Prologue

How can I improve my health visiting support of parenting?
The creation of an alongside* epistemology through action enquiry

What kind of knowledge is this?

This thesis is an account of an action research enquiry into my health visiting support of family relationships with children's well-being held as priority. I show the process of my learning and the development of my practice as I create my living theory (Whitehead,1989) of health visiting. The process therefore is appropriate for exploring the complexities of improving and evaluating professional activity. Emergent epistemological * and ontological assumptions upon which my thesis is based are that knowledge is dialectically constructed in dialogical collaboration with clients, colleagues, research associates and others who are each engaged in their own living 'processes of becoming'. It might help if I explain what I mean by this but first, I describe the structure of the thesis.

What will you find in this thesis?

In this *Prologue* I explain the nature of the knowledge this enquiry generates, the emergent values and the contribution my development of them makes to health visiting in an account of

---

* For explanation of alongsideness in practice and alongside epistemology - see pages 3, 209 - 216 and the Glossary:226.

1

my learning process as I improve and come to know my practice. I create an alongside epistemology, which I believe makes a contribution to the scholarship of enquiry.

Chapter One outlines what I try to achieve as health visitor, what I seek to influence in family relationships, and the rationale behind attempting to improve my practice. I introduce Adlerian theory, which is influential in my learning.

Chapter Two explores major research paradigms and where my living theory fits in relation to existing nursing action research. I use Lewin's action research as a comparison for my own and explore the usefulness of values and ethics in creating an alongside epistemology.

Chapter Three introduces a landscape overview to enable focus on particular features of enquiry whilst keeping the whole in view. I introduce the research players, early methods of exploration and data collection, particularly with parents, the Bath Action Research Group (BARG) and the Health Visitor Research Group (HVRG) (Pound, et al,2001a,b).

Chapter Four continues viewing the landscape where I explore the qualities of relationships and use a questionnaire to discover parents' perceptions. Through 'early recollections', by using videos within presentations and looking wider to my work in communities, early years education and with professionals involved with children and adolescents at Tier One, I develop my values.

Chapter Five shows my emerging understanding of the value of alongsideness in educational relationships in primary prevention. I explore the implications of my personal beliefs on my agenda for health visiting and come to new understanding.

Chapter Six introduces video and story telling to show the development of my awareness about democratic relations in solving family problems in secondary prevention. I demonstrate the Crucial Cs for changing a parent's behaviour. I reflect on the gap between knowledge and action for parents and myself, the part humour plays in my relationships and the balance of control with responsibility in parenting.

Chapter Seven uncovers contradictions to be addressed in tertiary work when I balance priorities for the sake of children while remaining alongside parents. The impact of my personal history on decisions I make becomes evident. I come to understand how the profession has not prepared or supported me in meeting the depth of need I encounter and I expose a gap in services for families in greater need. Identification of need moves me into community-based and profession-based activities in pursuit of change.

Chapter Eight traces my values through the thesis as they develop into an explanation of my alongside epistemology. I identify a unity of moral purpose behind my health visiting and recognise applicability wider than my practice. I show how embodied values can be transformed into standards for judging practice and for judging my claims to knowledge. I consider the contributions of my enquiry and plan future research.

What are my values?

The process of my coming to know values important to my practice, and to live them reliably, is developmental through the process of enquiring. I offer them to you here for judging the quality of this thesis. Without attempting to explain them fully (because they develop through the thesis), here I summarise my *values* at the time of writing:

> *Alongsideness* has emerged as the central motivating value I attempt in all of my relationships. It relies on my *respect for people*, whom I see as being in a *process of becoming*, as I am myself. As I foster *connections* with people, often using *light-heartedness,* I also need to *accept differences* in other people's beliefs. My endeavour to ensure individuals experience their *self-determination* calls for my *encouragement* of their process. At times when my decision-making is clouded by complex situations, I turn to my *responsive responsibility,* especially to maintain balance between acting for parents and the interests of children.

What contribution to knowledge does this thesis make?

I believe I make a contribution to health visiting knowledge by demonstrating the development of an alongside epistemology for understanding, evaluating, improving and explaining health visiting practice towards research-based practice. This new scholarship of enquiry offers health visitors methods for understanding and embodying values and transforming them into living standards of judgement for improving and explaining practice. My explanation of the health-enhancing and educational possibilities of alongsideness in practising and researching relationships includes the complexity involved when diverse needs are to be met. I illuminate the importance of my personal history in the embodied values and living theories of my health visiting. I believe the full significance of the possibilities of a new epistemology for health visiting enquiry will unfold over future years as others seek academic credibility for reflective practice and Clinical Governance (Department of Health,1999a).

How do I locate my alongside epistemology in relation to established theory?

Responding to a draft of this thesis, Norma Daykin, my co-supervisor, pointed to considerations that appeared unresolved from the enquiry's beginning. I now recognise this was because of my difficulty in understanding them. This prologue is dedicated to my reflection on the nature of the knowledge I generate in practising. Norma cites:

> *the need for a more substantive theoretical framework underpinning the thesis*

and,

> *concerning engagement with established theory ... resolving problems of eclecticism.* (e-mail,5.2.02)

I need to clarify where my enquiry is located amongst existing knowledge and how I demonstrate reflexivity in the eclectic choice of theories I draw upon.

I draw on several 'disciplines' of knowledge. In the beginning I turned to psychological research for answers about the effects of negative experiences on children's well-being; sociology to understand the context of children's lives; history to understand changes in their status; philosophy for discussion about human rights, religion and the law (to name a few) (Pound,1995a). I read about the construction of knowledge in which my enquiry would be set (Ritchie,1993). More recently, I used psychoanalytic theories for understanding human emotional need and relationships. No one discipline could provide me with a ground from which to launch an enquiry about improving my support of family relationships for the sake of children. *This* was what I wanted to know. *How to do it* in practice. My enquiry therefore needed to be grounded within my practice, keeping an open mind to all the unexpected possibilities from the diversity of circumstance and focus I meet there (Ghaye&Ghaye,1998:122). Whitehead (1989) suggested I could create my own living theory of health visiting as I responded to new questions arising from changing perspectives on children's lives, on health visiting and my own view of them (Chapter Two:28).

