

Chapter four

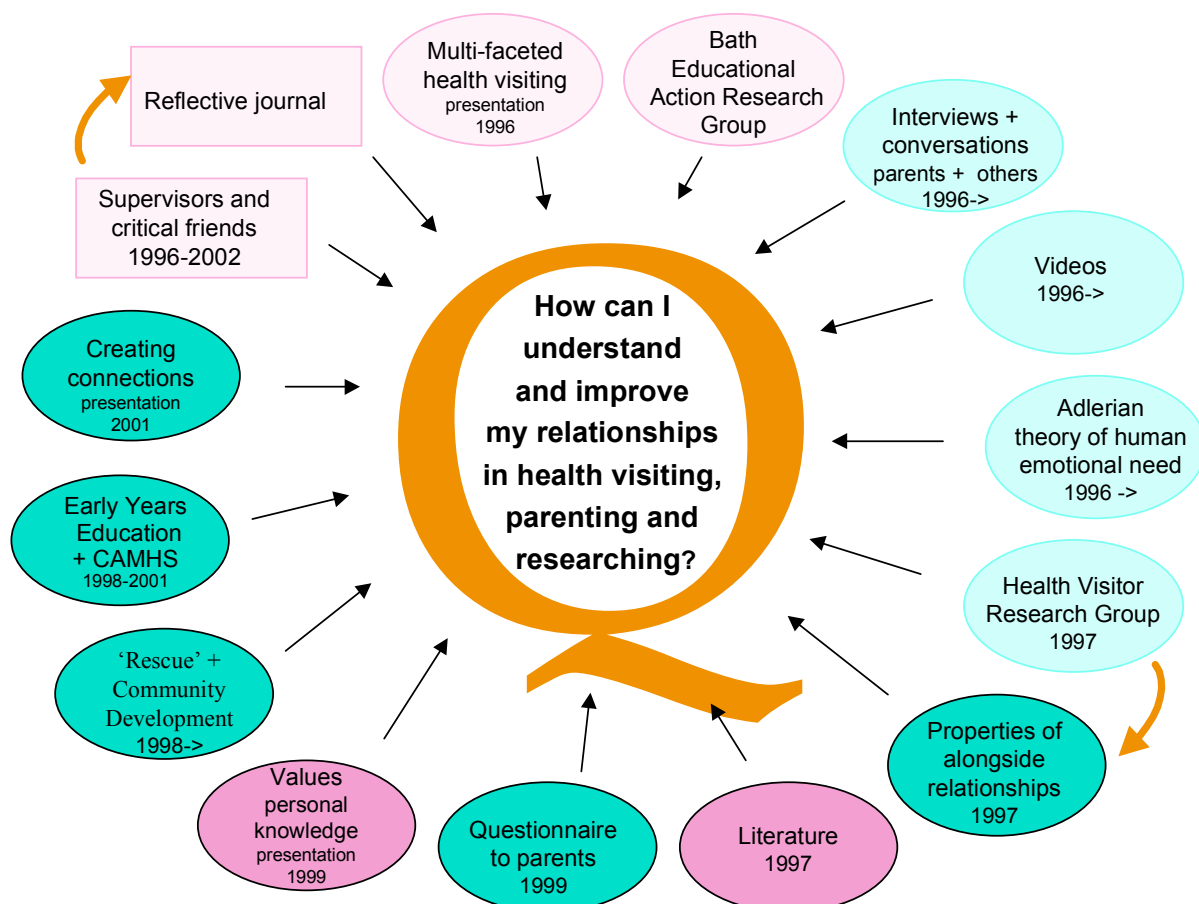


Exploring alongsideness while applying it in different arenas

In the last chapter I explained the early research processes from which alongside collaboration grew in my health visiting. In this chapter I continue showing the chronological process represented clockwise in the map below and coloured darkly. Blue indicates enquiry with families, colleagues and others. Pink denotes enquiry with research colleagues. I explain how I looked more closely at the properties of alongsideness, explored its relevance and contradictions by using a questionnaire and widened the scope of my actions beyond casework. Compass symbols indicate views of the whole research landscape. Binoculars indicate features within the landscape and my process for examining them. Magnifying glass symbols indicate insights emerging from the process.



The enquiry process continues 1997 - 2002



Research over view 1996-2002, the second part



Exploring the properties of alongside relationships

I decided to explore the properties of effective, connected relationships. From videos and during interviews and conversations, I learnt about relationships that people found helpful or harmful to their feelings about themselves. I heard how individual beliefs about their relationships are formed. In a first exploratory paper (Properties Paper One, 8.9.98) I reviewed evidence I found for my developing awareness of the centrality of relationships in my work. How I am with clients appeared to be one key to their continuing openness towards me. It seemed not only to be the appropriateness of the message, but the climate in which it is given, which influenced its usefulness.

I scanned my journal, interviews, HVRG and BARG notes to identify insights about components of relationships. Some were contradictory. I found some parents wary that I might tell them what to do (interviews, D, J, 12.6.96; S, 19.11.96; journal, 23.5.97). Sometimes the same people also welcomed my expertise (interviews, S, 6.5.97; C, 30.6.97; M, B, 3.7.97). A

'good listener' and 'a great encourager' were identified (interviews, S,19.11.96; C,30.6.97; M, B,3.7.97). Descriptions of 'friendship' appeared contradicted by a few who also saw me as 'like-a-mother' (Video Three,2.6.97, journal,4.7.97, 21.7.97). I was aware of a special magic that happens, a feeling of being at one with another person, when communication is pleasurable and it feels we are 'connected' (journal,10.4.97). Jack Whitehead referred to a 'life affirming energy' that he witnessed (journal,24.5.99) and in a video an M.A. student identified 'a total communication style' (UWE, journal,25.2.97).

I created a framework for exploring the complexity of my health visiting relationships as a tool for discussion with parents and colleagues (Properties Framework,11.12.97). In it I surmised what a *parent wants, doesn't want and gains* from our relationships and asked what my health visiting skills were and what I needed to do to meet parents' expectations. Considering experiences parents described in their relationships I asked myself, 'Do I do those things too?', 'Do I contribute to that feeling of hurt they describe?' and 'How can I help people feel better about themselves?'

Not surprisingly, considering my position as their health visitor and 'friend', I found it difficult eliciting negative data about myself from parents. Critical friend, Karen John, helped me realise I could remain open to critique, but by putting my energies into recognising *positive* features in my relationships I could understand and do them more. Comments of a BARG member however, helped me realise that I needed to guard against the written result appearing like a self satisfied 'victory narrative' (journal,14.5.01).

In a second paper (Properties Paper Two,25.9.98) I reflected on my understanding of effective relationships and to ask how I might check if I demonstrate these properties in mine. Having asked those around me, I returned to the literature for insights about helping relationships.



Literature extends and validates my understanding of relationships

To check my perception of effective relationships, summarised in the Properties Framework (11.12.97), I looked to find what Adler (Ansbacher,1958, 1964), Rogers (1961) and Egan (1990), had to say about helping relationships. I recorded my debate with their writing as I read (journal,30.7.97-23.8.97). I found similarities and differences between the relationships implied in the theories of Adler and the therapeutic relationships described by Rogers. Both see life's journey as a process of change with creative possibilities for individuals in much the way that action research was envisaged by Lewin (Chapter One:17).

