

Chapter seven



Exploring contradictions raised by alongsideness
in tertiary and community work

Locating the issues

In the previous chapter I explored alongsideness when parents' concerns required more active use of my health visiting expertise. Collaboration developed in a climate of co-learning for identifying and solving problems. In tertiary work with families who have serious relationship problems, the influences on my alongsideness are more complex and messy. I am less eager to commit my experiences and ideas about this work to paper because my turmoil of inner debate continues to leave me uncertain. This work is filled with dilemmas. I believe this is evident in the messy conflict in my thinking through the early part of this chapter. Knowing that the spirit of living knowledge allows me not to 'know' with certainty now, but expects my openness to finding out, that gives me courage to show you where I have reached in my thinking. I invite you to join me in trying to understand the complexity and contradictions between parents' needs and children's needs and conflicts within myself as I try to meet them.

Referring to my swimming analogy (Chapter Three:60) I see the deep waters of tertiary work presented as 'rescue and restoration'. I recognised literature surrounding my interest in children's rights and physical punishment usually focused on child abuse from a social work perspective. I wanted to work at an earlier stage, before serious problems became obvious for

children. I therefore decided not to research my work where children protection was the issue but to focus on prevention. As I reflected on alonsideness in 'shallow waters' (Chapters Five, Six) I realised that I am also the same person using similar ways of being when I work with people in crisis. I mean that the way I present myself feels intuitive often without special forethought. I have learnt to trust my way of relating and my expertise and just be me with people whatever their situation. But I also felt I was not doing enough or my actions were ineffective when children need protection. This chapter explores this concern.

It fits for me that people in crisis need the same respect, acceptance and autonomy as everybody else. They do not need it less because they seem not to behave well themselves. Stopping parents from harming children remains a priority, but I want to go further and work towards all children experiencing early years that nurture their well-being. To do this, I need to ensure parents experience and recognise the value of respect themselves, so they may offer it to their children. As I refocus on tertiary work the swimming analogy alters. I see my intention to be offering a life buoy to families floundering in deep water. I may 'hold' or take control with the aim of encouraging parents to assume responsibility, as they are able. I begin to see the preventive possibilities of tertiary work emerging and creating tensions. Am I preventing or protecting? (Waters,1993).

My current thinking is this: I can see how a lifetime of disadvantage might build from beginnings in which connections with significant people, parents for example, are distant, unrewarding or worse, abusive. A childhood lacking responsive, encouraging connections with others, possibly punctuated with criticism, may kindle feelings of isolation, inadequacy, insignificance and discouragement. The words 'high criticism, low warmth' summarise this climate (DoH,1995:19). Moving to school and feeling like an outsider, possibly with failure to achieve educational standards, feelings of inadequacy and hopelessness may increase. Later attempts to create adult relationships with others who also have little experience of warm, reciprocal relationships is likely to lead to difficulties in realising dreams of romance and closeness. Feelings of inadequacy and relationships based on conflict and dependency may become a way of life. Health visiting usually intends building on people's strengths, but I wonder if becoming a parent and believing health visitors watch and give advice to overcome perceived deficits in childcare, compounds feelings of inadequacy. Discouraging experiences may not stop there. Involvement by child protection social workers when parenting is judged substandard, may lead to surveillance and decisions in the interests of the child, that unintentionally undermine parents' autonomy and sense of self-worth.

Now not for a minute am I saying that health visitors and social workers should not be acting in the interests of children. I came to this research with a 'rights for children' agenda, which has

not vanished but has become coloured by a ‘chicken and egg’ perspective that asks questions about useful action. I noticed that towards those becoming adults in a climate with few opportunities for practising democratic skills, blame appears to replace the empathy usually accorded the young. It feels too simple to restrict myself to attempting to contain poor parenting through surveillance and by telling parents what is wrong when that is inappropriate for other parents. Experiences bolster my belief in the inherent worth of people. Even the most discouraged parents would prefer warm relationships with their children. I believe that in the interests of children I need to work alongside parents as they try to become the parents they would prefer to be. This represents a shift in my intentions. I started researching believing that I knew what was good for children and wanted parents to know it too. I now believe parents know what they want for their children but they might need help in finding it. I now intend to start where parents are and help them progress towards their goals, rather than where I think they should be. A tension emerges.

Dr. Penelope Leach’s response to my Ph.D. Transfer paper (January,1998) reverberates in my reflections. Comparing it to my previous writing about children’s rights as a public health initiative, when reforming the law was in the forefront of my mind, she asked where the children had gone and:

Can children (all and always) wait while parents to grow through self-realisation? (Personal letter,20.3.98).

This question uncomfortably reminds me of the dilemma, who is my client, parent or child? Where do my responsibilities lie? I will explore the messy interplay of balancing alongsideness and responsibility. For reasons of confidentiality and because of the intransigent nature of tertiary work I did not make videos of families or even hand accounts back to parents. Instead I asked for colleagues’ opinions about my interpretations and used my journal, child health notes, field notes and personal letters.

Thinking about alongsideness with families in greater need

Looking back in my journal for emergence of this tertiary work in research reflections I find evidence of my growing awareness. I recorded my need to be accepting and encouraging as I formed a relationship with an eighteen-year-old mother, while holding concerns for her child. I wrote:

First visit. Her mother took me upstairs to meet Leah and her partner Jason. They were still in bed. I was aware that I needed to be totally accepting of them because in the past I have felt it more difficult to communicate with very young parents. The house, but especially the bedroom, smelt badly of condensation mould so that it was unpleasant being there. I said nothing. It appears it is usual because the whole house smelt like it. The midwife said she

mentioned it. She is still visiting because of the baby's infected eyes - clamidia¹. Leah seems very dependent on her new partner. They were open about him not being the child's father. (Journal,15.9.97).

...

Fifth visit. I experience real warmth and acceptance from them. Jason was chatty and friendly. He rather dominates the conversation and Leah appears dependent on him. I felt brave enough to mention the condensation and need for ventilation because of Leah's asthma and (baby) Brad's cold. (Journal,29.9.97)

In the child health notes I recorded Leah's lack of urgency about getting treatment for her Clamidia even when I told her it could lead to her infertility. She said she did not like using telephones or travelling on buses so I made alternative arrangements for their treatment. She came alive however, when she spoke about her success at singing karaoke in local pubs. This was what she really wanted to talk about. I wrote with unusual length in the child's notes about Jason's dominance and asked what his demeanour might mean for Leah's confidence and for Brad who was not his child (child health notes,15.9.97-29.9.97). I intended working at building Leah's confidence gradually, over time as she grew with her child. Brad was growing and appeared to be responding in usual ways.

The process was too slow to make enough difference for Leah or her children. It was not Jason who physically abused Brad and Leah's next baby, but a subsequent partner. He was a benign looking young man who moved in when Leah was rehoused to a new area. In court she chose this new partner over her children when their multiple injuries led to both children being removed by Social Services. Sadly, her ambivalence led to them being offered for adoption. Suspected or actual abuse is distressing to deal with but at least it is clear where health visiting obligations lie and the action that needs to be taken.

