Appendices

Appendix I
Informed consent letter- an example

Robyn Pound health visitor Grosvenor Surgery 26 Grosvenor Place BATH BA1 6BA ☎ 01225 480133

Action research into health visiting practice at Grosvenor Surgery

Towards a supervised Masters degree

29.6.97

Dear

This is to give you some background to the study and to ask if you would like to help.
I am undertaking a research project looking at my practice as a health visitor working with parents and children. My interest is to improve ways of supporting parents in the early years, especially at the time when relationships with children are developing. It is by reflecting with parents on our experiences both as parents and on the health visiting process that I understand what I am doing so I can improve it. I believe this process may be helpful for parents as well as you put ideas into words.
After eighteen months of talking with people and doing a lot of thinking I am now looking at a rather broad span of themes which have arisen. I am interested to know:

- how you see the health visiting you have received so far
- about things which made a difference - anything which added to what you know about parenting
  - anything which was a hindrance to your being a parent
- how we communicate - which qualities work best in our work together
- what you anticipate you might need in the future
- anything else you think I could do to improve the way I work

As I consider this to be a collaborative study which relies on the opinions and experiences of parents and colleagues, I welcome your questions and suggestions about how to proceed.
Please ask if you need more detail than I give here:

Q. What is the purpose of the study?
A. My health visiting experience suggests there is a need to find more effective methods of supporting parents in the early years. I will be asking parents about their experiences, the hopes they have for their children, the support they feel they need, and how those needs can be met. Parents will in effect become co-researchers whose views will influence the research process and the results.

Q. Who is being studied?
A. This has become a study of *myself* as I ask you to help me understand and improve the way I support you in being the parents you want to be.

Q. Who will take part?
A. Parents from Grosvenor Surgery are invited to join different parts of the study. Both you and your partner are welcome to take part if you wish, but there is no obligation for either of you to be involved. You can decline to take part at any stage. Not taking part will not influence the health visiting support you receive.

Q. What is expected of me?
A. I would like to ask you if you can help me answer the above questions. The interview will take between 1-2 hours and be at your house unless you prefer somewhere else. I welcome your opinions and am keen to consider your ideas about how I can offer you the best support.

Q. What will I get out of it?
A. Having the chance to think about your hopes as a parent can be useful in planning how you will achieve them and the support you might need. It may be a useful way for you to share these thoughts with your partner. You can influence the health visiting you and other parents receive.

Q. Will the interview be recorded?
A. With your permission I would tape record the interview so I can listen properly and don't need to take notes. You can have typed notes of the conversation afterwards if you wish.

Q. Is confidentiality guaranteed?
A. It is. Notes of our conversation will, if you agree, be for my research supervisor and my eyes only. If any quotes are used in the final account fictitious names will be used and your family will not be identifiable. Codes of confidentiality which apply to health visiting apply to this study.

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Action research into health visiting practice at Grosvenor surgery

I would like to take part in the study as described above.
Signed.....Date.....
Signed.....Date.....
You can change your mind at any stage with out influencing the health visiting service you receive.

Appendix II

Questionnaire to parents on my caseload

Results

QUESTIONNAIRE ABOUT YOUR RELATIONSHIP WITH YOUR HEALTH VISITOR - ROBIN POUND

With this questionnaire I am trying to understand and improve my work as a health visitor.

I welcome your opinion about the way I work with you.

I would be grateful if you could spend a few minutes answering the following questions.

The questionnaire is being returned to someone else for analysis, so please feel free to be honest and open with your responses.

Here is a list of attitudes and behaviours of health visitors some of you have spoken about.

I would like to know how much you agree or disagree that these statements are like ME.

Please place a tick against the statement you agree most.

Q1

Questions about how I am with you?

	strongly agree	agree	disagree	strongly disagree
Speaks to me in a warm friendly voice	☐	☐	☐	☐
Does not seem to care about me	☐	☐	☐	☐
Seems emotionally cold to me	☐	☐	☐	☐
Frequently smiles at me	☐	☐	☐	☐
Does not listen very well	☐	☐	☐	☐
Gives me time	☐	☐	☐	☐
Enjoys talking things over with me	☐	☐	☐	☐
Is not easy to contact	☐	☐	☐	☐

Q2

Questions about how I do things with you?

	strongly agree	agree	disagree	strongly disagree
Appears to understand my worries	☐	☐	☐	☐
Wants me to make up my own mind	☐	☐	☐	☐
Makes me feel a burden	☐	☐	☐	☐
Invades my privacy	☐	☐	☐	☐
Knows what she is talking about	☐	☐	☐	☐
Does not like me to make my own decisions	☐	☐	☐	☐
Tries to tell me what to do	☐	☐	☐	☐
Keeps my personal things private	☐	☐	☐	☐

PTO

Q3 **Questions about how much I help you?**

	strongly agree	agree	disagree	strongly disagree
Gives me useful information	☐	☐	☐	☐
Does not help me as much as I need	☐	☐	☐	☐
Makes me feel better when I am upset	☐	☐	☐	☐
Does not seem to understand what I need or want	☐	☐	☐	☐
Is someone I can confide in	☐	☐	☐	☐
Tries to make me dependent on her	☐	☐	☐	☐
Cannot help me solve difficult problems	☐	☐	☐	☐
Encourages me	☐	☐	☐	☐

Q4 **What is the most important thing about me as your health visitor?**

Q5 **Is there anything else you would like to say?**

Would you now please return it in the enclosed stamped addressed envelope

Your answers will remain anonymous

Please ask if you would like to discuss this study further

Thank you for taking the time to complete the questionnaire.

Clinical Effectiveness Department/ SNAP Software/ Work of the HV/ RP/JR March 1999

QUESTIONNAIRE ABOUT YOUR RELATIONSHIP WITH YOUR HEALTH VISITOR - ROBIN POUND

With this questionnaire I am trying to understand and improve my work as a health visitor.

I welcome your opinion about the way I work with you.

I would be grateful if you could spend a few minutes answering the following questions.

The questionnaire is being returned to someone else for analysis, so please feel free to be honest and open with your responses.

Here is a list of attitudes and behaviours of health visitors some of you have spoken about.

I would like to know how much you agree or disagree that these statements are like ME.

Please place a tick against the statement you agree most.

Q1

Questions about how I am with you?

	strongly agree	agree	disagree	strongly disagree
Speaks to me in a warm friendly voice	80.9%	19.1%	0.0%	0.0%
Does not seem to care about me	1.5%	1.5%	20.6%	73.5%
Seems emotionally cold to me	0.0%	0.0%	19.1%	77.9%
Frequently smiles at me	61.8%	33.8%	0.0%	1.5%
Does not listen very well	1.5%	2.9%	29.4%	63.2%
Gives me time	58.8%	35.3%	1.5%	0.0%
Enjoys talking things over with me	61.8%	35.3%	0.0%	0.0%
Is not easy to contact	0.0%	11.8%	48.5%	36.8%

Q2

Questions about how I do things with you?

	strongly agree	agree	disagree	strongly disagree
Appears to understand my worries	58.8%	39.7%	1.5%	0.0%
Wants me to make up my own mind	39.7%	45.6%	4.4%	4.4%
Makes me feel a burden	0.0%	0.0%	25.0%	70.6%
Invades my privacy	1.5%	0.0%	25.0%	70.6%
Knows what she is talking about	50.0%	45.6%	1.5%	0.0%
Does not like me to make my own decisions	0.0%	0.0%	33.8%	63.2%
Tries to tell me what to do	0.0%	2.9%	45.6%	47.1%
Keeps my personal things private	50.0%	42.6%	0.0%	1.5%

PTO

Q3 **Questions about how much I help you?**

	strongly agree	agree	disagree	strongly disagree
Gives me useful information	52.9%	44.1%	1.5%	0.0%
Does not help me as much as I need	0.0%	8.8%	36.8%	50.0%
Makes me feel better when I am upset	47.1%	36.8%	2.9%	1.5%
Does not seem to understand what I need or want	0.0%	4.4%	36.8%	54.4%
Is someone I can confide in	52.9%	36.8%	4.4%	0.0%
Tries to make me dependent on her	0.0%	2.9%	30.9%	61.8%
Cannot help me solve difficult problems	2.9%	7.4%	42.6%	39.7%
Encourages me	58.8%	36.8%	0.0%	0.0%

Q4 **What is the most important thing about me as your health visitor?**

0.0%

Q5 **Is there anything else you would like to say?**

0.0%

Would you now please return it in the enclosed stamped addressed envelope

Your answers will remain anonymous

Please ask if you would like to discuss this study further

Thank you for taking the time to complete the questionnaire.

Clinical Effectiveness Department/ SNAP Software/ Work of the HV/ RP/JR March 1999

Appendix III

Human Emotional Needs and Mistaken Goals

Logical consequences versus punishment

Encouragement versus evaluative praise

Mistaken Goals of Behaviour and the Crucial Cs

Child's Belief	Child Feels	Child's Negative Goal	Adult Feels	Adult's Impulse	Child's Response to Correction	Crucial Cs	Constructive Alternatives	Child's Belief	Child Feels	Child's Positive Goal
I only count when I'm being noticed.	insecure alienated	**ATTENTION**	irritated annoyed	REMIND What again?	stops temporarily	**CONNECT**	Replace negative attention with positive attention. Plan activities together. Don't ignore the child. Ignore misbehaviour. Teach self sufficiency	I belong	secure	CO-OPERATION
My strength is in showing you. You can't make me You can't stop me. .	inadequate dependant others are in control	**POWER**	angry challenged	FIGHT I insist you do as I say	misbehaviour intensifies	**CAPABLE**	Don't try to win. Give opportunities and choices so child can display power constructively. Maintain friendly attitude	I can do it	competent self-control	SELF-RELIANCE
I knew you were against me. No one really likes me. I'll show you how it feels.	insignificant	**REVENGE** Get back Get even	hurt or wants to punish	PUNISH How could you do this to me? us? them? I'll teach you a lesson	wants to get even. makes self disliked	**COUNT**	Avoid anger and hurt feelings. Maintain appreciation in relationship. Offer chances to help. Seek support and help in identifying positives. (Don't give up)	I matter	significant valuable	CONTRIBUTION
I can't do anything right so I won't try. If I don't try, my failures won't be so obvious	inferior useless hopeless	**AVOIDANCE** Display of inadequacy or learned disability	despair I give up. hopeless	GIVE UP It's no use.	passive no change more hopeless displays inadequacies	**COURAGE**	Notice only the strengths and ignore the negative. Set up steady exposure to manageable tasks that have a guarantee of success. No criticism.	I can handle what comes	hopeful willing to try	RESILIENCY

Remember: Misbehaviour is a symptom of the child's discouragement about being able to feel the Crucial Cs.
Use encouragement and natural and logical consequences.
Consider and agree on choices together.

