England'. Perhaps this is an emotional protection to better manage emotional demands. She was reluctant to leave the duty desk and go into the field where she would have to make independent decisions. Vivienne on the other hand was able to offer emotional support to the carer who was being abused by her son, however she colluded with the victim and made the son out to be 'all bad'. This had the knock-on effect of failing to recognise the complexity of the son's mental health problems. These coping mechanisms affect decision making as they block professionals' ability to see the real or full picture (SQ4).

Ruch (2021) underlines the importance of social workers being aware of transference. When working with the abused, transference can elicit harsh or abusive responses by social workers unknowingly (Bower, 2005). In the Observation (Case 12), when a carer cancelled care arrangements, the response by both the social worker and senior was that the individual had 'exaggerated' how severe her situation was. Transference may have caused this harsh view and automatic conclusion, preventing both from considered alternative reasoning for what might have been happening (SQ4). Similarly, Vivienne had a harsh response when a mentally ill man was violent toward his mother. She suggests that since he was at the hospital, he "could have spoken to the doctor". Structurally speaking, harshness and an absence of empathy can be transferred into the wider system (SQ5). It is seen being mirrored via the threatening behaviour of the performance team representative or the callous way the organisation sends emails to staff members when restructuring. As described above, the Organisation appears to avoid difficult conversations and emotions that accompany them. Taken together, this shows depersonalisation and a denial of the significance of the individual, both social defences (Whitaker, 2014).

THEME 3: Unconscious Factors: Organisational Culture, Hierarchy and Power

"A failure to explore the primitive, hidden agendas in organisations can lead to behaviour and decisions that are at best maddening, at worst brutal" (Lowe, 2013, p.149). Understanding the organisational environment and identifying the unconscious factors at play are core parts of this research. Themes one and two above identify the presence of psychic or social defences and reveal the anxiety generated by the nature of the work and the way this affects decision making (SQ4). The transfer of abuse dynamics from practitioners into the organisational system shows how decision-making can be affected. In the literature review, the literature around how race, power, and diversity influences decision-making is explored. Organisational culture, hierarchy and power are unconscious factors that show up through the Observation theme 'signs from the environment'; such as 'Grill a Christian', 'White men, grey suits' and the organisational culture theme of 'those people decide'. In the Interview themes, it lay in individual cultural differences and the safeguarding practice environment, as well as what individuals shared about their experience of the organisation. The following sub-themes collate these to identify the key organisational unconscious factors.

3.1 Unprofessional emotions

Sam was keen to reassure me that he did not discuss any of his cases anywhere else as he knew it was 'unprofessional' to do so. In the interview, he spoke about feeling disgust, commonly experienced in child protection work and some practitioners can feel uncomfortable admitting (Ferguson, 2011). He felt able to speak about some emotions to his team but felt for the most part that he ought to keep more intense emotions 'under wraps'. Vivienne described putting up a front in supervision and where '*you don't want to be seen as the stressed out one'*. Similarly, Serwa described that in the work, *'you (must) keep emotions separate'.*

These and other examples from the research show how emotions, or the emotional impact of work, were judged by team members as better left unsaid. This is not to say there was not some recognition of it. Andria and Sameera, in their role as managers, described the importance of expression. The use of laughter was actively promoted. To some extent, this could demonstrate and enable emotional resilience. It could be considered a healthy defence mechanism as part of an emotionally functional team. Whitaker (2014, p.153) wrote about shared laughter providing "a type of socially acceptable permission to share a forbidden emotional or shared response". When difficult safeguarding scenarios arose, this team had a mechanism for navigating them and an outlet for dissipating the emotional strain.

Andria repeatedly came back to the question of how the experiences she discussed might influence her practice today. She denied they had changed anything. It may have been that her determination to not show any impact was because she perceived fault or weakness as a senior, experienced practitioner. She talked about resilience and learning to 'shut off' from the safeguarding cases. She then shared an example where she discovered her daughter was in personal contact with an individual known to the MAPPA panel. This disclosure attracts an increased level of psychological and emotional demand as the potential threat posed by this dangerous individual became an intimate one against her own family. She does not share how this made her feel and jokingly says 'thanks' to me when I bring it up and remind her at her follow-up interview. She coped by shutting out the horror. This was a merging of professional and personal life, yet Andria reverts to not speaking about how this really felt, so as not to be viewed as 'unprofessional'.

"The role of emotions is at the core of literature regarding relationship-based practice and the separation of feelings from professionalism can be seen as an anathema in an interpersonal profession" (Hennessey, 2011 in Ingram, 2013, p.5). This organisation's culture of avoiding difficult emotions translates into perceived unprofessionalism. Unspoken and unseen emotions were not processed and therefore in a state of organisational denial. It left practitioners to find their own way to make sense and contain them (SQ6). In the absence of appropriate support to make difficult decisions, team members sought out people in other teams, spoke to their partners or even their dogs.

3.2 'Not the Expert'

Widespread negative perceptions around practitioners' competence causes paranoia and distrust in the organisational environment, the reaction to which are the social defences referred to above. The attempt to enforce a hierarchy of decision-making is another product. Sameera directly spoke to it when she refers to "*collective decision making"* but then said, "*some people cannot make decisions*" which was "*why you've got decision-makers"*. The observation theme of 'those people decide' is the hierarchy of decision-making. Decisions were made from 'above'. Control of information is another indicator of how decision-making power was taken away, so that practitioners were not trusted to make decisions. Sameera sought to control information about providers, the consequence of which was that her team could not make properly informed decisions (SQ6).

'Grill a Christian' conjured up images of saviours burnt to death. It could be the reality of how social workers felt: despite their best efforts, they were always found 'guilty', and their decisions were perceived to be 'wrong'. 'Grilling' of social workers over decision-making was seen as part of organisational culture because of the dominant negative perceptions around competence. Sameera presented as anxious, admitting that even she, the manager, was made to feel like she did not have expertise. She went on to say she wanted to surround herself with experts. Her reaction could be explained as being a result of projective identification (as outlined in the literature review). She (and other practitioners) may have internalised the projections of incompetence by others and struggled to believe that they were not true. It explains some of her own feelings of inadequacy or fear around her team members' competence. These negative perceptions caused other professionals to be hostile and discriminatory, treating practitioners as though they had insufficient or no expertise. Practitioners' decisions were undermined, meaning they often found themselves having to battle to make decisions that were supported by others or trying to defend their decisions and themselves (SQ6).

3.3 Entrenched Inequity

The Observation exposed patriarchal and racial dynamics within the team. It suggests entrenched organisational power hierarchies. The optic set out in the Observation may provide a window into what Black staff experienced working there and is an influencing factor that should be named. The institutional climate that minority ethnic people experience within predominately white institutions should be borne in mind (Fletcher et al., 2015). If whiteness was dominant, Black people may have felt consciously or otherwise that they should stick together (safety in numbers). This separation may represent Black members of staff feeling treated differently. Perhaps Black colleagues sought solidarity, especially if their experience included being under surveillance by White men. Inequity features in the difficulties Black safeguarding professionals report experiencing given the absence of Black senior leaders (Brown, Solarin, and Charles, 2021), or the absence of any hope of eventually having them, given the realities of institutional racism (Lowe, 2013). The black professionals interviewed for this research either left, were leaving or wanted to leave their job.

Status characteristics such as gender, race and class are pervasive and have an insidious effect (Lowe, 2013). Andria is observed to be shocked by her treatment of a White senior man as he asserted his status to make her the 'coffee-runner'. She did not challenge his instruction, implying a hierarchy of power. In the interviews, Sameera's description of discrimination as 'just a reality' emphasised it as a constant for her. However, she did report that her experience was not always negative in that sometimes she is elevated to a higher status by external professionals thinking that she was a doctor. Status beliefs associate greater general competence and perceived expertise of different people (Lowe, 2013). Sameera being seen as a doctor meant she was seen differently and her decisions more respected.

Sameera disclosed challenges managing staff members with 'fixed views'. She expressed concern about how certain types of people referred in for safeguarding, were 'seen'. She made me aware, albeit indirectly, that certain clients would experience discrimination by professionals in the organisation. Sameera could have played her experiences of prejudice down but chose to share her concerns with me. She may have wished to expose this as a factor that impacts professional practice (SQ2).

3.4 (Un)Safe space

Where reflective spaces were not safe or well-handled in the practice environment, they had a negative impact on practitioners. The approach as a 'critical friend' ended up being hurtful, demoralising and publicly shaming: another abuse dynamic mirrored in the system.

Participants expressed concern about whether the organisation really caredabout its employees' well-being. Their experience of the 'reform' through restructure painted a rather grim picture of poor communication and decision-making by senior management that led to rumours, distrust, and fear. Andria felt that practitioners had become so disempowered in this environment that they were unable to stand up for themselves for fear of reprisal or bullying and she questioned if they could really do their jobs as a result (SQ6).

"The power of being listened to cannot be under-estimated, especially when placed against a backdrop of practice evaluations, such as SCRs, which highlight the failings of practitioners but rarely give voice to their views and a research norm of survey techniques aimed at testing practitioner decision making." (Aylet, 2018)

An unsafe practice environment parallel to an absence of containing mechanisms might explain why the interview space itself had such a powerful impact on interviewees. Sam may have spoken for the first time about the difficult case that reminded him so deeply of his mother. It may have been so difficult and painful that he felt unable to take part in a follow-up interview to revisit it. This propensity to identify and counter-identify with extreme pain is not always consciously known by practitioners (Rustin, 2005). Sameera admitted that she found the interview strange as it was the first time she had been able to talk uninterrupted without someone responding or engaging with her. Both Sameera and Andria may have found the interview space anxiety-provoking and sought reassurance from me as the researcher (and perhaps also safeguarding peer). As Sameera disclosed, the interview made her realise her need to feel that she could speak to someone about cases openly without feeling judged (SQ2).