Looking back now at how I approached my enquiry, I realise that it is a distinctive feature of research-in-practice that I chose established theories for their possible usefulness to my search for understanding and improvement. New insights about my practice emerged, demanding more questions and further search for possible answers. Some answers I looked for amongst existing theories. I checked their relevance and fit as I created my own theories about my work with families. In contrast, social research is more likely to start with a theoretical grounding as the basis for critical theorising in the light of new evidence arising from the research field. In this case, the result is a new modified general theory useful for application by others. I wanted to understand and improve *my own* practice by starting with skills I had already (after more than twenty years) in order to search for new ways of working in my particular changing circumstances. I would create personal theory not as an end in itself, but in order to advance my practice (Bassey,1995:46). Ultimately, I believe the contribution I have made is significant for its applicability to health visiting research beyond myself, especially the methods for generating living standards of judgement.

I wanted my research to influence children's well-being and health visiting more widely than just my practice but my intention was not to create a theoretical model for application by others. My first interest was in the widest complexities of *my own* practice. The endless possibilities of working with people and groups living unique lives in unique circumstances demanded my attention. I wanted to know how to do it better. The richness of variety and context, including myself as practitioner, and my learning how to respond to it, would get lost if I endeavoured to create a generalisable model of practice constrained by categories from established theory and technique. This thesis is therefore an account of my learning as I come

to new understanding about *how to do it* in practice by constructing my own theories relating to my own unique case (Bassey,1995:7).

I find existing literature helpful for offering new insights, critique or validation of my emerging theories.   My resistance to using the traditional method of starting with authoritative texts as a basis for theory-building was puzzling. It is only now, at the end that I begin to understand why my fundamental misunderstanding occurred.   It appears to be a matter of research expectations at variance with each other (Chapter Two).   I am interested in other people's theories and frameworks if they help me understand and take forward my own. What I want to know is often beyond the experience or knowledge available in texts to be found in university libraries. I notice that my search for answers is more fruitful when it has purpose directly related to my enquiry (Pound,2000:368)

I do, however, draw heavily on some established theories.   In Chapter One, I introduce Adlerian theory that I use to understand human relationships (Lew&Bettner,1996). I also find models produced by Caplan (1966), Beattie (1991) and Fox (1995) useful for understanding aspects of my processes of discovery (Chapters Three, Eight). Less helpful for answering my question, 'how do I improve what *I am doing here?*' are general frameworks of health visiting. It is the *I*, *here* and *am doing*, my specific search, that reduces the usefulness of general theories in this case (Whitehead,1993:70).   My reflective self-study in collaboration with parents and others, and the theories arising from it, therefore continue to emerge from and be tested in my practice.

On examining health visiting use of frameworks, Twinn notices:
> *reluctance to develop and use conceptual frameworks to inform practice has contributed to the ad hoc development of practice and to the development of different paradigms.* (Twinn,1993:320)

She asks whether:
> *confusion and conflict afflicting health visiting ... arises from a reluctance to respond to change - or the lack of a framework to underpin practice.* (Twinn,1993:319)

Carnell recognises a limited 'fit' of health visiting models for actual practice. I relate to her conclusion that:
> *health visiting has probably been wise to reject the drive to use nursing models ... a single model might reduce complex human characteristics and situations into something that can be conceived within the components of a model.* (Carnell,2001:85)

The health visiting research I found was by 'outsider' researchers in that they were studying people other than themselves (Chapter Two:40).   These studies were useful for prompting questions about myself and stimulated cycles of reflection (Chapter Four:83).   Interpretative paradigms were most often used to capture aspects of health visiting common amongst a

sample in particular places and times. To create theories about health visiting recognisable for their unbiased validity and likely replicability, researchers attempted to minimise their involvement in terms of preconceptions and personal values. In a search to find what is generally true in a sample of health visitors, tiny variations, constellations of knowledge or individual modes of presentation, which may have made the work effective, are inevitably lost. I speak here of the complexity of personal beliefs and values that colour individual perspectives and ways of being. Personal agendas are 'lived' in the less tangible professional actions that impact on clients (Pound,2000).

The importance of identifying theory-practice gaps

My question was different. I wanted to respond to what I believed to be important in an emerging climate of children's rights and to find ways of promoting it in my work with families. I could not study other health visitors because at the time it appeared that colleagues were not asking similar questions. Anyway, I wanted to answer my own questions such as, 'what do I need to know?', 'why are certain things important?' and 'how do I do it?' I could not know in advance what all these questions would be or exactly how I might seek answers. I had identified a theory-practice gap between my new knowledge about children's rights (recognising their denial in family life) and my lack of skill for addressing problems I saw. In Chapter Two I describe how action research became a way I could improve my practice in response to complexities of my work and the people I meet. Here, I concentrate on the importance of *I*, as single practitioner, in closing this theory-practice gap.

As my reflective enquiry progressed, I experienced three stages in my attempts to close gaps I identified, initially in family life and later within myself. First, I sought new 'how to' knowledge from those already experienced in other fields (Dinkmeyer&McKay,1989; Lew&Bettner,1996; Rogers,1961; Egan,1990; Chapter Three). At first appearance, the theory-practice gap in family life could be narrowed by my acquiring new knowledge. New ideas inspired me and offered fresh possibilities, but were hard to reflect in what I did. A second stage involved exploring the theories, and checking their appropriateness as I worked. I was discovering messiness in answering the complexity, uniqueness and uncertainty of applying theories to real-life practice (Schön,1983:18).

In a third stage, the gap became more about knowledge 'embrained' [1] but not fully internalised as my personal embodied[1] knowing to be lived in my work. McNiff develops the idea of internalised '**I**-theory'[1] as a dialectical form of theory, which is a property of an individual's belief system often called tacit knowledge (McNiff,2001:22). I have come to realise, it is the

---

[1] For the terms embrained, embodied, **I**-theory and **E**-theory see Glossary

values underpinning my knowledge choices and tendency towards certain ways of being that are important for creating my practice, as much as analysing the eclectic, external '**E**-theories'[1] informing my style.   I needed to understand why certain things were important to me, and what was important to the families I sought to help.   As I learnt new skills for exploring relationships with families, I reflected on the part I could play in parents' learning about their relationships (Chapters Five, Six, Seven).   I came to understand the importance of knowing both myself in relation with others and myself with relation to my personal history, my beliefs and my emerging living theory of health visiting.