Talking with the health visitor in the new area I could see that within the parents' difficulties coping, injuries to the otherwise healthy looking children were signs that this couple were unable to understand or respond to the children's emotional needs separately from their own. We empathised with Leah's dilemma of needing companionship for herself and help with the children. Neither of these young people knew that this young man, so willing to care for the children, had his own legs broken in the first months of his life. We asked ourselves, 'how could they possibly put the children first when they seemed to have so many unmet needs themselves?' It was a relief that Leah gave up her fight for the children. We were not called to give evidence against her in court. In this case the job was too big for Leah and for us, her health visitors. Her children could not wait. Questions about what more I could have done are muted here in comparison with those where long-term neglect is the concern.

¹ Clamidia - A sexually transmitted disease

Balancing alonsideness when a parent neglects her children

In the Women's Refuge I met Helen who was pregnant and had four-year-old Mel. Helen had tattoos, body piercing, partly shaved and brightly coloured hair and spoke of not caring about what people thought of her (journal,29.5.98). My impression grew that she really meant she needed to be accepted for who she was. I came to know her, Mel and the new baby Ollie over the following year. Midwives' reports about her lack of energy, her inappropriate priorities and inability to get organised appeared accurate. I joined them in finding the amount of time devoted to discussing tattoos and the sculpting of her hair frustrating. The care taken over her hair did not match her badly decayed, broken teeth and infected gums. I was aware of how easy it would be to focus on these things in a voyeuristic, negative way and to slip into a habit of regularly criticising her amongst ourselves. I felt that if I allowed myself to do that I would find it harder to like and be at ease with Helen and treat her with the respect and acceptance I believed was important. After a few months she agreed to have dental treatment so as to be less preoccupied with toothache, but even with the help of a family support worker, 'good enough' care of the children was hard to achieve.

I managed to get one-month-old Ollie admitted to hospital over Christmas because he had not regained his birth weight. He gained weight over four days in hospital then remained static again once he came home. I felt it was important to remain friendly and encouraging with Helen to boost her self-worth and effort, but I also felt ill-at-ease about never really saying clearly enough that Ollie was not getting enough food. I was balancing encouragement with what I saw as criticism of her, which could undermine her confidence further. Ollie had to wait. Two weeks later I wrote in my journal about a pivotal visit:

Friday, I did a joint visit with the social worker and family support worker because we are all concerned how flaccid and lethargic he is and how little concerned Helen seems about his feeds. She says he takes five ounces when he obviously doesn't. He is very hard to feed. He is limp and pale and yet not ill, as Helen and Mel have been with flu. He had put on no weight in the last week. I was struck by the seriousness of the situation and allowed myself to speak my mind knowing the hurtful impact it would have. I said I was stunned by the difference between Ollie and another baby I had just come from who was a week younger. 'The other baby is alert, podgy, pink and taking lots of notice. Ollie is pale, lethargic and limp'. I said it was serious that he was not getting enough food to keep him alert or for his brain to develop healthily. Helen cried. The social worker suggested referral to their Family Centre, arranging it immediately. (Journal,15.1.99)

Over the weekend Ollie put on weight and was pink and more alert when they arrived at the Family Centre on Monday morning. I wrote:

Helen held him and appeared genuinely surprised and pleased when he looked into her eyes and mouthed a response to her. I felt she didn't do this very often. Thinking about this later, I realised my intention to be fully accepting and non-invasive of Helen - to be alongside - was

acceptable to Helen but did not define the limits clearly enough for the sake of Ollie. Although an alien method for me, by speaking my mind I was being clearer. I was being overtly judgmental and Helen heard me. It was necessary because the situation was dangerous for Ollie and Helen did not appear to empathise with him.
(Journal,18.1.99).

I went further as I wrote about variations of health visiting alongsideness having similarities to parenting:

I see here a closer link for the health visiting role with parenting than is usually obvious. The parent needs boundaries of safety and behaviour to be spelt out clearly with consequences if necessary, for the sake of the child. It is a bit like being 'held/contained'.
(Journal,18.1.99)

Dilys Daws in speaking about sleep problems in babies describes the complexity of emotions in being a parent:

*We see how subtle is the process by which mothers and babies move from their early closeness to seeing themselves as two separate beings. Sleeping problems illustrate difficulties at every stage. **Receptivity to the needs of a baby, sensitivity to their fears and spontaneous offering of comfort need to be tempered with a gradual setting of limits.*** (Daws,1989:4, My **emphasis**)

Helen had trouble being receptive and responding to Ollie's needs. He seemed to give up calling for her day or night. I am fascinated with the similarities between Daws' description of a healthy parent-child relationship and my relationship with Helen. I was responsive to her need to be encouraged and 'held' through difficult times but seemed to have trouble setting limits for her and acting for Ollie. I am uncertain if this is a difficulty because I concentrate on encouragement and not giving up even when she is not coping or is it because staying friendly is easier than confronting her for Ollie's sake? Am I trying to *prevent* future ill-health or *protect* Ollie? The problem is, there is a child waiting who needs care *now* and relationships involved in taking protective action are different (Waters,1993).

Helen found excuses not to attend the Family Centre so it was back to the family support worker and me to support their progress and monitor. Between us we visited regularly, encouraging Helen and building on the shock from my words and the social worker's actions. I wrote:

Helen and T (neighbour) are open and friendly and engage in banter. Both particularly like to put me down in various ways by telling me I am incompetent at filling in weight charts or putting on nappies. I have always made a point of trying to reduce my powerful position and increase clients' status, worth and decision-making. In this case H and T have taken it up and use it so it makes me feel a bit irritated and I wonder if I should allow it. They seem to like my visits. I don't detect any sub-agenda beyond them needing to feel OK in comparison with a seemingly more powerful me. Helen and Ollie are both looking healthier. Ollie has

gained weight. Helen is optimistic and the flat cleaner and a bit better organised.
(Journal,10.2.99)

Asking Helen how she felt about what I had said in January, she replied, 'I want you to tell me if I'm doing something wrong'. She then asked what the word was that I had used about him. We talked about what 'lethargic' meant and how Ollie was now growing and more alert (field notes; Helen's story, BARG,13.5.99). I was moved on this occasion, as with other parents involved in child protection proceedings, by Helen's recognition that I was doing my job and it was the 'right' thing to do. Her question about lethargy showed she had been thinking about what had happened. For a time she became more responsive towards Ollie and he gained weight. I wondered if this was enough. I asked myself if the intensive support the family support worker and I gave maintained a poor situation for Ollie, which otherwise might have deteriorated to the point where removal by social services was a possibility. On the other hand to do nothing would condone neglect, abandoning Ollie to worse. Neglect would be on our part and progress towards a humane and caring society that strives for children would stand still.

Penelope Leach's question about whether children can wait brings this dilemma into focus. I now need to ask how I balance parents and children as clients and realise my responsibility for the well-being children in my actions. What are my responsibilities? B&NES child protection procedures (2001) outline procedures for implementing The Children Act (1989). In this document the UN Convention underpins the roles and responsibilities of agencies working with children, who suffer or are likely to suffer significant harm. No absolute criteria are given for judging 'impairment to the extent of constituting significant harm'. Impact on the child is considered from 'compilation of significant events both acute and long-standing, which interrupt, change or damage the child's physical and psychological development'. Contextual factors, such as the family's strengths and supports, and the degree, severity or duration of ill-treatment or neglect, are taken into account (B&NES,2001:1.4).

