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The everyday risk work of Dutch child-healthcare professionals: inferring ‘safe’ and ‘good’ parenting through trust, as mediated by a lens of gender and class

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Abstract Amidst intensifying policy concerns with children’s wellbeing and development, healthcare professionals are required not only to assess risk of abuse and neglect, but to manage risk of ‘poor parenting’ more broadly. Drawing on 15 in-depth interviews and non-participant observations of 61 professional-family interactions, across four preventative public health services for children in the Netherlands, we explored how professionals accomplished such risk work amid intractable uncertainties. Building inferences from brief encounters with families, professionals gauged the extent to which they trusted parents to care ‘appropriately’. This trust developed most readily with parents experienced as ‘familiar’ by the largely middle-class female professionals. Harnessing Schutzian phenomenology, we analyse the related manifestations of social structure within the interactional-dynamics and lifeworlds of risk assessment. We argue that social structures of gender, class and ethnicity can be seen as influential both through the differing potential for ‘we-relationships’ to be formed and via the generalising and stereotyped knowledge applied in their absence.

Keywords: child public health, qualitative methods, risk work, Schutz, trust

Introduction

During the twentieth century, the dominant Western framing of childhood shifted from one in which children ought to be disciplined and protected from themselves to a belief that children should be happy, able to play and require protecting from the world (Ansell 2005). A related sacralisation and increased emotional valuing of childhood (Zelizer 1994), interwoven with shifts in social welfare governance (Donzelot 1979) and paediatric medicine (Halpern 1988), has shaped an intensifying concern with the wellbeing and development of families and children (Elizabeth and Lerner 2009, Reich, 2005).

Within such social and policy contexts, child rearing is increasingly conceptualised and medicalised in terms of harm prevention and risk. Scholars in child sciences have asserted the importance of problem detection and early intervention in children’s lives (Lee *et al.* 2014), based on evidence of different probabilities of outcomes across categories/groups, in order to prevent disruptions in childhood and serious psychopathologies in adulthood (Béhague and Lézé 2015). This extends ‘risk work’ beyond a small number of abusive or neglectful families

(c.f. Reich 2005) to include almost all families within the welfare concerns of the state (Donzelot 1979). In the Netherlands, risk-management has assumed a central role in the daily work of professionals, reflecting the current policy infrastructure around child-healthcare¹ (from here on CHC). The ongoing development of professional procedures and instruments for risk signalling and interventions via evidence-based programs is prioritised (Hermanns *et al.* 2005; Postma 2008) as is the case in other European countries, for instance 'Every Child Matters' in England² (DfES 2004). Such wide-ranging, future-oriented and 'fateful' policy conceptualisations of children's development and education have emerged out of more enduring policy traditions, informed by and informing various constructions of childhood (Donzelot 1979, Hoffman 2010).

In practice, every Dutch municipality provides low threshold CHC walk-in centres for all children between 0 and 19 years. Municipalities implement national protocols for child examinations, whereby 15 meetings (alternating between paediatricians and specialist CHC nurses) in the first four years follow a pattern of immunisations and developmental checks which are registered in each child's electronic file. The CHC teams receive newborns' birth information from the municipality and they call families for a home visit after birth to perform a newborn screening, followed by an intake at home by the CHC nurse. After the intake, the family receives a new appointment with the CHC pediatrician at the CHC centre, where all subsequent visits take place (Dunnink and Lijs-Spek 2008). Legally-speaking, CHC is not compulsory but in practice it functions as a comprehensive system, working with 92.8 per cent of Dutch children aged 0–4 (99.8% aged 0–2) and their parents (CBS 2010). 'Families at risk' are specifically targeted for additional home visits, more intensive programmes and/or are referred to specialist healthcare and welfare services (Postma 2008).

Functioning at 'access points' to broader systems of scientific-expert knowledge and state intervention (Giddens 1991), CHC professionals stand as key figures in overseeing the interests of vulnerable children (Wubs 2004) via the application of 'risk factors' (Postma 2008, Vink and Detmar 2012). Professionals' risk work requires them to identify, assess and manage negative risk factors and positive protective factors, therefore optimising children's developmental potential (Hoffman 2010, IGZ 2009, Kuo *et al.* 2006, Postma 2008). The prioritising of children's development above the family (Wubs 2004) has entailed the framing of parents both as sources of risk and protection (Hoffman 2010, Lee *et al.* 2014) and as risk managers themselves (Groenendijk and Bakker 2002).

Organisational pressures to ward against the 'reputational risk' posed towards CHC services have pushed professionals towards increasing preoccupations with assessing risk (Lee *et al.* 2014, Rothstein 2006, Warner 2015). Risk management strategies may, however, result in distancing effects between professionals and service-users (Brown and Calnan 2013). In 2010, an influential Dutch Internet forum advised parents to stop sharing their worries with professionals in CHC centres because of concerns regarding professionals' trustworthiness. A mainstream newspaper reporting on these tensions called for empirical research and a public debate in order to 'chase away the ghost of distrust from the [CHC] consultation rooms' (Trouw 2010).

