Fabled Uncertainty in Social Work: A Coda to Spafford et al
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Fabled Uncertainty in Social Work

A Coda to Spafford et al.

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Abstract

- *Summary*: In a recent issue of this journal, Marlee Spafford and her colleagues reported on a Canadian study of social work, medical and optometry students. One of their findings was that the novice social workers viewed the acknowledgement of uncertainty as a hallmark of professional competence. Drawing on data from UK-based studies of professional reasoning, this article challenges the notion that social work has embraced and engaged with uncertainty.
- *Findings*: Despite the obvious ambiguities of many cases, much of the time social workers often feel very sure of their formulations. This is because social work takes place in the terrain of human relationships about which we all, *qua* human beings, routinely make moral evaluations in everyday life. Rhetoric of complexity and reflection should not be confused with uncertainty.
- *Applications*: This article endorses Spafford et al.'s respect for uncertainty and tentativeness, but argues that it is folly to think that we already have it in social work. A tentative and sceptical vocabulary of the emotional and moral domain is required if social work is indeed to embrace and acknowledge the limits and fallibilities of its technologies and practices.

Keywords case formulation culture emotion moral judgement professional identities uncertainty

Introduction

I read with interest the article by Marlee Spafford and her colleagues, in the August 2007 issue of this journal. The article, 'Towards Embracing Clinical Uncertainty: Lessons for Social Work, Optometry and Medicine', caught my eye as I have undertaken a number of ethnographic studies of professional reasoning in a range of child health and welfare professions. Specifically in relation to

the place of uncertainty in social work practice, the findings from these studies are at odds with some of the conclusions made by Spafford et al. I thought it may be useful to articulate the differences and attempt, where possible, to generate some explanations for them. The article is not a straightforwardly a 'response' to Spafford et al. I have no reason to doubt the veracity of their claims, or the quality of their analysis. It is intended as a coda, a closing section, or a cautionary note about the generalizability of their assertions.

Spafford et al. argue that 'Social Work students viewed the acknowledge-ment and examination of uncertainty as a touchstone of competent social work' (p. 155) and further, 'social work students in this study are socialized to embrace uncertainty as a natural element of professional work and development' (p. 171). This claim is made on the basis of analysis of transcripts of supervision sessions. I have no quarrel with this finding as student supervision takes place in the context of a set of pedagogical assumptions about novice status and one of social work's legitimating narratives is the capacity to reflect and 'confess' one's limitations (Taylor, 2006; Taylor and White, 2000). Thus, it is not surpris-ing that novices should offer up confessionals in this context. Spafford et al. contrast this with the accounts of student optometrists and medics. The case presentations of medics in particular are contrasted with those of social workers and it is argued that the former are characterized by an attempt to conceal doubt or uncertainty. Again, this is not entirely surprising since case presen-tation in medicine is often 'made earlier' for the purposes of demonstrating diagnostic competence in cases where there is a *right* answer. These prepared presentations will indeed, as the authors note, provide rehearsal opportunities for the display of professional confidence integral to medical socialization. However, I have seen many case presentations in medicine where there are a number of competing differential diagnoses and where junior medics are *expected* to demonstrate doubt and uncertainty and that they have not jumped to conclusions.

So, here I want to engage in conversation with Spafford et al. on the following grounds:

1) Whilst I have no disagreement with their analysis of the data they are not comparing like with like. For example, had they looked at student social workers presenting a case in a multi-disciplinary meeting, I will wager they would have found fewer displays of uncertainty. Had they looked at junior doctors seeking informal advice from senior colleagues, or discussing cases amongst themselves, I will wager they would have found more instances of students 'owning their own limits' – there is no other way to seek advice, and seeking appropriate advice is one of the criteria for assessing junior doctors' competence (Stewart, 2006).