My theory-practice gap had moved from need to find new techniques, to need to more fully understand *what* I was trying to do, *why* I was doing it and *how to* reliably *live* it. This third kind of gap in my (embodied) **I**-knowledge becomes evident when my intentions, no matter how forcefully claimed, are not matched by reality. It relates closely to Whitehead's perception of *I* as living contradiction when values are not lived, that is they are denied in actions (Whitehead,2000a:97; Chapter Two:36).   Experiences, challenges from people and uncomfortable feelings that I could be wrong, trigger my reflection and my search for alternative meanings, and ways of being.   In this way values germinate and develop (Chapter Seven).   I found this clarification of distinctions between theory-practice gaps useful. Although more training is often required to fill knowledge gaps or to stimulate my interest in trying something new, once new knowledge is available *I* as practitioner need to embody it as my own in order to live it effectively. This may partly explain why training does not predictably result in changed practice. Here lies the importance of reflective self-study in collaboration with others and particularly the scrutiny of values for developing and improving effectiveness.

My account of the educational process of my coming to know should be as illuminative as the accounts of clients' processes of learning and changing what they know and do while in relationships with me.   Here lies the important centrality that *I* holds in my question as practitioner as I ask, 'How can I improve my practice?' (Whitehead,1989).   In this thesis, *I* am first a health visitor intent on improving the climate and experiences of children. Inevitably entangled in this is *I* as person. I bring to my practice the values, beliefs and agenda from a personally influential history, as do all practitioners (Pound,2000; Chapter Seven:174).

Reflexivity and rigour in dialectical enquiry
A second aspect of Norma's response concerns my attention to internal and external reflexivity in using my insights and other people's theories for the creation of my own. Insights emerge from my reflection on experiences, often in dialogue with others and sometimes with the literature. In the process of discovery I check emerging insights in my practice and rely on

dialogical engagement with others in continual searching for illuminating questions and answers (Chapter Two:43-45).

Increasingly collaborative relationships in my research and practice encourage mutual learning and openness to exploring meanings in on-going dialogical debate (Chapters Five, Six).   Our relationships are essentially value-based and founded on engagement with each other.   Early in the research process I moved away from detached observation of families (as research subjects) and *my* involvement in the process became a subject for research (Chapter Three:59). Verification of emergent insights involves dialogical scrutiny with those involved as I work (Chapter Five:117) and is continually explored for appropriateness in wider circumstances (Chapter Six:143; Chapter Seven:181).   Whitehead suggests social verification of knowledge in this way is dependent on epistemological assumptions and consensus about verification systems amongst those enquiring within the paradigm (1993:134).   I recognise Sarah Fletcher's concern that 'in-house' collusion could occur in attempts to support one another and insights may need to be tested amongst people viewing them from competing paradigms (conversation,4.3.02). In this way critique also comes from literature. This relates to Winter's first principle for assuring rigour (1989:43; Chapter Two:43).

Behind the observable dialogical processes lies my internal dialectical engagement and interpretation of meanings in the process of embodying insights (especially values) so I can live them as I practise.   Whitehead describes contradiction as the nucleus of dialectics, through searching for and exploring opposing ideas (1993:56).   In Chapter Two (:45) I demonstrate this process as I consider the idea of myself as a person worthy of respect.   Critical reflection (as in finding contradictions) and understanding the processes that led to my assumptions and how they could become distorted led in part to my own emancipation.   Respect for people emerged as a value appropriate for practice.   Here the 'intra'personal dialectical process, in which I examined beliefs underpinning my values, co-existed with an 'inter'personal dialectical process in which I reflected on my beliefs with others who were examining their own (Lomax&Parker,1995:303).   I therefore see dialectical process as being an *alongside* coming to know in collaboration with others, as much as it is about scrutinising opposing ideas (Whitehead,1989).

Probably one of the most significant personal discoveries from this enquiry came as I stood back from looking at each of the parts and recognised the significance of each of them in uniting my understanding of the whole of my enquiry in relation to myself and my practice. Jack Whitehead refers to Socrates' explanation of the two ways of coming to know: breaking things into separate components and holding things together under a general idea (Whitehead,1993:70).   Those thinkers, he says, who can hold both the one and the many

together are dialecticians. I became aware of a determined thread running through many parts of this enquiry. It could be summarised by an initial question:

How can I be more proactive if they (parents) *do not identify the problem I see?* (Chapter Three:59).

It reappears in:

How do I convince others that children have rights? (Chapter One:15)
How do I understand the modesty which others say interferes with my message. (Chapter Three:67)
Where are the boundaries of acceptable behaviour for children? (Chapter Six:154)
Why do I turn crises into jokes? (Chapter Six:155
How do I understand that looking on the bright side avoids people's real pain? (Chapter Seven:177)
Do I collude with distressed parents and forget who my client is? (Chapter Seven:172)
How do I stand up for democratic principles in the face of opposing views? (Chapter Two:51)

I could use each of these questions to begin explaining my whole thesis. That, in itself is interesting to me because it indicates the cohesion of my enquiry process. But my purpose for pin-pointing them here is different. Within these questions, I see a major contradiction within myself from which I have gained hope in my increasing understanding of it. Reading the text enables me to recall the passion I feel for doing something about injustice I see, especially that experienced by children. Sometimes I recognise self-doubt about my beliefs and my ability or right to express them. The latter has been so evident in conversations with BARG, friends and family that it became a joke causing some people to agree in kindly, jesting ways that, no, I didn't know anything worthwhile so why bother? Confronting me in this way made me reconsider and grow in confidence.

My passion for children's rights also caused confusion in that some people assumed my energy to act so tenaciously in the face of resistance must have been fired by a need to redress abuse in my early life. I did not recall childhood abuse, but questions about this led me to explore my past for clues about antecedents to the importance I now hold for equality, autonomy and light-heartedness (Pound,2000; Chapter Seven:176). Examination of this contradiction between energising passion for what I am doing and self-doubt has helped sharpen my focus on what is important. Alongsideness as a way of being came easily to me. I believe it is how I tend to be (Chapter Five). The enquiry has involved understanding the fuller dimensions of being alongside when self-doubt or conflict occurs. Contradictions for alongsideness within myself became especially poignant when my concern for meeting the needs of parents (so they could empathise with their children) meant children's needs risked being overshadowed (Chapter Seven). I found it hard to change to a more authoritative stance when also trying to 'be there' for parents. My instinct was to take the easier option. I needed to trust my instincts and hold them in focus while recognising that needing to remain alongside, and lingering self-doubt, may be useful safety features for recognising and balancing moral dilemmas in practice.