Risk assessment of parental behaviour, as an emerging feature of CHC services in the Netherlands and elsewhere in Europe, has received limited investigation from a more critical social science perspective. Hopma and colleagues (2014) point to a 'hidden curriculum' within CHC in the Netherlands, comprised of the values and beliefs of policy-makers, focused on particular notions of security, as shaped by broader cultural developments within Dutch society (see also van den Berg and Duyvendak 2012). Studies from Nordic countries have also emphasised the influence of 'common sense' categories and reproduction of gender norms within child-oriented risk policy and assessments (Møller and Harrits 2013; Tiitinen and Ruusuvaori 2014). This reflects more specific child protection and historical studies

emphasising the inherent normative tendencies of CHC, wherein class, ethno-racial and gender distinctions are reproduced (Donzelot 1979; Reich 2005). Recent work interrogates the categories emerging from policy frameworks (e.g. Møller and Harrits 2013) but professionals' everyday interpretations of 'risk' and how professionals come to *know* risk have received much less attention (Gale *et al.* 2016).

In this article we analyse practices of risk-assessment within professional-parent(s)-child interactions in Dutch CHC centres. As the basis of our analysis, we first outline a more constructionist-phenomenological framework for conceptualising risk work. Then, following an outline of our data collection and analysis, we analyse observational and interview data, focusing upon how professionals inferred children's future prospects and related risks from interactions with children and parents. By inquiring into the phenomenological lifeworlds of professionals' risk assessment practices, we: (i) develop understandings of how inexorable uncertainties around 'risk' assessment were overcome through practices of intuition, emotion and trust (White 2002, Zinn 2008); (ii) analyse how such sense-making practices were shaped by the relative socio-cultural proximity of the parent-other to the professional-self (Schutz 1972, Van Duursen *et al.* 2004); and (iii) explore how these 'modes of knowing' were embedded within social structures, not least those of gender and class.

Theoretical framework

The starting point of the analysis presented below is an unearthing of the underlying sense-making processes by which social actors give meaning to the world around them. Following Husserl's edict to go 'back to the things themselves', Schutz (1972) encourages us to interrogate broader social phenomena in terms of the individual actions and modes of thought through which these are made manifest. This enables a more precise and detailed understanding of individuals' actions and interactions. Moreover the approach illuminates how these motivational and interactive processes contribute to, while being shaped by, wider social structures (Berger and Luckmann 1967, Schutz 1972):

the meaning of particular social phenomena can be interpreted layer by layer as the subjectively intended meaning of human acts. In this way the structure of the social world can be disclosed as the structure of intelligible intentional meanings (Schutz 1972:7).

Our Schutzian-phenomenological approach correspondingly forbids us to take 'risk' at face value, even though it is employed unproblematically in many health care settings as an ostensibly effective basis for intervening in uncertain futures. Risk is most neatly defined as 'the probability that a particular adverse event occurs during a stated period of time, or results from a particular challenge' (Royal Society 1992: 2). When subjected to further scrutiny, however, we see that 'risks' involve countless assumptions which must be taken-for-granted in order for risk assessment to function (Heyman *et al.* 2013). The general acceptance of particular outcomes as adverse – as defined by some (powerful) groups, and not others – through the influence of scientific and other systems of knowledge, indicates that risks are never merely neutral and technical, but profoundly political, moral and value-laden (Douglas 1992, Møller and Harrits 2013, Szmukler 2003). Furthermore, probabilistic attributions linking particular adverse outcomes to decisions or behaviours involve the grouping of these outcomes within one relatively homogenous 'category', overlooking the variations within (Heyman *et al.* 2013). While the probabilistic aspects of working with risk receive the most attention within the medical-

science literature, the values, categories and time-frames intrinsic to risk remain much more implicit and insidious (Heyman *et al.* 2013, Szmukler 2003).

The policies, organisations and training in which CHC professionals in the Netherlands are embedded compel them to work with risk; to adopt it as real. Professionals are furthermore required to consider more nebulous risks regarding 'poor parenting' more generally, as well as risk of more specific forms of abuse (Postma 2008). This 'risk work' is far from a simple task. Alongside implicit valuing, categorising and time-framing, risks above all comprise 'inductive probabilistic reasoning' connecting various 'factors' with outcomes (Heyman *et al.* 2013: 5). While this approach works well in comprehending patterns of outcomes across larger groups, an ecological problem remains where risk information is much less useful in predicting outcomes in individual cases (Heyman *et al.* 2013). Low base-rates of child abuse greatly increase error-rates of risk assessment tools (Szmukler 2003). This problem, coupled with the low tolerance for child-safeguarding accidents or errors amongst the media and general public, leave professionals in a decidedly precarious position (Warner 2015).

Amidst the vulnerability and uncertainty faced by CHC professionals and the limited utility of 'risk knowledge' for decisions about individual cases, Zinn (2008) denotes the use of other tools for coping with uncertainty – especially emotion, intuition and trust. These approaches combine aspects of more rational-calculative reasoning with less formal modes of knowing which are indispensable when acting towards the as-yet-unknown future (Möllering 2001, Zinn 2008). These strategies overcome the limitations of probabilistic-induction through gut-feelings, tacit knowledge and relying on others (see also Anspach 1997, Polanyi 1967), working 'in-between' the rational and non-rational (Zinn 2008).

