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Short Article

Opening doors or building cages? Looping effects of diagnosis in residential child care: A phenomenological account

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Abstract:

Children living in residential child care encounter dense networks of assessment, screening, and diagnostic language. While such classifications are commonly intended to support care planning and access to resources, they also shape how young people are anticipated, engaged with, and come to understand themselves. Drawing on Ian Hacking's concept of looping effects and a phenomenological framework, this conceptual article examines how diagnostic and care-status labels function within residential child care as interactive markers that participate in the formation of identity, agency, and everyday practice. Synthesising existing research with illustrative vignettes drawn from the literature, the article traces a pathway via which labels move from initial classification to anticipation, interactional routines, documentation, and resource allocation, before being reinforced or modified. A phenomenological analysis foregrounds the lived experience of being a 'care child', showing how diagnostic language subtly shapes embodiment, temporality, intersubjectivity, and agency. The article concludes by identifying points at which looping effects can be interrupted, offering implications for reflective practice, documentation, and inter-agency work in residential child care.

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Introduction

> There is something that causes me the greatest difficulty and continues to do so without relief: unspeakably more depends on what things are called than on what they are […] creating new names and assessments and apparent truths is enough to create new 'things'.
>
> (Nietzsche)

The diagnostic environment in residential child care

Looked-after children have markedly higher rates of psychiatric disorder and interactions with dense assessment infrastructures, particularly in residential settings (Ford et al., 2007; NHS Digital, 2023). Residential care sits within a wider pathway through which local authorities and health services seek to meet complex physical, psychological, and developmental needs, alongside foster and kinship care, and, where necessary, more restrictive options such as secure accommodation or inpatient CAMHS (Cameron-Mathiassen et al., 2022). Residential homes are staffed by trained professionals who provide 24-hour care and support, addressing children's social, emotional, educational, and health needs. Because policy and practice prioritise keeping children within families wherever safe, kinship and foster placements are typically explored first; when these are unavailable or disruptive, residential care may be indicated.

Many young people in residential settings have experienced significant adversity, compounding the complexity of their needs. As Brown et al. observe, staff are 'arguably supporting some of the most complex children in society' (2019, p.3). Needs arise from a dynamic interplay of biological, psychological, social, and cultural factors, and lived experiences are often expressed as challenging behaviour that is subsequently interpreted through diagnostic and classificatory lenses.

Children entering residential care will usually have already encountered assessment tools and classificatory language through statutory processes, school reports, placement reviews, or contact with health services. The point here is not that screening is illegitimate: the strengths and difficulties questionnaire (SDQ), for example, is a widely used and validated brief screen of psychosocial difficulties (Cummings & Shelton, 2024). Nor is diagnosis reducible to a label; in clinical practice it involves

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structured appraisal of symptom patterns and impairment relative to specified categories (Sims et al., 2021).

In residential contexts, however, these instruments and terms travel into everyday life. They circulate through files, handovers, and meetings, shaping how young people understand themselves and how adults anticipate them. For this reason, this article does not ask whether labels are true or false, but how they show up and take hold in residential life. Brief practice vignettes illustrate lived encounters with screening results and diagnostic language, before a phenomenological analysis examines their looping effects with respect to self-perception and care.

This matters for three reasons. First, identity: prior to any formal diagnosis, the status of being a 'looked-after child' is already socially meaningful and may be taken up as a public identity—sometimes proudly, sometimes defensively, sometimes as a stigma to be managed. Second, practice: screens and diagnoses can function as scripts for response, shaping risk framings, staffing decisions, and behaviour policies, and potentially narrowing curiosity about what else an action might mean. Third, opportunity: the same information can open doors to support when held lightly and discussed well or build cages when treated as the whole story.

The analysis proceeds in four sections. First, it specifies the looping effects of diagnostic language in residential care, following Ian Hacking's account of interactive kinds and 'making up people', tracing a sequence from label to anticipation, interactional routines, documentation, resource allocation, and, ultimately, reinforcement or modification. Second, it develops a phenomenological core, showing how diagnosis is lived in embodiment, temporality, intersubjectivity, and agency. Third, it examines the emergence of the 'care kid' as a social identity and the conditions under which identity becomes a script. Finally, it draws practice implications aimed at holding labels lightly so that they open doors rather than build cages.