I started with Adler because the parenting programme I chose for its affinity with democratic principles was descendant from his theories (Dinkmeyer&McKay,1989). Adler's basic assumptions about the *self-consistent life-style*, *uniqueness* and the *socially embedded* nature of individuals were an easy fit and extended my understanding (Adler,1931). He points to the *creative power* of individuals in constructing *life-styles* (Chapter One). He suggests advancement of *social interest* in the people around us, acts as a buffer for the tendency of individuals to strive for perfection and superiority over others (Ansbacher,1958, 1964). Individuals attempt to realise 'dimly envisaged' *self-ideals* or personal *goals* arising from *life-styles* created through past experiences. I explored my own early recollections to identify my personally created *life-style* so that I could better understand my beliefs (Powers&Griffith,1987:8; Pound,2000). The Crucial Cs (Lew&Bettner,1996) draws on these assumptions (Chapter One:19)

Reading about the progression of Adler's ideas through his work made it clearer why I felt at ease with his theories. Although Adler never called it action research, Lewin expressed regard for Adler's optimistic process and ideas (Ansbacher,1958:12,129), Adler did not believe in categorising concepts into opposites, preferring to remain open to variety within possibilities. He chose to keep his theories accessible and not give them complicated names in the way his colleague Freud had done (Ansbacher,1958:326-328). I particularly like his view of human progress:

Do not forget the most important fact that not heredity and not environment are determining factors.– Both are giving only the frame and the influences which are answered by the individual in regard to his styled creative power.
(Ansbacher,1958:flyleaf).

In my journal I wrote at length about my growing understanding of Adlerian theory which holds social context, and individual process as being of central importance (journal, 28.7.97-23.8.97). This was thrown into relief by reading about Freud, the behaviourists and scientific researchers who dissected behaviour into parts, out of their context and often frozen in time. In these cases specialist expertise is necessary for analysis of problems and definition of solutions. My enquiry was encompassing many aspects of my health visiting with families in a process over time. I wrote:

An explanation is beginning to form for why health visitors have something important to offer which eludes experts who are remote from their clients. The specialness of health visitors is their knowledge of the social context of families' lives. Add this to a drive towards equality - a true partnership between client and professional which does not disempower by standing high and proud as professionals with special secret knowledge. (Journal,28.7.97)

But I also felt disquiet when reading some interpretations Adler made of 'goals' motivating his patient's behaviour. He named nail biting, thumb sucking and masturbation as 'abnormal behaviour' and homosexuality as 'perverted'. My concern grew that it may be possible as

professionals to make mistakes when interpreting people's behaviour and to act in ways that are not in their best interests (journal,2.8.97). These concerns heightened for a time when I read Rogers' contrasting style.

Roger's way of being, through engagement with and acceptance of the thoughts of the other, intends to encourage understanding and change towards positive directions for both therapist and client (Rogers,1961). From Rogers' work I thought particularly about listening carefully without interpreting or formulating solutions, so as to understand the other more fully. Really trying to understand, he says, increases responsiveness for both parties (1961:20). Pressure on me to be the skilled professional who knows the answers lifted as I began to soak in the idea that I could devote my energies to really understanding the other's meanings. In putting what I believed to one side, and giving my entire attention to the other person, I could enable that person to hear, accept and understand 'herself', 'her' fears and 'her' discouragement (or 'his' of course). We could both learn from that process. This resonated with my experiences during interviews. For example, Sonia said:

You are someone I can empty my head to...its like a roller coaster, it all seems to come out and as I'm talking I'm thinking, 'now where's that come from?'
(Sonia's first taped interview,9.11.96).

Greater honesty with parents was possible as I shifted focus from them as subjects, to my own learning about supporting them. With increasing conviction I now declare myself as co-learner with parents. In Chapter Seven I will show how I continue to find honesty, as in genuine relationships in which I declare my own feelings, to be difficult to achieve sometimes (Rogers,1961:52). In my efforts 'to be there' for people I can still lose sight of recognising and articulating my own feelings (Chapter Two:45) I need to remind myself of the salience of Rogers words,

I find I am more effective when I can listen acceptantly to myself, and can be myself...I am angry, I do feel rejecting towards this person or, that I feel very full of warmth and affection for this individual... (Rogers,1961:17)

and:

As I try to listen to myself and the experiencing going on in me, and the more I try to extend that same listening attitude to another person, the more respect I feel for the complex processes of life. So I become less and less inclined to hurry in to "fix things", to set goals, to mould people, to manipulate and push them in the way I would like them to go. I am much more content simply to be myself and to let another be himself.
(Rogers,1961:21).

I was energised by Rogers' words, but also realised my clients did not see themselves to be in a therapeutic relationship with me, anymore than they saw themselves in an educational one. We did not have the time it would take to work fully in Roger's way.

In my journal I wrote:

The practical problem for health visiting is the time it takes for people to muse on their feelings about a problem and to be able to gradually come to an answer themselves. It has to be more time effective to brainstorm their options with them, according to their style. Using the Adlerian model I can give them information to help them consider their beliefs. The special learning point from Rogers for me is that through careful listening I can understand their interpretation of the problem. By mirroring it back I can increase their understanding of its extent and the possible solutions. (Journal,3.8.97)

Reading Rogers led me to reflect again on my sub-question :

Am I as client-led as I think I am and how can I also be proactive if I notice potential problems?

Although I continued sometimes raising smacking as a topic for discussion during the first two years of this research, I moved into a period of greater listening and less advice-giving (Chapter Five). A questionnaire to all families raised further questions about the differences between the mind-work of Roger's therapy and the varying amounts of advice parents expect (Chapter Five). Much later (2001), I began to think about families with more entrenched problems. I wondered if I placed too much of my energy in supporting parents' growth, so they could relate more responsively with their children. How many children had to wait too long while their parents worked towards self-realisation and where did my responsibilities lie?(Chapter Seven). But I rush ahead. In 1997 I had not begun thinking in any depth about the tertiary stage of my study. In the meantime, I was thinking about relationships in primary and secondary prevention (Chapters Five, Six). My intention was to enable parents to be more confident in their abilities to find solutions.



Encouragement a universal need

Here is an insight integrated from all phases of the enquiry. Encouraging an optimistic climate by focusing on the positive, rather than searching for, and attempting to prevent, future errors works well with children and is no less valuable for adults. Encouragement bolsters self-esteem, hope and independence. It builds courage to keep trying. Focusing on people's faults can accentuate feelings of inadequacy and trigger resistance, defensiveness and discouragement. By emphasising reflective self-evaluation rather than reliance on other peoples' opinions, individuals can experience their personal worth and take responsibility for their actions. This is not to say the opinions of others are of no value, but individuals may need to be assured of, and believe in, their personal worth before critique is useful to them.

Encouragement bolsters resilience against the inevitable discouragements of life. This insight underpins the fundamental change through this thesis from my wishing to correct the wrongs of parents, by alerting them to their wrong-doing, to moving to an 'alongside' relationship. Alongsideness values the inherent worth, good intentions and knowledge of parents and children. I can now ask what parents wish from their relationships with children and how I can help them to

find it. Mistakes can be seen as opportunities for learning when the mistake-maker is hopeful about finding new ways.