These different logics of action and decision-making amidst uncertainty are not mutually exclusive. Emotions and intuition are very much part of what it means to trust (Barbalet 2009) and in turn become interwoven with more procedural considerations of risk. In contexts where 'risk assessment' is partly or more largely shaped by who professionals feel they can(not) trust, the everyday construction (inferring) of knowledge about others – in our case parents – through interactions becomes highly salient. Within this inferential construction of knowledge about others, phenomenological theory points us towards the greater 'concreteness' of knowledge derived from face-to-face interactions, in contrast to the relative remoteness of more abstract information (Brown 2009). Schutz (1972) delineates different intensities of 'knowing' others and understanding their actions and motives. The 'concreteness' of this knowing is determined very much by the proximity of the other to the self. Accordingly 'we-relationships' provide the most intense and compelling ways of knowing others, where common lived experiences and correspondingly shared stocks-of-knowledge facilitate familiarity and mutual understanding. In contrast 'they-relations' are more remote, abstract and thus 'flatter' in terms of depth of knowing (Schutz 1972: 8).

Data and methods

The analysis was informed by interpretative phenomenological approaches. This framework led us to focus upon ongoing, embodied and negotiated processes of sense-making and expectation-construction amidst uncertainty (Schutz 1972, Smith and Osborn 2003). Interpretative phenomenological analysis is chiefly concerned with depth of analysis rather than common themes across larger numbers of participants. In this sense we explored the ways in which understandings of self, others and social contexts are constructed and the various formats through which sense-making in the present is shaped and structured by lifeworlds emerging out of the past (Berger and Luckmann 1967).

In-depth interviews with professionals ($n = 15$; 9 nurses and 6 doctors; mean duration = 75 minutes) were conducted alongside 61 observations of consultations with ten of these 15 professionals. Observations were performed in a more non-participant manner. Each observation was followed by a brief informal interview whereby professionals were asked about their understandings and logics of reasoning (Van Duursen *et al.* 2004, White 2002). This design aimed to develop insights into how the professionals interpreted and understood interactions with families. Observations granted insights into professional risk assessment and enabled the possibility of triangulating professionals' narratives (what people say they do) with observations of this risk work (what people actually do), with knowledge gleaned from observations helpful in interpreting interviews and *vice versa* (Matthews 2005). The tensions that emerged when triangulating these two sources of data were useful in providing a window into some of the more taken-for-granted aspects of professional lifeworlds which are fundamental to phenomenological analyses (Brown *et al.* 2016, Schutz 1972).

The interviews and observations were located within four local services, purposefully sampled (in terms of urban-rural locations and levels of socioeconomic and ethnic diversity) within the national CHC (JGZ) system. The services were located across the Randstad area spanning several major Dutch cities. After meeting the professionals in a team meeting, ten of the eleven professionals agreed to be interviewed, with nine of the ten agreeing to being observed during consultations. Snowball sampling was used to access professionals within two other locations, thus increasing the total number of interviews ($n = 5$) and observations ($n = 1$).

All participants were women, reflecting Dutch CHC more broadly as there appear to be almost no male CHC professionals (van Lieburg 2001). Twelve of the interviewees were aged between 0 and 4 with just three aged between 4 and 19. Professional participants had different degrees of experience, varying from one year to 29 years (mean = 10 years).

Due to the initial explicit focus on professionals' handling of uncertainty in decision-making, informing and consent were more focused on professional participants. Professionals were informed through a meeting and/or an information leaflet about the general nature of the study, on the basis of which they could consent to being interviewed and/or observed. The potential presence of a researcher was explained to parent(s) before observations and they were able to consent to or refuse this. The short, informal follow-up interviews with professionals after observations were similarly focused on logics of decision-making from the professionals' perspective and for this reason parents were not asked for consent. As later became evident in the analysis, however, decision-making was profoundly interwoven with professional-parent relationships. For this reason, if the research was to be repeated, we advocate obtaining parental consent for the brief follow-up discussions as well. The study followed the ERC research ethics protocol.

Interviews explored the general aims and tasks of the job, relationships with parents, views of good and bad parenting, decision-making, working with risk, and uncertainty involving particular parents and children. The latter considerations were brought up later in each interview, in order to see how risk and uncertainty emerged within professionals' initial accounts.

Interview transcripts, alongside extensive field notes from observations (and the brief interviews after each consultation), were initially analysed through a more 'open', constant comparison approach by which commonly recurring and salient themes emerging within professional narratives were identified; alongside patterns within observations. This initial coding was sensitised by social theoretical literature on risk and uncertainty, alongside the interpretative phenomenological orientation of the research. Following an abductive logic, these theoretical

insights were in turn critically reworked in light of emerging themes from the data (Meyer and Lunnay 2013). Core themes were then subjected to more specific investigation, through the triangulation of interview and observational data, assessing patterns of corroboration and inconsistencies within these. A hermeneutic circle was invoked by which specific interview excerpts, or observed interactions, were interpreted in light of wider narratives of the professional involved and vice versa (Smith and Osborn 2003). Double-coding and critical discussions of analytical frameworks were used to enhance the validity and consistency of our analysis.