Neglect is hard to take action on under the law in that the burden of proof about the harm it inflicts rests with professionals. We monitor while continuing to work where physical and emotional neglect of children is suspected, but difficult to prove sufficiently so decisive action can be taken. Through surveillance of the whole context of the child's world, assessment asks if it is 'good enough' and what further action could improve it? I find this difficult because thresholds of 'good enough' under law seem very high in the degree of neglect or abuse that is tolerated. Social Service resource limits mean systems have been developed for prioritising 'children in need'. There is a gulf between what is acceptable to statutory bodies and recent research into the importance of early parent-child interaction for long-term mental well-being of children. Current knowledge informs us that children need more responsive early relationships than is often achieved (Nash,1997; Rickford,2001). This informs my decision to

work towards parents' self-growth in trying to secure better outcomes for children. I then become so absorbed by parental concerns that children risk being forgotten as I wonder where to stop encouraging parents and set limits for them instead.

Alongsideness and the protection of children

Alongsideness is such a way of being for me now that I decided to try an even more alongside approach while working with Julia who was terrified of having her second child removed by Social Services. My decision exposed further questions. I had known Julia for six years since I arrived at the practice when she was eighteen and had a three-month-old daughter. I was a central player in the removal of this first child because exposure to chaotic, dangerous and frightening experiences was identifiable as emotional abuse. An image remains with me of the tiny girl appearing to make herself even smaller in a corner of the sofa. She sat watchful and still while stories of fights and police coming in the night were told. I cannot recall seeing an eighteen-month-old child sit still for so long before (child health notes,28.11.95). Within days the child experienced a car chase in which she bounced about on the back seat alone, unrestrained. Voluntary care escalated to enforced adoption over eighteen months as Julia's apparent hopelessness rendered her incapable of co-operating with Social Services.

After a couple of years living in another area, Julia returned with Clive, aged one. He was robust, socially engaging and appeared less affected by his unpredictable, but less violent environment with Julia's changing cluster of youthful helpers. Julia obviously found his physical care easy but continued to lurch between a variety of crises. She had spent time in prison for car crime but after another offence got probation on a 'Wheels' project working with cars, while Clive went to a childminder (child health notes,30.9.98).

My visits always centred on managing the current crisis so preventive work seemed impossible. Julia said she did not agree with smacking because of her own experiences. I found it hard to comment on mild threats I heard her use because she was always preoccupied with more pressing problems. In 1999, a friend looked after Clive while Julia served another prison term for car crime. When they returned, they lived in yet another symbiotic set of relationships with transient young adults. Clive became increasingly difficult to manage. I could find no opening for thoughtful work because of more pressing crises until multiple complaints from neighbours about Clive being left with young carers led Social Services to instigate a 'risk assessment' (child health notes,5.4.00). I believed Clive was unlikely to be removed because he was not showing significant signs of distress by Social Services criteria. I therefore decided to try an additional strategy to my usual method of presenting weaknesses amongst strengths to the case conference. I believed my giving evidence altered our relationship sometimes

increasing a parent's feelings of inadequacy and hopelessness as I became 'critic'. Julia and I had been through this before.

Julia was angry and defensive about the latest accusations saying how hard it was to lose a bad reputation. She refused to co-operate with Social Services because of the previous result. I sympathised and listed the positives, the hopeful signs of her growing maturity and Clive's resilience. I explained why people were concerned for his well-being. I said I would submit a report, which she could see, and undertake the health and development parts of the risk assessment assigned to me (child health notes,7.4.00). I wanted to keep communication open and remain alongside her as much as possible because when the risk assessment was over it was likely that our work would continue. This was an opportunity to offer more. I recognised Julia's need for control over her life and asked how I could help her keep out of the gaze of Social Services. As we talked Clive, who was nearly three, repeatedly slammed the kitchen door to get her attention. Julia threatened him with a warning, 'Stop that! I am counting! One! Two! Three!' He did it more. Distracting her, I pointed to how her threats had escalated since he was a baby and how soon they might not be enough. I reminded her how she always said she did not believe in smacking, but unless we did some thinking about this now, she might feel she had to carry out the threats and actually hit him (it was likely that she already did). There would be good reason for people to be concerned if she started hitting. Julia agreed violence could escalate but she did not know what else to do.

I asked how it would be if together we worked on managing the bits of his behaviour she found difficult. We could keep what we were going to do to ourselves and at the end of the 'risk assessment' she could decide if she wanted to report what we had been doing to the case conference. Julia looked pleased. I wondered if it was right my doing this and then decided it was more likely to work than anything else I could think of. Preventive work had never been possible before, but she was motivated now. I felt optimistic and recognised her conspiratorial glee to being in some control. About Clive at that visit I wrote:

He was shy at first but became very enthusiastic about the measuring equipment, showing great stickability and thoughtfulness in playing with it. He responded with enthusiastic joy to the arrival of his small neighbour friend and set about finding his own clothes (nude) so he could go out. Clive's cheery, enthusiastic personality is infectious and he appears immediately likeable by all. (Child health notes,7.4.00)

The case conference chairman respected our explanation and recorded my duties as 'monitoring health and development and offering support' (case conference notes,12.4.00). Julia gave up her evening bar work, limited the number of young people staying at her house and kept to her contract with Social Services to care for Clive herself. She began to join the unusually close network of young families amongst her immediate neighbours. Julia worked

hard at the Crucial Cs and thought about some of the painful areas of her life. Her mother had left when she was eleven and after a time she went into Social Services 'care'. A catalogue of tough experiences and fractured relationships had happened ever since. From thinking about her own experiences she began to consider how it might feel to be Clive (child health notes, 5.5.00). We planned to continue talking about managing specific problems the next week. When I arrived, Julia was sitting on a wall in front of the flats with other women. She had been showing them the Crucial Cs. About this I wrote:

Neighbours thought the CCs leaflet was crap, making jokey remarks like, 'Give them a good hiding. That's what I say.' I reminded Julia that she liked the Crucial Cs last week. I suggested we do it with the whole street to get mutual support. Julia and a couple of neighbours agreed it's a good idea - they want tea and chocolate biscuits. Inside the flat - Julia said she was trying hard to be calmer but was frustrated because Clive had bitten the neighbour's boy and played up when the social worker came resulting in him being put in his room. (Child health notes,12.5.00)

I could see progress might be less while there were powerful influences amongst neighbours. She was learning to get on with them too. Julia was enthusiastic about joint sessions but suggested the flats were too small for group-work. She suggested the Junior School canteen and I went to arrange it, leaving her to talk with her neighbours. Arrangements took weeks because GP Bob Gibbs died unexpectedly in May derailing my efficiency and significantly affecting Julia. She relied heavily on his unstinting benevolence. When I finally took the invitations for her to distribute she said, 'Where's my name? I thought I was going to be leader with you'. I took it away, added her name, printed more copies and sent them back for distribution (visits diary,23.6.00).