Asking the parents - the questionnaire

I wondered to what extent parents recognised the properties of our relationships and planned a questionnaire to give parents the opportunity to speak anonymously about their perceptions of what I do and how I am with them. I wondered if their views had similarities to my own and which factors I had not considered. I had found difficulty eliciting negative data and wanted to try another way of allowing parents to express their views. An anonymous questionnaire could test what I had found and ask open questions to elicit new information. Supported by Jenie Rifat, the Quality Nurse in our Clinical Effectiveness Department, I constructed the questionnaire.

Karen John recommended the Parental Bonding Instrument (Parker et al,1979; Wilhelm &Parker,1990) as a validated measuring tool that could be adapted for my purpose. The aim of the PBI was to survey the parental contribution in parent-child bonds by asking their adult children. I recognised similarities between the reciprocal, dynamic and evolving relationships of democratic family relationships and the qualities in health visiting relationships that I believed to be effective. From the Properties Framework (11.12.97) I drew up a bi-polar list of positive properties matched with factors I considered to be negative, for example, collaborative/authoritarian. I used these dimensions to create new questions as I adapted the PBI questionnaire for its new use. Questionnaires designed for seeking opinions from patients of community psychiatric nurses (Gournay et al,1993), general practitioners (Fitton&Acheson, 1979) and health visitors (Weatherly,1988) also offered help with the wording of further questions (questionnaire development papers,24.10.98, 1.11.98).

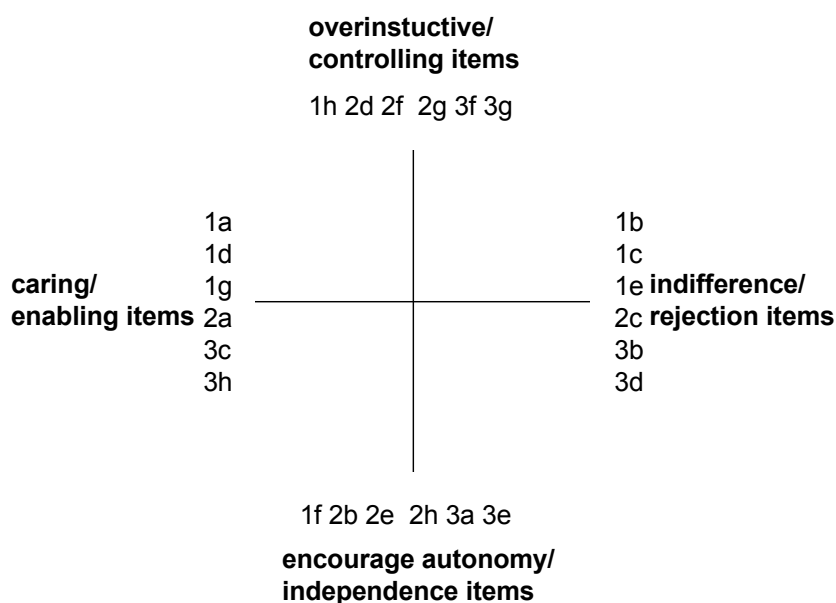
Parker's two-dimensional use of 'care' and 'overprotection/control' as parental contributions to parent-child bonding, related to the health visitor-parent relationships in my Properties Framework. I preferred the words 'care/enabling' and 'overinstructive/controlling' as indicative of roles in health visiting more related to education than protection. Retaining twelve of the PBI questions, I composed others about my knowledge and skills, accessibility and confidentiality to make a total of twenty-four questions. Half the questions were intended to test aspects of 'care/enabling' and the balance 'overinstructive/controlling' relationships. In turn, half of these groups of questions were expressed negatively to avoid the tick-box responses forming a pattern in the Likert scale (see figure below). I changed the PBI coding pattern to score 1 or 2 for 'agree' or 'strongly agree' and the same for 'disagree' or 'strongly disagree'.

disagree’. This would allow maximum scores of 24, from each questionnaire response to ‘care/enabling’ questions and to ‘overinstructive/controlling’ questions. In this way a high score for ‘care/enabling’ should attract a low score for ‘overinstructive/controlling’ at the extreme ends of the Likert continuum providing the most decisive results.

Coding example:

	strongly disagree	strongly agree	agree	disagree
Care/enabling question	<input type="checkbox"/>	②	①	<input type="checkbox"/>
Over instructive/controlling question		<input type="checkbox"/>	<input type="checkbox"/>	① ②

The pattern of positive and negatively worded questions:



Two sets of similar questions (2b, 2f and 2a, 3d) intended to test internal validity as changes meant the questionnaire could no longer rely on the PBI’s past testing of validity and reliability.

The introductory words on the questionnaire explained that I wanted to improve my health visiting and invited opinions about how I worked. I was not asking about other health visitors. Two open questions asked, *What is the most important thing about me as your health visitor? Is there anything else you would like to say?* To assure anonymity and to allow parents freedom to be open in their responses, Jenie agreed to post, receive and analyse questionnaires on a SNAP¹ computer programme. There were no marks on the forms, and I asked no questions from which individuals could be identified.

The questionnaire went through several drafts in consultation with Jenie the Quality Project Nurse, health visitor colleagues, research supervisors and colleagues, individual parents and the Research Director for the Trust. A final pilot, canvassing the next six parents who walked into the surgery, confirmed they were willing to complete the questionnaire. A third open question about measuring health visiting appeared puzzling so was dropped.

All the parents held anonymity to be important. For this reason I gave up options for detecting social status from returned questionnaires so confidentiality would not be doubted (questionnaire&covering letter: Appendix II).



Questionnaire results

In April 1999, 111 questionnaires were sent to a possible caseload of 118 families. Of the 7 families excluded, 2 had very little English, 3 little contact with me and 2 were out of the country. Five of the families had only school-aged children with whom I had regular contact. The remaining 106 families had children under five. Looking at social classifications as described by the Office for National Statistics, I find a little less than half of the families appear in categories called **1.2** 'Higher professionals' and **2** 'Lower managerial and professional occupations'. A further 15% appear in **6** 'Semi-routine occupations' with the remainder evenly distributed across occupations **3, 4, 5, 7** and **8**, 'Never worked/long-term unemployed'.

Seventy (63%) of the questionnaires were returned to Jenie within a month. Six made themselves known by signing the questionnaires, referring to their children by name or to specific incidents that identified them. Although I assume it was mostly mothers who completed the questionnaires, it may have been fathers so here I refer to respondents as 'parents'. SNAP analysis provided me with numbers of responses and percentages in each category but I undertook the scoring as shown above by hand. The Likert scale ticked boxes scored 1283 for 'caring enabling' questions showing my intention was positively evaluated by the parents who replied. All ticked 'speaks to me in a warm friendly voice'. In contrast, questions referring to 'overinstructive/controlling' items totalled 38. Eight (12%) found me 'not easy to contact'. Six parents (9%) ticked 'does not help me as much as I need' and Seven (10%) 'cannot help me solve difficult problems'. These statements were interesting because they related to statements written in reply to the open questions and triggered a new line of enquiry.

¹ SNAP computer software used by the Clinical Effectiveness Department.