Vivienne realised the space provided her with the opportunity to properly reflect on a case (involving a death where she felt impacted by it) and her own practice in a way she had not previously. She admitted that she felt 'strangely better' afterwards and added that it had helped to 'offload', lift her stress and she feel more grounded. She felt worried that as a researcher, I 'didn't get much back' and that she had 'got more' from it than me. It highlighted the power of this interview method to disarm participants, enabling a free flow of obscured narratives that sat just beneath the surface, unprocessed. It exposed the tougher aspects of their experiences in decision making (SQ2). Andria found the interview space 'like a counselling session' which suggests she had insufficient emotional support. Cynthia was pleased to be able to express how she felt and to be 'able to talk about some of these issues'. The space felt safe enough for her to disclose her personal history. The comments show how close to the surface and unresolved these issues might be.

The environment had inadequate mechanisms for practitioners to identify for themselves how their personal feelings, including those related to their biographical histories, may influence their practice and decision-making (SQ2). At times, they exhibited a lack of ownership over their role when reflecting on the decision-making of their cases. Some practitioners appeared to be able to reflect more than others. Some were defensive: "I did nothing wrong" or "not our responsibility". Some participants demonstrated their reflections with a list of questions they asked themselves following a case. However, as with Vivienne, even where she used reflective questioning, it did not change some of the behaviours she recognised were crossing the professional line. Without supportive reflection, practitioners do not safely confront their unconscious drivers for decision making (SQ2).

THEME 4: Emotional factors: Helplessness, Horror and Death

Bower (2005) discusses how clients bring practitioners into close contact with their internal worlds through their emotional impact on the worker. She describes how this can be gross and overt, or subtle and insidious. Workers may feel confused, fragmented, inadequate, despairing or enraged (Bower, 2005). Many of the case scenarios brought up by interviewees exposed these emotional responses.

Practitioners were able to verbally articulate some of their feelings. For some, it was apparent in their non-verbal communication or behaviour. Sam described feelings of disgust and abhorrence. Vivienne felt unexplained guilt. Andria and Cynthia showed feelings of anger over injustice. Serwa disclosed sadness and heartbreak; and Sameera's anxiety and dread was palpable even if she did not say it explicitly.

Participants' non-verbal communication uncovered feelings of anxiety, being overwhelmed and even dread. There was the speed at which Isabela spoke, Cynthia taking deep breaths, and Serwa's reluctance to do either of her interviews, repeatedly cancelling or re-arranging. My stomach churning when I heard details of a particularly severe case or when I needed to take a break from the Observation, were countertransference reactions. They were examples of the hidden impact of intense emotions elicited by the work.

Severity of abuse was identified in the literature as impacting decision making. It was also a theme in this research. This occurred particularly when practitioners had to face the horror of people's circumstances or their death which left them feeling helpless. It caused some practitioners, Serwa for example, to feel like situations were futile and there was no point in trying as 'we can't do anything'. All of these appeared to affect decision making differently and influenced practitioners' capacity to think (SQ3). It generated 'irrational expectations' around how practitioners could help, particularly because the nature of some cases meant that there were no clear solutions (SQ4). The impact of repeatedly dealing with this severity of abuse can cause secondary trauma (as outlined in the literature review) and is why effective containment is so important (SQ2). This is explored further below.

4.1 Capacity to Think

The Observation theme of 'sonic violence' demonstrates how practitioners tolerate high levels of noise while dealing with the rigours of safeguarding work. It raises the question of how practitioners are expected to make decisions with clarity in such an environment. The Observation and Interview data show examples of how emotions could impact practitioners' capacity to think. Andria described how she could not '*get clear in my head'* and needed to go home (away from the organisation) and discuss her situation with her partner; Cynthia described how she needed to do the same. It

was difficult to just think rationally when faced with an intense emotional reaction and potentially traumatising situation (SQ4). “The impact of the working environment on the social worker’s competence and ability to think has been written in many inquiry reports and studies on decision making” (Foster, 2009, p.66). Andria and Cynthia found themselves unable to think within the organisational environment. They are later seen emerging clearer about what they needed to do: moving away from the situation and seeking counsel from elsewhere outside the organisation – perhaps where they both felt safe to do so, enabled their capacity to think about the decision they were presented with.

Serwa’s client was so severely scammed, he ended up homeless (case 6.2). This seemed behind her feelings of helplessness and loss of hope. She described heartbreak and sadness, and later said that this reflected the evil in society. Rustin (2005, p.273) suggests that “some hurts are essentially unbearable, and threaten your sense of humanity, your sense of being a person”. Serwa was clear that the responsibility for what happened lay with the client himself not listening and police inaction. However, she assessed the client as lacking capacity. The rejection of her having responsibility in tandem with the upward delegation of responsibility (Lyth, 1988) indicates possible defences to the anxiety generated by the situation and by her own need for preservation. Whitaker (2014) found that practitioners tended to use splitting and projection as a means of getting rid of difficult and unwanted feelings and to retain a sense of being 'good' in contrast to the 'bad'. It was seemingly necessary for Serwa to resist responsibility and to feel that she was the goodness. In other words, she had done all she could and so could place the badness into ‘the evils of society’ or the police who ‘did nothing’.

Harvey (2017) highlights how safeguarding decisions have repercussions on the internal world of the social worker, which in turn affects their judgment and capacity to remain emotionally involved. It seemed that Serwa had reduced capacity to think. She was unable to really explain why no action was taken by the legal team considering she had assessed the individual as lacking capacity in relation to his affairs. This possibly led to her ‘turning a blind eye’ and justifying ‘inaction’ and a vulnerable person may have been abandoned. Similarly, Cynthia may have found the lack of support and experience of being attacked by others, such that she did not want to lead the safeguarding process despite being responsible for it. Constant

undermining of one's ability affects capacity to think and ultimately meant 'leadership' in the safeguarding process was compromised (SQ6).

Dignity is stripped from those experiencing abuse and the cases practitioners deal with mean that this is regularly encountered. It was striking to witness the inability of team members to recognise or label it. The 'blank bubbles' seen in the Team's Project (see Observation) powerfully represent an empty thought bubble or one where 'the right words' were missing. Isabela turned to the internet to find words in the absence of being able to articulate her own. The psychoanalytic ideas of 'unthinkable anxiety' (Winnicott, 1962), and 'nameless dread' (Bion, 1962) capture what was happening. Articulating the emotional difficulties in the work was difficult, or in some cases out of reach. It appeared that the organisation itself struggled to support practitioners to think about complex areas. Practitioners then tried to make them 'pretty' or more bearable by using a cultural soother, like having a cup of tea.

Similarly, we see in the interview finding that Sameera's capacity to think is compromised when she is unable to reply to the question about how the domestic homicide case influences how she responds to cases today. Her struggle possibly suggests that this case did have an impact on her in a way that she had not quite yet managed to verbalise. Her fumbling to find words intimates an anxiety articulating her thoughts.

4.2 No clear solutions

"The right decision may not be obvious; options may appear so unattractive that practitioners are left searching for the 'least wrong' answer" (Preston-Shoot, 2014, p.8.). Feeling helpless was a recurring theme throughout the data sets and there may well be a link with negative perceptions of competence. In an adult safeguarding work context, where often there are very few 'solutions' to horrible and frightening situations, it is likely many professionals may be left feeling helpless. The dominant feeling of helplessness may be about practitioners' feeling a lack of control over the circumstances of the cases or a false perception of how they are expected to help (SQ3). Safeguarding children legislation enables practitioners to intervene based on assessments of risk, however the same powers do not exist for adults. The MCA provides adult safeguarding professionals with some powers to make decisions where an individual is deemed to lack capacity. However, professionals may succumb to helplessness when they find themselves unable to use those powers

because the individual involved in an abusive situation has no cognitive impairment. Professionals are left questioning how to effectively help or whether they can do anything at all (SQ3). As adult safeguarding is 'newer' than child protection, often there are expectations that helping responses will be at a similar level or way, when this cannot be the case. Social workers may find themselves arguing with other involved professionals about what can and cannot happen. Where situations are particularly anxiety provoking, the demand from other professionals on social workers 'to help' is hard to manage.

4.3 'Irrational' expectations

Those working in this area face criticism for allegedly interfering when they intervene and for alleged neglect or worse when they do not (HHJ Mackie KC in *Davis & Davis v West Sussex County Council* [2012] EWHC 2152). Sameera identified this difficulty when describing how practitioners were 'unable to intervene' in the example of the mother and daughter domestic violence (case 1.3). The impact of high levels of anxiety led practitioners to assume that when they saw the ambulance, the mother had been killed by the daughter. Their default reaction was that they were and would be held, responsible. They said: "we're done for". A statutory review was not initiated suggesting no link between the death and any lack of intervention or handling of the safeguarding issues. Based on what they described, practitioners remained involved, trying to manage the risk within the constraints of not interfering in the mother and daughter's right to continue their relationship and despite the risk of violence.

This scenario shows how emotions, i.e. fear of consequences, drove them to explore all possible options and to not give up on seeking to mitigate risk (SQ3). On the day the mother died, there were two social workers visiting to check on her, there was an active plan in place to monitor the relationship in the absence of stopping the relationship or violence. Their decision-making appears robust despite the intensity of emotion, difficulty of the situation and lack of obvious solutions. Yet practitioners were left shocked and terrified, even when they learned the real cause of the death. Both had to go home from work. The impact of the death seems disproportionate. It points to the likely impact of a wider political blame culture, on perceived culpability.