2) The authors extrapolate from their work to suggest that their findings may in some way be illustrative of enduring professional identities and behav-iours. Here they come perilously close to eulogizing social work's putative

embrace of uncertainty and reproducing some rather tired notions of complacent medical dominance. My own data, or at least my reading of them, challenge these views. Certainty and uncertainty are a good deal more context-dependent than has been suggested by Spafford et al. and professional identities a good deal more malleable. Specifically, in the UK at least, the notion that the day to day practice of professional social work can accommodate, let alone embrace uncertainty is erroneous.

My ideas on this matter developed substantially whilst I was analysing a corpus of data from a two-year ethnographic study of an integrated child health service (White, 2002; White and Stancombe, 2003). The service comprised paediatric inpatient and outpatient facilities, a child and adolescent mental health service, a child development centre and social work team. Methods included observation of clinics, ward rounds and staff/team meetings, audio-recording of interprofessional talk in meetings and other less formal settings, such as before and after clinics, the tracking of a number of individual cases through the services and a documentary analysis of medical notes. The study generated many hours of audio-taped, naturally occurring conversations between various professionals in meetings, over coffee, in corridors and so forth. On analysing these data, I was struck by how many markers of uncertainty – 'it might be, but I'm not sure', 'I know the test says this, but you can never tell' – there were in doctors' talk about relatively 'technological' matters like test results. I was equally struck by how relatively few such markers there were in social workers' talk, which often took the form of complex characterizations of people, relationships and so forth. Moreover, when doctors were discussing relationships, their talk too became much more apodictic in flavour, with fewer markers of uncertainty. This was something of a surprise, but it did not prove too difficult to generate what I think are reasonable candidate explanations.

These I shall articulate in due course, but first, some data. The following extract is taken from pre-clinic briefing sessions between a consultant paediatrician and a registrar.

Extract 1

CON: He's been in with asthma but that's not why he comes to see us. The main reason is some hydronephrosis – I think I've got the last scan seems to have a problem attending [reading] Repeat ultrasound October 99, it's still hydronephrosis, further up urinary tract infection, yeah, for definite.

REG: That's back in April

CON: Back in April. DMSA [dimercaptosuccinic acid – test to assess scarring and relative function of kidney] clear. Mild right sided hydronephrosis with prominent renal pelvis mainly extra renal, no scarring and no (.) reflux. So, I suppose I thought that the best way was to do repeat the ultrasound if the kidney was blowing up . . . It's difficult sometimes with these mild hydronephrosis. You never know whether it's the beginning of –

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REG: Or whether it's borderline-

CON: Or whether it's just the way they're made-

REG: Yeah, yeah

The consultant's account has a number of markers of certainty 'urinary tract infection, yeah, for definite', but these are juxtaposed with markers of uncertainty, warranted principally by clinical experience, 'It's difficult sometimes with these mild hydronephrosis', accompanied by references to the limits and fallibility of the technology. The difficulty in adjudicating between the normal and pathological is explicitly stated.

I have said that this kind of exchange was more commonly seen when clinicians were discussing what appeared to be the more technological aspects of medicine, with fewer markers of uncertainty when they were discussing psycho-social cases which demanded judgements about matters such as parental competence or love.

Extract 2

CON: Ben Owen – you've not had the pleasure, of this mother. Mother is under our psychiatrists she is a (2.0) oh (2.O) factitious illness gives the wrong impression. She's got a [neurotic] state really, somatization

REG: Right, right.

CON: Somatization, really *severe* somatization disorder

REG: Right, yeah

CON: You, you may have met her as soon as you meet her, she'll go on – he's constipated, severely constipated

REG: I think I probably, what's he got? Yes, it's all, yes

CON: She looks ill and as soon as you meet her she looks ill and she'll come out with all of her complaints. He has severe constipation actually required a manual when they first brought him in to extract the masses of faeces, but recently he's relapsed and the problem seemed to be that mum had relapsed as well so everything went down and he had to come in for an enema-

REG: That's right, that's right. That's how I know him, I didn't see him

CON: No well and mum couldn't, it had to be done here because mum can't cope at home, she can't cope. He was much better, but he was on sort of 30 mls of Picolax a day. His bowel is just sort of-