A Lew & BL Bettner (1996) A Parents' Guide to Understanding and Motivating Children. Newton Ctr MA: Connexions Press

The major differences between consequences and punishments

	Punishment	Logical Consequences
Teaches	Arbitary power, external control	Cooperation
Adult's emotion is	Anger	Friendly, concerned
Adult's action is	Hurting, arbitary, often impulsive	Seeking agreement, related to behaviour, thoughtful, deliberate.
Adult's focus	On the past (what happened) on what ***can't*** be done	On the future (needs to be done). On what ***can*** be done
Child feels	Belittled, inferior	Capable, respected
Child remembers	Injustice, humiliation	Personal contribution connection between behaviour and results.
Purpose is	Control over others	Self-control

Encouragement	**Evaluative Praise**
an attitude	a verbal reward
task, or situation-centred	person-centred
emphasizes effort and improvement	earned by being superior
may be given during the task	job must be well done and completed
shows acceptance	is judgemental
fosters independance	fosters dependence
emphasizes self-evaluation	emphasizes others' opinions
develops self esteem	develops self consciousness

From: A Lew & BL Bettner (1996) Parents' Guide to Understanding and Motivating Children. Newton Ctr MA: Connexions

Appendix IV

Publications during the enquiry

a. Pound, R. The significance of personal history in the values and agendas of health visitors. *Educational Action Research.* 2000, **8.** 2. 361-376.

b. Pound, R., Dams, M., Gammon, K., Martindale, J., Page, C., Stapleton. J. Practice and Knowledge: An action research approach. Part One. *Community Practitioner.* 2001, **74.** 2. 54-56.

c. Pound, R., Dams, M., Gammon, K., Martindale, J., Page, C., Stapleton. J. Practice and Knowledge: An action research approach. Part Two. *Community Practitioner.* 2001, **74**. 3. 104-106.

Educational Action Research, Volume 8, Number 2, 2000

'Every Time the Phone Rings the Twins Climb on the Table. Help!'
The Significance of Personal History in the Values and Agendas of Health Visitors

ROBYN POUND
Grosvenor Surgery, Bath, United Kingdom

ABSTRACT In one reflective phase of a larger collaborative action research study the author explores the values and personal beliefs that affect her health visiting agenda with families. By examining early recollections from childhood, adult experiences and critical incidents in conjunction with the literature and themes from other phases she begins to build her theory of health visiting, identifying values that appear to be implicit in descriptions of good practice. Reflection on the realisation of these values in her practice forms a trigger for identifying contradictions when values are denied and effectiveness is affected. The question arises, where should control lie in health visiting? The author identifies personal beliefs, which if used in some ways could reduce the effectiveness of her work. To live her motivating values consistently she needs to reconsider the validity of some long-held personal beliefs. She begins to construct a more responsive style of relating 'alongside' families. In this way, they enquire and learn together as she takes account of their individual needs and personal resources. She looks particularly at the usefulness of humour and playfulness.

Introduction

In this article I show why an exploration of my personal and professional development as a practitioner is a valuable phase in my action research approach to the question *how can I understand, improve and explain my health visiting practice supporting family relationships?*

I shall describe one reflective phase that forms part of a research study in which I am creating my own living theory (Whitehead, 1989) of health visiting. I have enquired collaboratively with parents, health visitor colleagues, educational researchers and others. This phase concerns the values and personal beliefs that motivate my approach to working with parents. I have undertaken a quest to become more genuine – authentically

myself – in my relationships and to help distinguish my own agenda from that of parent-clients. To clarify, by values I mean guiding principles I judge to be important for reaching positive states in life, by beliefs I mean firm personal opinions I hold, and agendas appear to arise from preoccupations in personal beliefs and professional remit. This process of reflection helps me come to a fuller understanding of why I behave the way I do when relating with others. I am interested to examine the beliefs I hold and their influence on agendas within my work with families. I will also explore the safety-net factor of values in promoting good practice. Personal beliefs and professional remit held up to the scrutiny of values may bring contradictions into focus. Amongst the values I find are key to effective practice are 'respect', 'autonomy' and 'equality'. I describe the origins of these values for myself and, by clarifying my meanings, I come to understand how I might use them to improve what I am doing.

'Working in partnership' and 'listening to children' are generalised aims described in policies for people working with children and families [Department of Health, 1989; British Association for Community Child Health (BACCH), 1995]. Respect, autonomy and equality are implicit in 'working in partnership' and 'listening to children' as good practice in this article. I set out to show the importance of personal motivating values for practitioners if theories of good practice are to be fully realised in our work. Values such as these are described by other practitioners who have adopted them during their own life journeys (Laidlaw, 1996; Cunningham, 1999). Therefore, the values are likely to be generalisable.

It is by noticing contradictions, when good-intention values do not match reality, that a search for reasons may be fruitful (Whitehead, 1989). It was to look for possible contradictions, as well as curiosity that I also looked at how humour and playfulness influenced my effectiveness. Early childhood recollections, shared reflection of adult experiences and critical incidents within my work are the means I used to arrive at explanations. I draw from several phases of this research towards PhD. To begin I will tell a true story, a critical incident (Benner, 1984) which led me to ask, 'Why did I say that?' The names have been changed.

> *A young woman, Clare, asked for help in coping with her 18-month-old twin sons. Clare resorted to threats and smacks throughout every day with the result that the boys were stonily defiant as they moved from one battle ground to another. Life was a nightmare. Very movingly she said, 'Just half an hour in the morning and half an hour in the afternoon when I enjoy being with them would be wonderful'. She was desperate and in tears. What will it be like when they are older? She had visions of teenagers out of control.*
>
> *At our first meeting I used a process called the 'Crucial Cs' (Lew & Bettner, 1996) that I find useful for helping parents understand*

what is happening and to increase empathy with children. Working through the process together she gradually came to her own conclusion, 'So smacking is really no good, I shouldn't be doing it'. As the visit came to a close we came up with some things she could try instead.

The next week, again she was desperate, 'It was all right after you went, and the next day, but I couldn't keep it up. It all made sense, but I can't be expected not to smack. It's too hard.'

She cried.

'Lets look at it again', I offered.

The most urgent problem was the telephone. When it rang, the boys climbed on the table out of reach looking at her defiantly. Sometimes Sam took a bite out of fruit from the bowl. Clare was frightened they might fall to the hard floor. Worse, the defiance made her furious.

We had been through every suggestion I could come up with. I felt hopeless.

'How much does it matter they get on the table?' I said, 'If it didn't matter they probably wouldn't want to do it. What would the very opposite of what you are doing now, be? You could say, 'Quick kids, phone's ringing, everyone on the table!'' Clare smiled, and then she laughed. Putting her hands to her face, she laughed and laughed, rocking backwards and forwards. I waited. I felt a bit silly; it wasn't that funny. She glanced briefly at me and started laughing again. 'Next you'll have us all *on the table. Wait 'til I tell Alan.'*

It was a stupid suggestion. I knew it. But unwittingly, I had broken the cycle of hopelessness. When she recovered, Clare was able to start looking again at things she could do. In the end her solution was her own, involving some booster seats she had in the attic.

I visited regularly over the next month, just being there and giving her encouragement as she talked through her experiences. Every visit she reminded me of what I had said. I mused on the power of humour. (Archive, 1998)

In my opinion this:

- relieved the tension;
- indulged for a moment in ridiculous fantasy;
- showed she did not need to take the problem at face value;

- showed she could be creative in finding answers for herself;
- gave her more space and freedom to relate to her children;
- showed I didn't have the answers either;
- increased our 'connection';
- made her feel better – she was able to try again.

Being playful is just one feature of the way I work. I realise that how I am with people is as important as the knowledge I use. If my aim is to explore what I am doing and explain it, I need to show something of my personal as well as my professional development. I chose this story to begin to show how I work collaboratively with parents. Together we are making our own enquiries. Clare is seeking better ways to parent while I am thinking 'how can I be more helpful?'. Trying to understand my present practice as a health visitor, I need to understand the fundamental values that motivate me and my style of behaving as I do. Why do I hold some things to be so important? I need to look at where I have come from and understand the past. I can use that understanding to focus on improving my effectiveness in the future. In other words begin to know myself. I can ask, 'Am I always true to my values when I work? Do I do what I think I do, and if not, why not?' By answering these questions I can come to know my own practice as a health visitor in what Winter calls a form of 'improvisatory self realisation'(1998). Furthermore, I can begin to find standards by which my practice may be judged (Whitehead, 1989).