Alongsideness as a way of being grows through this thesis into an *alongside epistemology* also relevant for researching process, dialectical theorising and an approach to critiques.   Jack Whitehead reminded me of the importance of demonstrating that I have taken critiques seriously and considered other ideas in the creation of my own.   An alongside epistemology is dependant on my remaining open to challenge in all researching relationships.   Through my responses I can demonstrate an 'aesthetically appreciative and engaged response' to the texts and critiques of others (D'Arcy,1998).   I believe you will find an alongside epistemology recognisable in the practising and researching relationships throughout this thesis (Chapter Two:51; Chapter Eight).

I feel relieved to have finally found understanding about where I stand amongst methods for creating knowledge.   I now recognise the answers were, in part, already there to be found (McNiff,2001:4-6; Whitehead,2000a).   *I* needed to do this thinking for *myself*, exercising my own critical judgement and creativity for embraining and embodying my understanding of my alongside epistemology of enquiry.   At last, I *really know* what it means for me to engage with theories of others in understanding, creating and internalising my living theories of practice. To work at openness to perspectives and critiques, even if I do not understand what they mean at first, extends possibilities for understanding my own.   I believe an alongside epistemology such as this has important implications in the opportunities it creates for those it touches.

I also see the struggle for acceptance that an alongside epistemology faces amongst dominant epistemological traditions (Chapter Two).   I have sympathy for Whitehead's call for the creation of a new discipline of educational research (Whitehead,2000a) and Schön's call for a new scholarship within a new epistemology, which considers practice as a setting not only for the application of knowledge *but also for its generation* (Schön,1995:29).   I believe this thesis can initiate that bridge for nursing.   I will support practitioners' searches for their own theories of practice, by asking what is really important here, what actually happens and how can it be improved, evaluated and explained?

Knowing as a way of being in relationships

Now I look at another kind of knowledge integral to what really matters to clients in alongside relationships.   I am referring to less tangible knowledge that is observable in lived relationship experiences as a 'life affirming energy' from the power of connection.   The simplest way I can understand this is in three memories.   My earliest recollection from childhood, around the age of four, is of a small white flower in a hedge near our house.   I can still see it and recapture my wonder at its simple beauty.   Such an intense moment of pleasure, recalled at intervals through my life, is like joy in life itself.   This feeling is not always shareable with another person but sometimes the attempt is worth the effort for the connection it creates.   My second memory is

about one of my sons on a picnic when he was quite young. As he gazed into the grass, I heard him tell his friend, 'If you wait quietly, nature will come to you'. I do not know if he was rewarded by his friend's engagement with this idea. My pleasure was in his making the attempt.

A third, more recent memory, is of a moment of playful nonsense experienced as I walked across a sunny car park. I felt the need to hold up my hands to an invisible steering wheel and 'drive' into a space that a driver waited to park in. A shared glance and grin, the briefest moment of connection that felt as if we understood each other before I walked on, my heart leaping in ridiculous excitement, hoping the driver felt the same or at least did not think me crazy. Bataille (2001) describes such exuberance as an 'assent to life' in erotic energy from transgressed taboos. I find it is capable of lifting spirits and transmitting hope. It seems to me, that experiencing pleasure in the simplest things, a thing of beauty or a moment of connection, and attempting to find and share it, may be a key to enhancing my own and others' well-being.

A mother who appeared mildly depressed spoke of trying to remain 'mindful of the moment' amidst the relentless tedium of mothering (conversation,10.3.02). I was reminded of our shared experience two years before. A heavy fall of snow before Christmas meant I needed to cancel visits except where I could walk. Lois had no concerns about the sleeping three-week-old baby but worried that she had not made her Christmas cake. The snow outside added extra festivity and excitement to the naughtiness of my spending time weighing fruit on the baby scales and making cake. The fun of this special event has lifted both our spirits in the regular retelling of it ever since. I believe the long-term value of experience such as this is real, spreads beyond ourselves but is hard to quantify.

My knowledge will continue to evolve in a climate of changing circumstances for as long as I practise. The social climate and my perceptions of it have changed over the last twenty years. The difference is that I now have a more 'disciplined' means for enquiring, improving, evaluating and explaining how I approach new challenges. New meanings and motivations emerge in co-learning dialogue in my practice and research. This is what I try to share with my health visiting colleagues and anyone involved with children.

Chapter one

How do I promote rights for children in my health visiting practice with families and the community?

My journey begins

In this enquiry into my health visiting support of family relationships, research process and professional practice are so closely entwined in function and purpose that they endure together in partnership. I therefore attempt to illuminate a process of enquiry with families, practitioners, researchers and others spanning six years. My endeavour is to understand, improve, evaluate and explain an aspect of my work that has importance for me. The choice to do it as Ph.D. research came about because the problem before me seemed too complex to undertake alone when, at the time (1995), few others in health visiting appeared to be asking similar questions. I wanted my discoveries about how to support family relationships while promoting rights for children to have credibility and influence. I invite you to join my growing understanding of alongsideness as a way of being as it emerges from reflections in my practice. I speak directly to you reader, because my process continues to live and evolve in partnership with all who are interested in discussing ideas emerging here [2].

---

[2] My email address is: robyn_pound@yahoo.com

By way of introduction I will explain what it is about family relationships that I seek to influence, what my health visiting is trying to achieve and what I hope to improve in my practice. My rationale for collaborative educational action research and the theoretical background to my thinking should emerge.

What am I trying to influence in family relationships?