When the day came, the school nurse assistant and I set up the crèche and tea and chocolate biscuits. Nobody came. On the telephone Julia said, 'Oh sorry, I'm just coming'. She never arrived (visits diary,30.6.00). The invitations had not been distributed. I realised I had expected too much of her. I had given her more responsibility than she could cope with if I considered her previous poor ability at keeping appointments. It took weeks for me to acknowledge that I felt hurt. My normal resilience was wobbled by Bob's death. I acted as if nothing had happened. The case conference decided she had made progress and her son was not in significant danger (case conference notes,21.7.00). The firm hold of the Social Services 'risk assessment' had forced Julia into thinking about Clive and making some changes. It also gave me an opportunity to begin preventive work.

After discussing the parenting group experience with colleagues I realised I had not been genuine with Julia in that I had contained my feelings because I did not want to increase her distress. I was also floundering under what felt like siege conditions in a grieving community. I felt resentment that I always 'came up trumps' and coped with Julia's numerous emergencies

because not to would mean a worse result. This time *I* was struggling too, but I continued trying to cope (Chapter Two:45). Health visitor colleagues suggested it was not helpful for Julia because by continually shielding her from my feelings I denied her the opportunity to understand the effect of her actions. It was not that she was ungrateful, but my always coping *for* her might prevent her from realising the consequences of her inaction or actions on other people. She might benefit from a more genuine relationship in which my feelings were also important. In fact it would be respectful of her as a capable person if I was honest and expected her to take responsibility for herself.

I am reminded of Belenky's description of 'silence' and 'received knowledge' as recognisably describing Leah, Helen and Julia. I recognise that experiences of mutuality and reciprocity are most likely to enable their growth (Belenky et al,1986:35). I recall the need for receptivity and sensitivity, matched by limit-setting and wonder about the dual implications for myself and in different ways, for Julia (Daws,1989:4). Similarly, Rogers describes 'congruence':

It has been found that personal change is facilitated when the psychotherapist is what he is, when in the relationship with his client he is genuine and without "front" or facade, openly being the feelings and attitudes which at the moment are flowing in him...By this we mean that the feelings the therapist is experiencing are available to him, available to his awareness, and he is able to live these feelings, be them, and able to communicate them if appropriate.
(Rogers,1961:61)

Grief altered my ability to cope with other people's problems encouraging my review of personal boundaries, and a need to be genuine for Julia's sake as well as my own. Moira Laidlaw's comments on this chapter were helpful. She asked if more than limit-setting it was my *responsive responsibility* to be clear. I have an obligation to act in response to needs I recognise. I wonder if my taking responsibility for my relationships and actions is as educational for parents as it is for me. Difficulties that parents experience in taking responsibility for their behaviour stimulate questions, as if mirrored back to me. This is sequel to learning that occurs when parents empathise because they recognise their own feelings reflect the children's (Chapter Six:152). For me empathy is easy compared with responsible action that risks conflict.

As health visitor I am like an authoritative parent, if I remain genuine in voicing my beliefs and concerns, being respectfully friendly but firm, while risking and containing parents' anger and hurt as they reflect. We are all in processes of becoming responsible for ourselves. I act to meet my professional obligations not only to protect children, but also to influence societal expectations towards equity of rights for children. Interpreting this for myself, I now might say I more fully live my educational responsibility to parents and children when I respond to my own as well as to their emotional needs. This is part of the *responsively responsible* action I need to take if I am to act for a humane, democratic and caring society. Alongsideness as 'value'

creates further opportunities for mutual learning. I think *responsive responsibility* might be my most important insight for understanding recurring contradictions I find in myself (Prologue:9).

Another colleague asked if a degree of professional distance and objectivity is needed if practitioners are to keep themselves safe (conversation about this chapter,13.7.01). I began to see the impact of personal perspectives on individual practice style. This led me to wonder about the relevance of aloneness and mutuality as I describe it, has for practitioners who struggle with painful personal histories. Other readers of this chapter asked if I needed supervision for this work, or even psychotherapy to help me understand the dilemmas I identify? I agree that more robust supervision than health visitors receive at present is needed if the degree of involvement I am suggesting as necessary is to be offered. I had written about the 'lived emotional experience of health visiting' in a letter to planners of the proposed Primary Care Trust, who intended cutting health visiting support (letter to PCT,16.11.00). I am drawn again to seeing the importance of practitioners generating theories of practice as we reflect on what each of us is doing (Ghaye&Ghaye,1998:42-44).

When Julia telephoned with her next crisis (she needed another pregnancy termination) I listened as usual. I told her I cared about her and would help, but was fed-up that we still appeared to be lurching from one crisis to another. I told her I wished we could work in a more preventive way *before* things went wrong. I said I tried to be reliable and help where I could, but felt let down when she didn't manage to keep our appointments. She apologised saying, 'You are important to me'. I know this is true. She heard me and seems to try harder to keep appointments. At last she has agreed to regular contraception and speaks about 'thinking ahead'. In August she asked if I could write a character reference for the Magistrate's Court as she had been caught driving without a licence again and this time was likely to go to prison for a year. I said I could not do that but I could say that another custodial sentence was not in Clive's best interests because she is working on her relationship with him (letter to magistrates,16.8.00). To my amazement she got probation!

Clive becomes harder to manage as he gets older and although the Crucial Cs provide a language for our discussions, progress is slow with Julia. She is frequently despondent when she cannot act to prevent situations deteriorating. Even though she is still unable to give his needs priority she begins to show insight into how he might feel. She said:

You know the other day I'd had enough. I said to him, 'If you keep on like that I'll send you to your father'. He got hysterical, 'No, not father'. He was so scared. He's never met his father. He doesn't even know who he is. It was just because I said it. He thought it must be a bad thing. (Child health notes,26.1.01)

She may be moving towards seeking counselling. When I asked, she said:

Julia: When I went to 'Off the Record'² I lied to them Robyn. I lied. I didn't want them to know what I am really like.

Robyn: I think you are on the move now Julia. You are a woman on the move.

Julia: It's my birthday next week. I am twenty-four what have I done. I haven't had a life.

Robyn: You have had a life! You have the most happen to you of anyone of twenty-four I know. Its just that you keep it behind a great big curtain because it is too painful to look at it. (Child health notes, 26.1.01)

I waited as she gazed into the middle distance and thought. 'Yes'.

In his first year of school Clive had difficulty following instructions and appeared vulnerable in a group. Teachers found his aggressive outbursts and determined attempts to leave the school hard to manage. Exclusion was considered. With the help of the early years worker (Chapter Four:100-103), with teachers, Julia and I shared what we were all trying to do. Clive gradually settled and began to make friends.