Findings

The uncertainty of 'risk assessment'

As noted already, CHC in the Netherlands is increasingly preoccupied with assessing risk regarding individual children and parents. Probabilistic relationships between categories of people and outcomes are invoked within health and welfare contexts to render uncertainty more calculable (Zinn 2008). However our findings denoted several limits to risk knowledge in assessing whether a child or child's development was at risk: Children's individual situations were perceived as ambiguous, contacts with parents and children were brief, and professionals were required to interpret nebulous possible signifiers of difficulties with regard to an unknown future.

Ambiguities surrounding parents' and children's situations

As an attempt to standardise and support ways of inferring diverse children's futures, CHC professionals referred to 'risk groups' and related factors, as defined at national and organisational levels. Each of these categories has been scientifically related to adverse outcomes for children's development, especially where multiple factors combine (Hermanns *et al.* 2005; see Møller and Harrits 2013 for a critical assessment). Risk factors included poverty, single parenthood, teenage parenthood, living in a bad neighbourhood and social isolation.

Our professional participants claimed to perform the assessment of individual parents and children by weighting these risk factors against other potential protective/insulating factors. Children deemed 'at risk' in relation to risk groups were highlighted in their electronic files, in order to be followed more carefully over time. However these 'risks' were described as difficult to standardise. It was particularly the more experienced professionals who claimed that individual cases needed to be considered on their own merits:

It's a heightened risk, but it's not by definition a risk. . . . That's what I've really learned after all these years; leave them at home, those stereotypes. (Nurse 9; 21 years' experience)

Some of the professionals described risks in individual situations as fluctuating over time rather than fixed to category memberships. Case-specific contingencies were emphasised further where parents and children were described as responding differently amidst ostensibly similar risk situations:

One child can carry a much heavier burden than another. (Doctor 6; 29 years' experience)

Professional judgments of specific cases also varied. Attempts at standardisation had not overcome the ambiguity and subjectivity in evaluating risk within individual family situations:

It depends on who [which colleague] you talk to, is my impression; how heavily you weight [a situation], when you act and when you let go or wait and see. That's very personal and this makes it difficult for me as a beginner. You need to develop your own [risk] boundaries. (Nurse 8; 3 years' experience)

Fleeting contacts with parents and children

Further challenges involved appointment timeslots (10–20 minutes) which were described as very short for making adequate risk assessments. Obtaining sufficient contextual knowledge to evaluate a child's situation was thus difficult, especially because parents themselves decided what they did and did not say, and to whom, within the limited face-to-face time:

It's not always as realistic, to be able to see everything. It's a snapshot . . . what we had yesterday, with the mother that had thyroid cancer and told her complete story to the assistant [in reception]. If I wouldn't have heard it from the assistant and I wouldn't have asked, I wouldn't have known about it at all. (Doctor 2; 2 years' experience)

These limitations were also reflected in the observations:

A mother came in with her son and urged the doctor to hurry with the vaccinations, after which she left to rush to another appointment, leaving the doctor behind with her unasked questions. (Field notes; observation 1).

These fleeting contacts allowed brief glimpses of family life which were considered neither representative nor a natural reflection of how children and parents functioned more generally. Cases of abuse were perceived as particularly difficult to identify within these brief encounters, because parents would usually be the 'perpetrators' themselves and they could easily 'hide information' (doctor 3; 22 years' experience):

In a consultation of 15 minutes, you can't judge whether a child is abused or not . . . When parents provide desired answers and try to hide something; that's possible. We can't look inside one's head and we see children for 20 minutes. Well then you can't see what horrible things might happen at home – when the child is calm and cooperative during the consultation, everything is well and parents say it's all fine. (Nurse 5; 1 year's experience)

Uncertain and ambiguous futures inherent to professional risk work

CHC professionals' ostensible role was to systematically observe and interpret the physical and social functioning (and associated risks) of a child in its (family) environment and the interaction with its parents in the present, alongside references to the past. Electronic files were read and new ones were completed in order to document and evaluate signs regarding child development. Alongside the use of these more structured approaches, our observations also noted how immediately visible 'child signs' were interpreted in more informal ways. In one follow-up interview a nurse was asked to explain why in two earlier cases, involving toddlers displaying rather similar behaviour of headbutting the floor, she judged one situation as problematic and not the other (Field notes; observations 51; 53):

Yes, and that's just my feeling, my experience, like: this mother is a bit messed up with something . . . I didn't worry about [her] child at all, for sure. But that doesn't mean that

when there are no worries at the moment, [that] they could not arise. So that's why the child gets extra attention. Because they slip through so easily, you know. (Nurse 9; 21 years' experience)

The professional decision-making referred to here, as in many cases, was not based upon clinical records or structured assessment tools regarding child development. Instead the impression that the child's environment (a 'messed up' mother) was potentially harmful was inferred far more informally in relation to the mother. Using (gut) feelings (a sense that something might be wrong) and personal experience (comparing a family to previous encounters with other families) appeared essential to this nurse, as to the other professionals, in interpreting signs about a child's situation with regard to future development.