All of the 69 questionnaires that had written comments spoke positively about qualities such as: warmth, encouragement, friendship, listening, approachability, availability, flexibility, humour, being non-judgmental, help with problem-solving, that I 'know' them and am 'there' for them. Half of the 84% who ticked that I 'helped' also wrote about my helping them to help themselves. Eight added that they would have liked more direct advice. Half of these acknowledged there may be no 'right' answers or that they could understand what I was trying to do. I became aware of a feature in my work about which I had previously been unaware. I had been preoccupied with trying not to disempower by being the knowledgeable expert. The questionnaire showed me that some parents were frustrated by my, 'on the one hand you could do this, but on the other...'(Q.47). Some parents appeared to need more direction than I recognised. In Chapter Five I look in more depth at different influences on the amount of advice parents might need.

There were inconsistencies in ticked responses, which when compared with other ticked boxes and the written comments, may have been attributable to literacy problems or English as a second language. The statement 'wants me to make up my own mind' (2b) appeared to be ambiguous for some respondents. It was intended as 'encouraging autonomy' but could have been interpreted as referring to 'indifference' and scored accordingly. Similarly, 'tries to tell me what to do', intended to show 'overinstruction/controlling', may have been interpreted as my trying to 'encourage autonomy'. I would amend wording for future use and omit 2b as 2f and 2g are also similar.

From responses to the questionnaire I recognised a good deal of interest and goodwill towards the project. Parents wanted to be helpful. Recognising some parents' responses, and reading the positive statements of parents who have dealings with me because of child protection issues was moving. Some responses showed parents also recognised that it is not only what I know but who I am in relation with them that has importance for them (Qs.6,42,70). During construction of the questionnaire I noticed how closely dimensions I explored related with ideas about relationships and professionalism emerging in the HVRG. I had written:

I read about Fox's (1995) 'vigil' and 'gift' which identifies two aspects of caring in nursing, the surveillance/professional expertise and the 'enabling celebration of otherness'... This now fits with what I am coming to know about letting people be themselves, grow themselves and about the potentially disempowering nature of professionalism. This is central to my original question about how I can be proactive (meaning use my professional knowledge while observing and judging my clients) while being client-centred (allowing them to call the tune, initiate their own enquiries from their own starting point towards their own goal). (Journal, 22.8.98)

In the HVRG we drew these two contradictory strands together to describe a process where we 'hold' and direct when needed, with a view to handing decision-making back as soon as possible (Pound et al,2001b).

Appropriate use of this questionnaire

I am concerned this questionnaire might be used in ways I did not intend and be harmful to health visitors. It was intended for evaluation of my own practice by asking questions I wanted to know about myself so I could improve what I was doing. General application by one person, a manager for example, to evaluate others would be inappropriate because of the personal nature of the questions. For its intended use for aiding my reflections in searching for improvement, I needed to design questions that asked what I wanted to know about myself. Any other use is likely to feel intrusive, cause defensiveness and be unlikely to promote useful reflection.



Values, beliefs and personal knowledge

For a conference (presentation, Leeds,23.6.99) I decided to present a paper about my personal and professional learning. I wanted to think about the impact of my'self', my personal history, beliefs and values, which influence the agenda I bring to my practice. My personal knowledge and the risk of prejudice (Chapter Five) was still in the air, but I felt more confident and wanted to identify roots to qualities that are hard to grasp or explain in relationships.

I produced a biography of my early years believing the particular levelling circumstances of 1950s rural New Zealand and comparative freedom and warmth of my childhood played a part in my suspicion of hierarchy. I believe I found the seeds to respecting people and the importance that personal autonomy has for me (Pound,2000). Earlier, I had explored my early recollections with Karen John who was training in Adlerian psychotherapy (Archive,1998). Together we had analysed my recollections to identify my personally created *life-style* (Powers&Griffith,1987:8). Adler looked to earliest recollections from childhood to locate personal symbolism and meanings that an individual continues to rehearse and express as attitudes towards all experiences of life. He said:

There are no 'chance memories'. Out of the incalculable number of impressions which meet an individual, he chooses to remember only those which he feels, however darkly, to have a bearing on his situation. Thus, his memories represent his 'story of life', a story he repeats to

himself to warn him or comfort him, by means of past experiences, to meet the future with an already tested plan of action. (Adler, cited in Powers&Griffith,1987:187)

Beyond infancy, Adler suggests, evolving explanations are tested by experiences that serve to confirm or disconfirm these prototype beliefs. Memories that came to the foreground for me held subconscious significance. Later, by identifying contradictions within my experiences I was able to make fuller sense of my personally created *life-style*. My family, critical friends, clients, colleagues and educational researchers, in dialogue, all helped my deepening understanding by challenging and questioning (Pound,2000). By examining experiences from adulthood, critical incidents, literature and themes from other phases of the research, I began to identify and question values I hold that motivate my relationships and practice. I found contradictions. Some had arisen in other phases of the research but others, such as views of control, offered fresh topics for reflection. I grasped the opportunity to look at my playfulness and humour that had been a source of embarrassed self-consciousness and appeared as a sub-question in my Transfer Paper (1998). I continued to explore these topics for publication (Pound,2000) and I will come to them again in Chapters Six, Eight.



Embodied values in practice

The process of working towards a conference presentation and then publication was a period of rapid dialectical growth, enhanced by lively engagement with others (Pound,2000). My brother and his wife, critical friends and BARG gave hours to dialectical debate. ‘Respect’, ‘autonomy’ and ‘equality’ emerged from my reflective process as values I hold to be important in my relationships. By equality I refer to my motivation from the beginning of the project that children are worthy of the same respectful treatment that adults expect. I found roots for these guiding principles growing through my history (Pound,2000). Values were developmental as I explored their depth and meaning for motivating my practice (Laidlaw,1996) and as a safety-net for practice (Chapter Two:47).

‘Acceptance’ and ‘warmth’ joined as supporting values. ‘Acceptance’ offers personal warning about the risk of forming assumptions about people’s beliefs and future actions (Chapter Five) or feeling defensive about critique (Prologue:10). ‘Warmth’ was identified by BARG members as a ‘life affirming’ quality in my relationships with others (journal,24.5.99). Warmth feels key to creating meaningful connections with people (questionnaire responses; Chapter Five). My brother recognised characteristics he also inherited from our family. A sense of playfulness and enjoyment of the bizarre, absorbed from our father, is noticeable in actions we both described as weird, embarrassing, but importantly *us*. I reflected on how humour influences my work

(Pound,2000; Chapter Six), Smiling and laughing together over mutually understood silliness appears to be an effective means of reducing power (Chapter Six).

Alongsideness seems to be the umbrella value, which holds all the others together. For me, exploring origins to my values helped me feel more confident as a thoughtful product of my life experiences. Old intriguing questions about the origins of passions, which at times did not match those of people around me, are partly answerable now. I can be myself. But this is not the end of the story. My brother asked questions about the usefulness of my personal history to other people (journal,29.6.99). He seemed to be agreeing with Winter who, in response to an early draft of my article, said:

I am worried that many readers of the Journal may respond by thinking, 'It's all right for her - she's a warm and wonderful person and had a warm and wonderful childhood, but what about me, with all my unresolved anger and self doubt: where do I find the personal resources for this style of working?' (Letter, Richard Winter,28.6.99)

Similar responses were made during my 'Creating Connections' presentation (Bath,21.2.01). How can I offer my own insights emerging from my research without causing self-doubt or defensiveness in colleagues? Focusing on positive attributes so I can develop them, rather than focussing on faults needing correction, does not fit comfortably with common societal expectations that call for fault-finding for change. I understand the critique and it caused me to realise that connection with the audience and tentativeness in my claims are important for retaining other people's feelings of competence, apart from my own.