Research in Context

I have described elsewhere my journey of discovery as I decided to work in a more preventive way (Pound, 1992, 1994a, 1998). I believe that, with others, I have been effective in the public health arena, raising awareness about the emotive issues of physical punishments and rights for children. Now, 10 years on, all the major child interest groups support change to protect children (Alliance, 1999). Professional policies and focus of work with families is under scrutiny. It became time for me to draw back from public campaigning and look at my own health visiting practice. I needed to find how to work more effectively with parents and how to support them in being the sort of parents they so often describe wanting to be (Pound, 1994b). My awareness grew that it was not only relationships between parents and children that I needed to consider, but also those between myself and parents. These required the same properties of respect and negotiated partnership if we were to make the best use of our time together. I wrote in my journal:

> *The No Smacking campaign was in effect telling people they were wrong – criticises people – the very same thing that is so damaging to children ... another reason for working in a different way – starting from where people are and helping them to work it out for themselves. (Archive, 10 September 1996)*

Beyond reviewing my relationships with parents, I began to understand the contradictions between public health campaigning in which I used awareness raising and the giving of information to convince, and the self-growth nurturing aims of health promotion.

Amongst the many facets of this research I have asked, 'How do I understand what good relationships consist of? How do I help parents find them?' To this end, I am exploring an Adlerian model of human emotional needs designed by Lew & Bettner (1996). This is the method I was using with Clare in the story. Introducing her to the basic emotional needs of humans to *connect* with others, to feel *capable*, to *count* and to have *courage*, increased her empathy with her children. It gave her fresh vision for finding solutions. The model now equally helps me to understand what is happening in my own relationships with clients, and why I feel and act the way I do.

In another concurrent cycle I ask the question, 'What are the *qualities* involved in effective helping relationships?' By asking parents what they like and don't like about their key relationships I was able to question myself about how *I* am with them. Recently, I sent out a confidential questionnaire asking how they see their relationship with me. To ensure anonymity they were returned to the local Trust Quality Unit. Sixty-two per cent returned. All but one made comments and the Likert scale tick boxes revealed predominantly positive responses to the identified qualities. Clare made herself known. She said, 'I had times when Sam and Harry my twins were at a difficult age. She came and saw me. I was in tears it was so bad. Together we got around the problems' (Q53). The qualities and process she appreciated, made evident in the boxes she ticked, will be briefly introduced later.

In a third research cycle, also running concurrently, I convened a Health Visitor Research Group to discuss matters of concern to us in our practice. We talked about the multiple facets of knowledge we bring into our 'art' as we relate to clients. Two articles have been accepted for publication (Pound et al, in press). Presentation of ourselves as value-laden human beings is central to our articles. Some of the qualities explored in my questionnaire were identified in this group. We examined the conflicting approaches to health visiting which arise as dilemmas for me in different forms throughout this article. Where does control lie? Are we nurturers or professional knowers?

I am grateful for the on-going source of debate about philosophical and methodological issues at a weekly Educational Action Research Group. Here, I receive support to be creative and use my own voice.

This present cycle is about examining the sources of my *beliefs and values*. I wanted to identify them, understand more fully what they mean to me and how my work is affected. Through reflection on the past, my intention is to understand the origins of my beliefs. Why do I hold some with such passion? Why do I behave the way I do? Following these beliefs

through time I both grasp a fuller meaning and understand how they meld into motivating values. Starting with early childhood recollections, using a process described by Powers & Griffith (1987, p. 185), I explore the roots to my attitudes as they formed in my childish subconscious. Reflecting on adult experiences and critical incidents from my work (Benner, 1984, p. 36) I track values emerging into my reflective consciousness.

Contradictions: the building and challenging of my values

The values I speak of here are my commitment to 'respect' for people, personal 'autonomy' and 'equality'. By equality, I refer to my belief that children are equally valid human beings worthy of the same respect and consideration as their parents. Now, to explain the development of these values for me, I hope to show the multi-layered and sometimes competing themes, which together make up myself and the way I see the world.

I shared my early recollections with a critical friend who was undertaking Adlerian psychotherapy training (Archive, 1998). Together we analysed my stories to identify my own personally created 'style of life' (Powers & Griffith, 1987, p. 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 the 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, p. 187)*

Beyond infancy evolving explanations are tested by experiences that serve to confirm or disconfirm these prototype beliefs. The memories that came to the foreground for me held subconscious significance. I checked them with my family, but interpretations I made with my critical friend were my own. Later, by identifying contradictions within my experiences I was able to make fuller sense of my personally created 'style of life'. My family, critical friends, clients, colleagues and educational researchers, in dialogue, have all helped by challenging and deepening my understanding of how this influences my relationships and my work.

Warmth and the Roots to 'Respect' as a Value

I will start by telling you about my family. I grew up in 1950s rural New Zealand. My mother was a nurse who, because of the remoteness of where we lived, became a teacher in my father's school. This was a new farming district that was being opened up by returned servicemen. There was no

electricity or any services. The nearest town was a dusty 70 miles away. My mother needed to be organised and in control to get by, running a household and full time job in such primitive conditions. Organisation and control extended to her management of us. When I asked how she achieved such control over us, because it wasn't obvious to me, she said, 'I used my personality'. I recognise this way of being now in myself as a mother. She had a large warm bosom, like a cushion you could lay your head on and she shared it readily with us. Cuddles remain a feature of how we communicate. Alongside the warmth and security I also recognise the dull voiceless conformity of a 'good girl'.

It is not so easy to isolate incidents that indicate the growth of this aspect of myself. However, it appears to be a common reality for women. Like students in the Belenky et al study (1986, p. 196), I recall times when acknowledgement that I was someone who 'knew' something took me by real surprise. I was 40 before it dawned that I might have some important things to say.

Back to my family. My father was thin, emotionally less available, but sported a wicked sense of humour. He could make a joke out of a disaster. I have absorbed his sense of the bizarre and also his use of humour as a way of coping with difficult situations. I see him as influential in my development of playfulness and naughtiness (Griffiths, 1999). Although I do not remember the incident, I am told that early in his career he ceremonially cut up his government issue leather punishment 'strap' in front of the school. According to my mother, 'He told the children and teachers there were better ways'. This indicates a commitment, I believe, to respecting children. The difficulty I have trying to remember punishments leads me to conclude that they were not a major feature of my childhood. A contradiction exists here in that I do remember two occasions when I was smacked. I remember these as unfair and confusing, made more shocking by their rarity. My claim remains that predominantly warm, safe relationships, relatively low in criticism have given me an optimistic grounding. Here, positive and negative experiences form part of how I see myself and other people. I approached parenthood with no strong commitment to use punitive methods to control my children. However, inexcusably, I too lashed out in frustration on occasions when my need to feel in control was thwarted and 'using my personality' did not work. Here, again, lies the dilemma. How much am I able to cede control to others, in this case, children?

Developing Personal Autonomy and a Sense of Equality

Having control over some aspects of my life is important to me. I recognise increased energy, creativity and committed action when I have it. Back to early memories. My parents were too busy either working or providing to interfere much with us. For me and my older brother, freedom to roam and 'do' spawned independence, and an embryonic feeling for autonomy. I have several memories to remind me how it grew. Here is one:

My mother felt that encouraging me to knit a singlet for the baby she was expecting would increase my involvement in the new event. I was nine. Progress with 2 ply wool and fine needles was slow and I lost enthusiasm.

'Can't I make something else?'

'Finish this first and then *you can make something else'*

Coming home at lunchtime to find a mess of wool and dropped stitches, because the cat had been playing with it, was the last straw. Even my mother knitting some rows to get me going did not help. My interest in struggling with this project was nil. Not being able to find other fine knitting needles, I secretly made some by scraping matches until they were rounded. I then cast on and knitted a tiny singlet for a tiny doll. The astonished admiration of my parents added to my sense of achievement. I went on to try my hand at a tiny fair-isle jumper and then a whole wardrobe for the doll and her husband.

I did not mind the reputation of being stubborn or head strong. My parents' forbearance never made me feel it was a terrible thing to be – just bloody challenging!

I believe this story says something about my developing sense of independence and determination. A catalogue of stories like this point to the value I now place on my own autonomy within my work. Recognising I work well when I am self-directed and can see good sense in what I am doing, has helped me clarify the importance of fostering self-reliance and being in control for others. I see the value of encouraging parents to take responsibility for their decision making and fostering the same for their children. Encouraging parents in their personal enquiries requires me to work in a partnership that encompasses amongst others, the values of respect, autonomy and equality. The very fact that I am a health visitor assuming special knowledge could be inherently disempowering. Giving over control and decision-making means consciously relinquishing it myself. From Lew & Bettner (1996) I recognise that having a good deal of autonomy in certain areas of my life makes it possible for me to still feel competent when giving the lead over to others.

In a fifth (16) of the questionnaires, parents wrote about the contradictions between giving advice and supporting parents' own decision making. Nine similar comments can be represented by this, 'She listens and empowers instead of just giving answers out of a book. She respects the approach I have to child care and gives suggestions in line with that approach. She has even been supportive about decisions which are contrary to her personal feelings ... I respect that' (Q49). I believe the qualities indicated here are part of the climate Clare was describing. On the other hand seven said things like, 'Occasionally, our health visitor has been too

keen to try and get us to the point of finding a solution when we really wanted to be just told what to do' (Q32). Some people obviously found my style frustrating. Have I been too keen to *not* be in control and to encourage people to make decisions when they are not in a position to? I need to work on being more sensitive to which approach is appropriate and find a balance between giving advice and fostering client's own decision-making.

I am clearer now that my late development of a confident voice is in contrast with an earlier confidence in my creative ability. Belenky et al (1986) in their study of *Women's Ways of Knowing* concentrate on women's development of a sense of mind, self and voice. I recognise the developmental stage of believing in the knowledge of authority figures (1986, p. 35). I relate, too, to a later intuitive stage of subjectively 'just knowing' (1986, p. 52). Now I believe that I am beginning to construct my own knowledge by integrating several patterns of knowing (Belenky et al, 1986, p. 131; Pound et al, in press). Belenky's study is about mind-work and sense of self. It gives little consideration to women's knowledge of what they can 'do' which may be belied by a voice which struggles to be heard. I think of Sarah, now a parent, who from the age of six came home from school to get supper for her siblings because her mother was drunk. This young women has no doubts about her knowledge of physically looking after others. She struggles to maintain relationships (Archive – taped interview, 1996). Belenky's patterns of knowing are useful for health visiting because they indicate the different stages in 'developing the power of our minds' we may have reached. This may offer insights into why some parents want more instruction than others. Starting by building confidence in the knowledge of 'doing' feels important in working with parents.