Winnicott (1962) describes the concept of ‘good enough parenting’ as a way to recognise that there is never an easy or perfect way to care. Good enough care was provided in most of the examples discussed by participants, but these never sunk in, and irrational expectations dominated.

4.4 Absence of containment

The literature review defines containment and the importance of its provision. This particularly resonates for practitioners carrying out safeguarding work, where the nature of abuse elicits difficult and unbearable emotions. Bion’s (1962) concept of containment as “being able to make sense of one’s own feelings as a consequence of having had sense made of them by a thinking other” ought to be seen where safeguarding practitioners are receiving sufficient containment, so that they are able to provide containment to their clients in turn. Throughout the data it is conspicuous in its absence. Despite the extensive support that Isabela received, she repeats the version of her account over and over. Cynthia similarly repeats, almost word for word, her traumatic experience. A repeated urge to tell the same story suggests the mind is still trying to make sense of what has happened. The issue is unresolved, and repetition indicates how unprocessed it still is. Sameera’s own levels of anxiety and self-doubt suggested she did not receive containment, and it was unclear what kind of support she received to enable her to contain her team members.

Andria felt that she received support from the manager but admitted that she did not receive emotional support. She conceded she had felt forced into thinking about how to sustain in the work, another impact of the absence of containment. The data also shows how social workers often become containers for other professionals’ anxiety. All practitioners recognised the difficulty of the work and the absence of any safe space, as noted above, meant that there were no mechanisms in place. Containment is evidently a requirement to ensure good decision-making.

THEME 5: Emotional Factors: Individuals: influences and needs

Each participant brought a fresh perspective to the way they responded to each of their cases. It was apparent that their individual unconscious and emotional factors

influenced their responses. As each participant's personal story became more central to the narrative, unresolved personal histories emerged as increasingly influencing factors. The interview data captured how practitioners' biographical histories affected their responses. It pointed to how each social worker's unresolved personal history and cultural background affected motivations in practice. Certain cases elicited emotional responses, which influenced judgments and decision making. As revealed in the literature, there are positive impacts of certain negative emotions and evidence of this was found in this research. Individuals with more professional (and perhaps life) experience, were better able to recognise the unconscious factors at play and therefore make better decisions, even if unknowingly. These are explored below.

5.1 Unresolved personal history

There were examples in the data where the impact of personal history negatively impacted decision-making. Cynthia was furious at the neighbour's inaction about a domestic abuse incident (case 6) because they did not intervene. She claimed that this undermined the credibility of their statement to police. Witnesses can be reluctant to get involved or fully register the perpetration of abuse and act on it (Middleton, Sachs and Dorahy, 2017). There are several reasons why people feel unable to intervene or involve police. Cynthia's personal history of domestic violence caused her strong personal, emotional reactions to similar scenarios that presented in her cases. Perhaps in her personal experience, she felt that no-one called the police for her or that they did not do enough. Perhaps the perpetrator was not prosecuted. It appears in this scenario that Cynthia's own, unresolved personal experience around domestic violence may have interfered in her ability to consider genuine (other) reasons for the neighbours' actions. Bingham (2011) highlighted that to establish all relevant facts, including those that might support an alternative interpretation or conclusion to the one that is favoured, "requires the decision-maker to avoid bias and personal interest" (in Preston-Shoot, 2014, p.29).

Vivienne felt she was able to get her son everything he needed, and he was 'doing well' now and as such, her belief that she could do the same for her cases was vindicated. Her professional practice was driven by a sense of justice linked to her

own experiences with her son. She made decisions that pushed to achieve what she thought was right, without always considering the alternative, including the persons' view. Her decisions came with a cost: in one case (5.1), significant risk of financial loss for the client. She justified her decision by believing the client had 'felt empowered', but her words contained a telling distinction: "she came across like she was empowered...". From a psychoanalytic perspective, not only do straightforward adult anxieties get provoked through the work, but also intense, primitive anxieties such as powerfulness, omnipotence, and guilt (Harvey, 2017). The determination by some participants to help resolve their clients' situation may have been driven by these primitive anxieties, to the extent that some practitioners believed that they had more power and control over the outcome than they really did. This negatively affects decision-making where decisions are made based on what the individual practitioner needs or in reaction to individual practitioner's primitive anxieties (SQ3).

5.2 Positive impact of [negative] emotions

Andria's identification with the case (4.1) meant that she did not so easily succumb to confirmation bias or 'groupthink' type of decision making. This enabled her to continue to advocate and 'be the voice' of the young woman where other professionals appeared to have concluded that she was making the abuse up. Andria's emotional response was that of a parent and influenced her decision-making through a desire to ensure that the young woman was believed and protected. Whilst the true cause of the young woman's injuries was never established, by taking a different position to the rest of the professionals, Andria could challenge the availability bias in their decision making. As an unconscious response, it became a protective factor within the wider context of adult safeguarding work. Similarly, the experience of 'failing to help' had an emotional impact but did not appear to lead to poor decision-making. Andria's decision to continue working with her hoarder client came from her perceived failure with the last one. She wanted to prevent the same outcome: a positive impact of the original perceived failure.

Participants' identifying with their cases exemplified emotions being elicited within practitioners but having a positive effect overall. Persistence in difficult cases where others had given up, showed that. Identification with the case meant there was a deeper connection with the individual and led to greater insight, empathy, and an

ability to act effectively. This has been found in child protection research and shown to make a clear difference in the quality of the decisions (Harvey, 2017). For example, the personal 'bug bear' of injustices that Vivienne described, was also what drove her decisions to take extensive action. Both Vivienne and Andria's passion for injustice were personal value frameworks, which influenced their perspective on 'fairness' and meant that they were not afraid to challenge professionals whose points of view they did not agree with. This links to some of the literature on the benefits of negative emotion (as outlined in the literature review) and appears to have prevented groupthink or cognitive bias (David, 2016).

5.3 Cultural background

Hutchinson et al. (2015) found that the way child protection concerns were identified, defined, and responded to, were influenced by practitioners' religion, faith, and associated cultural dimensions. Data gleaned from the interviews identified some of the ways in which different cultural perspectives affect decision making. Several authors have highlighted how personal and professional values may conflict or compete in social work practice (Banks, 2021). This data demonstrates challenges that arose when different value frameworks influence perceptions on what is right and therefore how practitioners should or should not respond. "The family should resolve this", as an example, left Serwa feeling uncomfortable about getting involved because culturally, she considers it intrusive and inappropriate. It made the responsibilities of the job difficult to manage and caused conflict in judgments and decision-making processes, particularly in the context of what the organisation expected of her.

Cynthia's outrage that UK society treats their elderly so poorly compared to where she came from, is partially behind her behaviour towards other professionals. She repeatedly challenged them, particularly the police who she felt did not prosecute violence against older people where they should. The charity Action against Elder Abuse produced a report with this exact finding and complaint (Action against Elder Abuse, 2006). They found that prosecuting crimes against older people or the use of special measures to support vulnerable older people was limited and that perpetrators rarely went to prison (Fitzgerald, 2016). Cynthia's rageful

determination, emerging from both her personal experience and cultural background had a positive impact here. It drove her to challenge other professionals' decision making and a discriminatory (ageist) justice system that placed insufficient value on older people's lives.

5.4 Emotionally enabled through experience

Some participants were more affected by emotional factors than others within the organisational environment or the primary task. This seems to relate to their level of experience, which enables an obvious emotional capacity to cope and respond to the challenges before them. As a newly qualified professional and ASYE, we see the difficulty Isabela had handling the situation in the first case she shares (3.1). Whilst it is clearly a difficult situation, a more qualified practitioner may have had the skills to contain or de-escalate what unfolded. Isabela's inability to do so resulted in her being traumatised by the experience. It may be that as a novice decision maker she was able to perceive critical factors in the environment, but less able to understand what those factors meant or effectively perceive what was likely to happen in a dynamic and changing situation (Whitaker, 2014).

Learning how to navigate rigid processes and deal with anxiety within the system improved with experience**.** Vivienne's response to the GP surgery's rigid process, for example, was to politely encourage a different decision by saying she was 'hoping for more flexibility'. She had learned to push for different decisions by others within the confines of the system and therefore refused to feel helpless. Vivienne's experience enabled her to respond differently to scenarios that generated anxiety in the system. When her client died, she calmly took steps to establish exactly what had happened. Her experience dealing with life and death cases meant she was more able to step back, not react, and as she described: not "*join in*" with the anxiety. Instead, she was able to respond in ways that de-escalated and contained it.

The literature identifies practitioner experience as a key factor in effective decision making. It links to the recognition-primed decision (RPD) making model because experience allows practitioners to pick up familiar patterns which enables timely decisions. Whitaker (2013) noted that this was because experienced practitioners have developed more sophisticated (internal) processes to analyse and evaluate complex information. Andria's years of experience evidently enabled her to do this

but it also meant she was able to support others to respond differently. In the Observation, she stepped in and used laughter to de-escalate a staff member in a neighbouring team, who felt uncomfortable about my presence as an observer. In other examples, she could see that the social worker had not yet picked up on who the real abuser was (case 4.4) or that the social worker(s) could not see the full picture of what was going on. She was able to contain her own anxiety to support these social workers to discover these and in so doing, develop their abilities to do this in the future. Sameera was also able to recognise herself becoming defensive about being questioned by other professionals and reflect that she did not need to react.

5.5 Summary of discussion and overall findings

This chapter identifies the unconscious and emotional factors apparent from the research that impact decision making in adult safeguarding. The research methods adopted have managed to sufficiently answer the research questions.