Practical alongsideness

I recognise now that it is the *values* motivating my practice that may have applicability for others. Practitioners arrive at values through their own processes and adopt them as guides to practice because they are believed to be effective for certain desirable ends. It is *why* they work that makes them important and transferable to other contexts. 'Basic emotional needs' help me understand why alongsideness is a value that encompasses respect, acceptance and autonomy, and enhances connection and co-operation in relationships. If I believe people need to connect with others, to feel capable, recognise their own significance in the world and retain resilience to cope, then experiences of respect and self-determination are the means. I need to live these values consistently in my alongside practice because they are embodied in me and lived in all of my relationships.

Here lies a dilemma. How do I explore and demonstrate this lived way of being?



Making presentations

Preparing for and giving presentations has provided an important stimulus for in-depth reflection on each of the lines of enquiry I was considering at the time. Apart from informal presentations to BARG, HVRG and M.A. education students at UWE, nursery staff, parents and colleagues and Tier One workers, I made seven conference presentations: Bath, 15.4.96, Harrogate, 28.9.96, London, 25.6.97, Leeds, 23.6.99, Bournemouth, 9.5.00, Bath, 21.2.01, Bristol, UWE, 27.3.01. (Sources:231).



Learning from presentations

I learnt from the reflective periods before all the presentations as I explored the content and shared the process with critical friends and fellow researchers. In 1996, colleagues Kate Gammon, Mandy Dams and I organised a regional conference to stimulate practitioners thinking about how we might adopt positive parenting in our practice. My presentation asked *Do children have rights and what is abusive?* Looking back from my thinking now in 2001, I see my urgency to convince was reflected in the overhead slides and script of my presentation. I recall uncomfortable, defensive feelings and the mixed responses of colleagues who must have felt cajoled by me to think and work in a different way. I now understand uncomfortable feelings meant values of respect and acceptance of people's points of view, not understood by me until later, may not have been evident for the audience. My passion to see change, which took little account of the feelings of those I was trying to influence, offers a marker for my learning.

In the swimming analogy for multi-faceted health visiting and co-learning I began to explore words that were antecedent to alongsideness (Harrogate,28.9.96). I became aware of the uniqueness of my research methodology within health care (London,25.6.97) and came to recognise the significance of my personal history and agenda in my work (Leeds,23.6.99). I thought about the relevance of my new understanding for work with very vulnerable families (Bournemouth,9.5.00) and explored the use of videos for identifying, explaining and validating qualities in my relationships (Bath,21.2.01; UWE,27.3.01).

The early presentations were more fruitful in the preparation process than the delivery. '*Creating connections ...*' however, was different because I also concentrated on creating a more participative co-researching climate with the audience (Bath,21.2.01; UWE,27.3.01). I wanted to mirror the parenting, health visiting and researching relationships I claimed were evident in the three videos with Sally's family, by involving the audience. I became aware that the mellow climate of Sally and Peter's family, observable on video, arose from their creation of a tiny democracy in their relationships with their children. They *all* appeared relaxed in the

knowledge that they were valuable beings. This fitted with my knowledge of the family over several years. Moira Laidlaw commented on this interpretation I made about the video:

*Moira: Yes but it isn't all down to the family. If you had been a dictator you wouldn't have sat on the floor including the children while you worked with Sally. It **looks** simple **because** it works.*

Robyn: The point is, it is those relationships which work so well for children that I am trying to mirror in my relationships working with families and in researching. (Video Eight, Bath, 21.2.01)

I also learnt from this presentation that by offering one tiny, personal aspect of the research for close scrutiny I could offer access to the larger study. I agree with Roger's variation of this insight:

What is most personal is most general ... the very feeling which has seemed to me most private, most personal, and hence most incomprehensible by others, has turned out to be an expression for which there is a resonance in many other people. It has led me to believe that what is most personal and unique in each one of us is probably the very element which would, if it were shared or expressed, speak most deeply to others. (Rogers,1961:26).

I had previously felt stuck in the need to start each time with a history of why I needed to do this research this way and tag an aspect of new learning on the end. Time allocation always prohibited much depth in exploring the new aspect. This time I was to learn another way. I worked up my story by writing it out in full as usual. I concentrated on every word to assure clarity and conciseness. This meant I was anxious I might forget important words in the delivery. In spite of BARG entreaties to talk around the subject in the way I did with them, I memorised the script and held the paper for reassurance. Overhearing a rehearsal, my son Alistair echoed BARG with something like:

*Mum, I have been listening to you. It's monotonous. Making brief eye contact is just a token. It's meaningless. It's patronising. They won't take in much of what you say. You need to speak **with** the audience directly. (Conversation,19.2.01)*

He was right. The relationship I spoke about was not evident in the presentation. Moira suggested Alistair's comment was possible because of the 'alongside' relationships she said she witnessed within our family (taped conversation,25.3.01).

BARG members helped me rearrange the content so I could be confident in interacting with the audience without a script. I gradually felt more able to think on my feet, responding and enjoying a degree of connection with the audience as I would in other arenas. On video, I see an engaged audience responding to my question 'what did you see?' (Video Eight, Bath,21.2.01). They reported I was 'friendly', 'democratic', showed 'complexity within apparent simplicity', made a visual 'tableau with the family', showed 'an ease of embodied knowledge'. These comments appear to mirror the evaluative responses of the Tier One training (page 106). A question from the Bath audience about families who do not experience such a mellow family climate made me realise I needed to find ways of presenting the work I do with discouraged

families. Here I also intend relating in respectful, alongside ways. I had been thinking about alongsideness in this more complex arena.



‘Rescue’ in tertiary work and community development

In writing-up this account I returned to my journal to look for times when I began to think about the relevance to tertiary work of insights from the ‘shallow waters’. I found evidence of my beginning to think about contradictions arising in the messy uncertainty of working with very discouraged families. In attempting to improve outcomes for families I tried new ways of working. Chapter Seven offers an account of these reflections. Ethical implications come into view when I need to balance my responsiveness to needs with responsibilities in alongsideness.

Working in an area outside my caseload, I joined a community initiative which intended developing a support group for very disadvantaged families (journal, May 1999-May 2000). From insights gained from a year working with this project I enlisted parents in my own area to create a group of our own. A community development project developing a Healthy Living Centre in our ‘deprived’ estate provides a management umbrella while also linking our energies with other local initiatives (Chapter Seven).

My reflections are within my journal, field notes and child health records. In this phase I asked parents informally about their opinions but did not make videos or offer stories back because of the intractable nature of the work and the need to be encouraging and to maintain trust. Instead, by discussing my interpretations with the other professionals who knew the families, I increased my understanding of the complexity of this work (Chapter Seven).



Families with school-aged children

Here I flag up a feature that emerged, but because of its possible size as a future project, I decided not to pursue more fully. This is what I saw. Responding to a request by a Women’s Refuge to help residents understand their children’s behaviour I used the Crucial Cs with a group of women (journal, 22.5.98). It was a surprise that one result of the discussion was increased empathy for violent partners (to my knowledge, no one returned home as a result). These women were particularly isolated from their extended families and I noticed that five women maintained an informal support network when they were rehoused in our area. I continued to be asked for practical help in managing their older children.