Loneliness as a Root for Empathy

As children we spent a lot of time alone. In my last years of primary school I could not find friendship amongst the small number of peers in the next tiny school we moved on to. My brother asked me recently, 'Where were you during those years? I can hardly remember you.' Thinking back to desolate periods when I was short of good friends made me aware of how it feels to be isolated. Like litmus paper now, I recognise loneliness in people. My empathy has roots here. Over recent years, times of worry in my family caused me to reflect on the qualities involved in supportive relationships. For me, friends helped by taking my distress seriously, by listening carefully, but without telling me what to do. Special friends make me feel better but don't interfere. It feels normal now, to try and be warm, open and friendly to my clients, even those who I do not instinctively like. I work with them because it is my job. I find I usually grow to like them more as I come to understand them better and I receive as much from these relationships as I give.

Several parents spoke in their questionnaires about friendship and a couple of motherliness. Friendship and motherliness are different

relationships. Here is the same dilemma about the degree of control I should assume. I wonder if, as Belenky implies (1986, p. 35), it says something about parent's readiness to make their own decisions? In the Health Visitor Research Group we identified a contradiction here between our intention to support parents in making their own decisions and our giving advice as professional knowers. In Paper II (Pound et al, in press) we explain that taking more lead by giving advice can be a stage in the process of empowering parent's self-reliance. Our aim is to start where our clients are able to operate, if that means a 'holding' or an advice giving role, with the intention of shifting our relationship to a more equal one where the parent takes greater part in decision making. I am now coming to call this complex process of responsive relating – 'alongsideness'. It is as if I am standing alongside parents encouraging them to find answers to their own questions, rather than as an instructor who knows both the questions and the answers. In this way, I can be sensitive to parent's current personal resources and 'hold', help, provide information or just 'be there', while they work it out, as seems appropriate. In this way, we are learning together.

In the questionnaires most made statements such as, a kind warm person and easy to talk to ... (Q64). A client with multiple problems, including literacy wrote, 'very is to talk to about any problums conering me or my child'. A common theme was '... there when I need her' Q65). Several mentioned my sense of humour. I have had a problem collecting negative data from clients. When I asked, the doctor I work with thoughtfully shook his head and said, 'no, usually positive'. I feel that I can rely on both the teachers and the health visitors to speak up if they disagree with me. I feel that by asking myself 'am I living my values here?' I have been able to notice times when I felt uncomfortable with clients and have got it wrong. In a future phase, I will need to think more about how to encourage clients to express their negative feelings about my work. When I ask them about features which don't work, I am more likely to hear about other unnamed health visitors or hypothetical stories. I can ask myself if I do these things too.

Let me offer an example. A mother's letter sent from another area speaks about her daughter's 8-month development check:

> *Child experts are forever quoting 'praise good behaviour' and ignore bad. Perhaps they should apply it to their parents as well. There was no 'well done' for the fact that apart from the occasional jar of fruit, I cook all of her food with fresh wholesome ingredients, only criticism that it didn't have any lumps in it! Nor praise for the fact that she is sitting up and supporting herself beautifully, only criticism that she wasn't crawling or rolling. If health visitors don't want to have a reputation as interfering old busy-bodies they should show an interest in the parents as well as the kids. (Archive – letter 4 July 1997)*

I recognise how easy it is on a busy day to concentrate on achieving ticked boxes in the child development book, and not to respect the knowledge and autonomy of the parent.

Hierarchy as a Contradiction to the Levelling Society

I turn now to look at where the strong views I hold about social inequalities come from.

The practical difficulties of pioneering in, 1950s rural New Zealand may have been as much of a leveller as commitment to any particular philosophy. However, the politics of New Zealand of the time espoused the ethos of open opportunity for all (Graham, 1981). Attempts here at cultural uniformity, social integration, and above all equality were formalised in law by early comprehensive welfare and education systems.

Of course, it is true that New Zealand did not achieve the egalitarian 'a fair go for all' aspired to by many. The demands of rapid enculturalisation made it hard for Maori to succeed in a 'pakeha' world. Maori priorities were different, but their resistance to 'peaceful co-existence' and 'the humanitarian goal of amalgamation' (Sinclair, 1980, p. 87) were not to become obvious to me for another two decades. So my rosy picture here of liberal humanitarian ideals firmly rooted in a national ideology are not the whole story. Our family had advantages of status and a salary that became the obvious symbols of social stratification for New Zealand. However, I still believe that the nuances of a national psyche in some way suffuses the souls of its initiates. I reaped advantages from growing up in the particular levelling circumstances of the time. Looking back, I identified a contradiction, which complicated my view of people. My parents' passion for creating educational opportunities for all children was confused by another message that we were in some ways different from some other people. Awareness dawned when I found myself considering warning my own young children from some associations. I couldn't find the words to say why! It triggered my thinking. I can say that the 'value of people' has been developmental for me over the years and is now central to my creation of 'alongside' relationships.

Arriving in Britain as a nurse in, 1968 it seemed to me that everyone wore some kind of uniform, which stated who they were, what they did and their status. People seemed to know their place and be comfortable with it. Accents, clothes and ways of being were badges of rank so that other people would know who you were and how to relate to you. I was bemused and tried to capture some of the accents and find ways of explaining this curious class system in my letters home.

But who was I? Where did I fit in? New Zealand friends suggested we had an advantage being unplaceable in the British social hierarchy. It meant we could just be our own friendly selves anywhere and people would make allowances and just accept us as good, keen, honest, slightly naive

colonials. The delicious irreverence I soaked up from my father led me to find the whole thing rather funny. At times I enjoyed the challenge of insisting on being myself. I seemed to be excused my ignorance, called 'refreshing', but also I recall a vague determination at times not to succumb to accepting confinement within the hierarchy.

It was about 20 years working as a health visitor and being a mother before I began to feel properly angry about hierarchy in all its forms. I had noticed the effects on women and joined the feminist movement in a grumbly sort of way, but it seemed to me no one was speaking up for children. Children appeared at the bottom of the pile and received the full force of adult frustrations, as legitimate targets. It was the hitting I noticed at first (Pound, 1992). Pre-1990 parents seemed unquestioning that it was the right and expected thing to do. Physical force and threats appeared to take precedence over verbal communication as the method of control. More than that, it seemed that this process of clarifying for children their place in the world endured across generations. I had no reason to doubt that most parents loved their children and wanted the best for them, but daily, I saw what control by force did to family relationships (Pound, 1994b). I began to think about the implications of hierarchy for me and what I believed in.

I now appreciate the significance of the comparative lack of religious instruction in my early years. My sole reason for telling you this is to show what appears to be a fairly influential piece of my personal creation of my 'self'. The effects of some beliefs on family relationships began to dawn on me. A particularly poignant introduction to the bewildering world of other people's beliefs came in, 1991 when I attended a lecture about parenting in a city church (Archive – field notes, 1991). I heard things which did not fit my view of people in the world. A lay preacher told us of the authority of God. God, he said, delegates his authority to man as head of the household. It is man's duty to train his children to honour God's authority because, 'children are born selfish with sin'. My optimistic view that people have a tendency towards the positive did not square with this.

He went on to say that man may share his duty by delegating it to his wife. Children must learn to respect authority, obey and be repentant. Physical and emotional coercion remain methods for assuring that they do. 'Pain is a deterrent when reasoning is impossible' he said. The hierarchy and good order is thus maintained. From this lecture I flashed up a mental image of a hierarchy.

God
delegates his authority to
Man
who may share it with
Women
to maintain the hierarchy.
Children
must respect, obey and repent.

From this now extreme, but at one time widely held view, I came to recognise the degree to which such beliefs have pervaded the knowing of our societies. Similar views and diluted variations came at me from all directions, including from professional colleagues. Nearly every one said, 'what's wrong with smacking?' when I first raised it. Experiences through this time were foundational for my understanding the significance of personal history in informing the values and agendas of practitioners. At times, I felt very alone and deviant when talking with people, and I needed all my determination and resilience to retain my confidence. Some negative beliefs I met also felt uncomfortably close to some of my own, but did not fit with my emerging ideas about how it should be for children. Here, is an aspect of the same dilemma about degrees of parental control, while allowing children greater self-determination.

Later, a research associate questioned assumptions I made about a parent and the work I considered doing because of her religious beliefs and how they may be interpreted in her actions with her child. I am beginning to find new understandings as I ask myself, 'how can I maintain genuinely respectful relationships if acceptance is an issue for me?'

Hierarchy and Playfulness

I return now to look at humour as one method of living my values. Continuing to use past experiences and recent critical incidents in my work I began to think about the part humour plays for me now. Griffiths extended my understanding by introducing the idea of playfulness and naughtiness as 'a survival technique for not succumbing to social injustice' (Griffiths, 1999, p. 8). I strongly recognise her explanation that it may be 'a delight in being bad, testing boundaries and flouting expectations ... pushing out the boundaries and claiming the space'. In some instances where I recognise this happening, the words 'naughtiness' or 'playfulness' are helpful. I am so grateful to Griffiths for helping me to understand this side of myself, which in the past has left me ponderous in reflective embarrassment. The weirdness fades revealing a more confident me.

I experience no devious or malicious feelings, but an almost subconscious playful desire to challenge a system, which requires me not to be true to myself. One example puzzled me at first. I am grateful now to have its subconscious purpose clarified in my mind. Talking with clients, I found myself sometimes referring to the GP I work with by his first name, when he is usually called 'Doctor'. Sometimes the client looked blank and I needed to add, 'you know, Doctor Gibbs'. On a few occasions I did it in front of him without any sign that he minded. Now I realise it was a playful liberty with the underlying intent of inviting clients into a partnership with us as more equal participants in deciding their care. After all, everyone calls me 'Robyn'. I recognise relationships with GPs are, from necessity, different.