Emotions and tacit judgments were in this way vital to inferring the potential hampering of the child's development and these interpretations came to the fore as a crucial mode of decision-making. Yet uncertainty and 'worries' endured, despite formal and informal strategies, because professionals were required to infer the (unknowable) future. As the above excerpt indicates, judgments implicitly invoked a future timeframe and involved the fear that certain issues, nebulous as they were now, would grow into bigger problems later on.

Assessing 'risk' via trust

As noted thus far, formal-rational risk assessment was of limited utility for professionals while brief encounters with parents left substantial residual uncertainty about a child's future. CHC professionals were nonetheless required to build inferences about the future, as a means of bridging over lingering unknowns (Möllering 2001). Drawing on experiential knowledge and gut feelings, the professionals continuously constructed inferences regarding the 'subjective meaning-contexts' and 'motives for action' (Schutz 1972: 187) of the parents and children during their brief interactions. The more parents appeared willing to share about their and their children's lives, the more concrete professionals considered the knowledge drawn through these inferences.

This inferring of an actor's likely behaviour and reliability in the future, based on interpreted pasts and interactions in the present, is better conceptualised as professionals' trust in parents, more than formal risk assessment (Zinn 2008). Moreover, the development of a parent's trust in professionals, in facilitating parents' talking openly and frankly, was also described as crucial to acquiring more concrete knowledge:

I find it good parenting when [...] parents [...] dare to tell you they find things difficult.
(Doctor 5; 4 years' experience)

Emerging from these 'leaps of faith' (Möllering 2001), the effective exchange of knowledge about the child and parenting and, subsequently, a growing mutual understanding (Schutz 1972) were highly valued and commonly emphasised as important:

It doesn't work to just hold things against parents, you know. You need to take care of being on the same page first, before you get them to a point [where] they will follow you.
(Nurse 7; 11 years' experience)

In practice, trust in parents' motives and capacities was more readily established with parents who were more like the professional(s).

Some parents are for some reason just closer to you and live sort of a similar life as I do, and that makes it easier, because it's easier to sense them. (Nurse 8; 3 years' experience)

From interview and observational data it appeared to be easier for professionals to understand, 'sense' and trust parents who were, in a taken-for-granted way, more similar; who therefore 'felt' closer. We labelled such proximate interactive experiences 'we-relationships' (Schutz 1972), wherein rich mutual understandings were formed and from which inferences about the future felt more concrete.

Such we-relationships were found in 20 per cent more cases (coded in our interviews and observations) with parents who displayed characteristics similar to the professional (concerning gender, educational level and ethno-cultural background) than with parents who had different characteristics. Nevertheless, professionals still developed close direct relationships with many parents with different background characteristics to themselves. Professionals described being eager to understand and get to know parents who were open to them, thereby going beyond gender, class and ethnic differences.

You know less richly how things are going exactly; I mean you don't know each culture so well. But [...] when parents are open to CHC, it doesn't matter so much which culture they come from, then I feel like I'm having a good conversation and you're building a nice bond. (Doctor 2; 2 years' experience)

A condition of effective relation-building appeared to be that these latter parents also shared ideas and awareness of the 'child's best interests', for instance by breastfeeding, appearing sensitive to the child's needs and/or being 'open' to the professional's expert knowledge and advice. Indeed, common stocks-of-knowledge regarding broadly 'normal' parenting norms facilitated exchange with the majority of parents and this characterised the daily work of our professional participants:

I see many normal children, you know. Very normal, nice parents [laughs] ... [Even in the in-between cases] you're going to figure out 'what can I offer?' Because it's not about: here [risk] boundaries are crossed. At most you think: 'it would be nicer when [the situation] would be like this' and: 'is it useful for this mother when I offer that [advice]?' That's actually the normal work. (Doctor 6; 29 years' experience)

Accordingly, 'normal' good (enough) parenting was perceived as encompassing a fairly broad spectrum. So long as particular risk-related 'boundaries' were not crossed, professionals were able to adapt knowledge and cooperate with specific parents in face-to-face contact.

In terms of crossing boundaries beyond the normal, not following good practice was inferred most seriously as a problem for parents that had different characteristics on top of this. In only one observed case in which a parent possessed 'other' background characteristics alongside deviating parenting norms and knowledge was a we-relationship observed as developing:

A father with a 'lower social class' background made it clear he didn't value his daughter's development being measured as it was done in the consultation, neither were there other signs of common ground between him and the nurse. Yet, she developed some kind of rapport with him and later evaluated him as being a 'loving' parent. (Field notes; observation 38)

By contrast, in several cases in our data the relationship with parents who were 'other' regarding both background and parenting approaches resembled a more remote 'they-relationship' (Schutz 1972). In such cases (coded in 19 interview excerpts and four observed cases) remote

and/or limited contact with a family led the professional to resort to more stereotypical knowledge ('ideal-typical' knowledge in Schutz's terminology) and related inferences (for example relying on correlations involving membership of 'risk groups'). In a few more extreme cases, the relationship had become even more remote, with parents rarely or never attending meetings and moving out of sight. In these situations professionals relied solely on generalised risk group stereotypes. In the absence of deeper insights greatest uncertainty was expressed around these most distant parents:

It is precisely the risky families who you often see even less, since they don't show up [and] without leaving a message. Families who are open and express themselves . . . they form the easy group. But the risk group [parents], who are not open, don't show up, don't show disclosure and don't see everything [like we do], that's the difficult part. [The government] can say: 'you are responsible for this case', but how responsible can you be? (Nurse 2; 12 years' experience)

Professionals thus referred to the dilemma of a knowledge vacuum, in which there was no clear basis for action and where they just had to 'wait and see'. Despite this remoteness itself being interpreted as a 'risk', attempts to proactively manage risks across they-relationships were perceived as potentially problematic for already fragile trust relationships. A trusting relationship with some level of proximity – in order to be 'on the same page' and gather concrete knowledge about a particular family – proved to be essential for any meaningful assessment of risk at the individual level.