True to the developmental nature of coming to know, awareness of a problem for children's well-being and their long-term mental health grew for me over several years. Awareness came from experiences helping parents manage difficulties in relating with their children and from having children of my own. Over the years, I had developed a range of helping strategies that I drew on and modified for situations I found. In 1988 I pulled some of these together for a dissertation towards my adult education teaching certificate (FAETC) and then published it a year later (Pound,1989). In the heady energised months that followed, I began to notice gaps between therapeutic warmth that I advocated for problem-solving and the experiences of children I witnessed everyday. Threats and smacks appeared to be common, unquestioned methods of gaining children's compliance (Newson&Newson,1989; Smith et al,1995). Two incidents stood out from many as I began to notice:

A 1989 baby clinic	**... and another**
This story happened in a church hall baby clinic where community doctors used to come to do developmental checks of children. A young woman brought her six-week-old baby for her check. She also brought her mother to help with the toddler. He was around fifteen months old. As they waited the little boy explored the room. He took no notice of the rug with toys and books. He preferred people's handbags and things his granny thought he should not touch. She followed him around tapping his hand and saying 'No!' The child became excited by his game. His eyes sparkled and he giggled. His granny was embarrassed. She appeared frustrated as she chased after him and I could tell they would not come again. It dawned on me that not only was this ineffective as a way of dealing with a young child - she could have played with him on the rug - more important, her daughter, was learning this technique from her own mum. A scenario of escalating conflict and future behaviour problems was easy to imagine. (Pound,1991a)	Again in 1989 a very young mother placed her toddler on the scales to be weighed and raised her hand in threat to make the child sit still. I tried not to notice. But I had not forgotten the young woman's anguish at being punched by her partner the week before. I remembered her angry tears followed by her resignation. How could I help her change her future and the future for her child? How could I help that child grow up knowing how to respect herself enough so she did not expect to feel humiliated and powerless in her relationships with others? How could I help her grow up knowing how to model something different for her own children? This incident and my knowledge of the family's circumstances raised issues which were fundamental to my work in child protection (physical and emotional abuse), mental ill-health (poor self-image, drug abuse and violence), health promotion (teenage pregnancy, smoking). All were implicated in the parenting style demonstrated here. This mother was reproducing the only style she knew. (Pound,1996a)

As I spoke with parents and colleagues I was surprised how frequently I was asked, 'What's wrong with smacking?' I searched literature for evidence of why it occurs and its potential harm and decided it was a public health issue requiring awareness-raising. The Commission on Children and Violence report (1995) encapsulates the range of multi-disciplinary inquiries I read about causes, effects and social policy surrounding violence. Maccoby and Martin (1983) introduced me to the effects of different parenting styles. I found myself seeking persuasive means to convince people of the harmful effects of smacking and involved myself in media campaigning and public events[3.] I produced a leaflet, with sponsorship from a health promotion department (Pound,1990), and an article for our professional journal (Pound,1991a,b). Campaigners who had been successful in banning corporal punishment in schools now turned their attention to legal reform for the family and I joined EPOCH[4] as soon as I heard of it (Newell,1989; Rädda Barnen,1992; Leach,1993; Pound,1993). Perceiving my lack of credibility as field worker I registered for a health studies BA degree and used it to explore multiple threads to what I came to see as a human rights issue for children of which smacking was just one facet (Freeman,1983; Pound,1994a,b). These themes included the history and construction of childhood, women's issues, health promotion, medical ethics, human rights and research methods.

I found the task of keeping rights for children on the public and political agenda both invigorating and stressful as I created and responded to media events[3].   As children's organisations joined EPOCH and modified their policies towards hearing children[5] (BACCH,1995), I turned my attention to the practicalities of health visiting within families. Parents' attitudes towards children, family relationships and discipline appeared so firmly rooted in personal and social history, including religion, that the task was more complex than offering alternatives to punishment (Pound,1994a, 1995a, 2000). Here emerged my first question:

> *How do I influence rights for children in family life?*

A second followed:

> *What **are** healthy family relationships anyway?*

---

[3] For example: local BBC radio (19.11.90, 31.12.90, 22.7.91), HTV (16.12.91); Bath Evening Chronicle (19.12.91, 31.12.91, 20,3.93, 23.3.93,10.7.93, 20.7.94, 6.3.96, Appendix V); *No Smacking Week* street campaign in the first week of 1992; seminars with Childminders' Association (18.5.91, 8.5.92); Bath Area Child Welfare Group - professional network interested in children (3.7.92, 30.3.93).

[4] EPOCH, End Physical Punishment of Children was later to become *'Children Are Unbeatable!'*, an alliance of over 200 child interest organisations with an aim of gaining equal protection for children under UK law.

[5] See also the Children Act (DoH,1989a) and the 1991 UK ratification of the UN Convention on the Rights of the Child (Newell,1991)

I began searching for a research method (Chapter Two) and exploring the nature of human need in relationships (Chapters Three-Six).

A third question arose:

> *What part can I as health visitor usefully play in influencing social formations?*

Before describing the context of my health visiting practice, I introduce theories that are important to the course of this enquiry.

Where do I find help in understanding relationships?

Limits to behaviourism

Until this time my techniques for helping families were largely responsive to problems presented by parents and were influenced (although decreasingly) by behaviourist theories (Pound,1989). I experienced limits to the usefulness of conditioning techniques in that older children were not always convinced by 'reinforcements', which felt manipulative to them, and outcomes did not reliably endure (Skinner,1981). Behaviour modification denies that feelings and intentions determine what we do and acts on the premise that:

> *Our behaviour is the product of our conditioning. We are biological machines and do not consciously act; rather we react to stimuli.* (Eysenck,1987:76)

To achieve more lasting outcomes from problem-solving as children became older, I turned to involving them and hearing their views (Pound,1989:43). To act in an earlier more preventive way than behaviourist responsiveness allowed, I wanted to find a more educative process for families, which enabled individual views to be heard. I noticed that manipulating children with rewards kept decision-making, power and responsibility for their behaviour in the hands of their parents (Chapters Two, Six, Seven). The climate it created sometimes appeared to legitimise critical and punitive actions, which parents could find hard to change. Climates such as these are hierarchical and out of tune with the philosophies of human rights and encouraged my search for something different (Newell,1991).

I found parenting programmes, based on theories of Adler, showed ideological promise for promoting rights and help for my understanding of democratic relations.   The programmes I turned to in 1996 were Systematic Training for Effective Parenting (STEP, Dinkmeyer&McKay,1989); Parent Effectiveness Training (PET, Gordon,1970); Parent-Link (Parent Network,1984-1986), and later the Crucial Cs (Lew&Bettner,1996).   I now use the Crucial Cs and aspects from the others (see below).   All are derivative of the Adlerian theories I summarise here although my understanding of them develops through the thesis.

Encouraging social interest to curb a striving for perfection

Adler (1870-1937) took a holistic view that the complete person, not just discrete parts, is what matters. Individuals, he suggests, are expert on our own personalities but we may need guidance to understand ourselves (Hooper&Holford,1998:9). Adler's view of people as creative and self-determining, with subjective outlooks, means our world is not how others see it but how *we* see it. He concluded that human behaviour is goal-oriented, in contrast with Freud's view of our being innately 'driven' (Ansbacher&Ansbacher,1958). We subconsciously choose our behaviour he suggested, according to perceptions from our *life-style*. By life-style, Adler meant an individual's view of 'his' world and place within it. *Life-style* is established from early life experiences and used as a plan for understanding and coping with future experiences.