REG: -Huge

This extract is again taken from a discussion at the beginning of a paediatric outpatient clinic. The consultant begins by stating the child's name, but the 'mother' is immediately introduced as a troublesome party with the ironic statement 'you've not had the pleasure' and by assigning her to the deviant category

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'psychiatric patient'. With the statement, 'you, you may have met her as soon as you meet her, she'll go on – he's constipated, severely constipated', the consultant makes an implicit link between the symptom (constipation) and the mother's character. This needs very little elaboration, its relevance is not questioned by the registrar who appears to hear it as an account of what caused the problem. That is, by describing the mother and her behaviour, the consultant establishes the child's complaint as a psychological response to inappropriate parental management.

In the next extract a social worker is describing one of her clients. Here there is no explicit reference to theory, but the popular version of psychological ideas is used to produce a formulation about the case which is clear and unequivocal and forms the basis for the social worker's work.

Extract 3

Yes, I mean she's a very angry person but, so there are a lot of issues probably in the past that she could perhaps do with working through, whether she will or not I don't know. Her family have all turned against her because she drinks . . . In fact really if she had a more supportive family I think her problems would be a lot less, it's just that she's completely on her own with an aggressive nature. I mean, I was quite pleased today because I've had quite a few conversations with her about her aggression and how she deals with people and in the core group today I mean she started off saying she was going to kill the head teacher, she was going fucking punch her and all this sort of thing, but she was quite assertive really. She said what she had to say, not in a way that I would . . . so perhaps a bit of it's sinking in I don't know.

Here the social worker makes use of popular psychological knowledge. Her formulation draws implicitly on the ideas about early trauma associated with psychodynamic theory – 'so there are a lot of issues probably in the past that she could perhaps do with working through'. It makes explicit attributions of cause and effect ('really if she had a more supportive family I think her problems would be a lot less'), but also blames the client, or rather her drinking habits, for her not having a 'supportive family' – 'her family have all turned against her because she drinks'. She uses reported speech to support her claims about the client's aggressiveness, but goes on to mark the effect of her own interventions 'but she was quite assertive really. She said what she had to say, not in a way that I would . . . so perhaps a bit of it's sinking in I don't know'. This relatively popularized knowledge grants an apodictic, undisputed and irrefutable status to the formulations and enables the social worker to categorize and process the case and also to account for her actions. Moreover, because it invokes her status as eyewitness, it would be exceedingly difficult to challenge without compelling contradictory evidence.

These tendencies are even more evident in this extract from Sally Holland's ethnography of child and family social work.

Extract 4

> Mrs James presents as a passive young woman, expressing little change in her emotions. Engaging with her has been difficult, not only due to her missed appointments, but her personality is such that she does not initiate and maintain conversation. However, once given the attention, she can appear cooperative, she holds no strong views or opinions on matters relating to her life circumstances. Factors of her background, her motivations, the concerns she has, or her plans for the future are not known. (Extract from assessment report, Holland, 2000: 156)

The language in this written format has a more technical gloss, and a certain expertise is implied. The social worker is not easily duped: she can see beneath the surface – Mrs James only 'appears' cooperative. However, the claims are similar to those in Extract 3. They require very little in the way of argument or persuasion. They appear straightforwardly as simply so.

The data above illustrate that, in technological domains, clinicians often seem to display a degree of scepticism and uncertainty about the technologies themselves and the diagnoses they may suggest, whereas when opinions are proffered about human relationships these appear to be delivered with much less equivocation (for further detail and other exemplars, see White and Stancombe, 2003). In the domain of human relationships, then, professional talk centres not so much on uncertainty, but on complex characterizations. These formulations may or may not be accompanied by references to specific theories. That is, the popular nature of the ideas invoked apparently exempts practitioners from the imperative to justify their actions using formal knowledge. In the slippery world of relationships and interaction professionals seem to suspend disbelief, whilst in more rational-technical activities they seem to be more likely to display scepticism. So, how do we explain this apparent paradox?