The Crucial Cs proved just as useful for finding understanding of challenging behaviour amongst older children and adolescents. I usually had no idea what would emerge as we began discussions and was open with parents that it was a learning experience for me too. Parents appeared relieved to have someone who would listen and give them hope. I understood the value of this as I had young people of my own and welcomed support from my friends. For adolescents, a sense of belonging appeared just as important as for infants and 'mis'behaviour often seemed to occur when they felt isolated (field notes, W,1.6.98; G,3.6.98). Feelings of inadequacy and insignificance in the family or peer group appeared to cause defiance and vengeful behaviour, which in turn parents found hurtful and frightening (field notes, M,2.3.98; S,8.1.99; J,12.4.00; H,26.4.00). Some parents found facing challenges to their authority and setting limits to young people's behaviour difficult to handle and avoided it (field notes, S,8.1.99; H,26.4.00; Chapter Six). Karen John suggested this might be due to parents' feelings of inadequacy. Lack of courage made it hard for them to be clear and strong about what was important to them. One family's lack of clear boundaries appeared to be a factor in the ten-year-old boy's trouble with the police when out after dark (field notes, S,10.9.99).

In all these families parents appeared to gain empathy for their children by thinking about the Crucial Cs and found understanding about why problems occurred. Possible solutions sometimes emerged. Insight into how feelings are mirrored between parents and young people was a common outcome. One father said, 'You don't have to say any more. I understand now', when it became clear that punishing the boy for his drug-taking made the situation worse (H,26.4.00). Pessimism, decreasing courage to face situations or risk-taking amongst the young people appeared to mirror parents' apparent hopelessness and despair (field notes, W,1.6.98; M,2.3.98; S,10.9.99; H,26.4.00). I felt useful as an easily accessible supporter and attempted to help where I could but realised there was much more to know about working with young people involved in risky behaviour or law breaking, and their families. I have difficulty helping parents to set limits to behaviour for young people when they seem unable to be clear and hold confident boundaries for themselves (Chapter Six). Health visitors and school nurses are in an excellent position to support families with young people because parents welcome someone alongside and accessible, over a long period. Emotional distress and mental health problems appear to be increasing amongst children (Ahmad et al,1998). I intend revisiting this aspect of my work in future enquiries.



Alongsideness in tertiary work - reflections and more questions

I started my research believing my task of improving family relationships was complex and I should 'learn to swim in shallow waters' in a preventive way with parents who have the personal resources to make changes. In other words, leave restorative work in the case of serious

relationship problems or child protection issues to another study. My scope broadened as I began to understand human emotional need and the possibilities of alongside relationships. It may be more accurate to say that I did not usually stop to consider which stage of need families were in or what style of relationship or method of working I should adopt. My approach to all families intends to reflect my increasingly conscious motivation to respect people and foster their self-determination. I tried to carry these encouraging, accepting and trusting alongside relationships into my child protection work. My skills emerging 'in the shallows' of prevention gradually became more thoughtfully considered as I reflected on working with families in greater need (Chapter Seven).

From Adlerian theory I have come to understand that people who experience their basic emotional needs are more likely to enjoy a sense of connection with others, feel significance in the world and behave co-operatively. On the other hand, feelings of inadequacy, isolation and hopelessness make it hard for parents to reach out and give children what they are not experiencing, or seldom experience themselves. I recognise the need to work alongside parents for the future mental well-being of their children. To increase my connections with parents and attempt to encourage a sense of competence, self-worth and resilience, I intend working to create relationships that avoid criticism and engender hope. For parents coping with a lifetime of discouraging experiences, I found contradictions in the alongside relationships I tried to create (Chapter Seven).

When asked if alongsideness became collusion with parents, whose actions are identified as neglectful, I also needed to think about the expectations of my employers and my responsibilities towards children. I was prompted to ask if the children could wait for parents to become self-aware? I considered the need to balance complexities behind responsiveness to parental need with responsiveness and responsibility towards children and the contradictions for my decision-making. The process requires interplay of both as I work to encourage parents' growth in order to secure warmer, more responsive family relationships and a healthy climate for the child. Respect and self-determination for the parent is sometimes in uneasy balance with action to 'respect' the child. In this reflexive process I became aware that my own personal history is likely to colour the way I interpret situations and the decisions I make (Chapter Seven; Pound,2000). These insights seem to heighten the importance of individual practitioners' own enquiries and theory creation to inform complex practice decisions.

Noticing isolation and inadequacy experienced by very disadvantaged families, in repeating cycles of discouragement, I worked to increase a sense of community, which could offer ongoing support and encouragement in larger social networks. In Chapter Seven I describe the community development project in which, amongst other projects, local mothers helped set up

an independent support group for isolated families. Looking at children's experiences beyond the household I was drawn to involve myself in other areas of influence on their lives.



Looking wider to colleagues, early years education and CAMHS

The principles of health visiting intentions to 'search for health needs' remains unchanged since their definition (CETHV,1977; Chapter One). It was 'stimulating an awareness of health needs' and 'influencing policies which affect health' beyond my caseload which motivated my public health campaigning for rights for children in 1989 (Pound,1991a). By involving myself in the Healthy Living Centre project (Chapter Seven) I intended to 'facilitate health-enhancing activities' for the benefit of the whole community as well as my clients. Looking wider, I involved myself in activities I believed could affect the future mental well-being of children by increasing the democratic impulse of relationships in education, health and social care.

Health colleagues

Between 1997 and 2001 I ran seven Crucial Cs workshops for health visitor and school nurse colleagues. A questionnaire to nineteen health visitors still in the area (October 2001), who attended at least one workshop, elicited a sixty-eight percent (13) response. Of these, seventy-six percent (10) said they used aspects of it in their work, sometimes alongside STEP (Dinkmeyer&McKay,1989; Chapter Three). Five of these use the Crucial Cs as a tool for helping parents understand their relationships. One wrote:

I go through the Crucial Cs asking parents how it feels to 'belong' etc... ask how the child feels - then go through the child's belief and how parents react to it. Usually I then offer the STEP book to follow up the whole issue of parenting skills. (Questionnaire, health visitors,October 2001)

Another integrates the Crucial Cs into conversations but finds dedicating more time impossible because of the sheer numbers of families she encounters with serious problems (conversation,23.11.01).

Five other areas of work outside my general practice casework also helped me understand the applicability of my emerging insights to fields beyond health visiting. Summarised here, they are my involvement with the Local Education Authority Behaviour Support Plan² (B&NES,1998), work with staff and parents in a private nursery, influence in the appointment of a LEA Behaviour Support Worker, involvement in the review of child and adolescent mental

² Behaviour Support Plan - DfEE require Local Education Authorities to prepare a plan for the management and education of children with behavioural difficulties by December 1998.

health services (AHA,1997/8, 2000) and multi-disciplinary projects training professionals who work with children and adolescents with emotional difficulties (Ahmad et al,1998, 2000, 2002).

Early years education

In March 1998, I was invited to be a 'link member' of the Behaviour and Discipline Working Group of the LEA Behaviour Support Plan. This arose from my long relationship with a local head teacher during the children's rights campaigning years. Speaking at a public consultation meeting I raised the importance of listening to children and the need to include them in the process of deciding their behaviour management in schools. I suggested the UN Convention on the Rights of the Child should be reflected in policy documents about children in line with all other child-focused professions. Later, I wrote:

There appeared to be a united feeling that it is impossible to address the rights of the child because of numbers. Teachers were feeling stressed and criticised. They take on board the need to help parents but say they cannot be social workers. I agree. In retrospect, I now feel they should move their focus from working with parents in parenting classes (let others do that) and focus on making things better for children by addressing what happens in school. To create the most child-friendly, enabling climate possible in school will promote pro-social behaviour. (Journal,10.9.98).