Unconscious factors include the pervasive presence of anxiety, generated by the nature of the work, which subsequently transfer into practitioners and the wider organisational environment. This causes psychic and social defensive reactions that show up in the form of gatekeeping, keeping secrets, the need for processes and the assertion of unhelpful performance measures. These are reactions to anxiety but anxiety provoking themselves. They interfere with decision making by trying to control the way decisions are made and by whom. They cause confusion around what the ‘right’, best possible, decision should be. They cause practitioners to feel that they need to make decisions away from the organisation where they have more autonomy and less scrutiny.

Tensions arise when the decisions practitioners want to make conflict with what the organisation says should be done. Ethical dilemmas emerge, and practitioners may ‘go rogue’ and decide in opposition to the policy position. This is not to say that this approach leads to bad decisions - quite the opposite, there is evidence that it may have had the better outcome. There was some evidence that decisions made in secret (or autonomously) meant there was less oversight or accountability, raising whether defensible decision-making could be evidenced.

When decisions were difficult, defaulting to the policy or procedure is sometimes helpful as it provided practitioners with a clear position to take and meant less decision-making effort is required. However, it appears to have institutionalised their thinking and there was evidence that practitioners became automated and regurgitated what they were told; that they were so disempowered that they could not make decisions without a manager telling them what to do.

The dynamics of abuse being transferred and mirrored in both practitioner and organisational behaviour is illuminating and shows the importance of understanding them so that they do not unconsciously collude or repeat the very abusive behaviours they are trying to protect against. The added difficulty is noted when other professionals who are supposedly working with practitioners to safeguard adults at risk, treat them aggressively, undermine their decisions, or collude themselves. Feelings of powerlessness arise and may lead to practitioners taking decisions that protect, such as moving someone into a care home, but which may not be in line with the adult's wish or a positive long-term outcome.

Facing the truth of abuse is difficult and the research found how covering up, denial, optimism bias and turning a blind eye are often unconscious responses that negatively influence decision making. The often gruesome or confusing contradictions that arise in the work and captured in the 'paradox of abuse', make decision making responses extremely challenging. In response to the intensity of the emotions, the psychological phenomena of splitting and paranoid schizoid positions were evident because practitioners used these to cope. However, it affected decision making because the real picture was obscured. Transference from abuse cases elicited reactions that were harsh and prevented practitioners from considering alternative explanations as to what may have been going on with the person.

The unconscious and emotional dynamics of the organisational environment reveal a culture where speaking about emotions is not seen as professional. Emotions not processed and/or denied by the organisation, leave practitioners to find alternative ways to make sense and contain them. The hierarchy of power over decision making means practitioners' expertise is frequently disregarded and the processes by which decisions should be made controlled. Practitioners become so disempowered in this environment they may not stand up for themselves. The power hierarchy also perpetuates racial and gendered inequality. Discriminatory views exist and these

influence how decisions are made about certain types of clients referred in for safeguarding. There are insufficient safe spaces for practitioners to express their difficulties and receive the support that they require to make effective decisions. An unsafe practice environment joined by an absence of containing mechanisms might explain why the interview space itself had such a powerful impact on interviewees. Without supportive reflection, practitioners cannot safely confront their unconscious drivers.

Emotional factors include the intensity of emotions that affect practitioners' capacity to think. Practitioners needed to seek external counsel, away from the organisational environment. Feelings of helplessness made decision making difficult particularly where there were irrational expectations as to what might be achieved. It did not appear to negatively impact decision making (only the experience for practitioners) and there were several examples of negative emotions positively impacting decision making.

Individuals' personal history positively and negatively impacts decision making. Cultural background affects the lens through which situations are assessed. This makes decision making challenging; however, it also reveals how differing positions enable unjust or discriminatory decisions to be challenged. More experienced practitioners have increased capacities to handle the intense emotions directed at them or that emerge through the work. This means less defensive practice and a broader perspective on what may be going on in cases. As such, practitioner experience and expertise are seen as a mitigating factors around unconscious and emotional influences in decisions.

The next, and final, chapter will conclude the research and suggest future practice considerations.

Chapter 8: Conclusion and implications for adult safeguarding practice

In the introduction, I shared the case of Amy, a disabled woman in a domestic abuse scenario. In that case, the pressure on adult safeguarding professionals was to try and protect Amy from ongoing abuse despite her wish to remain in the relationship. A review was initiated to try and understand her ultimately death. Rational explanations for this fatal oversight could not be found. My clinical background meant I could highlight at the time, how this oversight was likely due to beneath the surface factors influencing the decisions of the practitioners involved. Clinical thinking and psychoanalytic perspectives are uncommon in statutory adult safeguarding settings. I was led to undertake this research because I could see there were advantages in increasing the use of this type of thinking to support adult safeguarding practice. Child safeguarding literature has already started to explore how a deeper understanding of below the surface factors is helpful within statutory safeguarding practice. These gained real traction following Eileen Munro's (2011) review of child protection. My literature review revealed some efforts to explore factors affecting adult safeguarding decision-making but none that examined the influence of unconscious or emotional factors. I have sought to address this through this research. These factors appear in individuals and organisations and come with the territory of abuse work with adults. They bleed into professional decision-making processes on personal and structural levels.

8.1 Telling an untold story

My primary research question was: what impact do emotional and unconscious factors have on decision-making in adult safeguarding? To answer this, I researched a statutory adult safeguarding operational team (within Social Care Services) by conducting psychoanalytic ethnographic observations and free association narrative interviews. The Observation provided a mechanism for objectively viewing day-to-day adult safeguarding activity in the workplace. The interviews provided a safe space for practitioners to share their experiences of certain cases confidentially and without fear of reprisal. My clinical training in psychoanalytic social work provided the skills required to utilise these methods. The use of psychoanalytic concepts such as transference and projective identification helped to identify the unconscious and

emotional dynamics at play. This approach enabled me to identify how the unconscious dynamics of cases transfer into individual practitioners and the organisational environment they work in.

This research tells the untold story of what adult social work practitioners face in their work with adult abuse. The Interview participants were asked to describe a case that stays with them, one they still think about. Within the safety of a confidential interview space, practitioners shared story after story – many with unpalatable narratives of adults, incredibly vulnerable, being exploited and abused in cruel and unthinkable ways. Their job is to find a way to help them whilst having to think the unthinkable about the dark side of human nature.

This research describes abuse psychology and the powerful unconscious processes that occur in the course of this work. It explains why helping is not as straightforward for a social worker in adult abuse. Abused and often 'capacitated' adults deny they are being abused, reject help, become violent themselves, or simply cannot see the severity of their situation (Bower, 2005). This means they can be severely harmed - sometimes fatally - regardless of how hard the social worker might try to help. Understandably, this leads to social workers encountering frequent and intense emotions. Yet social workers feel that they do not have permission to admit or share difficult emotions that they are experiencing themselves. Organisations and statutory settings are simply not set up to hear about it and therefore do not respond effectively. Social workers are largely isolated, when they experience overwhelming feelings of helplessness and emotions caused by death or horror. This is a vital aspect of this untold story. It makes the argument for reflective supervision and safeguards for emotional wellbeing all the more germane.

8.2 Lived experience of the research

The social workers in my study had learned to shut off their emotions or come to believe it was 'unprofessional' to speak about their emotions. As a psychoanalytic researcher, researcher reflexivity encouraged and enabled me to identify these emotions within myself. I intentionally paid attention to the emotions I was experiencing whilst undertaking the study. During the observation and interviews, I noted when I felt overwhelmed by strong emotions or had physical reactions to visceral feelings such as

disgust. I used my own emotional experiences (using countertransference) as an instrument of insight. I worked full-time throughout the research process and so simultaneously was involved in complex adult safeguarding work. As such, I became acutely in tune with the emotional material of both my own cases and those shared with me by the research participants. This enabled me to draw connections between my lived experience of the research and the participants' lived experience of adult safeguarding work.

Being an 'insider researcher' meant I could access understandings that an outside researcher would not likely have. It was clear from the interviews that practitioners shared personal and deep contemplations with me. I found being an insider difficult at times because I had to give up my 'manager' role and take up the researcher mantle. However, it allowed me to see things from a different perspective. I came to recognise how I, too, had unknowingly identified with negative perceptions of competence, perceiving social work practitioners in a certain way. In the end, being an insider researcher led me to a far deeper appreciation and admiration of the people who chose to do this work. This study found ways to tell the untold stories of passion, bravery, and the successful outcomes that often exist, despite the immense challenges and often personally taxing nature of the work.

8.3 Key Messages for Practice

This study has offered a unique perspective and significant contribution to understanding adult safeguarding practice. These are the key messages:

1. **A technical-rational perspective and approach to decision-making is limited in effectiveness in an adult abuse context.** A naturalistic approach which considers context realities of front-line decision making, should be adopted instead. In other words, a deeper recognition and appreciation of how decisions are made within an adult safeguarding context are necessary to ensure practitioners have the support they need to do this work and if organisations want to mitigate against the unconscious and emotional factors that exist and can impact practitioner decision-making.

2. **The nature of adult safeguarding work impacts professional decision-making in adult safeguarding work**. This might, on first reading, seem trite or obvious. However, it is a hidden factor that emerged from most of the research themes of its own accord. The stories of the people experiencing abuse or neglect impact practitioners and their decision-making. The practice reality involves dealing with horror, death, and regular feelings of helplessness, which comes directly from the nature of the work. Many of the case stories stay with practitioners because of how they personally affect them. A practitioner identifies with a narrative or character within the case in some way, or something about practitioners' personal history affects how they respond. Personal history greatly impacts practitioners' motives, views, and decisions. This research has drawn attention to both the negative and positive impact this can have on decision-making and is why exploring this in reflective supervision is needed.