In the absence of proximity, CHC professionals were merely experiencing uncertainty rather than managing risk. We noted above how this residual uncertainty and social distance was 'tackled' using crude knowledge of risk groups which, as seen above, were bound up with marginalised groups. Literature on the construction of these risk groups or categories (Heyman 2013, Møller and Harrits 2013) has emphasised their political-moral dimensions and potential role in reproducing inequality. In the next section we move to explore how the reproduction of gender and class structures may similarly emerge through the dynamics of professional-family interactions, in some cases in tandem with institutional risk categories.

A mediating lens of gender and class

Gender and a responsabilising focus on mothers. The ostensibly inductive data gathering and categorising of risk assessment has been seen above as being entangled with more inferential features rooted in trust and emotions and, correspondingly, with social background and related feelings of (un)familiarity. All professional participants in our study were female, reflecting CHC as a highly gendered sector (van Lieburg 2001). Professionals often referred to their own motherhood experiences (or not being a mother yet) and to their own mothers. It appeared easier for them to understand and feel for mothers (cf White 2002), for example as being torn between personal needs and those of their families or in feeling responsible for their children. Such empathy accordingly facilitated an experienced deeper knowing of mothers, as also shaped by the relative absence of fathers in encounters.

Fathers were less often present at appointments (16 of 61 observations) and professionals claimed to have much more frequent direct contacts with mothers. Accordingly, although fathers' increasing involvement was very much welcomed and praised, the professionals still spoke about fathers in more general, remote and thus stereotypical terms (Schutz 1972): fathers were assumed to work either fulltime or they had one caring day per week;³ they were described as more direct in their communication and wild in playing with their children; and fathers with a higher educational level were assumed to be more 'involved'. Father's qualities

as carers were only mentioned in greater detail in a few atypical cases, such as where fathers took over the caring role when mothers experienced severe mental health or alcohol problems.

Stereotypes about mothers, for example assumptions regarding their considerate behaviour and part-time working arrangements, were also expressed. However the sense-making, descriptions and evaluations of mothers were far more diverse and precise; they were, for instance, 'natural', 'possessive', 'chaotic', 'sensitive', 'career minded', 'unstable', 'cold', 'sweet' or 'insecure'. The quantity and quality of face-to-face contacts can therefore be interpreted as enabling greater apparent depth and nuance in their understanding of mothers (Schutz 1972). Even when fathers were present, their presence was less central to the professionals' experience:

'I have to confess that I'm usually focused on mother . . . Father is sitting there as well of course and is also a fully-fledged caregiver of his child and he has questions. But . . . somehow, you're sometimes missing out on signs [of the father].' (Nurse 5; 1 year's experience)

In everyday practice therefore, the judgment of a child's future often related to a trust or distrust of mother's capability and sensitivity. Preceding one consultation, a nurse praised a family that was described as having migrated from India:

These children are so sweet. Very intelligent, very careful. Parents are very much focused on education. [They] are hyper intelligent. They are so great with the children. The children are triggered exactly in the right way to learn, but are still allowed to be a child. Mother finished university with three children. She's a sweet woman. She is now at home until the youngest is one-and-a-half.

Subsequently it was the father who came to this consultation, with his shy son who resisted doing the eye test. The nurse reflected afterwards on the difference between her earlier praise and the later consultation:

'Mother is always very sociable. Father works hard. Mother is more like 'come on, just do [the eye test]'. Normally mother comes, I had never met father.' (Field notes; observation 12)

This example reflects commonalities across the data, where the focus of evaluations of parents and children's performances appeared to be mostly based on relationships with mothers and, especially, understandings of their sensitivity towards their children. Trust in the mother was sufficient for trust in parents, with assumptions regarding mothers' central role making fathers' characteristics less relevant.

This focus also meant that when a child was deemed 'at risk' the professionals typically ascribed the responsibility to act to the mother. The mother was usually the key point of communication, regardless of her other (employment) roles or duties. Gender norms thus came to structure the interactions upon which risk assessments were based, through feelings of proximity and familiarity, as well as in advice given to parents:

Interviewer: Do you advise on that – number of hours worked?

Doctor: No. Only when I see for instance a mother working four days who is struggling, has a hard time, then I would discuss it. [. . .]

Interviewer: And do you sometimes also advise father to work less?

Doctor: Not really. No, never. [Laughs.] No. (Doctor 1; 7 years' experience)

There was therefore a tendency to responsabilise mothers – and not fathers – to establish a work-family balance and reduce risks to children, as a means to overcome uncertainties about the children's present and future functioning.