Ethical considerations in responsive responsibility

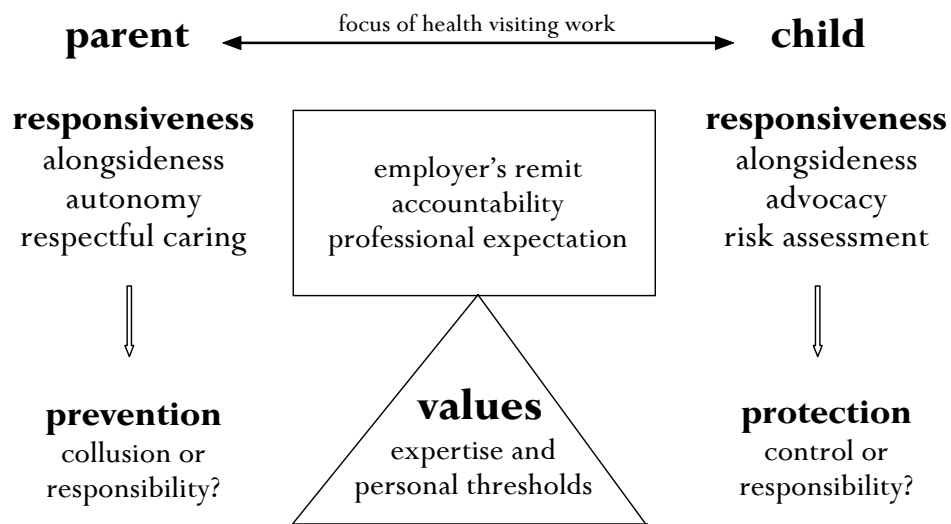
Discussing this chapter with Stephanie Bailey, Child Protection Adviser, who knows of most of these families, I began to consider fresh points of view (conversation, Stephanie,13.7.01). Stephanie asked if my stance of being alongside Julia in this case put me on the other side from Social Services, perpetuating Julia's impression of them as unhelpful and punitive? She also asked if in my stance I was colluding with Julia? I was interested in these perspectives having not considered them before. I can see how my stance might make some social workers seem like 'bad guys' in a task, which is already difficult for them, assuring me the easier 'good guy' role. This relates to the issue arising throughout this chapter about who my client is and how to be clear about limits to parent's behaviour towards children. Collusion refers to the possibility of my condoning parental abuse or neglect of children. I see my actions as 'responsible' if my intentions are to use my expertise to improve well-being of children.

My previous experience of Julia is that she became defensive, more hopeless and refused to cooperate in a similar situation, and then lost her child, the right decision for the circumstances. She was fearful of escalation like this happening again. Seeing Clive's situation as different, I believed he was likely to remain with her. Our working relationship therefore would continue. I wanted to find a way of helping her create a warmer climate for him by building her confidence in herself while the firm hold of the risk assessment stimulated her motivation. I believed she could do it. I can see I have ethical questions to answer because I have appeared

² 'Off the Record' - A free counselling service for people under twenty-five.

not to stand firmly side-by-side Social Services by undertaking undeclared work with Julia, within child protection procedures (B&NES,2001). I also see that I was clear with Julia that things needed to improve and that I could help her. My decision was to look for a strategy likely to have the best outcome for Clive and Julia. By helping her retain some control over decision-making, and by showing trust in her ability to make changes, I believe I opened new doors for her. She was energised by her task, became reflective and made real effort (child health notes,5.5.00).

Stephanie helped me think about the dilemmas arising in this chapter. Working with parents, I am responsive both to their needs and to those most likely to enhance well-being of children. Alongsideness could risk my collusion with parent's needs over those of children, or the procedures of other professionals. Responsiveness to children is paramount and requires my assessment of need and action on their behalf. This is my responsibility through professional remit and the expectations of society. Pivotal for balancing my decision-making is my professional expertise and my personal thresholds of morality, observable in practice as embodied values. For me, these values are under an umbrella of alongsideness, which is held up by respect, self-determination, responsive responsibility and equity of rights for children. Values provide a safety net by keeping my actions under constant tension. I show my attempt to balance protection *now* with prevention for the *future* in the following illustration.



Balancing responsive responsibility

Adapted from diagram suggested by Stephanie Bailey in response to this chapter

The significance of my own personal history

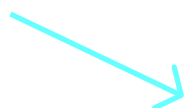
Insight into the significance of my own history in decisions I now make was stimulated by visitors to BARG. Mitchell and Webber (1999) introduced their enquiry into image and

identity through artistic forms of representation (journal,21.5.01). They spoke about interpreting underlying meanings held in nostalgia created by old photographs. I wondered about an incident at work and its relationship to an old school photograph. I remembered the 1950s class photo taken in rural New Zealand (below). I was eight and had bare feet. This was significant because I hardly ever wore shoes to school. It was so normal for me to have bare feet here that I remember once being sent home to get my shoes because it was winter and icy.

School photo, 1955



The normality of my bare feet came into my thoughts because of a work incident a few years ago. A family under surveillance for neglect kept their immunisation appointment but the children had walked to us barefoot in the streets. Practice staff were concerned that this was a sign of neglect, but bare feet held little significance for me. Although the children were dirty, I saw them as robust, cheerful and showing usual milestones of development. I knew their mother to be warm and responsive towards them. I recalled visiting a homeless hostel where I was astonished by the social skills of the three-year-old as he helped another child climb over upturned chairs. He held her hand and gave verbal encouragement.



There were also good reasons to be concerned for these children. I knew about times when their father was home and could be violent towards their mother under the influence of drugs. When the family were rehoused to another area incidents resulted in all four children being removed and eventually placed for adoption. I wonder what part the personal beliefs of practitioners played as we collected and presented evidence about families. Had I been too

understanding of this family's circumstances which, when viewed from another's perspective, might have been seen differently? It continues to worry me that I might have missed something or been too 'barefoot' and accepting.

BARG members thought my story implied it was poverty that led to my not wearing shoes as a child. They were surprised to hear my parents were salaried teachers. We wore no shoes because it was normal for children to be barefoot in that place. The photo shows most of the children in my class with bare feet and none looks poor. My mother tells me bare feet arose from the particular circumstances of the place and time. In the next school we moved to my peers were mostly Maori for whom poverty *was* a reality. Here we *all* wore shoes because it was normal to do so, at least at school. I have no photo of this because, my mother tells me, parents could not afford to buy them, so they were not taken. Thinking about bare feet links with my exploration of the significance of personal history on the values and agendas of practitioners (Pound,2000). In this paper I looked in some detail at my early recollections, adult experiences and critical incidents in conjunction with literature and themes from other phases of the research. I used early recollections from childhood (Powers, Griffith,1987) to locate personal symbolism and meanings that I continue to rehearse and express as my attitudes towards experiences in my life. From the context of my New Zealand childhood, and later experiences I explored the background in which my values developed, I particularly became aware of my attitudes towards hierarchy and religion. I concluded:

So my rosy picture here of liberal humanitarian ideals firmly rooted in a national ideology are not the whole story ... However, I still believe that the nuances of a national psyche in some way suffuses the souls of its initiates. I reaped advantages from growing up in the particular levelling circumstances of the time. (Pound,2000)

In this paper, using the work of Griffiths (1998), I also looked at how I use playfulness and humour in my practice. Experiences in my life and my own personal characteristics seem to colour the way I understand experiences in my work as a practitioner. If bare feet give me a certain view of the world, what other variations do I bring to my interpretations of what I see and the decisions I make? (journal,21.5.01). This brings it home to me that alongsideness as I describe it is made-up of my own constellation of values and they are also developmental *as I examine them*. Other people's versions will inevitably be coloured by their particular interpretations of their worlds. It tells me how important practitioner action research must be for understanding, developing and embodying our own values within our contexts. My search for understanding continues in tertiary work where neglect or serious relationship disharmony persists. In the meantime, the wider usefulness of alongsideness shifted into a community development project where I hoped to enhance social networks.