I continued responding to drafts of the Plan and raising the necessity for a whole school ethos of respect for children. I suggested robust support for teachers who find relating with children difficult (Response letter,1.10.98). Paragraphs were added to the Plan to reflect some of these views (1998:10-13) but my impression remained that the policies were for the management of children's disruptive behaviour and for the sake of well run schools. I was disappointed that the UN Convention (Newell,1991) was still not mentioned in the final copy of the 1998 LEA Plan. It was not until 2001 that the LEA signed up to the UN Convention, ten years after campaigning began in Bath (Evening Chronicle,17.12.91-24.2.01). I was also disappointed that the suggested methods for managing behaviour remained reactive and behaviourist (B&NES,1998:25).

Following my link with the Plan I was invited to a planning meeting for creating a post for an 'early years' behaviour support worker (journal, 3.11.98). I heard that teachers were already doing a good job and it was parents who needed training so children reaching school age were manageable. To the meeting I recounted conversations with teachers who found young children increasingly difficult to manage. I also spoke about parents' stories of their children's school experiences. In the meeting, the focus shifted gradually from the LEA investing in parenting classes so more manageable children would appear in school, to more effective support of teacher-child relationships in classrooms. My suggestion of canvassing early years teachers' opinions verified my observation that teachers were asking for help (journal,13.1.99).

Once appointed, the new worker adopted the Crucial Cs for supporting teachers. She attended sessions I offered nursery staff and parents (see below).

Early years worker's response

On reading this account the 'early years' worker said she uses the Crucial Cs in her work with individual children and in training teachers. She will join a parent and me in Infant School staff training in 2002 (conversation,27.2.02; Chapter Eight).

Nursery Staff

In June 1998, I had been invited to help nursery staff understand a three-year-old boy's behaviour. Jamie, a quiet only child who had limited language, pushed and scratched other children. His mother was worried that the nursery might exclude him because other parents complained their young ones came home frightened or injured. Jamie's mother, who I had known since his birth, suggested that I might know what to do. I was not sure I knew much about nurseries but agreed to observe him (field notes,1.6.98). The nursery staff told me the 'time-out' chair did not change his behaviour and he needed constant surveillance. They were open to my being an observer and welcomed ideas.

I saw Jamie in a group of five children with access to a range of play areas. He chose the sand table where he used little language but made contact with other children physically. The staff member assigned to watch him was a continual presence, giving suggestions and praise. She tried to anticipate Jamie's misdemeanours and divert him. His name was spoken frequently in a warning tone while other children were seldom named. The level of anxiety about Jamie heightened my feeling that he was like a caged lion coping for hours under constraints, which were unusual for him. I recognised the stark contrast in nursery to the less stimulating freedom, within isolation, that he experienced at home with his mother. She had made no complaints about his behaviour at home where he rarely saw other children and was unadventurous. He was in nursery because she recognised he needed more stimulation in several areas of his development.

When I described the contrast I saw with his home, the nursery manager said she recognised how hard it must be for him trying to communicate with children while constantly being called to order. She could see that 'time out' constrained him further by concentrating on his wrong doing without helping him cope with his inability to communicate. She agreed discouragement might explain his periodic disappearance under a table to be alone. It was easy to identify likely causes of his misbehaviour but more difficult to suggest what to do about it. I suggested as much freedom as possible with some targeted times when his co-operation was stretched. The manager agreed to try to help him find more effective ways of expressing himself. This would

mean shifting the focus to trying to understand why Jamie behaved this way rather than protection of the other children as first priority.

The openness of the manager helped me feel brave enough to say that although managing large numbers of children was not in my experience, I knew a model for understanding behaviour which staff might find helpful. To my delight she was interested and within two weeks a session was booked for all the staff at the end of their working day (journal,16.6.98). The manager and her staff grasped the Crucial Cs with enthusiasm and put it into practice immediately. It was later reflected in the nursery's detailed Action Plans for Jamie, sent to me for discussion (Action Plans,24.9.98, 26.4.99) Jamie's behaviour and speech improved and the manager reported that he showed only occasional aggressive behaviour towards other children if he was provoked (conversation: child health notes,28.10.98) The nursery manager agreed there was no problem about keeping Jamie at the nursery in preparation for school entry. His development however continued to cause concern and I observed him again a year later (journal,7.5.99). His mother reported that his confidence for communicating had deteriorated so that sometimes he could only manage 'stammered gibberish' and he was scratching again. Speech therapy and paediatric opinions were that his delays were not significant enough for a statement of his future educational needs.

In the nursery I saw a Crucial Cs sheet hanging on the wall and knew that the philosophy had been adopted (conversations, action plans,24.9.98, 26.4.99). In notes after my visit I wrote that the atmosphere was mellow and the twelve children in this age-group were engaged in a variety of activities (child health notes,7.5.99). The manager said that since the training they had given the children more freedom and only required them to sit together for the story or line up to go into the garden. I noticed the staff gave quiet guidance and let the children try messy things. It was marbling the day I went. I was impressed by the teacher's patience when my impulse was to lend a hand to prevent spillage!

In each area I saw that guidance was warm. For example I heard, 'If you three move down (the sand pit) there will be room for Jamie'. They did and Jamie played co-operatively with few words. Later, I saw him involved in a lengthy game involving some two-way conversation. The staff were observant but did not always react if there was pushing and shoving. I saw two instances where mild disruption dissolved without intervention. On one occasion Jamie raised a closed hand but did not use it. It looked as if he was trying hard not to scratch. Staff reported no longer using 'time-out' because they recognised misbehaviour to be the child's way of solving some felt difficulty. They used the Crucial Cs to try to understand before they responded. Jamie removed himself to play by himself three times in the hour before returning to his group. I agreed with the manager's conclusion that this as a sign of his discouragement

when he found communication difficult. He needed a lot of encouragement to boost his resilience (child health notes,7.5.99). I could come up with no new suggestions but felt the nursery staff and Jamie's mother also needed encouragement.

Nursery parents

I agreed to conduct two evening sessions for parents who had expressed difficulties with their children's behaviour. Twenty-five mums and dad's came (journal,8.6.99). I noticed everyone joined the bubbly and enthusiastic discussion, which lasted more than two-and-a-half hours. The newly appointed 'early years' worker was also present. In the second session I recapped the model and invited parents to share experiences (journal,29.6.99). It is hard to know the outcomes from these sessions because I have not seen the parents since, however I recognised the engagement that occurs when people are thoughtful and appear to be learning.

I am impressed how some people can hear the Crucial Cs philosophy once and 'just know' what it means. It seems to fit easily into what they know and do already. This was how it seemed to be for the nursery manager and the 'early years' worker. In a recent conversation the manager said,

'It is so much how I am now that I cannot remember how I used to do it' (conversation,24.7.01).

This shows the living, evolving nature of practitioner's knowledge, tuned according to personal history and experience and points again to the complexity of practitioners' individual theories of practice.