Social class and heightened levels of uncertainty

Processes of trust and uncertainty were also mediated by structures relating to and intersecting with 'class background'. A 'lower-social-class background' was the common term regularly referred to as a ('potential') risk factor in itself. Professionals' narratives indicated its (sometimes complex) association with an array of factors including lower educational levels, financial and psychiatric problems, intelligence, housing limitations, 'problem neighbourhoods' and non-hegemonic ethnic backgrounds.

Starting assumptions regarding such 'troubled' parents usually involved them lacking suitable parenting abilities. Parents were often approached by professionals who were drawing on generalised assumptions regarding what information parents could handle, in attempting to connect with them. Professionals referred to, and were observed, trusting parents from less familiar (non-white-Dutch-middle-class) social and cultural backgrounds when they were: 'open' about their parenting practices and the difficulties they faced; and willing to act in line with expert knowledge and professionals' advice. This enabled some familiarity and a shared (or in some cases imposed) understanding and way of acting on behalf of the child's 'best interests'.

In contrast, professionals reported experiencing many instances where low-income parents questioned hegemonic (intensive) parenting ideology and professional advice. Difference was in itself not necessarily seen as inherently unsafe and in interviews it was often stressed that professionals needed to move beyond their personal norms and understandings; regarding hygiene for example. Yet seemingly as a result of this resistance towards mainstream norms, the relationships between professionals and these lower-social-class parents more often resembled distant they-relationships.

As with earlier examples, professionals negotiated social distance via basic information already collected about these families and group-based assumptions, for example those involving class and ethnicity:

These people can't buy a baby bed and [my colleague] picked up a bed with her car. Mother said: 'my husband can pick it up tomorrow', but he didn't show up. These people do have another background; they are not so precise with time and maybe it also has to do with the relationship between father and mother, that they don't cooperate much. But the child just needs a bed. It's 11 months and it lies on the ground, this is dangerous. [Yet] they don't see the danger. Mother said: 'I don't have space for it' [. . .] A very different perception than us, you see this with foreign people. You should not lump them together [. . .], but I'm so happy when I can notice the response, then I'm like: just come and get [the bed]. Though maybe we're happier [with the outcome] than they are. (Field notes; following observation 31)

Professionals also experienced difficulties building trusting we-relationships with some university educated parents, who were also (although much less commonly) described as too critical and skeptical of the professionals:

'The people that don't open up; this varies a lot . . . [It's] often also those highly educated parents, saying 'Well, I don't know what it is you're doing here, playing games with the

kids, but it's actually just nonsense. And everything's fine, I can see all is fine, right?' Well, then you've also got a different type of relationship.' (Doctor 2; 2 years' experience)

But the use of more basic risk group indicators amid (they-) relationships grounded in difference led to divergent outcomes in terms of class. The uncertainty emerging within these relations appeared to be much less problematic in cases of higher educated parents.

Professionals made plenty of critical remarks about this latter group, but this was not accompanied by a targeting of these parents with extra professional help or (involuntary) supervision. Disapproval regarding either a lack of emotional care (in case of both parents working full-time) or overly emotional care (in case of uncertain/anxious parents with many questions) was expressed. However professionals were prone to interpreting this behaviour as the higher-educated parents' choice, or as not harmful enough to act upon, thereby granting these parents a level of autonomy. Professionals' handling of uncertainty about a child's situation was thus mediated by class: stereotypes about higher educated parents were less pressing in terms of risk attribution compared to stereotypes about lower educated parents.

In general, the CHC professionals distinguished between parents with at least an intermediate vocational training (or higher) and parents that had 'barely' or not pursued education after high school. After labelling a mother 'a natural' and 'knowing where to seek care', a doctor checked this woman's educational level and made positive remarks when reading in the electronic file that mother was a project manager (Field notes; observation 5). In this way inferred characteristics pertaining to educational/professional and gender norms could be seen to intersect:

A younger mother (aged in her teens) expressed that things were not going so well, because her baby cried the whole time. The nurse did not carry out normal developmental tests and explained to the mother that she would leave her to get on with things, stating she had faith in this mother and the wider family. This happened despite service protocols delineated such a context as involving multiple risk factors (due to mother's age and infant-behavioural factors). (Field notes; observation 28)

In our follow-up interview to this consultation, the nurse explicitly related her trust to the parent being 'such a sweet mother' and 'incredibly loving' and to her belonging to a 'good and warm' family. She added that people with this surname (common in the area) were usually highly educated (Field notes; observation 28). Here specific parent and child 'risk' signs were largely disregarded when a trust relationship was established with a mother, seemingly from a middle-class background, who was perceived as being sensitive to her child.

Discussion

These final examples and our wider findings shed significant light on the interactional-dynamics of risk assessment regarding children's future safety and well-being. Our Schutzian approach has focused on the underlying meaning-making processes of professionals' risk work within everyday (as opposed to 'high risk') CHC contexts. This illuminates how familiarity and trust, as structured through professionals' gender and social background, bore importantly upon experiences of uncertainty, inferences regarding parents and thus on 'risk' assessment and interventions carried out on behalf of the state. Manifestations of gender, ethnicity and class within understandings of parenting adequacy have been understood in the past through more institutional and policy-framework dynamics (Donzelot 1979; Daly 2013; Møller and Harrits 2013), with these more directly framing street-level interactions and decisions involving

vulnerable families (e.g. Reich 2005). By digging deeper into the inferential and sense-making processes of risk assessment interactions, these most elemental ways in which actors interpret the social themselves become loci for the reproduction of intersecting social structures (Brown 2009, Berger and Luckmann 1967).