I suggest that, contrary to Spafford et al.'s thesis that uncertainty is 'a touchstone of competent social work', there are at least three factors which may predispose social workers to depart prematurely from a position of 'respectful uncertainty' (Laming, 2003) about their assessments of people and situations.

1) Social work texts often rely substantially on relatively popularized, handbook versions of theory.
2) Social work often operates in the moral domain. We know from work in cognitive neuroscience that moral judgements rely substantially on affect – emotion – and that 'reasoning' appears to be added *ex post facto*. The emotional dog subsequently wags his rational tail (or tale!) (Haidt, 2001). Moreover, rather than destabilize these judgements, group discussion tends to solidify them, since affective judgements generate group norms.
3) Certainly in the UK, a combination of retrenched and over-stretched services, the demands of performance management and the impact of various information and communication technologies, means that decisions are made quickly on the basis of limited information, which means the

kinds of discussions Spafford et al. have seen in a pedagogical context are not typical of day-to-day talk in social work agencies.

Let us examine these arguments in turn.

Social Work and 'Take Away Knowledge'

The work of microbiologist and philosopher of science, Ludwik Fleck, who wrote originally in the 1930s, is relevant to my argument. Fleck was concerned with the processes whereby the tentative 'exploratory' science of the laboratory becomes transformed into something more stable. Fleck sought to understand how science changes as it moves from the 'esoteric' domains of the laboratory, into more applied settings and finally into 'popular', or 'exoteric' domains. He investigated this empirically, by analysing the structure of scientific literature, which he subclassified as 'journal' and 'handbook' (vade-mecum) science (Fleck, 1979: 111–12). Fleck pointed to the way in which laboratory science becomes gradually transformed and simplified as it becomes popularized. 'Journal science' is tentative and provisional, characterized by forms of expression, such as 'it appears possible that . . .' which invite the collective (community of scientists or practitioners) to adjudicate on the rightness or wrongness of the claims. In the extracts above it seems that the scientific language of technological medicine may provide a vocabulary through which uncertainty can be expressed as competence and savvy.

Fleck argues that over time journal science is moulded into a simplified form via vade-mecum (or handbook) science which results from the migration of ideas through the collective. Vade-mecum literally translated from the Latin means 'go with me'. In English, however, it has come to mean the kind of 'take-away knowledge' we find in textbooks. As handbook science travels further away from its sites of production via the media into the domain of popular science its status becomes even more simplified and 'certain'. Popular science is characterized by the omission of detail and of dissenting or controversial opinion. This transforms knowledge into something '[s]implified, lucid, and apodictic' (Fleck, 1979: 112). Thus, where judgements depend extensively on a combination of vade-mecum (handbook) science and popular wisdom, we may find professionals are often actually very good at carving certainty from ambiguity, as Spafford et al. indeed assert in relation to medicine (see Atkinson, 1995).

So, Fleck's argument is that, however specialized our field, a major portion of the knowledge we use is popular wisdom, or knowledge for non-experts. I suggest that this is particularly the case where judgements about people, relationships and personality are a central feature of the work – as is the case in social work (Stancombe and White, 2003; Taylor and White, 2006).

Moreover, social workers are particularly exposed to vade-mecum versions of psychological theories of various kinds. There are a number of obvious

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examples. The versions of attachment theory made available to social workers often lack the equivocations and caveats of the original works (Taylor, 2004). Indeed the simplifying 'lens' effect is intentional as Howe et al. argue below:

> [T]heories help to organize what we know. Theories also provide an economy of effort. They allow conceptual short-cuts to be taken. If the theory is powerful one, it might only take a few observations to locate a particular phenomenon as an example of a class of objects or behaviours . . . Hypotheses help to guide future observations, the results of which aid practitioners in further testing and refining their initial assessments and observations. (Howe et al., 1999: 228)