3. **The severity of cases that practitioners encounter, elicits intense emotions no matter how professional or experienced practitioners are**. This is important because this study has shown how the emotions elicited come from the nature of the work but also, as a consequence of it. If this is not recognised, social workers are left to view themselves as 'unprofessional' for even feeling these emotions. Practitioners need to be supported to deal with the emotional bombardment that comes with the work (Bower, 2005). In addition, the increasing realisation for social workers who do this work is that despite their best efforts, people will not respond in the way they want them to. As they start to realise that they may not be able to help them or achieve a positive outcome, they encounter and must deal with their own intense feelings of disappointment and helplessness. For some, experience brings growth and increased emotional capacity, but for others, the impact may be too great to bear and cause them to become sick or want to give up. With no appropriate vehicle for processing these difficult and conflicting feelings, the latter is likely to be seen. Reflective supervision which deals with these emotional factors helps to prevent burn out and assists staff wellbeing and staff retention.

4. **Abuse psychology highlights the common patterns seen in adult safeguarding work - these can impact decision-making.** These powerful unconscious dynamics transfer into practitioners and the organisational environment and affect decision-making in turn, often in negative or unhelpful ways. The emotional impact on the social worker may go beyond 'feelings', and professionals may find themselves behaving in strange or punitive ways by unconsciously colluding or repeating the same abusive behaviours that they are trying to shield clients from. Given this, understanding the psychology of abuse and the common abuse dynamics is part of the required expertise for adult safeguarding practitioners. This expertise is often seen in domestic violence practitioners, but less so in adult safeguarding practitioners who mostly come to safeguarding with generic social work training.

8.4 The management of adult safeguarding culture and practice

The message from this research and child safeguarding research is that organisational systems must give weight to the existence of the hidden factors that impact decision-making. This supports those tasked with carrying out statutory enquiries i.e. adult safeguarding practitioners and those with accompanying safeguarding responsibilities e.g., police and health professionals, to identify their influence when making critical decisions. An awareness of how unconscious processes can be transferred and affect professional judgment is fundamental. If professionals can understand the dynamics of abuse on a deeper level, they can respond consciously, not reactively, in pernicious ways e.g., turning a blind eye to abuse.

There should be a culture of talking about emotions as part of professional practice. My research shows that when practitioners experience strong emotions, they can often reflect the adult at risk or the abuser's feelings. Whitaker (2014) found that understanding emotional responses often told practitioners something important about the case. This study has also highlighted the usefulness of strong emotions. By reflecting and noticing strong emotions in safeguarding practice, practitioners and organisations

could better identify when these were positively or negatively impacting decision-making.

Adult Safeguarding practitioners must believe in the value of their work, to hold hope and retain optimism in the face of some of the darkest human behaviour. Amidst helplessness, horror, disgust, and despair that are inevitable in this line of work, receiving the right support is vital. This study has shown how in the absence of an emotionally informed organisational environment, unhelpful psychological coping mechanisms are adopted in response to the realities of adult safeguarding work. Blame and shame, defensive practice, scapegoating, rigid hierarchies, surveillance, and a focus on targets are common patterns and characteristics of a dysfunctional organisational culture (Earle et al., 2017). If managers and organisations want to see good decision-making, they must commit to setting up safer working environments that allow vulnerability and emotionality alongside a meaningful learning culture. The evidence for how these produce better decisions and outcomes already exists.

8.5 Strengths and Limitations of the study

Reason (2008) argued that the study of error ('human as hazard') traditionally received greater attention than the study of skilled practice ('human as hero'). This is important, as noted in the literature, because so far there is very little adult safeguarding research that explores everyday practice. Much of the more recent research has focussed on safeguarding adults' reviews and only interrogated cases where things went wrong. Like performance data, this can misrepresent the real picture. Increasingly stress is being laid on valuing social work expertise and placing greater trust on practitioners (Preston-Shoot, 2014), but it is high time that they are properly valued. A strength of this research is that it has captured the untold stories of social workers who do this work and shone a light on the excellent work that goes on, despite the immense challenges.

As a safeguarding professional, one of the main strengths of this research for me personally was the benefit it had in my own practice. I worked on complex safeguarding cases and led departments in safeguarding lead roles throughout my research and writing of the thesis. Deepening my own

knowledge and engaging in regular reflection meant I was continuously confronting my own unconscious and emotional contributions and acknowledging how these might be impacting what I was doing. This helped me to do the same for other safeguarding practitioners I worked with, giving advice, providing supervision, or through the training I delivered. As a social work professional, evaluating one's own work and being committed to learning is a critical part of ensuring that current practice can lead to better outcomes. Being research-minded, open to deeper reflection of my own subjective experiences, and thinking about the more complex dynamics in safeguarding cases is now ingrained in how I work. It has enabled me to develop new models for practice.

The research design was psychoanalytic, which provided a platform for me to explore unconscious factors that were effective. Therefore, this research has gone some way in proving the viability of the psychoanalytic frame in explaining these aspects and their impact on practice. The research also explored psychoanalytic concepts. Projective processes like transference, projective identification, and psychological defenses of splitting and a paranoid, schizoid position were useful in identifying the unconscious processes occurring.

This was a small but rich qualitative study. As noted, one of the challenges in this research study was that I could not control what I would observe in the team on the date and time I agreed to attend. As such, there were limitations to how much direct decision-making I observed. I could not observe other spaces where more decision-making might occur, such as 'team huddles', supervision, or direct client-facing visits by social workers in response to safeguarding issues. A free association narrative interview approach meant that very few direct questions were asked. As such, I could not elicit responses to my specific research questions, only infer how the narratives shared related to these. In addition, inferences can be made from the rich data however, wider generalisations cannot. The research is open to scrutiny by those cynical about a psychoanalytic approach. The location of the study was somewhat 'typical' of other local authority adult social care teams however as outlined; most local authorities opt for not having adult safeguarding only operational teams so it was less typical in

the practice arrangements. Whilst this local authority was one the larger ones in the city, there would likely be significant differences to those outside of the metropolitan area/greater London and so possibly less comparable to the rural, semi-rural or even other UK cities.

Unfortunately, one of the main gaps in this research study is that my interpretations were not fed back to participants. As the research took place over a number of years (part-time doctoral research process), it meant there was no realistic opportunity to feedback interpretations to participants as a form of robustness or triangulation. More research is required to legitimise the discoveries further and advance understanding.

8.6 Recommendations

1. **Adult Safeguarding Training needs to be strengthened to ensure adult safeguarding practitioners have the expertise needed to do this work.** Adult Safeguarding training must support practitioners engaged in adult abuse work to acquire a level of expertise, which includes an understanding of how the emotional and unconscious factors inherent in the work affect professional decision-making. Given the paradox of abuse and the often-difficult contradictions that arise in this field, training needs to support practitioners to acquire a sophisticated understanding of adult abuse psychology and the complex dynamics that arise in practice. In psychology, the term 'dialectic' describes the tension between two contradictory viewpoints, where a greater truth emerges from their interplay. Knowing how to 'hold the dialectic' whilst carrying out adult safeguarding enquiries is necessary to ensure enquiries and responses are not affected by biases, or unintentional collusion and remain impartial and fair.

2. **Organisational Responsibility: Statutory Adult Social Care departments must ensure there is a provision of reflective and restorative supervision for those undertaking adult safeguarding work.** The role of supervision cannot be underestimated in adult

safeguarding. In statutory settings, supervision is often focused on case management or driving the completion of the administrative 'paperwork'. Opportunities for supervision in adult safeguarding work need to be expanded. This study has highlighted why adult safeguarding practitioners need appropriate and safe spaces to explore their own emotional responses in order to do their work well. Critical reflection is a well-established requirement of social work practice and there is extensive social work theory that covers this. However, the ability or capacity to critically reflect is developed over time (Harvey, 2017).

These can be advanced within informal, formal, and peer-led supervision, or simply in safe spaces for reflection.

There are several models of social work supervision (Research in Practice for Adults (RiPFA) toolkit, 2017) which support reflective practice. Children's services have more recently recommended Swartz Rounds (SRs)[8] as a type of group supervision. Research has demonstrated that these are effective in reducing the psychological impact of the work (Wilkins et al., 2021). These groups provide a way for staff to meet and share stories and include the emotional aspects of their work. The reflective and restorative supervision model developed by Wallbank and Wonnocott (2015) is specifically for safeguarding supervision. It supports professionals to think critically, reflect, and make decisions (Wonnacott and Wallbank, 2016). It advocates for the supervisor to provide a safe and emotionally contained space. Harvey (2017) points out that developing reflective capacities that consider unconscious processes may be the most important element of supervision and this study supports that premise. Improving these capacities will help professionals to recognise important signs of hidden influence and identify where they may be negatively impacting their responses and decisions.

[8] Schwartz Rounds are traditionally used in Health settings to provide a structured forum where all staff, clinical and non-clinical, come together regularly to discuss the emotional and social aspects of working in healthcare.

3. **Individual Practitioner Responsibility:** This study has highlighted how individuals' personal history directly affects decision-making in adult safeguarding work. Practitioners must take responsibility for deeper reflections of their emotional world and how these interface with their professional work. Demanding and using Supervision spaces is also the responsibility of individual practitioners, as is the recognition of how the work impacts them personally. Dealing with adult abuse is emotionally draining and exhausting. It can cause discomfort, trigger fears, and evoke practitioners' own past experiences and traumas. Practitioners are likely to feel overwhelmed, that their efforts are futile, or experience an overarching sense of disbelief or cynicism. Adult Safeguarding cases can infiltrate practitioners' emotional worlds insidiously. As such, self-care and taking up opportunities for restorative supervision is essential if social workers are to sustain in this work.