This brings me to another use I make of humour. Quite consciously now, I act to reduce my own powerful position as a health visitor when

talking with clients. I realise new clients may be wary of me and not know what to expect or how to behave. Beyond introducing myself as Robyn, I attempt to put people at ease with friendliness and sometimes jokes about myself. I want to offer a relationship where my professional status does not disempower my clients, but encourages a climate of partnership in which we both learn as we work it out together. Humour and playfulness are methods of connecting. Clare's reminders of my nonsense are testament to this. By smiling and laughing together over mutually understood silliness our relationship has grown.

So What Does All This Mean?

Parents, my family, critical friends, health visitor colleagues and educational researchers shared in and questioned my reflections as I asked how my personal beliefs and values affect my practice. I used early childhood recollections, adult experiences and critical incidents in conjunction with theories emerging from other concurrent phases of my research to help identify the beliefs and values in my health visiting agenda. Understanding my subconscious intentions means I can be aware of preoccupations that may intrude in my relationships with others. Enhanced insights help me attempt to be more genuine in relationships and make the values I identified possible markers by which my practice may be judged. I claim to have shown evidence that I attempt to live them in my work. Searching for contradictions, incidents when I do not live my values, creates incentive for improvement by helping clarify causes.

Emerging with greater clarity from this phase, is the dilemma of where control should lie in all the different circumstances of health visiting, parenting and researching relationships. Grasping fuller personal meaning enables me to begin to construct 'alongside' relationships that are responsive to the complexities of individual need. Playfulness and naughtiness are one practical key to our connection. In these relationships, the endeavour is to enquire and learn together as we work it out, my clients and me. In this way, I am creating for myself my own living theory (Whitehead, 1989) of health visiting, within the health promoting remit of my employers.

Good practice in health visiting, named 'partnership' and 'listening to children', incorporates the values respect, autonomy and equality, which I identified. Many who shared my reflections describe similar values, which inform their work practices, having arrived at them via their own life journeys (Archives, 1996–2000). Winter offers:

> *The processes of action research provide a strategy for embodying autonomy and responsibility in professional work ... action research generates its own form of theory. This is a form which is integrative, critical and political: it is both personal and collective, a synthesis of values and understandings, and a response to the*

> *many methodological dimensions of practical action in complex organisations profoundly influenced by external political forces. (Winter, 1998, pp. 374–375)*

I expect the people most likely to relate to the practical aspects of this 'study of singularity' to be other practitioners (Bassey, 1995). Earlier drafts attracted recognition from readers who appeared to be moved by different themes within it, 'It made me laugh', 'It made me cry', 'Making jokes about yourself to put people at ease, I do that, I hadn't really thought about it before', 'Reducing power in your relationships. I think that's important' (Archives, 1999–2000). Bassey suggests:

> *The point about relatability of findings from one situation to another is that there is no guarantee that they can be applied, but the merit of the comparison is that it may stimulate worthwhile thinking. (Bassey, 1995, p. 11)*

I believe this article offers the chance to open discussions about the space between good intentions and realities for practitioners. Responses challenge, confirm and bring new avenues for exploration. In this way, I hope it is educational for others in the way I have found the process of writing this article is continuing to be for me. The values appear to be developmental in that coming to deeper understanding about what they mean, leads to areas of my life beyond my practice. A sort of living theory of life.

I offer it here to invite comments about its relevance for you.

Acknowledgements

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Practice and knowledge: an approach to action research

How can health visitors begin to understand and explain their knowledge and skills to inform improvements in practice? In the first of two papers, the authors explain how action research and a very personal approach allowed them to try to develop a model for understanding

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Action research is a method of developing critically reflexive practice in which theories are integrated and new theories of practice emerge.[1] McNiff *et al* [2] suggest that action research can lead to:

- practitioners' own personal development
- improved professional practice
- improvements in the organisation
- a contribution to the good order of society.

Collaborative action research also provides a forum for exploring ideas.

One of us, Robyn, was looking for a forum for exploring ideas coming from her own research about putting new parenting theories into practice in health visiting. Realising there were many concerns about health visiting beyond her own, she suggested using collaborative action research to investigate areas of common interest to herself and her colleagues.[1,3] Six colleagues expressed interest in forming a group to explore current topics of debate in health visiting.

At that time – 1997 – some of our concerns centred on the threat GP fundholding held for health visiting. We were aware of a general unhappiness about threats to good practice arising in part because we could not explain to policy makers what we were doing.

In the group our intention was to be as democratic as possible, so everyone would have equal voice and gain from the experience. Glennie and Cosier[4] suggest that such groups succeed initially if they have someone to suggest a subject area and a process. Ownership of the content and the process is then transferred to the group as soon as possible.

A structure for the group and ground rules emerged in the early meetings. In summary, these were:

- a closed group initially, to enable progress
- monthly meetings for two hours at lunch time
- meetings tape-recorded to capture moments of insight
- personal comments to remain anonymous in meeting notes
- work towards having something useful to say within 18 months
- commitment towards respecting each others' opinions.

Hunches and a 'sixth sense' about our work can mean we get to the point quickly and act effectively, but how can we explain this?

Using McNiff *et al* suggestions[2] for planning research we decided to:

- identify a concern
- imagine possible solutions
- implement solutions
- gather evidence
- evaluate evidence
- write a report.

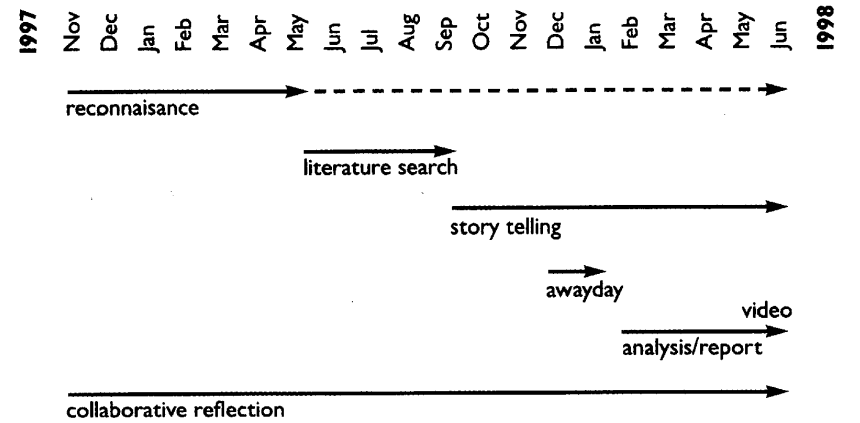
McNiff and others [1,2,5] suggest that when the concern is a practical one, several cycles of implementation and evaluation may be needed. In our case the process of seeking to understand remained largely within the group and felt more linear. Using the headings listed above, we now describe the reflective phases we identify as reconnaissance, literature review, story telling and analysis for report writing.

Identifying concern

The first reflective phase took five months as we clarified our purpose. We called this a reconnaissance phase, although reconnaissance continued to some degree throughout as we remained open to new themes and influences on our understanding.

We began talking about our current concerns for health visiting. Some of us felt that

Figure 1: Action - reflection phases



Robyn Pound
Mandy Dams
Kate Gammon
Jennie Martindale
Caroline Page
Jan Stapleton
health visitors
Bath and West Community NHS Trust

although we know we are helping our clients, and our clients appear appreciative of their contact with us, we find it hard to explain what we are doing, how we do it and what difference it makes. It was as if we knew a little about lots of things but were not recognised as experts in any one.

For example, when preparing evidence for court, Mandy was told: 'You can't say there is an emotional bond between that mother and that child, you haven't got a psychology degree. Your professional background will be questioned.'

There was also a feeling of insecurity because of the threat to health visiting from the pressure to balance resources. We are expected to show outcomes from our work and felt a need to demonstrate that we are, to some extent, research-based.

Kate expresssed her dissatifisfaction with the ways that the role of health visitors are described; 'just listing the tasks we carry out does not adequately explain how we do the job and why the process is so important for clients.'

Health visiting is difficult to research using traditional methods, so we wanted to find a way to show how we work and explore the ways in which our practice can be effective.

As Mandy said: 'I want to be able to describe what goes on while I am doing it and how important that is in terms of supporting people. I want to know how you can evaluate it and prove that it is good.'

Similarly, hunches and a 'sixth sense' about our work can mean we get to the point quickly and act effectively in helping people, but how can we explain this? We recognised that much of our professional knowledge belongs to each of us individually and privately. It appears that experiences on the job are internalised as intuition.

Robyn believes that her knowledge came from years of on-the-job experience, discussion and reading around the subject; in other words, her best knowledge to date.[6] She needed to ask herself whether her intentions were founded on a desire to do her best for her client or assumption based on prejudice. How much does being a product of society influence our attitudes?[7] We felt we drew constantly on different types of knowledge and wanted to understand more thoroughly how we acquired and used this.

We began to formulate sub-questions:

- what are the skills and knowledge we employ as health visitors?
- which qualities in our relationships with our clients make our work effective?
- how can we evaluate, improve and explain what we are doing?

Imagining a possible solution

Phase two consisted of three areas of activity: on-going discussions, best described as collaborative reflection; a literature search and story telling as we worked towards our aim of creating an explanation of how we 'know' and 'do' as health visitors.

From a literature review of the thoughts of others, a tentative model was produced for describing the different ways of knowing health visitors might use.

This model (which will be described in our second paper) formed the basis for the next phase of our reflections. We decided to focus on telling stories of incidents in our practice to try to make sense of, and find evidence for, the types of knowledge we were using.