The knowledge of the vade-mecum provides just such powerful theories, but that is not altogether a good thing. Imagine for a moment Arnold Gessell (e.g. Gessell and Ilg, 1943) undertaking the seminal experiments that led to his classification of the ages and stages of cognitive and sensorimotor development in infants. In his laboratory work he observed any number of variously compliant or recalcitrant infants with the aim of charting what *most* infants do at various developmental stages. Of course, for each of the behaviours he eventually mapped, there would be a good few infants who did not display the behaviour in question for any number of reasons, yet these variations are obscured in the line drawings he eventually produced of children doing what *most* children did, which in turn populate various professional textbooks. These texts do not invite scepticism, they invite categorization. When observing paediatric outpatient clinics, for example, it is striking how many children are referred from primary health screening because their bladders and bowels stubbornly refuse to follow the developmental trajectory at the pace dictated by the charts. Paediatricians have a set of questions which help to identify those children who may have an underlying disorder, but the vast majority are simply defined as 'maturational problems' and the therapy is parental reassurance. A 'diagnosis' of an attachment disorder by a social worker is far harder to falsify, since there are few human behaviours that attachment theory cannot reasonably plausibly account for. In sum, 'technologies' of assessment are the handbook embodiments of theories. As such, they can construct versions of reality and affect what we 'see' when we 'observe', as John (1990) notes:

> [J]ust as theories are underdetermined by facts, so facts are overdetermined by theory, which means that situations may be capable of a range of factual interpretations depending on the theory selected. Furthermore, individual psychological theories have been shown to be capable of such a degree of interpretive flexibility as to virtually incorrigible; it has sometimes been difficult to find situations, even when they involve quite contradictory outcomes, which they could not plausibly explain. (John, 1990: 127)

There is a danger that all that is revealed in the application of a theory are its own metaphysics expressed in the diagnostic fables of its votaries (White and Wastell, forthcoming). When we add supple theory to our innate equipment for making emotional judgements and our tendencies as information processors towards seeking to confirm our initial hypotheses (Kahneman et al., 1982), we

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have an intoxicating concoction rendering us dizzy and drunk on our own convictions. The cocktail is all the more sweet and heady when supped in the company of like-minded friends.

Social Work, Moral Judgement and Emotion

I have said that there is compelling evidence from cognitive neuroscience to overturn the Cartesian separation of reason from emotion (inter alia, Damasio, 1994). The perspectives, closely allied to each other, carry a number of appellations, for example, the 'sentimental rules hypothesis' (Nichols, 2004) or 'social intuitionism' (Haidt, 2001). Based on sound empirical work, they convincingly demonstrate, in the words of neuroscientist Antonio Damasio, that:

> . . . certain aspects of the process of emotion and feeling are indispensable for rationality. At their best, feelings point us in the proper direction, take us to the appropriate place in a decision-making space, where we may put the instruments of logic to good use. We are faced by uncertainty when we have to make a moral judgement . . . Emotion and feeling, along with the covert physiological machinery underlying them, assist us with the daunting task of predicting an uncertain future and planning our actions accordingly. (Damasio, 1994: xiv–xv)

The social intuitionist approach articulated by psychologist, Jonathon Haidt (e.g. 2001) is particularly apposite for social work. Based on painstaking empirics from experimental psychology Haidt shows that *reasoning* follows moral judgement not the other way round. So, to use Haidt's example, the process goes as follows: 'abortion feels wrong'. Why? 'Well, life begins at conception' *not* 'life begins at conception' *therefore* 'abortion is wrong'. Emotions are, then, indispensable (but not infallible) guides to decision-making. We had affect before we had language and thus verbal reasoning is often the post script to judgements made on other grounds (Nussbaum, 2001). If emotion and moral judgement are inevitable and necessary, but are constructed as murky contaminants to reason then we face at least three potential problems:

1) Affective/moral judgements are justified using other warrants and therefore are concealed and not debated.
2) Positive emotional responses, such as compassion, can be bracketed out by technological vocabularies, procedure, habit, rule and routine.
3) Certain behaviours can become transformed into 'moral violations' by normative understandings of the group for example, a team's views on mothering may predispose them to certain judgements, as Haidt notes:

> Because moral positions always have an affective component to them, it is hypothesized that reasoned persuasion works not by providing logically compelling arguments, but by triggering new, affectively valenced intuitions in the listener . . . Because people are highly attuned to the emergence of group norms, the model proposes that the mere

fact that friends, allies and acquaintances have made a moral judgement exerts a direct influence on others, even if no reasoned persuasion is used. (Haidt, 2001: 819)

I have seen this effect many times when analysing extracts of interprofessional talk. When professionals make moral judgements which are congruent with group norms very little argument is generated. This brings me to my final points about practice cultures and contexts.