Looping effects, concept creep, and 'making up people'

Labelling and diagnosis operate as interactive kinds: classifications alter self-understanding and behaviour, which in turn modify classifications and practices (Hacking, 2007). To illustrate Hacking's distinction, one might encounter a large rock on a familiar walk and remark that it is 'a very large rock'. This is a natural kind: the rock is unaffected by the

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description. Making the same observation about a person, by contrast, invariably affects the person described, creating new behaviours and experiences. Young people in care are interactive kinds.

Hacking's notion of looping effects captures how diagnostic labels can create new ways of being for those who are labelled—sometimes in the name of help, sometimes in the name of order, and often both at once (Hacking, 2009). Screening tools such as the SDQ orient professionals towards pre-existing categories, but the mechanisms of intervention—assessment, planning, and everyday routines—interact with the classified person and change them. The object of classification becomes a moving target. Parallel to this, Hacking describes 'making up people', whereby interventions open up novel modes of personhood that individuals may inhabit, negotiate, or resist.

Hacking identifies five interacting elements: (a) classifications, (b) people, (c) institutions, (d) knowledge, and (e) experts. In residential child care these map readily onto practice. Experts (e), such as residential staff, CAMHS clinicians, and educational psychologists, generate and legitimate knowledge (d), deploying it within institutions (c) such as homes, schools, health services, and local authorities that grant authority to their claims. This knowledge is applied to children and young people (b) who are classified (a) in particular ways. From the young person's standpoint, this network is often experienced as a coordinated effort to help, but it also sets the limits within which the self is seen and acted upon. With this framework in place, the following section traces how these elements move through residential practice to form a loop that can be reinforced or modified through reflective action.

From label to loop in residential care

The care status of being a looked-after child placed in residential care is itself a salient classification that organises how professionals anticipate needs and how young people anticipate being seen. Residential placement typically follows attempts to sustain family-based options, often coinciding with intensified screening and assessment. As a result, the label arrives with a dossier of prior narratives about difficulty, breakdown, and risk, deepening an already meaningful category and becoming a starting premise for interpretation, both within the home and across partner agencies.

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Labels invite anticipation. Staff prepare for 'likely' behaviours, while young people anticipate how staff will respond, and therefore may pre-emptively perform or resist the script they expect. Anticipation draws on prior files, professional training, and accumulated experience, but also on how young people have learned they will be treated. This co-anticipation can narrow curiosity on both sides.

Over time, anticipations solidify into routines: de-escalation scripts, observation levels, and the language used in behaviour support plans. While standardised responses are vital for safety, they can become label-led if not reflexively held. The very terms used, such as 'non-compliant', 'risky', and 'attachment-seeking', shape what staff notice and how young people narrate their own conduct.

Documentation and multi-agency narration further stabilise the loop. Files, minutes, and reports narrate the child, allowing descriptors to travel across agencies and solidify identities. Repeated phrasing can crowd out alternative interpretations, particularly when young people's own accounts are marginalised or lost through copy-forward practices.

These narratives then meet thresholds. Labels may unlock resources, such as one-to-one support or CAMHS referral, or justify restrictive responses, such as reduced access to community activities or education. When screening scores or diagnostic terms function as gatekeepers, help may depend on having a label; at the same time, labels can lower expectations or legitimate exclusion. Either way, resource decisions feed back into experience and data, closing the loop.

The loop culminates when labels are either reinforced by documented patterns and institutional responses or modified as alternative narratives gain traction. Where reflective supervision, careful language, and the young person's perspective are centred, labels can be held lightly and revised. Where they are not, initial classifications risk becoming the child's story.