The design of the study – small-*n* within specific municipalities focused only on professionals – was not oriented towards making general claims about Dutch CHC. We focused instead on an in-depth interrogation of the nature and processes of risk-work itself. Our findings denote the limited functionality – and thus use – of formal-rational risk assessment based on ‘risk groups’, as derived from knowledge of correlations between certain factor-categories and outcomes. This population-level knowledge was invoked but found to be of limited utility in overcoming uncertainty when making decisions in specific cases. Where possible, professionals overcame this looser categorical basis for considering future possibilities through a phenomenologically more concrete relational basis of knowing family futures. The manner by which detailed personalised knowledge was used as a basis for drawing inferences about future parenting behaviour and outcomes, in conjunction with emotions and intuitions, is more accurately captured by conceptualisations of relational trust (Barbalet 2009, Zinn 2008). Formal-rational models of risk assessment were of limited relevance.

These relational assessments of family contexts not only involved professionals trusting in parents but also required parents’ trust in professionals, in order for communication to be sufficiently open for concrete knowledge of parents and their practices to be elicited. As Lareau (2003) and Reich (2005) show, parents within poorer and working class families are less inclined to talk to professionals and teach their children how to talk to professionals in the manner that middle-class families tend to do. Accordingly, we-relationships (Schutz 1972) were more likely to be built with parents who the professionals felt an affinity with, that is to say parents who more fully shared stocks-of-knowledge with the predominantly white-Dutch middle-class female professionals. We-relationships could be built with less familiar parents where these ‘others’ displayed appropriate (intensive-maternal) parental commitment, disclosure about their parenting practices and openness to professional advice. Generally speaking, however, we-relationships were more straightforwardly built with more highly educated (often white-Dutch) mothers.

They-relationships, in contrast, failed to provide the concreteness of knowledge upon which trusting inferences could be made. In these more distant contexts, professionals resorted to stereotypical knowledge based on general assumptions and/or ‘common sense’ shaped risk-group categories (Møller and Harrits 2013). This weaker form of knowing was experienced as leaving large amounts of residual uncertainty which professionals regularly felt anxious about. Both these bases of more remote knowing tended to lead to middle-class parents being given the benefit of the doubt within they-relationships. In contrast, the cultural stereotypes and ‘risk groups’ applied by professionals could lead to some more disadvantaged family contexts being assumed risky until proven otherwise. The limits of formal risk-based knowledge were rendered most glaring amongst those families who remained most distant; where a breakdown of trust relations had rendered ‘risk assessment’ little more than guesswork amid a knowledge vacuum.

Social structures of gender, class and ethnicity can thus be seen as active both through the differing potential for we-relationships to be formed and via the generalising and stereotyped knowledge applied in their absence. These lifeworld structures also directed professionals’ attention towards mothers rather than fathers when assessing family contexts, with we-relationships forming more straightforwardly with women who were implicitly assumed and thus encouraged to adopt chief responsibility. The relative neglect of men amidst these interactional processes can be seen as supporting various negative outcomes: the reproduction of gendered norms of intensive mother responsabilisation; the partial disenfranchisement of good fathering;

and the relative overlooking of potentially dangerous men, especially in contexts where mothers form we-relationships with professionals.

More broadly, our analyses point to the usefulness of phenomenological and related frameworks for grasping and interrogating the pragmatic and interactive practices by which health and social care professionals handle uncertainty through risk. Triangulating interview data with observations, especially where brief follow-up interviews immediately post-observation are possible, appears to be especially useful in peeling back the 'layers' of professionals' lifeworlds (Brown *et al.* 2016, Schutz 1972) as they accomplish this 'risk work'. The formats of lifeworld assumptions (rooted in structures of gender and class) explored above are in some ways particularly bound to wider notions of good parenting. Risk work in other health and social care contexts will be grounded in different structures of assumptions and wider discourses, though Warner and Gabe's (2004) research in contexts of mental health services suggests that intersections of race and gender are strongly influential across quite different forms of risk work. While the cultural basis and value positions inherent to risk have long been recognised (Douglas 1992, Szmukler 2003), our framework is useful in deconstructing other forms of risk work towards a better understanding of how inequality emerges through dynamics of interacting and knowing. Such research would be a useful contribution to a critical medical sociology but can also inform a more reflexive practice among professionals.

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Notes

- 1 'Jeugdgezondheidszorg' (JGZ).
- 2 This policy framework includes the identification and protection of children 'at risk of harm', 'neglect' and broader 'negative outcomes' at an early stage though has been partially replaced by more recent policies since 2010.
- 3 In 2016, 26.6 per cent of Dutch working men worked part-time (Labour Force Survey - EUROSTAT, 2016). One 'daddy' day to care for their child is a familiar concept in the Netherlands, as reflected in our data.

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