Culture, Organization and Social Work

I have argued that certain aspects of occupational culture operate in exactly the way Haidt has expounded above. Team talk is often confirmatory and group norms and understandings are often reinforced by humour and story-telling. The following extract is taken from a transcript of a weekly social work allocation meeting in a children and families team in the late 1990s.

Extract 4

Team Leader: . . . One that Deborah's been out on today with Bev, and Deborah and Sally are going to finish it off this afternoon was a family called [name] where there's a sort of marital conflict and where father's made allegations about mother's treatment of the children which does appear to be over the top

OTHERS: uuuuurgh [laughter].

Team Leader: I know, I know . . . Deborah is either trying to see Mum this afternoon or she and I will try to see them together tomorrow, but it just is possible that this is one that will appear again and I just think that I want people to be aware. There are four children in the family and there's been a marital dispute, mother left and dad said the children had made allegations which sound a bit over the top so that's one that may be coming back to us I suspect, but at the moment we're trying to deal with it very clearly as a one off and getting them to get legal advice.

The team leader categorizes this case as a 'sort of marital conflict', which implies that the father's account may be subject to bias or partisanship. This ironizes the father's version and trivializes any risk to the children. By the collective exclamation 'uuuuurgh', followed by laughter, social workers display their shared knowledge that allegations of abuse made by estranged partners are problematic. This is typical of this kind of case-talk. As Haidt suggests, the team leader's description of the referral draws out 'affectively valenced intuitions in the listener[s]' who respond with shared laughter.

The tendencies to rush to categorization are exacerbated by organizational impacts of current policy in the UK. With colleagues I have recently completed a two-year ESRC-funded study of the impact of ICTs on professional practice (e.g. Connelly et al., 2007; Hall et al., forthcoming; Peckover et al., 2008). We are currently engaged in further a project under the ESRC's public services programme looking at the impact of performance management in children's services. Both these studies show how, in various ways, judgements *have* to be

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precipitous and *have* to be coded as certain – the technologies demand it and the timescales imposed by government preclude equivocation about cases, which simply *have* to be categorized as this or that. Table 1 shows a set of referrals which greet the team manager of a referral and assessment team in one of our sites.[2]

Allocation and disposal decisions are made very quickly, often based upon little more information than is shown here. They are thus likely to involve substantial amounts of tacit knowledge and to require the exercise of moral judgement about normality and deviance. This leads to early categorization of the case, for example, 'this is a non-familial assault' or 'this is a behaviour support issue', and these are associated with plans about what is done in these

Table 1 **'Monday morning': cases referred to 'Erewhon' office**

 1 Police referral following w/e call out. 3 children witnessed domestic violence. Mother taken to hospital with fractured nose. Father arrested.
 2 Sexual abuse, and child assaulted by mother.
 3 Information that child is having contact with offender who has convictions for sexual assault.
 4 Young child (3) shot himself with airgun whilst in care of father over weekend. Parents separated. Child in hospital.
 5 Extra-familial assault.
 6 Referral from police following domestic violence call out. Children in household.
 7 Fight between step-father and young person.
 8 Behaviour issues with a teenager. Police called by parents.
 9 Out of area child placed in 'Erewhon' area. Older half-brother has alleged that he was assaulted by this foster carer when he was living there.
10 Police referral. Called to argument between a mother and her sibling. Baby present. No assaults or damage reported. Baby not involved.
11 Referral from police following call-out to a domestic violence incident. Ex-partner attacked a woman who has young children.
12 Father with alcohol and mental health issues. Police referral.
13 Catering worker at school hit a child in the dinner queue.
14 Child with severe head lice. Non-engagement with services.
15 Referral from probation. Substance misuser in relationship with woman with three young children.
16 Allegation of physical assault by father to 14-year-old son.
17 Notification from police they need to interview a minor who witnessed an extra-familial assault.
18 14-year-old boy with learning difficulties and past history of abuse from his father. Now concerns about his mother's parenting.
19 Children in care of their mother. Father has a Residence Order but children and mother have moved away. Allegations from father about their care and role of new boyfriend (using alcohol, abusive attitude).
20 Telephone call from mother saying she needed help with the baby as she couldn't cope.