Adler believed that it is human to feel inferior because of our early experience of adults who appear more able and to have control of our world. Some early experiences may heighten a later need to overcome feelings of inferiority and to seek superiority through perfection or control. A common *life-style* goal for mastery and power in life is represented by attempts to move from feeling *inferior* to feeling *superior* in relations with other people. Adler saw our behaviour as socially embedded because humans do not thrive well alone. Refocusing efforts on our aptitude for *social interest* has potential for curbing excessive need for significance and power by striving towards group or community goals (Ansbacher&Ansbacher,1964). Adler likened *social interest* to identification with and empathy for others. This means co-operation, learned initially through sharing with mothers in babyhood, and self-development of individual abilities to connect with others for the good of ourselves and humanity as a whole.

Encouragement is a key word in Adlerian psychology (Ansbacher&Ansbacher,1958:341). Adler's position was that in having both choice and control in situations we are more able to take responsibility for our lives. By focusing on a positive future and with encouragement, children can learn from the consequences of their behaviour also how to face disappointment. It is through interpreting negative events rather than punishments that children learn to change their behaviour. Changing attitudes towards past discouragement and building resilience for coping with and learning from future events is the basis of Adlerian counselling and guidance. Adler established child guidance clinics across Austria (Lake,1987:6) and considered the significance of *birth order* for individual *life-styles* (Hooper&Holford,1998:13).

How has Adlerian theory endured?
Adler's writing is easily accessible and often inspirational but without a closely argued coherent alternative to theories of his contemporaries, Freud and Jung, his ideas have remained open to criticism (Lake,1987:7). His theories are said to lack objective rigour and refinement while appearing to over simplify inherent complexities of the subject. It has been up to others to refine his insights. These are clearly recognisable in Maslow's hierarchy of needs (1954);

Rogers' faith in individual's motivation towards self-fulfilment (1961); Beck's cognitive behaviour therapy (1976); Dreikurs' goals of behaviour and courage to be imperfect (Dreikurs&Soltz,1964); and a range of parenting programmes (Smith,1996:16). Karen John (2000) integrates theories of group behaviour, particularly Lew and Bettner's interpretation of Adlerian theory (1996) with Bion's assumptions based on primitive impulses of groups (1961).

Branches of Adlerian theory that inspired programmes for informing parenting, notably PET and STEP, both inform this enquiry. Drawing from Rogers (1961), Gordon devised strategies for enhancing communication skills in his PET (Gordon,1970:64). I find *reflective listening, I-messages, 'who's problem is this?'* and *negotiated problem-solving* useful as they are presented in a further derivative, Parent-Link (Parent Network,1984-1986). Inspired by Dreikurs' *goals of misbehaviour,* Dinkmeyer and MacKay (1989) further developed *natural and logical consequences, encouragement versus praise* and *family meetings* in STEP, while also using Gordon's communication strategies.

STEP has a long history of development in USA. I like it because the philosophies embodied in the UN Convention (Newell,1991) are clearly recognisable while parents' needs are recognised. Dinkmeyer and McKay describe democratic child rearing as:

> *based on equality and mutual respect. Equality means that parents and children are equal in human worth and dignity. Although we all have different abilities, responsibilities, and experiences, we are nonetheless all equally worthwhile as humans. The democratic method doesn't give young children the same privileges as older children or their parents. It* does *give their privileges equal consideration. It doesn't mean young children have a part in all decisions. It* does *mean that parents recognise the importance of children's wishes. It means parents involve children in decision making when it is appropriate.*
> *The democratic method aims to help children become responsible by setting limits for them and giving them choices within those limits ... sow the seeds of courage and co-operation ... working with his or her individual qualities, not trying to change them.* (Dinkmeyer&McKay,1989:15)

The relationships are hierarchically flat and embrace an optimistic and encouraging communication climate where, not only is it acceptable to be imperfect, but learning for improvement can result. Dinkmeyer and McKay describe Dreikurs' goals of misbehaviour (1964) in children as seeking 'attention', 'power', 'revenge' and 'displays of inadequacy'. Consequences of behaviour replace rewards and punishments with the intention that children will develop 'self' rather than parent-imposed control (Chapter Six:154). Family meetings are recommended for sharing values within families so that ways of meeting them can be discussed.

Lew and Bettner (1996)[6] further developed STEP *goals of misbehaviour* by looking behind them for the underlying *human emotional needs* motivating each 'mistaken goal' of behaviour. These

---

[6] A reprint (2000) quotes Robyn Pound on the back cover.

are the *Crucial Cs* I explore in this thesis.   All humans, they suggest have a need to *connect* by feeling a sense of belonging with others. This relates to children seeking 'attention' when they feel isolated.   Other needs are to feel *capable* (relates to 'power'), to experience personal significance - to *count* (relates to 'revenge'), and to feel *courage* to cope with life (relates to 'inadequacy'). Misbehaviour is therefore seen as the mistaken ways, however unconsciously, children attempt to satisfy unmet emotional need to experience 'belonging', 'competence', 'significance' and 'resilience' (Appendix III; Chapter Six).

How do I understand human need?
As a way of understanding meanings of 'social need', Bradshaw (1972) devised a four-type classification.   Need defined by experts as desirable and used as a standard against what actually exists he called *normative need.* A unexpressed subjective need he called *felt need.* Felt need turned into action becomes *expressed need. Comparative need* is to do with equity.   He argues that 'needs' have their limitations as epidemiological identifiers for targeting policies or as a basis for evaluation because they are too imprecise, complex and contentious (Bradshaw,1994:45). I find his classification useful for locating meanings of *need* for my work with families and communities. In the course of this enquiry, I found *normative need,* identified by me, most useful when awareness of *felt need* by people led to their *expressing* a need for change.   In contrast with Bradshaw, I therefore find *emotional needs* useful for identifying relationship qualities and evaluating progress towards well-being.