4. **Statutory Adult Safeguarding Arrangements:** Adult safeguarding is a highly specialised practice area. The work can be as complex as child safeguarding work. It therefore requires the same infrastructure, resources and commitment that is seen occurring within children's services with child protection and safeguarding. In the literature review, Norrie et al.'s (2014) study which explored the best organisational arrangements for adult safeguarding was outlined. The major reservations were that specialist roles dilute the message that 'safeguarding is everybody's business' but the strengths included perceived objectivity and consistency in decision-making. This study further supports the argument for specialist adult safeguarding teams.

5. **Further research and literature are needed to inform Adult Safeguarding Practice -** A future task is to develop a model of decision-making for adult safeguarding work specifically – one that captures the presence of unconscious and emotional factors and a recognition of their influence in adult safeguarding practice. In addition, in the absence of a strong theoretical framework for understanding adult abuse, the legal framework is often over-relied upon, to give guidance on how best to respond. Adult Safeguarding Practice would benefit from

a more formalised and evidenced theoretical framework to help practitioners think about the primary task, i.e., adult abuse, and one that supports workers to recognise their limitations. Without a theory that explains unconscious and emotional processes in adult safeguarding practice, the decision-making challenges will not be fully understood.

Appendix 1: Literature review methodology

Sources, books and journals accessed for the literature review

I completed a Social Work masters at the Tavistock and so my starting point for the literature review was to collate the existing extensive research literature I already held in relation to psychoanalytic ideas as well as the collection of Social Work books written by prolific social work academics such as Michael Sheppard, Andrew Cooper, Brian Taylor and Michael Preston-Shoot, all of whom write about decision making.

My search process for obtaining more specific literature relating to my area of study involved using both primary and secondary sources from online databases, online journals, websites, libraries, and journals, through citation tracking and knowledge of supervisors. Examples of the online sources include:

The Tavistock Library online database where I could access:

- Journal of Adult Protection,
- British Journal of Social Work
- International Journal of Psychoanalysis
- Digital dissertations written by other social work students on the doctoral programme
- A wide range of e-books related to psychoanalysis, social work and decision making

ResearchGate and Taylor and Francis as online databases enabled me to access other relevant journals including:

- Journal of Elder Abuse & Neglect
- Journal of Interprofessional Care
- Journal of social work practice
- European journal of social work

Google Scholar – this online database enabled me to access wider international literature journals where searches flagged relevant literature around decision making

- International Journal of Nursing Studies
- Journal of Psychiatric and Mental Health Nursing
- Journal of Trauma & Dissociation
- Journal of the American Academy of Matrimonial Lawyers

Search terms

A search strategy was carried out, implementing the search term list (see below) within each of the above online sources, in addition to library collections.

The following terms were used in combination with one another:

- Adult Safeguarding
- Adult Abuse
- Adult Protection
- Vulnerable Adult
- Safeguarding

- Child protection
- Unconscious factors influencing decision making
- Emotional factors influencing decision making
- Emotions and decision making
- Factors influencing decision making in safeguarding

Appendix 2: Research and ethical approval letter

13th December 2017

Dear Janna,

Project Title:	**Safeguarding Adults: The impact emotional and unconscious factors have on decision-making.**
Principal Investigator:	**Professor Andrew Cooper**
Researcher:	**Janna Kay**
Reference Number:	**UREC 1617 86**

I am writing to confirm the outcome of your application to the University Research Ethics Committee (UREC), which was considered by UREC on **Wednesday 5 July 2017.**

The decision made by members of the Committee is **Approved**. The Committee's response is based on the protocol described in the application form and supporting documentation. Your study has received ethical approval from the date of this letter.

Should you wish to make any changes in connection with your research project, this must be reported immediately to UREC. A Notification of Amendment form should be submitted for approval, accompanied by any additional or amended do cuments: http://www.uel.ac.uk/wwwmedia/schools/graduate/documents/Notification-of-Amendment-to- Approved-Ethics-App-150115.doc

Any adverse events that occur in connection with this research project must be reported immediately to UREC.

Approved Research Site

I am pleased to confirm that the approval of the proposed research applies to the following research site.

Research Site	Principal Investigator / Local Collaborator
Local authority office	Professor Andrew Cooper

Approved Documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
UREC application form	2.0	7 December 2017
Participant Information sheet	2.0	7 December 2017
Consent form	2.0	7 December 2017
Proposed Weekly Observation log	1.0	27 June 2017
Interview schedule prospective participants	1.0	27 June 2017
Debriefing sheet	1.0	27 June 2017
Useful Contact Information	1.0	27 June 2017
Gatekeeper letter from Children's and Adults' Service – Ealing Council	1.0	7 December 2017

Approval is given on the understanding that the UEL Code of Practice in Research is adhered to.

The University will periodically audit a random sample of applications for ethical approval, to ensure that the research study is conducted in compliance with the consent given by the ethics Committee and to the highest standards of rigour and integrity.

Please note, it is your responsibility to retain this letter for your records.

With the Committee's best wishes for the success of this project.

Yours sincerely,

Fernanda Silva
Administrative Officer for
Research Governance University

Research Ethics Committee (UREC) Email: researchethics@uel.ac.uk

Appendix 3: Observation information sheet

Information sheet for prospective participants

University of East London
[Tavistock Centre: 120 Belsize Ln, London NW3 5BA]

University Research Ethics Committee
The proposed research has received formal approval from the University Research Ethics Committee
If you have any queries regarding the conduct of the programme in which you are being asked to participate, please contact:

Catherine Fieulleteau, Research Integrity and Ethics Manager, Graduate School, EB 1.43
University of East London, Docklands Campus, London E16 2RD
(Telephone: 020 8223 6683, Email: researchethics@uel.ac.uk).

The Principal Investigator
[Janna Kay]
[jkay@tavi-port.nhs.uk]

Consent to Participate in a Research Study
The purpose of this document is to provide you with the information that you need to consider in deciding whether to participate in this study.

Project Title
Safeguarding Adults: The impact emotional and unconscious factors have on decision-making.

Project Description

Since Eileen Munro's review of child protection procedures in 2010, there has been a growing body of knowledge seeking to understand the complex dynamics in child protection work, including what the emotional and unconscious factors effecting child protection workers are. I have however found relatively little research into adult safeguarding work and even less research exploring the emotional and unconscious factors involved in decision making in this area. My intention is therefore to undertake a qualitative research study that addresses this.

The nature of adult safeguarding can conflict with other adult abuse models such as domestic violence, because while it aims to uphold principles of empowerment and choice, there are clear 'duties of care', placed on professionals working with these adults. Practitioners often find themselves in complex dilemmas', trying to balance an adult's right to autonomy and choice, over the duty to ensure these same adults who cannot protect themselves, are kept safe. This balance can become stressful and emotionally

charged particularly when practitioners are working with adults who are making decisions to remain in abusive situations, and professionals feel unable to fulfill their duties to protect them

The aim of my research therefore hopes to achieve the following:

- To identify the key emotional and unconscious factors affecting decision making in safeguarding adults work and how this understanding can support practitioners in their decision making
- To understand whether the nature of the work impacts on decision making in adult safeguarding work
- To investigate how the stories of the people experiencing abuse or neglect, impact on practitioners and their practice, including decision making

My intention to explore practitioners' personal experiences and to highlight the role of emotional and unconscious factors within adult safeguarding draws me toward using a qualitative approach. I'll conduct interviews as well as utilising psychoanalytic observation.

Contribution required from your participation:

Observation*:* I will be observing you, (and your colleagues) within your team for an hour at the same time every week for a period of 3 months. You will receive a consent form, which will ask your permission for me to do this and whether agree to me making weekly recordings (after) of the observation. My observations will be discussed within a seminar group as part of the research process however all details will be anonymised and kept confidential.

Please note: While this is unlikely to happen, if you are a participant that is in a dependent relationship with me as a researcher, please note that your participation in the research will have no impact on any future assessment / treatment / service-use or support you may require.

Possible benefits/disadvantages anticipated by being a participant

Observation: You may find it strange to not be able to engage with the researcher and also it could feel hard to be observed while trying to do your work. The overall aim of this research is to identify both the helpful and unhelpful influences, which influence decision making for people who are most at risk. The benefit of this is that this knowledge can be used to improve responses from professionals and in some cases, improve the outcome of the interventions carried out. Understanding this may help to normalise the experience of the research process for you.

Support available to you following your participation

As a researcher, I won't be available to discuss any further thoughts or feelings brought about following your participation in the research, however I'll provide some useful contact information to you, where can seek support if you need this. I won't be providing

any type of feedback to you following the observation, however if you would like to receive a copy of the final report of the study (or a summary of the findings) when it is completed, I will provide my contact details so that you can feel free to contact me to request this.

Confidentiality of the Data

All information obtained remains confidential. If you make a disclosure is made that indicates that you or someone else is at serious risk of harm however, I will have to report this to the relevant authority.

Your anonymity will be ensured in the write-up by disguising your identity. All data collected will be stored safely with the researcher only. Any information shared with the researcher's supervisor or those involved with assisting the researcher with processing and analysing will be anonymised. Data obtained through the research will only be kept as per Data Protection Act (1998), which permits this for a limited time of 6-10 years (and then will be destroyed).

Location

The observation will take place within your workplace/team.