Enhancing social networks through community approaches

A community development charity on the other side of town was interested in starting a parenting group in their local school for 'disadvantaged families' who were unlikely to join any other group. Four young women describing themselves as 'survivors of difficult childhoods and disempowering partnerships' wanted to give something back to the charity who had helped them (journal,19.10.98). Kathryn, the facilitator, invited me to meet them. I have changed her name to give the group privacy. They intended creating a support network that was independent from statutory services. Responding to their request for accessible information about parenting, I introduced Lew and Bettner's 'Crucial Cs' (1996). They liked it. Reluctantly, because I did not know what the commitment would be, I agreed to introduce the Crucial Cs when the group was up and running. My involvement as health visitor was acceptable because not working in the area I was not involved with the families, and they liked my approach. My hesitation about branching into something new faded as I realised the advantages of joining a group for disadvantaged families, which already had funding, a crèche and clientele organised.

When the membership of more than two dozen women and men had been meeting for several months I was invited to introduce myself. The group sat around a low table in the Infant School library with coffee and biscuits. The non-invasive, personal growth approach was immediately obvious from the warm welcome made to every member (journal,17.5.99). I had been given such a build-up that I was unprepared for the group's demand to show what I had to offer, immediately. Flipchart paper was stuck to a door and I built up the Crucial Cs framework in the way I always did. The process took an hour and I felt pleased that it had gone well with everyone joining in. Afterwards I wrote:

Rick arrived late with another man. He is obviously used to dominating the group and kept up a running commentary of jokes and challenges. I felt able to keep up. In fact it was fun. From the exercise I felt the huge amount of discouragement and acceptance that things in their lives were just their lot, to be accepted. There was little recognition of anger or fight left in many of them towards the injustice and insensitivity they have experienced. It was my impression that I had to be totally accepting - 'alongsideness' describes well what I must do. If I was teachery or authoritarian I would lose credibility and they would close down as they have probably done with professionals who have tried to direct them in the past. I was pleased with the process. We had fun. At one point Kathryn pulled me back from only wanting to look on the bright side because she said it ignored or avoided understanding their pain. I was vaguely aware of not wanting to dwell on bad things but to look for the positive. Is this denial, avoidance? Or is it that bad things are not so bad that they can't be put to one side? I came away in awe of the mega job we had on here because of the amount of despair and hopelessness built up over the lifetimes of these men and women. (Journal,17.5.99)

I recorded in my journal the following week that I hoped to build on what we had done the week before (journal, 24.5.99). I was told the parents usually dribbled in after dropping their children at various schools. On this second occasion most had arrived by the time I got there. It

was a slightly different collection of people but just as many. At the door a volunteer said, 'I hope you've got all your courage today, Rick's in full voice'. Others whispered warnings as I joined the circle. There was an air of anticipation and I felt some were anxious that I might get hurt. Rick said he had been thinking about it since last week and had decided not to come, but changed his mind and brought his wife. He said it was 'all crap' what we did last week and he felt I had been trying to make them look as if they didn't know anything. 'We're not thick', he said 'I can't see the point of it'. I listened but did not try defending myself. I said I could cope with his anger. I felt strong. Several women said that they had found talking about feelings helpful and wanted tips for handling children. Rick and his wife spoke freely about the abuse they had experienced as children. They barely seemed to question it. Rick expressed sadness that one of his sons had raised his arm to protect himself when he thought Rick was going to hit him. He told how the boy tried to jump from an upstairs window because he was so depressed. The group listened and made sympathetic noises. No one passed judgement or made suggestions.

A member who had not been there the previous week spoke of her embarrassment that her daughter continually pretended to be a lion. A quietly given sensitive suggestion from Rick was absorbed into other ideas from the group. Someone pointed to the sensitivity he had shown. Again we had spent the whole hour talking about feelings!

I summarised in my journal:

This was a lively honest and open conversation. I felt confident again but realised the impressions I had last time about discouragement, and warnings in previous discussions with Kathryn, were proving true. These people do not want a top-down approach. They do not want to be patronised and told what to do by a middle-class professional who 'knows' and thinks they don't. During the session Kathryn again said it didn't help only looking for the positives because negatives were also real for people. (Journal,24.5.99)

I believe this indicates a contradiction I do not yet fully understand between what I have heard called cognitive behavioural therapy and psychotherapeutic approaches to change. My current understanding about this is that behavioural therapy is more likely to challenge client thinking and offer some direction. Psychotherapy is more likely to support clients in finding their own answers through exploring their feelings. I have not explored these differences more fully but feel I was attempting to direct people's feelings more than is usual in this group.

Kathryn reported that Rick had come to her saying, 'Good eh!' at the end of the session (journal,28.5.99). In later conversations with Kathryn I began to understand the 'holding' role our presence played for Rick and others while they told their dark troubling stories. I wrote:

A place where people can express themselves safely, where it is OK to speak and it will not get out of hand or shock. We as a group can cope and 'hold' members as they let out and explore dark secrets. On week two Rick recognised I was not shocked by him and he appreciated it. Kathryn suggested he felt 'held'. She said I offered some structure to the

group when I arrived, in the form of a framework. One week when I was away they said 'entertain us' and were noisy and uncoordinated. This is interesting - on the one hand I am there with something to offer (I am not certain what they see it as being). On the other hand it is not always appropriate to deliver it to them because they are doing valuable work themselves within the 'containing' structure of this something. (Journal,4.8.99)

Certain themes about relationships kept coming up. After a conversation with Kathryn I decided to try leading the discussion again. I remembered Rick's wish not to use pen and paper. I raised the idea of how it feels to 'belong' in a group of people. Most of the adults seemed to relate to pleasure from a feeling of 'belonging' with other people and the discomfort from feeling alienated. It was the next week when Rick, who had obviously been discussing it with his wife, commanded attention,

Rick, 'Now listen right, I've been thinking. You know my son Shane, my favourite ...' (Journal,18.10.99).

He went on to tell a painful story about his insensitivity towards his other sons. It was insensitivity that no one present could have missed. It felt shocking. The group sat silently and listened without showing any judgement of him. It seemed that Rick now felt safe enough within himself and in the group to begin to look out beyond himself. He could begin to see things from his children's points of view. We 'held' him while he explored.

Rick, 'That wasn't right what I done.' (Journal,18.10.99)

No one disagreed. This was one of the most magic moments of my research. Rick and his wife came every week. They seemed to be thinking and moving. His children's teacher reported Rick was becoming easier to communicate with and less defensive (journal,4.8.99). The family's health visitor recalled her surprise at seeing the couple sitting on a bench in calm conversation and on another occasion the family talking as they walked together to school. This was new, the usual picture had been parents bellowing threats as the children ran ahead (journal,13.3.00).