sorts of cases. More importantly, the Referral Team Manager explained she undertook a risk assessment score 'in her head', and then filled in the form to evidence her decision. This again suggests an *ex post facto* rationalization for a decision taken on intuitive grounds, bearing out Haidt's thesis above. The risk scoring is undertaken on the computer and forms part of the e-record that is 'workflowed' through to the assessment team; it is also printed out and signed, symbolically suggestive of scientific risk assessment processes, but in truth it is an expedient re-packaging of an 'intuitive' professional judgement. Institutional categories, then, exist precisely to carve certainty from ambiguity and they are more than fit for purpose.

Conclusion

Spafford et al. argue that, for social workers, uncertainty is a touchstone of professional competence, rather than a personal deficit. They argue further that an 'attitudinal shift toward accepting and trusting uncertainty in medicine and optometry might facilitate an enriched environment for novices and more open dialogue with patients about issues of uncertainty' (p. 171). I have no reason to doubt that this is what their data show, but have argued that these findings differ markedly from my own. This may be due their focus on education and pedagogy. I spend a good deal of my time as a social work educator trying to inoculate my students against the tendencies I have described in this article. Alternatively, it may be that things are very different for social workers in Canada. Certainly in UK children's services where my empirical work is located, uncertainty is rarely an option for practitioners.

The raft of government reforms and particularly the implementation of various e-enabled assessment instruments push social workers towards precipitous categorizations and action. Institutional categories are the pistons inside a swift disposal device. Varieties of moral judgement and the limber knowledges disseminated in handbooks provide the lubrication for the machine's efficient execution. It is noteworthy that a similar categorical tendency has been described by Gerhard Riemann in his work with German social workers.

> [M]any practitioners seem to expect from themselves – and assume that the others expect it from them, too – that they can demonstrate quickly that they have reached professional insights . . . The speedy determination of 'what's the case' seems to be a prestigious and often competitive activity. (Riemann, 2005)

Whilst research-informed approaches appear to offer the possibility of challenge to received wisdom, they are unlikely to change the problematics of 'case formulation', where the imperative is to decide what is wrong, not what works. The bald fact is that many social workers in statutory settings do not to have the time to notice uncertainty in their work. They may repent at leisure after they have acted, or when mistakes become retrospectively obvious, but they go about their business nevertheless and are forced to so do by the organizational

systems that are in place. If we are to have a debate about what might be done, it must start with some clarity about how social workers in their day to day work 'think'. I share Spafford et al's respect for uncertainty and tentativeness, but it is folly indeed to think that we already have it in social work. A tentative and sceptical vocabulary of the emotional and moral domain is the very least that is required and we are unlikely to find it in easy-read psychology or e-enabled assessment frameworks. Rhetoric of complexity and reflection should not be confused with uncertainty. We have just to peer through the cracks in the wall at our elderly neighbours the early psychoanalysts – ministers without rival of a heady brew of certainty – to see that the two are not the same.

Acknowledgements

Notes

1. Hydronephrosis is a condition in which one or both of the kidneys become swollen, due to a build-up of pressure when urine cannot drain from the organ.
2. These data were collected by Dr Sue Peckover, University of Huddersfield, Senior Research Fellow on the project.

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