How diagnosis is lived in residential care: A phenomenological account

Phenomenology asks how the world is experienced from the first-person point of view: how meanings are disclosed in the ordinary flow of life. Rather than beginning with categories, it begins with lived experience,

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tracing how bodies, places, time, and relationships become meaningful (Heidegger; Merleau-Ponty). This lens is particularly apt for residential child care, where practice unfolds in corridors, kitchens, and classrooms, and where labels meet bodies, routines, and relationships. Phenomenology is used here not to adjudicate diagnoses, but to clarify how diagnostic language and care status show up in experience and conduct, and how practice can widen rather than narrow a young person's possibilities.

Residential care is a highly regulated world, already saturated with meaning. Health and safety signage, observation practices, handovers, and behavioural language form part of the background through which the self is encountered.

Diagnostic language recalibrates embodied attention: how sensations and emotions are noticed, named, and managed. From a phenomenological perspective, bodily gestures are not secondary to meaning; they are meaning. Behaviour is expressive, a way of making contact with the world. Once a category such as ADHD, PTSD or LAC is in play, bodily signs are often attuned to through that lens. This can validate experience and channel support, but can also narrow the field of meanings available.

Labels also shape temporality, configuring how futures are imagined by young people and the adults around them. Anticipatory talk in plans can pre-configure trajectories, sometimes lowering expectations, sometimes offering a recognised explanation that makes progress feel possible.

Intersubjectively, the self is co-authored in relationships. Diagnostic words function as interactional cues, priming responses of patience, accommodation, vigilance, or escalation. Young people learn to anticipate being read through these cues and may perform to or against them.

Agency is likewise affected. Labels can legitimate asking for help and accessing accommodations, while also scripting what actions feel permissible and inviting adults to take over decision-making. Whether labels support or constrain agency often depends on whether actions are co-authored with the young person.

In residential contexts, care status itself becomes a publicly legible social identity. Young people actively manage disclosure, timing, and presentation, reporting differential treatment once their care status is

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known. Diagnostic talk can crystallise into a 'care kid' script that is taken up, resisted, or strategically performed.

Opening doors and building cages

Experiences of care exceed the categories through which they are managed. As interactive kinds, young people are shaped and 'made up' into looked-after children. This opens doors to support and services, but can also build cages. The looked-after label equips professionals with tools to intervene, yet it may also limit the horizon of who a young person can become. When expectations align too closely with system language, labels become the primary means through which young people understand themselves and their behaviour. Classification is not merely descriptive; it is performative, changing the people it names.

Where the loop may be interrupted

The residential pathway offers several points at which looping effects can be redirected. At the point of labelling, totalising descriptors can be avoided by anchoring language to specific contexts and incorporating the young person's own words into records and plans. At the level of anticipation, reflective supervision can surface assumptions and invite practitioners to ask not only what is happening, but what else this might indicate.

Within everyday routines, particularly behaviour planning, regular audits of language help to prevent the premature solidification of identity claims. Documentation and multi-agency narration are equally critical. Embedding the young person's perspective in minutes and reports, and checking for copy-forward bias, can prevent earlier classifications from hardening into unquestioned truths. At the level of thresholds and resource allocation, screening tools and diagnoses can be treated as prompts for support rather than as verdicts about capacity or risk. Taken together, these practices increase the likelihood that labels remain open to revision through lived experience rather than being reinforced through institutional inertia.

Limitations

As a conceptual synthesis using literature-derived illustrations, this article does not adjudicate prevalence or causality. Its contribution lies in clarifying mechanisms and practice implications to be examined in future empirical work.

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About the author

Marx Petrus Gertenbach has over ten years' experience working in residential child care across South Africa and Northern Ireland. Marx is currently a team leader in a children's residential home within the Health and Social Care Trust in Northern Ireland, where he supports staff teams in providing relational, therapeutic care to young people with complex needs. Marx holds a master's degree in conflict, peace and security, an honours degree in social work, and an honours degree in philosophy. He has been accepted as a PhD candidate in philosophy at the Queen's University of Belfast, with research interests centred on phenomenology, classification, and the lived experience of children in residential care.

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