Benner[8] defines an incident as 'critical' if it made a difference to a patient outcome, or if it went unusually well or did not go well. Experiences that we notice, especially those that were particularly demanding or ordinary and typical, can help nurses reflect on their actions.

We wanted to try and capture some of the quintessence of health visiting in our stories. Johns' work[9] encouraged us to think about the importance of our own and our clients' feelings about the work. He offers questions to ask of stories to help explore their significance.

We felt able to present our emerging ideas to colleagues at an awayday. This made us think about the changing dynamics within our group. We videotaped a meeting during the writing up phase so that we could see ourselves in action.

Implementing solutions

In the first two phases we thought about our skills and the types of knowledge we draw from, which we felt were particular to health visiting. As we shared ideas, the strength of our commitment to what we do shone out. Some of us recognised, and were shy about, our passion for the work because to others it might appear irrational, emotional and unscientific.

We asked how could we understand the specific knowledge we have acquired through doing the job? How can we claim that it is valid? Talking about experiences which stand out as important proved a useful wayof capturing significant elements in the work.

Each story acted as a trigger for other stories. Box 1 contains an edited example of one of our conversations, providing some indication of the living, evolving nature of our professional knowledge and the value of shared reflection.[10]

We tried to notice how we have come to know new things and to enhance what we know in the light of new experiences. Together, through critical collaborative reflection, we began to identify and confront contradictions between our intentions for desirable practice and what we were actually doing.

Effective practice appeared to demand certain qualities from the health visitors' style, but the problem of how to understand and explain how we knew how to work still hung over us. Where does our knowledge come from?

The literature review helped us clarify what has already been written on the subject of nurses' knowledge and developing expertise, notably Fox,[12] Carper,[11] Benner,[8] Johns,[13] Watson[14] and White.[15] It seems that professional knowledge evolves for each practitioner through an integration of personal characteristics, experiences and information to form attitudes and perceptions which affect how future experiences are understood.

Personal professional knowledge described in this way implies a 'total' available knowledge which includes aesthetic, empirical, ethical and spiritual patterns of knowing, as well the unique influence of the personal self, on how to do things and what is known.[11,13,14] The socio-political context provides the setting for what we know.[15] All knowledge, it appears, is subject to revision and change over time, and is thus 'living' knowledge.[10] The nature of this knowledge will be discussed in greater depth in the second paper.

We began by telling each other more detailed stories about our work. By asking questions about the stories and what made them critical we tried to identify the meld of knowledge and skills we were using. Each of us called on our own experiences to probe ▶

Box 1: An edited example from a conversation

C: 'Someone said the other day: "Oh, I don't like health visitors, they're so nosy." I went away and reflected quite a bit and now I think when I'm going into a house: "Do I need to know this?"'

M: 'That's why I have problems with the models some areas use. One I saw is a 10-page assessment and they ask specific questions about every single aspect of the family's funtioning and I think: "Do I need to know this?" Some people say: "Well, I would never have said anything if you hadn't asked me" and other times you get the complete opposite.'

R: 'Also, it doesn't give any credit to your professional skill in being able to allow the conversation to flow on to what is really important for the client at that time.'

J: 'Someone once said to me: "Because you asked questions, I feel I have to think of something." I was quite shocked by that.'

K: 'You might get it wrong because it's your agenda.'

C: 'The skill is knowing when to ask questions and when to listen.'

R: 'We are talking about an "art of health visiting".'

K: 'You can't get it right every time. Picasso didn't do a fantastic picture every time.'

◀ for meaning in what we were doing. We asked the questions 'why' and 'how' to fill in details. In turn we generated new understandings from the themes which emerged. Meanings were enriched by similar stories and counter-stories as we found similarities and contrasts in our purposes and styles. Some stories raised questions about the degree of emotional involvement we create with people and their problems.[11]

Box 2: A health visitor's story

'I visited to do an 18-month check. I thought: "This will be quick, straightforward, I'll be in and out in 40 minutes." This is a very attractive family, the husband is very supportive and helps. She is always smiling and telling amusing stories about what the children have been doing. This day she was preoccupied. I knew her fairly well and it helped me gauge her behaviour and mood. She's not someone who frequently asks for help. She might come to the clinic to ask but that's the most she'll do. This day she was quieter, less chatty, no laughter. She had nothing much to tell me about the children and there were only odd comments when I asked about how they were.

Her partner went out to get the older children from school and when I'd finished the check I turned my attention to her. On reflection I think it was probably a combination of those circumstances that made her chat: he'd gone, I was about to go but hadn't put on my coat. I said something like: "What about you?" She began telling me she had been suffering from aching joints and couldn't sleep. She had been to the doctor who said, "it's stress".

I asked if she felt stressed. Her eyes filled with tears. "I'm missing my mum. She died last year." She talked about the unexpected death, her sadness and how she had no-one to talk to. "He thinks it's time I got over it. He doesn't want to know. He can't cope with me like this." I recalled one of his comments when I arrived. He had been unusually insensitive. I sat there, a couple of questions, then I just let her talk. Something said to me: "Don't keep asking questions, let it come out." And that's the way it happened. It just got deeper and deeper into her relationship with her mother and her regrets. It wouldn't have taken much for me to cry with her. We just seemed to understand each other in a sort of wordless way. I felt very close to her.

Before her partner came back I asked how I could help. She said: "Can you help me explain to him how I am feeling?" It was amazing how sympathetic he was once she got talking about how she felt. The children bounced in and she lost her flow, so I left with an appointment to go again.

When I thought about it, her story had brought back feelings about my own mother. I felt drained.'

At this stage, as a group, we facilitated an awayday with colleagues in the city. Our aim was to boost morale by encouraging colleagues to celebrate health visiting through focusing on what we do well. We asked them to talk about their positive attributes. No one found it easy.

Here, too, storytelling in small groups helped make more obvious a unity of purpose. We offered our model of health visitors' knowledge for discussion and asked colleagues to consider contradictions arising from it (this will be discussed in paper two).

Gathering evidence

Our meetings were tape-recorded and summary notes made and circulated each time so that recurring themes and moments of insight could be retrieved. From this record, which includes transcriptions of some of our stories and conversations, the development of our understanding can be tracked.

Some clients were asked for their perceptions of some events we talked about. A videotape made of the group while we constructed this report reflects the respect we show for the contributions each of us makes.

Evaluating evidence

Our findings are evaluated through continued debate as we 'hold up' stories against our model of health visiting knowledge. Constantly sharing ideas led to a broadening and deepening of our perceptions of the complexity of health visiting. Ideas were either questioned or met with approval. Together we drew a picture of what we have learnt, referring back to meeting notes for stories and insights.

The importance of our intuitive knowledge learned through experience, and qualities such as empathy, authentic personal involvement and certain communication skills were found in so many of our stories. By being open to challenge from each other, a wider audience, such as colleagues at the awayday and you in this journal, we are finding a way of validating our ideas. We welcome your comments.

We constantly shared and learned from each other. We created a safe place for discussion and argument where personal opinions could be aired safely. A supportive bond developed between us which was evident in the degree of camaraderie and excitement heard on tape-recordings and seen on videotape.

We recognised that respect for each other, and value accorded to each point of view, supported personal and professional growth for each of us. No one has left the group. The result has been thoughtfulness in our practice. Jan's words spoke for us all, 'I've become much more aware of what I'm doing, how I'm doing it, and how the other person is reacting to me.' Within the city other peer supervision groups blossomed.

Report writing

Our stories were varied covering a huge variety of experiences. Some sounded too ordinary, a few too unbelievable to tell. Kate's stories stimulated discussion about the degree of engagement and commitment we were willing to make with our clients.

No one story explained the range of skills, personal attributes and knowledge which we felt fully described the 'what' and 'how' of our work. For this, and for reasons of client confidentiality, our story is a composite one to include common themes occurring in many of our stories. We wanted to show that only some professional knowledge will be research based. We believe our personal and professional knowledge is presented with a style and pace which experience has modified to be appropriate to the circumstances.

Like Cowley,[16] we were struck by the number of ordinary routine visits, such as those for developmental checks, which led to unexpectedly valuable work. Themes from several accounts have been combined to demonstrate some of the skills we identified, Box 2.

'A health visitor's story' shows how the skilled health visitor is able to shift gear from the policy defined developmental examination of a child, and negotiated problem solving, to an accepting, listening ear which allows the parent to voice anxieties safely, make sense of them and begin to plan her own solutions. The context of the family and the health visitor's previous knowledge are important in her understanding of the whole picture.

Here the health visitor moves beyond her research-based knowledge of child development to use personal attributes of empathy, experience-tuned intuition, communication skills and caring. Jennie showed her intuition: 'Something said to me, don't keep asking questions, let it come out.' An environment is created in which the woman can begin to understand her situation by voicing it, state her needs and recover.

Conclusion

Action research offers a method for practitioners to identify concerns, find possible solutions and evaluate and improve practice. Collaborative reflection describes a process in which all research members have as equal a stake as possible in the safe exploration of ideas.

Implicit in this is an atmosphere of respect and regard for each other. Sharing stories of our health visiting experiences offered a forum for exploring what we do. Each story invited similar stories to be told while our ideas gained credibility in the group. Looking for common threads, the purpose and style of how each of us works, began to be

Practice and knowledge: an action research approach

How can health visitors begin to understand and explain their knowledge and skills to inform improvements in practice? In the second of two papers, the authors explain how they developed a model to explore the knowledge and skills they use in practice and some contradictions built in

Community practitioner 2001; 74, 3: 104-106

A group of six health visitors used an action research approach to explore the question: 'How can we understand, evaluate and explain our health visiting skills and knowledge in the endeavour of improving our practice?' The process is described in the first paper in February's *Community Practitioner*.[1]

A literature review[2] helped clarify what is already written on the subject of nurses' knowledge and developing expertise.[3-7]

It seems professional knowledge evolves for each practitioner through an integration of personal characteristics, experiences and information to form attitudes and perceptions which colour how future experiences are understood.