Nursery manager's response

On reading this account of events in the nursery, both the manager and Jamie's key worker said they recognised the account as accurate. The manager wanted me to add that it was never an option to exclude Jamie because they do not have a policy of excluding children. However she recalled an incident when another parent was angry and outspoken with Jamie's mother, who had been worried that he might be excluded. The manager said she now sometimes helps the 'early years' worker in training seminars for her colleagues. They include the Crucial Cs and techniques she uses in her nursery (conversation,25.7.01).

Child and Adolescent Mental Health Service review

Through this period I was active in other areas outside my caseload. I joined a Joint Review of Services for Children with Emotional, Behavioural and Mental Health Problems as part of the AHA's review of all services for children with Social Services and Education (Visits diary,7.10.98-21.1.99). In the review team I represented primary care in Tier One, which is front-line work with all children. CAMHS representatives came from specialisms in Tiers Two-Four, from individual mental health workers to multi-professional teams (AHA,2000). My role

was to clarify preventive possibilities for primary care at Tier One and therapeutic work in Tier Two. There is minimal specialist involvement here. I wrote in my journal that I felt confident and useful as I became aware of how little the other professionals knew about the universal preventive service we offer. I suggested there was more that could be done in this preventive stage and asked about the merit of thinking about practitioner relationships with young people to enhance effectiveness across all of the tiers (journal,12.11.98; AHA,2000).

CAMHS training project

Linked with the review of services, a separate project was underway identifying and planning for the training needs of non-mental health professionals who work with children and young people in Tier One. I was excited to read the first report on which the curriculum project I was to join would be built (Ahmad et al,1998). Within the report I saw a possible solution to a problem I had become aware of while campaigning for children's rights. In 1989 I noticed that adult attitudes towards children, particularly in the matter of managing children's behaviour, did not appear significantly different amongst those trained for child-focused professions, to attitudes amongst the public generally (Pound,1991a). By this I mean that I seemed to have similar conversations with health visitors, social workers and teachers who were also parents, as I did with parents in my case load. In 1989, these workers seemed no less likely to blame children for their behaviour or to say, 'what's wrong with smacking?'. I believed that if the attitudes I heard informed the relationships of professional workers with their child-clients, it was likely there would be children receiving services who felt unheard at the very least. My impression was clearly articulated in the study by Butler and Williamson (1994).

Since 1989, with the implementation of the Children Act (1989) and the UN Convention (Newell,1991) came an increase in discussion about children in families, especially in the media (Kahn,1994). Most professions were moved to review their policies in line with these documents. I have noticed that conversations have gradually shifted so that I am now less likely to find myself in discussion about children's rights. Like other parents, professional parents frequently want to talk about coping with children. In Chapter Two I said that my focus shifted because of my growing awareness. The intra-professional and media debate through this time suggests that my shift was also part of a changing awareness in a changing social climate. The first exploratory report recognised growing recognition that children can also suffer from mental ill-health. It said:

There is enormous concern amongst agencies across the health, social care and educational sectors about the emotional and mental health of children and young people that they deal with ... this concern is a reflection of the inadequacy felt by many front-line staff in adequately meeting the needs of children. (Ahmad et al,1998:iii)

In time outside paid health visiting hours (because I felt it was important), I joined the multi-disciplinary curriculum planning group for Tier One workers. The planning group consisted mostly of specialists from CAMHS teams working with serious emotional and behavioural problems in Tiers Two and Three. I was aware their work involved reacting to serious problems arising in a small percentage of worrying children who cause concern. My concern was the climate for *all* children who met Tier One workers, not only those with emotional problems. The early meetings focused on 'worst case scenarios', referral systems and support for staff in contact with these children. As the meetings progressed I felt able to suggest that deterioration in behaviour problems and emotional well-being might be avoided for some children if underlying reasons were more widely understood. Serious behavioural problems in many cases may escalate from the normal responses of children, because their decreased resilience and emotional distress is not understood. The most noticeable children might overshadow the distress, which other children experience in some groups. The aim would therefore be not to do different things for children with serious problems but to work at creating a nurturing, resilience-enhancing climate for *all* children (letter to group,4.1.99).

Six months later, six pilot workshops on a range of topics were held in East Bristol for people from health, social services, education, youth services and voluntary organisations. It was externally evaluated (Ahmad et al,2000). Dividing one of the workshops into two, Karen John, shared '*Understanding and working with children and young people with emotional and behavioural problems*' so we could be interactive in smaller groups (Workshop Four,2.7.99). In 2001 the workshops were repeated in South Gloucestershire. We offered our workshop again. On this occasion Karen suggested a different presentation method in response to comments that the previous brainstorming method had produced a lexicon.

2000-2002 workshop evaluations

The 2000 report said:

"Many participants felt this was the most useful of all the workshops. It was valued for '*framing thinking around behaviours and interventions*'; '*understanding emotional needs and how we mirror child's behaviour and how we can respond to children to help resolve the situations*'; '*a clear working model to use with parents/carers and school staff*'; '*looking/sharing feelings and how to incorporate the model we work within today, into our everyday working with clients*'; '*seeing it from the way adults can change, not just changing the child*'; '*discussions with colleagues from other disciplines*'" (workshop evaluations: Ahmad et al, 2000).

The 2001 questionnaire responses included:

'I really liked Robyn's openness and the genuineness of her presentation. It is great to hear of people working/developing in a creative way' ... 'really good handouts - liked Robyn's training style, thought provoking' ... 'Robyn came across as a warm, experienced practitioner'

... 'the relationship is vital to the work we do. I thought Robyn modelled building a good equal relationship from the start'.

Several wanted the work groups to be smaller and a couple commented on my appearing nervous at the beginning (questionnaire responses in letter,6.7.01; Ahmad et al.,2002).



My learning from colleagues, early years and CAMHS

The relevance of more collaborative working relationships to disciplines beyond health visiting became obvious during my work with education and Tier One training. I became aware of different perspectives of other professionals who work with young people. Sometimes distressed young people want or need adults to take the lead and be strong containers of their intense emotions in the same way I found adults require during crises (Workshop Three,24.6.99) .

In each of the processes with early years, the CAMHS review and curriculum planning, I tried to use the Crucial Cs skills and become sensitive to valuing the skills and perspectives of other professionals. Coming from health visiting, which is not usually seen as a profession, which provides answers for other professions, I needed to use timing and pace in making suggestions in the way I do with clients. When my contributions felt appropriate they were adopted. I was aware of my old urgency to get to the point and move on quickly, because I felt I knew the answers and wanted people just to believe me. Of course it does not work like that. I am learning to trust the process of thinking that is necessary if people are to come to ideas for themselves. Now, I am more likely to recognise the cause of my irritation when I feel small amongst people who seem to be more powerful. The Crucial Cs are a useful reminder in these situations. If people feel valuable and included by me they are more likely to be open to hearing what I have to say. I am aware that if I feel small, powerless and inarticulate in multi-disciplinary teams I am more likely to be insensitive and try to steamroller ideas with little regard for others' feelings. I recognise I need to be aware of this possibility in myself and to work at forming respectful connections.

Now, as I seem to be more recognisable as someone who has useful knowledge, I need to be aware of a different possibility. With a helpful warning from Karen, I become aware that power is accumulated with my emerging success and the increasing regard I experience from colleagues. I need to be mindful to use the power this bestows in ways which live the respect, collaboration and sensitivity that I have come to appreciate as most enabling for myself.