On one occasion, I was surprised to be hugged by Rick when I arrived. He gave no explanation. Kathryn later reported that he had been irritated by my always being late. She had suggested he find a different way of dealing with it from being rude. I had not been aware it was a problem believing the time I could arrive had been established (journal,20.9.99). I missed the importance of his hints and the problem was not solved. Now, I realise I should have been clearer about timing and the limitations to what I could offer. Social activities were arranged outside the sessions. I wish I could show you photographs of the Christmas party, but feel it would violate families' privacy. The following spring, family groups totalling sixty three people went to Butlins on holiday. I believe the range of activities continues to expand. I attended for a year and learned about the special needs of this group and the inappropriateness of some intentions of statutory services. The unexpected death of Bob Gibbs the GP brought my membership in the group to an abrupt end. I drew back to concentrate on new and unique needs within our small practice. Many of the skills I had been learning became useful here too as we coped with our own and the community's grief and

began rebuilding the practice. Without our GP and practice manager (his wife) practice staff needed to pool resources to decide how to continue.

A Family Group and the Healthy Living Centre

Recognising similar unmet needs in a housing estate in my own area I joined a Healthy Living Centre development project with my first purpose of seeking independent charitable support for a local family group of our own (visits diary,20.4.99). The estate is a pocket of deprivation as shown by Department of the Environment, Transport and the Region statistics that place the Enumeration District covering most of the estate in the bottom 6% nationally (New Opportunities Fund application,2001). The area also has the highest proportion of black and other ethnic minority residents in the city. The social isolation of discouraged families, sometimes under child protection surveillance, led to my recognition that they needed support that was independent of statutory health, education and social services to allow families space to grow.

Here I list insights from this research on which the family group is founded:

- I believe people (practitioners and users) thrive and can become open to the emotional needs of others when they experience their own needs being met. I see these as the need to feel a sense of belonging with others, a belief in one's own competence, sense of worth and courage to handle whatever turns up.
- Complex problems and difficulties coping do not mean people living with disadvantages need respect acceptance and self-determination less. In fact they need to experience them *more* so they begin to feel better about themselves and in turn offer the same for their children.
- Effective relationships in alongside health visiting as I see it, mirrors values to be found in positive parenting (Lew&Bettner,1996), 'collaborative' researching (Chapter Two) and community development (CPHVA,1999:26). Educational processes towards well-being appear more effective in mutually respectful relationships and in a spirit of co-learning. This ethos requires power bestowed by professional remit to be minimised.
- Families may need support to enhance their self-worth before they can begin formulating their own questions about family relationships. Parenting classes may not be appropriate if parents are so discouraged and depressed that they are in no position to ask questions about better parenting. It may be more appropriate to offer parenting classes separately, for those able to benefit.
- The remits of statutory services to promote health, protect children and educate may unintentionally undermine people's basic need for connection, for significance and self-determination in decision-making. A history of disadvantages,

including perceived isolation and inadequacy in family relationships, at school and as a parent under the gaze of health and social services, may compound feelings of incompetence, alienation and discouragement.

- For statutory services, contradictions may unwittingly arise between stated aims of respect and self-determination, through working in partnership and the practices of surveillance, child protection and professional decision-making. For this reason an independent charitable body, outside the statutory services, may be more able to offer the unconditional acceptance and community support these families need. Statutory services can work in parallel.

These insights are congruent with the motivations of the National Service Framework for Mental Health (DoH,1999b:13-23), Supporting Families (DoH,1998), Our Healthier Nation Green Paper (DoH,1999c).

Public consultation by the Healthy Living Centre (Roadshow and Public Consultation,2000-2001) and Rapid Appraisal (Pound,1999; Murray,1999), asking the medical practice staff about local health needs, showed social isolation as a factor in mental distress. The HLC's bid for three-quarters of a million pounds of New Opportunities Fund money, to add to locally generated money, is intended to support community projects including the family group. This venture has now advanced to Stage Two in the application process. An established local charity for regeneration of a traffic-blighted area is the umbrella charity administering HLC funds.

In October 2000, a tiny Infant School in the estate (23 pupils) escaped closure on the strength of its intended community work (including the family group) in conjunction with the HLC. The school's urgency to act resulted in a local parent securing a small grant from the HLC for a six-week pilot in March 2001. A second parent, interested in joining the group, helped the HLC project worker and me advertise, interview and appoint a paid facilitator. Isabelle, the successful candidate has extensive experience of working with groups of people who find themselves socially excluded or with mental health problems. After the pilot project she wrote:

It's great to see your philosophy on paper - very inspiring and I agree wholeheartedly.
(e-mail, Isabelle,27.4.01).

A volunteer experienced in working with people who are unemployed, have addictions or literacy problems supports the facilitator. Staff of the 'Community Bus' are commissioned to offer a high quality crèche and stimulating play for children. Parents have opportunities to learn how to play with children. A black community worker offers help understanding mental health issues for ethnic minority groups and the local training centre for psychotherapy and counselling offers affordable psychotherapy when needed. The group operates in the school for two hours once a week in term time. Further funding from the PCT, B&NES and charities has allowed it to continue until HLC funding is secured.

From more than twenty appropriate referrals, seven mothers come, some regularly. We have not solved the problem of bridging the gap between identifying need and actually getting people to come the first time. Discouragement, depression and isolation experienced by our target group may make home visiting necessary to encourage attendance. The current families have very young children but it is envisaged that through the school and Social Services, parents of older children will be encouraged to attend. We hope that connections created in the group will gradually extend and be maintained in the estate.

The growth in confidence displayed by the two parents involved in planning and setting up the group shows the value of including 'users' as they feel able. Neither of the women had done anything like this before. They have both gone on to offer themselves to other HLC ventures. By reflecting on my own life as mother, in comparison with the lives of family group mothers, I recognised an advantage that makes my life easier. I have friendships with women with whom I have a great deal in common. We meet in an atmosphere of reciprocity and mutual regard. Caring about each other means sharing stories, offering comfort and encouragement through both troubling and good times. We all know there is someone there for us. Isolated parents may not have supportive relationships such as these with anyone. This describes my vision for the group.

As health visitor with a child protection agenda, my role belongs outside this family group. I offer support to the facilitators and work to maintain the group's high profile with other agencies. By increasing understanding of its purpose and philosophy I can encourage funding offers and appropriate referrals. Consultation with other agencies shows there is a great deal of interest in its development as a part of Bath's overall plans for tackling social exclusion by improving community support networks. The group is now free to develop in ways that seem appropriate to local need, with accountability to a small management committee.

I continue to be involved with the HLC and its other projects that include continuing public consultation, healthy social activities for families, the elderly, gay and other minorities, complementary therapies, a music carnival, credit union and a community garden. For motivation, I have in mind the gradual loss of a sense of community in which people look out for each other as described in Chapter Five (Leach,1994:12). I see my role with the HLC to be working towards realising a community-led approach to community development. This is not easy in an organisation run by statutory agencies and community members each with agendas of their own. I continually grapple with contradictions I see between what I understand to be our purpose and what is actually happening. The words of Aboriginal educator Lilla Watson are useful as reminder of what I think the HLC should be trying to do:

If you've come to help me you're wasting your time. But if you've come because your liberation is bound up with mine, then let us work together. (Wadsworth,1997:17)

The HLC is a story that is yet to unfold. In the meantime I look for the threads in my tertiary work.