Professional knowledge described in this way implies 'total' available knowledge, which includes aesthetic, empirical, ethical and spiritual patterns of knowing, as well as the unique influence of the 'self' on how to do things and what is known.[3,5-7]

The socio-political context provides the setting for what we know.[7] All knowledge, it appears, is subject to revision and change over time, and is thus 'living' knowledge.[3,8]

Professional knowledge and attitudes are, therefore, made unique for each nurse by personal influences. Figure 1 shows an adaptation of patterns of nurses' knowledge.[3,5-7] We used this framework as the basis for our discussions and developed it through story telling about health visiting.

Aesthetics

Aesthetics describes an 'art of health visiting', a creative, expressive style visible in the way our actions are experienced by others. It is professional knowledge presented with timing, pace and form and 'tuned' by experience to suit the circumstances of the moment.[3]

Our 'art' involves putting multiple theories and ways of knowing into practice, creating new theories about our world and how to act in it

At its best, it is an effective and satisfying experience which makes a difference for our clients. Our 'art' involves putting multiple theories and ways of knowing into practice and by doing so, creating new theories about our world and how to act in it.

Reflection on past experiences internalises our knowledge providing a complex body of clues to be used when approaching future circumstances. It is the wider perception skilled health visitors have, beyond the mere recognition and classification of clues, which gives our actions or conversations an aesthetic quality.[3,9]

As Benner[4] describes it: 'Often the perceptual grasp of a situation is context dependent; that is the subtle changes take on significance only in the light of a patient's past history and current situation.'

Skilled health visiting involves an appreciation and creation of singular, particular and subjective expressions of imagined possibilities.[3] Each expression is transformed into a health visiting action with a purpose in mind. In other words, each health visiting action arises from our individual perceptions of unique situations with responsive solutions.

Benner[4] describes how skills and knowledge progress from that of a novice, who utilises specific techniques in order to know how to do things, through various stages of skill acquisition, to the knowledge of an 'expert' who 'just knows' intuitively. In the group we recognise this 'sixth sense' when we cannot fully explain how we are able to come to conclusions quickly. It seems right to say our knowing is in our doing.[9] However, even the knowledge of experts is constantly subject to review and change.[8]

Empirical knowledge

Empirical knowledge emerges from the tradition of scientific research and is primarily focused on generating explanations which can be used widely in anticipating what might occur in similar situations.

It is limited to phenomena which can be identified, tested repeatedly and verified publicly, for example, in the development of the Edinburgh Postnatal Depression Questionnaire.[10]

But scientific theories provide information to guide only a fraction of what we use and come to know in our caring and health promoting roles. The empirical pattern of knowing clearly needs to be expanded to accommodate knowledge created through descriptive, interpretive or critical enquiry,[7] and the explanations of individual practitioners.[8,11]

This is the knowledge we use in practice. Professional practice such as ours is characterised by a series of unique events which cannot be found in books.

Each unique case calls for 'an "art" of practice which might be taught', Schon says, 'if it were constant and known, but it is not constant'.[9] In an art of practice there are no common properties only recognisable similarities.[3]

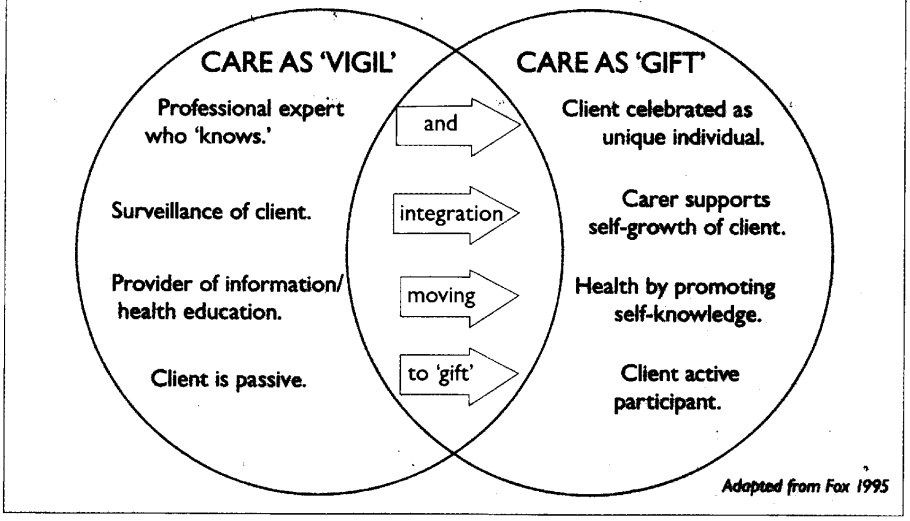
Ethical and moral knowledge

Ethical and moral knowledge describes our perceptions of right and wrong and our commitment to take action on it in our work. Client rights, client autonomy, the concept of service to people (the restoration and promotion of health), and our obligation to duty (what ought to be done) are some of the concepts of 'principle-oriented ethics'.[12] Using reason we weigh and balance ethical principles as particular situations arise. ▶

Robyn Pound
Mandy Dams
Kate Gammon
Jennie Martindale
Caroline Page
Jan Stapleton
health visitors
Bath and West Community NHS Trust

health visiting takes place.[7] Socio-political knowing includes the cultural identities and histories which inform the attitudes and beliefs of each 'player' – client, health visitor, policy maker.

Figure 2: Care as 'vigil' and 'gift': integration of conflicting roles



Collaborative reflections

To examine these patterns of knowing we told stories about our work. By asking questions about incidents which felt important, we tried to identify the meld of knowledge and skills we were using. We looked first at times when the work had gone well and we asked what it was that worked for clients.

In turn, we generated understanding from the themes that emerged. In our stories contradictions in the focus of health visiting became apparent. It is these conflicting aims of our work we offer for readers' comment.

Health visiting underpinned by health as a valuable attribute uses four main principles:[15]

- The search for health needs.
- The stimulation of the awareness of health needs.
- The facilitation of health enhancing activities.
- Influencing policies that affect health.

We accept that people do not like being told how to behave or having their competence undermined[16] and self-determination for clients is at the root of empowerment.[17] It was easy to find examples where client-led activity increased the effectiveness of our work, but how could we justify the opposite – when we took the lead and made decisions about what was necessary?

When we deliver information on health we establish ourselves as experts. When we shift into child protection mode and reduce the parent's decision-making skills we assume power, and when we undertake surveillance of children, the parent's knowledge, skills and decision-making may not be given priority. We have an aim to empower clients but we asked, are some of our actions disempowering?

Fox's model[13] of the 'vigil' and the 'gift' helped clarify the contradiction and spawned reflection. Professional-led activities Fox calls 'the vigil' because of the implied dependence of the patient on the professional. In health visiting these activities are surveillance, problem identification, solution planning and advice.

In other words, the knowledgeable role of the professional expert who may 'tell' the more compliant client what to 'know' and 'do'. In direct contrast, Fox identified an opposing relationship, 'the gift', which we identify as fundamentally important in health visiting.

This 'gift' he describes as the nurturing, enabling, accepting aspect of nursing intention.[13] A client-led, partnership approach to promoting health, is intended to celebrate the individual 'specialness' of clients and foster self-growth and independence.

From accepting clients' perceptions of their world we gain valuable insights to increase our own experiential and intuitive knowledge.

Fox[13] describes, however, how our attempts at nurturing client self-confidence and growth may be affected adversely by our being the ones who 'know' in our professional role. We see this tension in our stories. As Kate said: 'They are in conflict, but we are trying to do both and that's what makes health visiting so difficult to do and to explain.'

Interim support, advice and limit setting can relieve the situation and make it manageable until the client is able to take control, cope, move on and grow again. We identified 'holding' of clients in various forms to be a necessary part of helping clients to cope.

In child protection our aim might be to help children find space to grow. Parents can also be freed up and begin to 'repair' themselves in these circumstances. Our aim is to support clients as they move towards self-determination, personal growth and independence from us (Figure 2).

Carper's four patterns of knowing[3] – aesthetic, empirical, ethical and the personal 'self' – extended to add spiritual knowing[6] and socio-political knowledge,[7] gives a foundation for understanding the complexity of our evolving knowledge as health visitors. The onus is on us to remain open to improving what we are doing through critical reflection.

Fox's model[13] of the 'vigil' and 'gift' provides a useful vehicle for understanding two aspects of health visiting which are continually in conflict. Melding together the professional knowing of experts, the 'vigil', and being client-centred and accepting of the individual's own perception of their world, the 'gift', appears to begin to describe health visiting.

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Appendix V

Newspaper articles - Bath Evening Chronicle

Evening Chronicle Fri 27th Dec 1991.

Bath Evening Chronicle Tuesday Dec 31 1991

Spare the rod parents told in campaign

PARENTS are being urged to stop hitting their children in No Smacking Week from December 30.

Health visitors in the city are responding to the national campaign by mounting an exhibition of school children's pictures and a stall at the Guildhall, Bath.

The health visitors are aiming to encourage adults to make it their New Year's resolution to stop smacking children.

Parents will be able to ask advice on alternative methods of discipline at the stall from December 30 to January 3.

Artist Emma Coulby, who drew the picture used on the leaflets in Bath, will be on hand as the Mayor of Bath, Cllr Denis Lovelace, opens the exhibition at 11 am on December 30.

Library cuts

■ Emma Coulby helps to put across the no smacking message

We must spare the rod, says mayor

SMACKING is one of the causes of a violent society, the Mayor of Bath Denis Lovelace said at the launch of No Smacking Week.

Cllr Lovelace said if children were not smacked at an early age it would make for a better society.

Launching National No Smacking Week yesterday , which is being backed by Bath health visitors, Cllr Lovelace said it was difficult to become a good parent.