Disclaimer

You are not obliged to take part in this study, and are free to withdraw at any time, either before it starts or while participating, and you can refuse to answer any questions. Should you choose to withdraw from the programme you may do so without disadvantage to yourself and without any obligation to give a reason. There will be a cut off to when you can withdraw permission, and this will be (insert date) as I will have started using your information by this point – making it difficult to remove it from the analysis.

Appendix 4: Observation consent form

Adult Safeguarding – exploring the experiences of practitioners

Participant Consent Form

I……agree to participate in Janna Kay's research study.

- The purpose and nature of the study has been explained to me verbally and in writing.

- I am agreeing voluntarily to be observed alongside other team members within my team during work time for a period of 10 weeks (maximum one hour each week each time.

- I give permission for the researcher's observations of me to be recorded

- I understand that I can withdraw permission for the researcher use her observations of me, in which case, the material will be securely deleted. I understand that there will be a cut off to when I can withdraw permission, and this will be (insert date) as the researcher will have started using my information by this point – making it difficult to remove it from the analysis.

- I understand that anonymity will be ensured in the write-up by disguising my identity: however, I am aware that this research project has a small number of participants and there may be limits to the level of anonymity I can expect.

- I understand that disguised extracts from the researcher's observations may be quoted in the thesis and any subsequent publications if I give permission below:

  (Please tick one box:)

  - I agree to quotation/publication of extracts from my interview

  - I do not agree to quotation/publication of extracts from my interview

Signed by participant Date

…… ……..

Signed by Janna Kay Date

…… ……

Appendix 5: Debriefing form observation

Debriefing Form for Participation in a Research Study

Tavistock Centre

(University of East London)

Thank you for your participation in my study! Your participation is greatly appreciated.

Purpose of the Study:

I previously informed you that the purpose of the study was to explore the experiences of practitioners carrying out adult safeguarding work. The goal of my research is to understand some of the emotional and unconscious factors within this work with the view of gathering information that might help inform us better about the challenges of this work, and how practitioners can best be supported to do this well.

I realise that sometimes the process itself can provoke strong emotional reactions. As a researcher, I don't provide mental health services and I won't be following up with you after the study. However, I want to provide every participant in this study with a comprehensive and accurate list of clinical resources that are available, should you decide you need assistance at any time. Please see information pertaining to local resources at the end of this form.

Confidentiality:

You may decide that you do not want your data used in this research. If you would like your data removed from the study and permanently deleted, please contact me by the (insert date) so that I know you are requesting this be excluded.

Please do not disclose research procedures and/or hypotheses to anyone who might participate in this study in the future as this could affect the results of the study.

Feedback about the research:

I won't be providing any type of feedback to you following this observation, however if you would like to receive a copy of the final report of this study (or a summary of the findings) when it is completed, please feel free to contact me.

Useful Contact Information:

If you have any questions or concerns regarding this study, its purpose or procedures, or if you have a research-related problem, please feel free to contact me:

Ms Janna Kay

Email: jkay@tavi-port.nhs.uk

If you have other concerns about this study or would like to speak with someone not directly involved in the research study, you may contact the programme lead:

Professor Andrew Cooper

Email: ACooper@tavi-port.nhs.uk

If you feel upset after having completed the study or find that aspects of the observation triggered distress, talking with a qualified clinician may help. If you feel you would like assistance, please contact:

Samaritans:

This is a service for people who are going through a difficult time and who need a confidential place to speak to someone. The service can be accessed round the clock, every single day of the year.

UK helpline number: 116 123

Email: jo@samaritans.org

Website: http://www.samaritans.org/

Staff counselling line:

Your local authority has a confidential counselling service, which you are allowed to access free of charge and for which, you will remain anonymous.

The details for this are: (deleted).

*****Please keep a copy of this form for your future reference. Once again, thank you for your participation in this study!*****

Appendix 6: Interview information sheet

Information sheet for prospective participants

University of East London
[Tavistock Centre: 120 Belsize Ln, London NW3 5BA]

University Research Ethics Committee
The proposed research has received formal approval from the University Research Ethics Committee
If you have any queries regarding the conduct of the programme in which you are being asked to participate, please contact:

Catherine Fieulleteau, Research Integrity and Ethics Manager, Graduate School, EB 1.43
University of East London, Docklands Campus, London E16 2RD
(Telephone: 020 8223 6683, Email: researchethics@uel.ac.uk).

The Principal Investigator
[Janna Kay]
[jkay@tavi-port.nhs.uk]

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The purpose of this document is to provide you with the information that you need to consider in deciding whether to participate in this study.

Project Title
Safeguarding Adults: The impact emotional and unconscious factors have on decision-making.

Project Description
Since Eileen Munro's review of Child protection procedures in 2010, there has been a growing body of knowledge seeking to understand the complex dynamics in child protection work, including what the emotional and unconscious factors effecting child protection workers are. I have however found relatively little research into adult safeguarding work and even less research exploring the emotional and unconscious factors involved in decision making in this area. My intention is therefore to undertake a qualitative research study that addresses this.

The nature of adult safeguarding can conflict with other adult abuse models such as domestic violence, because while it aims to uphold principles of empowerment and choice, there are clear 'duties of care', placed on professionals working with these adults. Practitioners often find themselves in complex dilemmas', trying to balance an adult's right to autonomy and choice, over the duty to ensure these same adults who cannot protect themselves, are kept safe. This balance can become stressful and emotionally

charged particularly when practitioners are working with adults who are making decisions to remain in abusive situations, and professionals feel unable to fulfill their duties to protect them

The aim of my research therefore hopes to achieve the following:

- To identify the key emotional and unconscious factors affecting decision making in safeguarding adults work and how this understanding can support practitioners in their decision making
- To understand whether the nature of the work impacts on decision making in adult safeguarding work
- To investigate how the stories of the people experiencing abuse or neglect, impact on practitioners and their practice, including decision making

My intention to explore practitioner's personal experiences and to highlight the role of emotional and unconscious factors within adult safeguarding draws me toward using a qualitative approach. I'll conduct interviews as well as utilising psychoanalytic observation.

Contribution required from your participation:

Interviews: If you are interested in participating, you will need to be currently undertaking adult safeguarding work or have had at least 2 years of experience in this area. You can be from either a health or social care setting. As a participant, you will be asked to attend two interviews lasting no longer than 1.5hrs. The type of interview is a free associative narrative interview so there will not be a set of structured questions but rather one main question inviting you to share your experiences in an open-ended way.

Please note: While this is unlikely to happen, if you are a participant that is in a dependent relationship with me as the researcher, please note that your participation in the research will have no impact on any future assessment / treatment / service-use or support you may require.

Possible benefits/disadvantages anticipated by being a participant

Interview: You may find that the interview provides a space for you to talk about your experiences as a practitioner working within adult safeguarding. You could find it helpful to talk about some of the challenges you've experienced and what cases have stayed with you. Similarly, you may find the interview process difficult, and it might bring up old memories and difficult or distressing feelings that are unexpected.

Support available to you following your participation

As a researcher, I won't be available to discuss any further thoughts or feelings brought about following your participation in the research, however I'll provide some useful contact information to you, where can seek support if you need this. I won't be providing any type of feedback to you following the interviews, however if you would like to receive a copy of the final report of the study (or a summary of the findings) when it is completed, I will provide my contact details so that you can feel free to contact me to request this.

Confidentiality of the Data

All information obtained remains confidential. If you make a disclosure is made that indicates that you or someone else is at serious risk of harm however, I will have to report this to the relevant authority.

Your anonymity will be ensured in the write-up by disguising your identity. All data collected will be stored safely with the researcher only. Any information shared with the researcher's supervisor or those involved with assisting the researcher with processing and analysing will be anonymised. Data obtained through the research will only be kept as per Data Protection Act (1998), which permits this for a limited time of 6-10 years (and then will be destroyed).

Location

The interviews will either take place in your work-place or another local authority venue.

Disclaimer

You are not obliged to take part in this study, and are free to withdraw at any time, either before it starts or while participating, and you can refuse to answer any questions. Should you choose to withdraw from the programme you may do so without disadvantage to yourself and without any obligation to give a reason. There will be a cut off to when you can withdraw permission, and this will be (insert date) as I will have started using your information by this point – making it difficult to remove it from the analysis.

Appendix 7: Interview consent form

Adult Safeguarding – exploring the experiences of practitioners

Participant Consent Form

I……agree to participate in Janna Kay's research study.

- The purpose and nature of the study has been explained to me verbally and in writing.
- I am agreeing voluntarily to be interviewed twice for a maximum of 1-2 hours each time.
- I give permission for my interview to be recorded
- I understand that I can withdraw from the study, without repercussions, at any time, either before it starts or while I am participating, and that I can refuse to answer any questions.
- I understand that I can withdraw permission to use my interview in which case, the material will be securely deleted. I understand that there will be a cut off to when I can withdraw permission, and this will be (insert date) as the researcher will have started using my information by this point – making it difficult to remove it from the analysis.
- I understand that anonymity will be ensured in the write-up by disguising my identity: however, I am aware that this research project has a small number of participants and there may be limits to the level of anonymity I can expect.
- I understand that disguised extracts from my interview may be quoted in the thesis and any subsequent publications if I give permission below:

  (Please tick one box:)

  - I agree to quotation/publication of extracts from my interview □
  - I do not agree to quotation/publication of extracts from my interview

- Please tick this box if you agree to be contacted for involvement in future research projects by the researcher. □

- Please tick this box if you give permission for your data to be used in future research projects by the researcher. □

Signed by participant Date

…….. ……..

Signed by Janna Kay Date

…….. ……

Appendix 8: Interview debrief form

Debriefing Form for Participation in a Research Study

Tavistock Centre

(University of East London)

Thank you for your participation in my study! Your participation is greatly appreciated.