Pringle, commissioned to explore the developmental needs of children, ways these are normally met and consequences when they are not, identified necessary foundations for the emotional, intellectual, social and physical development of children (Pringle,1980). Without prioritising their importance, she cites need for *love and security*, meaning continuous, dependable, loving relationship and assurance of safety (I find this relates with 'belonging').   *New experiences* she finds prerequisite for growth in all aspects of development ('competence', 'resilience'). *Praise and recognition* is important for growth of self-esteem and encouragement of *personal responsibility* important for independence and shared values ('significance'). Pringle's needs, appropriate to stages of development, continue to require fulfilment, she says, throughout life (Pringle,1980:33-58).   All are interrelated and interdependent in subtle complex, continuous ways. They are relevant to my enquiry about children's well-being in family relationships. More recently, the Department of Health described a family climate high in criticism and low in warmth as least likely to be able to compensate for inevitable highs and lows in life (DoH,1995:19).

In my work with families, Lew and Bettner's model of human emotional need is particularly helpful for understanding why people behave the way they do. It is useful for enhancing parents' empathy for children's feelings and building awareness of unmet emotional needs that

motivate 'mis'behaviour.   Using Crucial Cs as learning process, helps *felt needs* motivating 'mis'behaviour to become *expressed needs* so that attitudes and behaviour can change.   Similarly, *normative needs* identified by myself, but not recognised by parents, need to be *felt* and *expressed* if change is to occur.   This necessary shift will inform my becoming proactive on behalf of children (Chapter Six).

What is health visiting for and where do I work in it?

My health visiting is part-time in two small general medical practices (Chapter Three:57). What appeals to me most about health visiting is the universal delivery and optimistic intention to prevent disease and promote well-being by enhancing health-creating possibilities.   That is, I work with individuals in communities with the broadest complexity of context in mind.   I found Caplan (1966) helpful for identifying changing depths of need amongst families as primary, secondary and tertiary.   Different relationship qualities and motivating values are required if work is to be effective (Chapter Three:60).   Beattie (1991:167) is useful for locating the multiple focuses of my actions (Chapter Eight:197), Fox (1995) for stimulating reflection on professional power and CETHV for defining our principles (1977).

I notice consistency of health visiting intention throughout our history as we responded to changing requirements of the society we serve.   Public health motivations of the Ladies' Sanitary Reform Association of Manchester and Salford (1862) concentrated on 'cleanliness, good management, good living, helping the sick and advising mothers on the care of their children' (Jameson,1956).   A century later the major health problems 'related less to man's outside environment than his own personal behaviour', referring to smoking, diet, exercise, alcohol and traffic accidents (Castle et al,1976).   Current policies include mental well-being (DoH,1998). Responding to health service reform, a working party identified four principles of health visiting:

- *a search for health needs*
- *stimulation of an awareness of health needs*
- *influencing policies that affect health*
- *facilitation of health-enhancing activities (CETHV,1977)*

My exploration has found these principles continue to remain relevant to meet changing demographic, health, social and political demands even amongst awareness that our interventions should move beyond individuals (Acheson,1988; Twinn&Cowley,1992).   I will not review philosophical debates raised by these working parties here.   I am fascinated however, to realise that I have needed to explore similar debates for myself in my attempt to discover, embody and 'live' my emerging values effectively in practice.   I believe this shows the importance of practitioners exploring their intentions during critical self-study if theory-

practice gaps are to be narrowed. I use the CETHV principles throughout this thesis to locate different approaches I use for preventing ill-health and promoting well-being.

In this study, I focus on families with children and people who have contact with them, but health visiting extends to all age groups as health needs are identified and work to influence them becomes possible. I recognise and value the privilege of having such easy access to people's lives across the age and social scale. This gives me unique opportunities as health visitor for gaining impressions about beliefs, functioning, difficulties and possibilities within our community.   Health visiting can also be called 'public health' in that it focuses on the underlying antecedents of health and disease, on multi-agency collaboration and on local community action (CPHVA,1997). Many of these perspectives you will find in this thesis, but I make no claims to comprehensiveness because my aim is to find answers to emerging questions. Primary prevention, intending to increase people's resilience to face life, is educational through supported learning and timely access to information and resources.   Growth of my co-learning in alongsideness is integral to enhancing my effectiveness (Chapter Five).

Secondary prevention in this enquiry explores problem-solving to improve relationships, minimise deterioration and promote learning for coping with the future events (Chapter Six). Tertiary work involves managing serious entrenched problems including child protection issues. When I began, I did not intend exploring my tertiary work because of the apparently different relationships involved in the protection of children compared with the educational processes of prevention - my concern in this enquiry (Waters,1993).   I included my relationships in tertiary work when I noticed similarities (and differences) in the emotional needs of these parents and children (Chapter Four:98).

Understanding health visiting relationships
Health visiting is recognised as a relationship-based activity (Pearson,1988; Twinn,1989; Chalmers,1990; Cowley,1991; Kendall,1991; Cuesta,1992).   A listening style, being approachable and offering appropriate information is acknowledged as important, but I recognise the confusion Clark (1984) described amongst health visitors and their clients about the role beyond 'making a relationship' and 'solving problems'. The DoH (1989b) endorsed a growing 'consumer-centred' ideology for practitioners supporting the idea that people do not like being told how to behave or having their competence undermined (Pearson,1991). Observing health visitor interactions, Kendall (1991) found client participation limited in planning their care while Traylen (1994) highlights difficulties health visitors experience when they become aware of potentially health damaging problems not identified by clients (Bradshaw's *normative need,* 1994).   Donabedian (1968), one of the earliest proponents of evaluating the *process* of care, maintained that health outcomes cannot be disentangled from the