Kathryn and Isabelle respond

In joint discussion with the leaders of both family groups about this account, Kathryn said she found the account very moving and 'real'. Recalling the incidents she said, 'Rick would love to read this...yes, he certainly does still come every week'. She spoke about the additional strain she experienced from being seen as 'mother' to the group and being required to know and hold every member. She reiterated the need for good supervision of the quality usually sought by psychotherapists.

Isabelle questioned 'collusion' as a way of describing the degree of involvement I suggest. I have since returned to the ethical dilemma it uncovered and extended my discussion. (Conversation,12.9.01)

Balancing prevention with protection in tertiary work

Penelope Leach's puzzlement over my Transfer Paper lay in the apparent disappearance of children's rights from my agenda and led me to a further question. What happened to children's rights as my primary motivation? In her letter she wrote about the children:

It's because I think they cannot (all and always) wait that I continue to believe that we need to work towards a basic societal acceptance of children's rights alongside supporting adults into parenthood. (Personal letter,20.3.98)

I agree about this but I become clearer that different intentions motivate different actions and I have found it hard to hold and balance all my good intentions all of the time, notably prevention with protection. I feel confident that my actions along with others, especially Penelope Leach and Peter Newell, have made a difference in a societal shift towards acceptance of rights for children (Newell,1989; Leach,1993; Pound,1991a, 1994). My untested observation is that punitive talk focusing on physical punishments, as a solution to problem-solving, is less frequent from parents in 2001. When I asked, I found current parents of young children appeared unaware of my previous involvement in rights campaigning. This leads me to believe they are probably not wary because I hold strong beliefs, but they may be guarded because of heightened social consciousness. Since 1989 most of the major child-interest groups have

adopted anti-physical punishment policies and principles of the UN Convention (Newell,1991; *Children are Unbeatable!* Alliance,2000).

In Chapter Two I wrote about my shift from ‘rights’ to ‘values’. I said values are useful because they are self-generated and embodied rather than imposed by authoritative others, as are ‘rights’. Laidlaw (1996) suggests the understanding and embodiment of values is a developmental process for practitioners. This notion had not occurred to me in 1998 but my reply to Dr Leach shows movement towards it. I wrote:

My realisation is that working with this child, and this parent at this moment, what is required is a process, which forwards parental understanding and actions. Speaking about children’s rights at that moment doesn’t easily come into it. In fact I think it can shut down communication. This is why I think the debate about rights for children should be active in arenas where there is a space to usefully think about it - not necessarily with all parents as a method of working. (Letter to Dr Leach,23.3.98)

This is a shift from my writing in 1991 when I suggested I needed to challenge smacking first ‘otherwise it remains an option to be used’ (Pound,1993:29). To Dr Leach, I also spoke about my own need after years of the conflict I experienced while campaigning for children:

I have enjoyed (and personally needed) the more harmonious and peaceful work climate created by trying to balance being Rogerian and client-led while also being a professional who knows things. My health visiting experience with parents, like my own mothering experience, is that parents mostly want to get it right, want to retain good relationships with their children (which by definition, requires respecting individual rights), but just don’t know how to do it. To keep the door open as a health visitor so I can raise awareness about what is needed, I have to have skills to know what is likely to support change for the better. (Letter to Dr Leach,23.3.98)

It seems to me now, in 2001, that ‘rights’ as a lever for social change sits more easily in the public health arena of legal and policy reform as identified by Beattie (1991; Chapter Eight:198). In my work with individual families, I believe the values I attempt to embody and ‘live’ in all of my relationships and in helping parents to review their parenting intentions is more likely to be effective for children than pronouncements about rights.

In this current chapter I again identified the importance of engagement with people, through creating and sustaining meaningful connections for the purpose of experiencing personal significance, enhanced energy and willingness to co-operate, and resilience for change. In the HVRG we spoke about the degree of engagement we were willing to make (Chapter Three; Pound et al,2001b). We noticed some health visitors became more involved with families and involvement took different forms, according to individual motivations as much as the needs of the family. In this chapter I noted that policies defining employer expectations, such as child

protection procedures, appear to require a degree of detachment with families for the smooth implementation of multi-disciplinary procedures.

Connections between parents and me have their own therapeutic worth but my intention is that it is also transferred to relationships between parents and children. If our relationships are not genuine in their 'connection' and honest about negative as well as positive things then the full range of learning opportunities may be lost for parents. I would not be treating parents with respect, or the trustworthiness demonstrated in my being as honest with them, as I expect them to be with me if I was not genuine. Sometimes I need to 'hold' parents in troubled times, as a parent does a child, and sometimes I need to take decisions out of their hands for a period. This is always with the intention of restoring it as soon as possible (Pound et al,2001b). My responding to things I see affecting children is educational for parents in a wider sense than just setting limits to their, or their children's, behaviour.

In the process of writing this chapter I have begun to clarify threads which meld the complexity and contradictions which make alongsideness as I am coming to know it. I have considered the possibility that I might collude with parents and neglect children. The notion of *responsive responsibility* I find helpful for clarifying what is a problematic dilemma between protecting children and preventive action for parents' self-growth. I work for a healthy future for children by seeking to influence positively the relationship climates of their early years. My remit requires me to protect children by hearing the little voices that might otherwise be easy to ignore. By living values becoming implicit for me in alongsideness I am making children's rights, amongst *all* human rights clearer for sections of society I touch. I know the words but balancing action is harder.

Tertiary work adds to alongsideness values

So how does my growing understanding here fit with values identified so far? All the elements of alongsideness identified in Chapters Five and Six continue to be relevant for tertiary work. *Respect, acceptance, self-determination* and *equity of rights* for children remain central motivators for my practice (Chapter Five). I recognise basic human need for belonging, competence, significance and resilience. These emotional needs are valuable aims in themselves. They are insufficient however to capture the health-enhancing potential of *connection* in relationships particularly through *light-heartedness* (Chapter Six).

Alongsideness, as it emerges from my exploration of work with very discouraged families, requires constant awareness of contradictions to be balanced between prevention and the protection of children. *Responsive responsibility* is important for balancing my responsiveness to the needs of children, parents and myself. I remain responsible to myself when I am to be clear

that my feelings are my own or mirror my empathy for my clients. Some kind of supervision is vital for maintaining this clarity. Alongsidness, including all the nuances of values emerging in the paragraphs above, provide a safety net of standards that I now use to understand, evaluate, improve and explain the quality of my practice.

Writing this chapter helped me identify why I struggled with dilemmas in tertiary work. I perceive that the profession has not prepared or supported me to work with the level of need I encounter. Furthermore, this account exposes a huge gap in services for families. Beyond the usual surveillance of health visiting, parents may need to be 'held' firmly and kindly, by people who can sustain 'being there' for them over years. Practitioners may benefit from psychotherapeutic understanding of complex processes behind becoming responsive, responsible parents and effective health visitors. In the next chapter I trace the development of values central to my practice, show how they constitute appropriate standards of judgement and explore applicability of my account for others.