Purpose of the Study:

I previously informed you that the purpose of the study was to explore the experiences of practitioners carrying out adult safeguarding work. The goal of my research is to understand some of the emotional and unconscious factors within this work with the view of gathering information that might help inform us better about the challenges of this work, and how practitioners can best be supported to do this well.

I realise that sometimes the process itself can provoke strong emotional reactions. As a researcher, I don't provide mental health services and I won't be following up with you after the study. However, I want to provide every participant in this study with a comprehensive and accurate list of clinical resources that are available, should you decide you need assistance at any time. Please see information pertaining to local resources at the end of this form.

Confidentiality:

You may decide that you do not want your data used in this research. If you would like your data removed from the study and permanently deleted please contact me by the (insert date) so that I know you are requesting this be excluded.

Please do not disclose research procedures and/or hypotheses to anyone who might participate in this study in the future as this could affect the results of the study.

Feedback about the research:

I won't be providing any type of feedback to you following your interviews, however if you would like to receive a copy of the final report of this study (or a summary of the findings) when it is completed, please feel free to contact me.

Useful Contact Information:

If you have any questions or concerns regarding this study, its purpose or procedures, or if you have a research-related problem, please feel free to contact me:

Ms Janna Kay

Email: jkay@tavi-port.nhs.uk

If you have other concerns about this study or would like to speak with someone not directly involved in the research study, you may contact the programme lead:

Professor Andrew Cooper

Email: ACooper@tavi-port.nhs.uk

If you feel upset after having completed the study or find that some questions or aspects of the study triggered distress, talking with a qualified clinician may help. If you feel you would like assistance, there are a number of options available for you to contact. These include:

Samaritans:

This is a service for people who are going through a difficult time and who need a confidential place to speak to someone. The service can be accessed round the clock, every single day of the year.

UK helpline number: 116 123

Email: jo@samaritans.org

Website: http://www.samaritans.org/

Staff counselling line:

Your local authority has a confidential counselling service, which you are allowed to access free of charge and for which, you will remain anonymous.

The details for this are: (deleted).

*****Please keep a copy of this form for your future reference. Once again, thank you for your participation in this study!*****

Appendix 9: Summary of cases discussed by participants

Cases discussed during the observation:

The following cases are summarised to capture the types of cases that were observed as being discussed by and amongst team members. These are referenced in the findings and discussion as (O:x) with x being the relevant number below:

1. The senior (Cynthia) talked to her colleague about an establishment including that there had been concerns about a man being so neglected his tongue had gone black.

2. A daughter who was the full-time carer for her mother, was accused of neglecting her mother. The initial concern was that her elderly mother had a severe pressure sore, and her daughter was refusing equipment. District Nurses then reveal that the mother was extremely difficult (and often unkind to the daughter) and was refusing the equipment and any formal paid care – which could have supported the daughter.

3. Parent of an individual who had serious mental health problems.

4. Son abusing his mother who had cerebral palsy and mental health difficulties. He was regularly violent toward his mother who still wanted to continue to be his carer. He had recently been in hospital after slicing open his wrists. The mother described how the blood had sprayed everywhere all over the floors and tables. He had cut through all the veins and tendons/arteries in his wrist and Doctors had to surgically repair each one – he had reduced use of his hand as a result. The son worked full time and had been awarded an OBE. Employers did not know about his violence toward his mother.

5. Man with Korsakoff's dementia and alcohol abuse reported he was sexually abused when in hospital. There was some evidence that he had an enema whilst in hospital.

6. Iranian activist who was beating his wife.

7. Domestic abuse case: a woman whose husband had dementia had started lashing out at her.

8. A young person who was street homeless. She had a tenancy but was found living with an older man and to be pregnant.

9. Concerns about a son's behaviour toward his elderly mother. When they explored the information further, the son was 72 years old, and his mother was 92 years old.

10. Elderly man dying. Care Home raised a safeguarding about the family, implying they wanted to kill him when they asked about 'assisted death'.

11. Whistle-blower had contacted CQC about a care-home. There were several people who had died: 7 cases when only 24 people lived at the home. Referrer was London Ambulance Service who expressed concern it may be about the home's DNAR policy.

12. A carer stated she no longer wanted the formal care package arranged for her. The senior expressed surprise as this carer had reportedly demanded this be put in place because she was not coping. Both the Senior and the social worker agreed that this woman had exaggerated how severe things were to get what she wanted at the time.

Cases discussed during the interviews:

Sameera spoke about three cases:

1.1. A man with dementia who was found tied up to the bed by his son and then later died in hospital

1.2. A young woman who had severe disabilities and two young children, who was killed by her husband (domestic homicide review).

1.3. A mother-daughter domestic violent relationship. The mother was an older woman in her 90s and she lived with her daughter who was in her 60s. The daughter reportedly had several disabilities and undiagnosed mental health issues. The safeguarding concerns centered around the daughter's behaviour and 'anger issues' which escalated to her pushing and fracturing her mother's shoulder. The mother did not want to press charges and did not want to get any type of protection orders or sanctions put in place. The mother reportedly said she could manage it and wanted her daughter to remain living with her. The mother dies but of natural causes.

Sam only spoke about one case:

2.1 A case of an elderly mother and her son who was financially abusing and chronically neglecting her. The son was taking all his elderly mother's money to fund his drug problem and possibly due to gang threats. Her daughters sent him pictures of how much weight she had lost to highlight that the son was leaving her to starve. The son would not allow anyone (professionals or other family members) to see her. The woman denied she was being abused until eventually whilst in hospital and away from her son, admitted it was happening.

Isabela spoke about two cases:

3.1 A concern raised about possible financial abuse of an elderly lady by an informal carer (friend). The informal carer finds out about the allegation against her and verbally attacks and threatens Isabela.

3.2 A 97-year-old lady who was a hoarder, lived alone, with no support in a house full of Hoard. It was inhabitable and full of mice. She was refusing all help and said she could manage fine. She then has a fall and dies a few days after being seen by Isabela.

Andria spoke about four of her own cases and one case that her supervisee was dealing with:

4.1 A young adult who kept coming into hospital with severe bruising and sometimes fractures. She said her father was sexually abusing her however other professionals felt she was self-harming – the real cause of her injuries.

4.2 Two hoarding cases: One where the person died. Another where she kept the case open (it had already been two years), kept visiting and doing his shopping, hoping to eventually convince him to accept help.

4.3 A MAPPA (high risk panel) probation case of serial rapist who would dress bizarrely and post pictures of himself dancing online. This same man came into her daughter's workplace. The daughter had no idea who he was and thought he was funny and had exchanged emails with him.

4.4 A man who had Lasting Power of Attorney (LPA) for his neighbour and arranged private care for him. The private carer was financially abusing him. The Social worker kept working with the LPA, but Andria knew that it was the LPA who was responsible for the financial abuse. She described how she was waiting for the social worker to realise this herself.

Vivienne spoke about four cases:

5.1 A retired teacher who was following the death of her mother became a victim of scamming. She was scammed £25k by the man who claimed he was 'fixing her floors and garden'. She believed she was in a relationship with him. She ended up signing her house over to him and lost all her money. In hospital, she realised what had happened. Vivienne supported her to fight a legal case and she got her house back, moved to sheltered housing and was reportedly happy.

5.2 A concern was raised by family members about their mother's partner. They reported he was keeping her in the flat, not allowing her to have access to her friends, or her family and isolating her. Vivienne concluded that they both had dementia and felt they needed support. Vivienne's view was the couple had cocooned themselves into the flat for 30 years and would not let anyone come in due to fear of judgment. She felt the family members disliked the man because the relationship had started as an affair.

5.3 A best interest's decision is taken for man to no longer have cancer treatment. He is placed in a care home who interpret this to mean 'no treatment' of any kind. He loses 10kg, his urinary tract infections go untreated and a blood clot on the back of his leg which causes him to become immobile, is not picked up because he is not sent to hospital by the care home staff.

5.4 A man who was being exploited, drugged, and scammed by a woman who was trying to get him to change his will, was discharged from hospital and later found dead.

Serwa spoke about three cases:

6.1 Family members (siblings) fighting over their mother's property and whether their mother should remain in a care home.

6.2 A man whose partner died and left him some assets – money and property, became a victim of a scam. Despite Police, GP and Social Worker telling him he was being scammed, he refused to believe them. Serwa assessed that he lacked capacity to make decisions in relation to managing his property and finances. She reported that no legal action could be taken because they required documentation from him that they could not obtain because he refused to engage. The man lost two houses and a significant amount of money (£500k or a million) and ended up homeless.

6.3 A man whose wife died, is placed into a care home where his estranged son starts visiting. There are concerns he is financially abusing him. His late wife had asked her friend to look after him and she was managing his money with no formal legal arrangement. She kept giving the son money because the man asked her to do this.

Cynthia spoke about four cases:

7.1 A husband who tried to strangle his wife. They are both in their early seventies. She had mild dementia. Police do not prosecute as they determined it was not in the public interests.

7.2 70-year-old woman was taken to hospital and found to have finger marks on her neck and bruises on her leg. She had fallen at home in the night and pressed her alarm pendent which called her son. The son was reportedly annoyed at having to attend to her. She reported that he got so angry that while she was on the floor, he kicked or punched her, in her mouth, and tried to strangle her. He also took a pillow and tried to suffocate her.

7.3 A woman in a care home had capacity and was sexually assaulted by one of the workers. There was no forensic evidence, and this went straight to court.

7.4 A young girl in her twenties kept going into hospital with severe bruising.

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