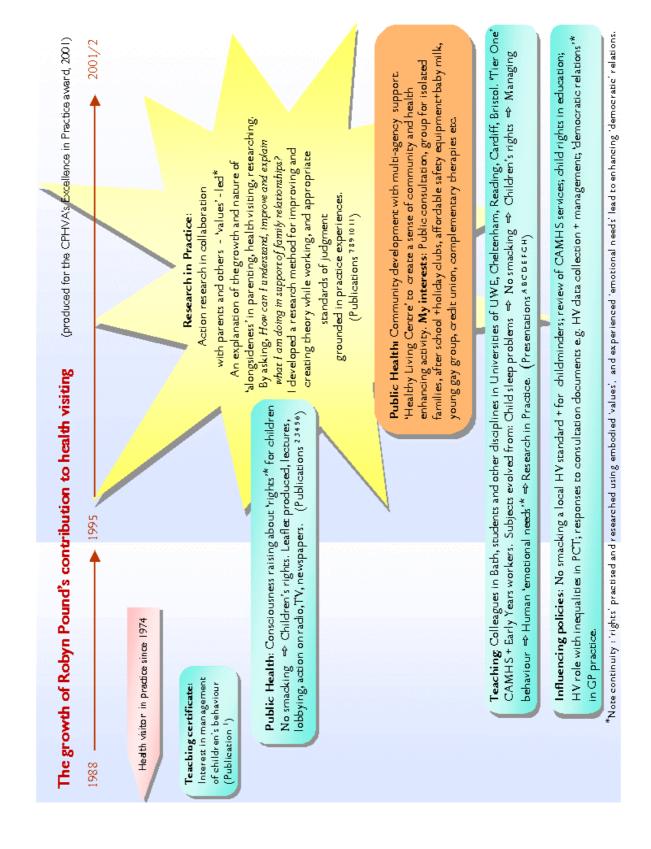*process* of interactions. This strengthened my resolve to explore *and* improve what I was doing by asking:

> *How can I improve my health visiting practice supporting developing family relationships?.*
> (Pound,1996b)

Subquestions emerged:

> *Am I as client-led in my agenda as I think I am?*
> *If I am, how do I raise issues the client has not yet identified?* (Pound,1998)

I wanted more detail about how to practise in the new area of rights for children. Fox (1995) raised useful questions about the implications of health visiting professionalism on caring relationships, particularly in relation to professional power. He describes two contrasting senses of caring. Specialist knowledge and surveillance, he calls the caring *vigil* and a more subjective enabling caring, the *gift*. My understanding of the implications of this paradox for my questions about being client-led whilst also being proactive, as a knowledgeable professional, has been developmental through the enquiry. The use we made of Fox's model in the HVRG is published (Pound et al,2001b) and I reflect in greater depth on its significance for me in Chapter Three:80). Schröch calls for research that can reflect on the professionalisation of health visiting while constructing a theoretical basis for our activities (1982:104). She suggests these are questionable aims for a group whose care is based on facilitation of self-knowledge amongst its clients. Twenty years on I believe I can reassure Shroch that reflective self-study in collaboration with clients can generate theories of practice while enabling client self-knowledge.

For the finals of the 2001 CPHVA MacQueen award for 'Excellence in Practice' I created a summary of my health visiting activities leading up to and through this enquiry (Community Practitioner,2001:433). You might find the following illustration helpful for locating the development of my reflection and its relationship with all I was doing.

The growth of Robyn Pound's contribution to health visiting

(produced for the CPHVA's Excellence in Practice award, 2001)

1988   1995   2001/2

Health visitor in practice since 1974

Teaching certificate: Interest in management of children's behaviour (Publication [1])

Public Health: Consciousness raising about 'rights'* for children ⇨ Children's rights. Leaflet produced, lectures, lobbying, action on radio, TV, newspapers. (Publications [2 3 4 5 6])

Research in Practice: Action research in collaboration with parents and others – 'values' – led*

An explanation of the growth and nature of 'alongsideness' in parenting, health visiting, researching. By asking, *How can I understand, improve and explain what I am doing in support of family relationships?* I developed a research method for improving and creating theory while working, and appropriate standards of judgment grounded in practice experiences. (Publications [7 8 9 10 11])

Public Health: Community development with multi-agency support. 'Healthy Living Centre' to create a sense of community and health enhancing activity. **My interests:** Public consultation, group for isolated families, after school +holiday clubs, affordable safety equipment+baby milk, young gay group, credit union, complementary therapies etc.

Teaching: Colleagues in Bath, students and other disciplines in Universities of UWE, Cheltenham, Reading, Cardiff, Bristol. 'Tier One' CAMHS + Early Years workers. Subjects evolved from: Child sleep problems ⇨ No smacking ⇨ Children's rights ⇨ Managing behaviour ⇨ Human 'emotional needs'* ⇨ Research in Practice. (Presentations [A B C D E F G H])

Influencing policies: No smacking a local HV standard + for childminders; review of CAMHS services; child rights in education; HV role with inequalities in PCT; responses to consultation documents e.g. HV data collection + management; 'democratic relations'* in GP practice.

*Note continuity : 'rights' practised and researched using embodied 'values', and experienced 'emotional needs' lead to enhancing 'democratic' relations.

How do I represent my enquiry?

I have chosen a narrative form of representation (Connelly&Clandinin,1990) to show the developmental, personal nature of my learning as practitioner and the learning of others. The educational nature of the enquiry, my generation of theory, the difference it has made to my practice and the lives of those it has touched should be traceable. I hope you, reader, might feel included in the dialogue. As much as possible I use language I understood before I started in the hope of producing an account that is accessible to those who have not undertaken journeys such as mine. Almost inevitably my new understanding is sometimes more adequately explained using the language of research (Glossary).

I agree with Jack Whitehead (2002) that written text can never reveal all of my knowledge about how I am with people and the influence that has on the effectiveness of my work. I am advised that videos could give you access to less tangible moments of my 'health-enhancing' (or the opposite) interactions with others. However, I have chosen not to present video clips in this thesis because I believe the insights that I *can* portray in text have significance within themselves. Exploring video to represent less tangible 'life affirming' ways of being (Whitehead, 2002; Chapter Five), could become a future enquiry. I offer 'still' photos from videos I made with Sally's family and shared with colleagues during the enquiry. I believe they show some of the climate I describe.

The multi-faceted, developmental nature of my process, visiting diverse fields over many years, means literature influencing my initial ideas may no longer be central to my current thinking. It does not therefore appear possible or useful to fully review all literature influencing this enquiry. My preference is to introduce theories that influenced my learning as they occur in my account of finding new insights and generating theory. Like Green, I will present texts that engaged and challenged my thinking, rather than trying to define my thesis in terms of all literature existing in the field (Green,1999). My use of influential theories is developmental and therefore spread throughout the text. I have included internal reference markers to help you follow the growth of ideas. For example Adlerian theory in the form of parenting programmes I began using in 1996 appears in Chapter Three. I consider his theory alongside Rogers in more depth in Chapter Four and again as it raises questions in practice in Chapters Six and Seven. As this account is the work of one practitioner, my evolving insights about practice might not reflect all possible views. In the spirit of living enquiry, I attempt to be reflexive and to remain open to possibilities for amending or defending my thinking.