He said: "It is the easiest thing in the world to become a father and slightly more difficult to become a mother but it is very hard to become a parent.

"One thing we lack in education is teaching young people how to become a parent and it is so easy when children are being difficult and awkward to hit them.

"They should explain and divert children's attention to make a better society in the long run.

"One of the reasons we live in a violent society is because children are taught smacking at an early age and one of the first words they learn is 'don't'."

Bath health visitor Robyn Pound, who has organised the week, which is being marked by an exhibition in the Guildhall, said: "We hope that parents will take this opportunity to try and not smack their children for a week and hopefully make a New Year's resolution to stop the habit all together.

"Children are the only section of society who are still unprotected by the law and we no longer consider it acceptable to hit children.

"It is a matter of listening to children and treating them with the same respect as you would any one else."

Six-year-old Bath schoolgirl Emma Coulby, whose drawing was used to illustrate the No Smacking leaflets, attended the launch to show her original drawing to the mayor.

Does sparing the rod spoil the child or can discipline become abuse?

Crime and punishment

A FATHER of two was last week cleared of assault after beating his two young sons with a leather belt. He gave them 'three of the best' on the backside after discovering they had destroyed a dining room chair. The case went to court after the boys' PE teacher found bruises on them. The incident has sparked debate on how far parents and teachers should be allowed to go when they are disciplining children. Ruth Bloomfield and Sally Pook spoke to two people with opposing views on child punishment.

BATH health visitor Robyn Pound was outraged to hear of last week's court case and has called for changes in the law to let children who have been hit sue their parents.

Mrs Pound, who is an active member of EPOCH, a national pressure group committed to ending the physical punishment of children and has worked as a health visitor for 19 years,

AGAINST: Robyn Pound

said the ruling is absurd and dangerous.

She said: "Children in this country do not have basic human rights. They are the only section of society which is not protected by the law against violence in the family."

She said: "The Bristol man would not have been able to do the same thing to his wife or even to a dog."

Mrs Pound believes that the case had set a dangerous precedent. She said: "What they have done has just further legitimised violence in the family against children."

Magistrates took just ten minutes to consider the case before dismissing all charges.

Mrs Pound said that a change in the law is necessary to help protect children. As a member of EPOCH she advocates making violence against children a civil offence, giving spanked children the right to sue their parents for compensation.

She said: "We need to make a clear statement that violence against children is not acceptable, not even smacking.

"We are not trying to take away parents' rights. But parents perceive that they have the right to do anything they like to their children in the name of parental discipline.

"Discipline is very important and children do need very clear limits to their behaviour set by their parents and those limits need to be enforced, but not by force. Physical punishment just gives children negative messages."

Mrs Pound said that children who are hit by their parents tend to go on to hit their own children, and a vicious circle of violence is established.

EPOCH was set up in 1989 by people who felt that the Children's Act had failed to address the problem of violence against children. The group was behind last year's No Smacking week.

Ruth Bloomfield

CONTROVERSY: debate rages on whether smacking is necessary to discipline children (picture posed by models)

FORMER headmaster Fred Naylor, who was head of the City of Bath Technical School between 1963 and 1968, has caned several children in his lifetime.

He does not think corporal punishment should be banned from schools and believes it should be there for parents to use as well.

He said: "There is a law against cruelty but there is no law against chastisement. The NSPCC say that any parent

FOR: Fred Naylor

who slaps a child is behaving inhumanely. It is nonsense really.

"To slap a child is perfectly all right. What we don't want to do is beat them or abuse them."

Mr Naylor, who lives in Box and is a former Wiltshire county councillor, said parents should be allowed the freedom to punish their children.

He said: "I would be against banning corporal punishment in schools. Schools should be allowed to have it if they wish, and certainly parents.

"I certainly believe it has a beneficial effect. Why else would you do it? We are not doing it because we are sadists.

"It stops children from doing whatever they were doing. It demonstrates that they have a higher authority to answer to and it gets them used to the idea that they cannot do what they wish.

"Rousseau said never reason with children and I think that is probably right.

"I did 11 years as a teacher trainer at the Bath College of Higher Education and the whole culture in all teacher training was that punishment was bad.

"The teachers had to justify their use of punishment and they were told, implicitly, that it was bad. The whole idea of it is that children can do what they like. That is the whole culture of modern education.

"As the feeling for punishment has waned in this country we have had increasing crime and violence. I think they are directly connected."

Mr Naylor said boys at the school, which closed in 1971, would be caned for impertinence, stealing or persisent lying.

He said: "Impertinence to masters is the worst of all. I caned when I was a headmaster."

Sally Pook

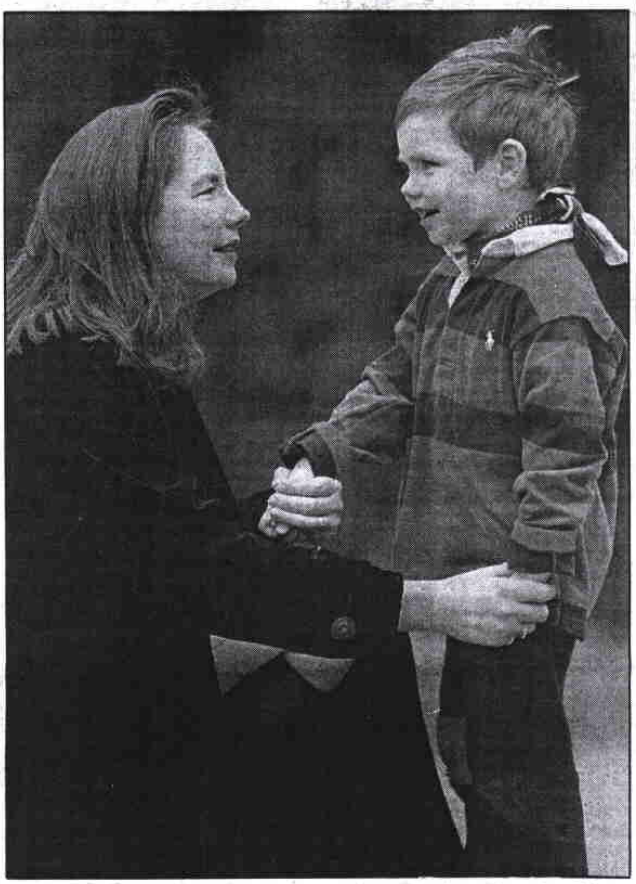
■ Talkback, Page 7

The Bath Chronicle
Wednesday March 6 1996

HAPPY FAMILIES: the positive parenting movement grows in Bath

How to make friends with your children

Do you spend too much of your time shouting at the kids? Is family life more a pain than a pleasure? What you need is positive parenting, as Chronicle correspondent ***Malcolm Rigby*** *finds out*



■ **POSITIVE APPROACH: we can learn to raise good citizens through talking and listening to our children** PICTURE: Brian Stevens. Posed by models

POSITIVE parenting is not just another buzz phrase for the middle classes of the 90s.

It is a real shift in outlook and approach to meet the changing needs of both parents and children as they have developed over the last 50 years.

Bath health visitor, Robyn Pound, said: "I think there is a greater awareness of the need to take children seriously and be warmer with them.

"At the same time, men and women are parenting now in different circumstances than in any previous genertion — parents are more isolated and have less support."

From a practical point of view the parents must have realistic expectations, and the children must have boundaries of acceptable behaviour, and both of these need to be talked about

- There is less practical help from the extended family, from the neighbourly mum next door, and the community in general
- Over the years there has been a gradual moving away from authoritarian parenting People want to have a better relationship with their children, to be friends with them
- Parents are aware there needs to be greater democracy within the family
- The media makes children aware that there are alternatives in family styles
- Shifting patterns of consumption have constructed a child and youth market, which means that children are more likely to express differing opinions
- The church offers less prescriptive support
- Children are more aware that they have rights — quite properly as they have been formalised by the United Nations.

Because of all these changes, parents want to do things differently but they don't necessarily know how.

The idea of positive parenting has evolved from the anti-smacking lobby and their encouragement of positive discipline.

Robyn said: "I find as a health visitor, more and more, parents are saying they don't want to use physical punishments but don't know what else to do.

"Positive parenting is about guiding and encouraging children in the process of growing up in a way which is satisfying for both parents and children."

From a practical point of view the parents must have realistic expectations, and the children must have boundaries of acceptable behaviour, and both of these need to be talked about. The discussion itself is a way of treating the child with respect.

Robyn said: "The difficulty of democracy within the family is that it can't be completely democratic, because children don't have the experience to get it right each time. That's why you need to set the limits."

Those limits are not laid down in stone, they will differ within each family depending on circumstances.

"Families have to create their own style which reflects their own values and beliefs. Research shows that parenting style is more predictive of child well-being than social factors such as divorce, single parenting or poverty."

The question parents want to know is what happens when those boundaries are breached?

The answer lies in shifting the emphasis from discipline imposed from outside to self discipline, so children learn to control themselves. For instance if a child does not do her homework, the responsibility should be seen as hers, she has to face the consequences.

Research shows that parenting style is more predictive of child well-being than social factors such as divorce, single parenting or poverty

Another example Robyn gives is the case of the reluctant riser in the morning. Too often, children right through to late teenagers have to be hurried and harrassed into leaving the house, to the discomfort of parents and children alike.

She feels that if the child is given the responsibility to get themselves ready in the morning, they will learn from their own experience, and facing the consequences of them, that it is possible to have a stress-free morning.

Health visitors in Bath are embracing positive parenting as a team. In response to their interest a conference takes place next month at Bath University on the subject, organised by the Bath and West Community Trust.

One of the key speakers will be Dr Penelope Leach, author of Baby and Child — a bible to many parents — she is now a well-known figure in positive parenting circles.

Chairing the conference is Batheaston primary school head Jacqui Coulby, who as a teacher has long been committed to the positive management of children's behaviour.

She said: "Bringing up children is a very skilful activity. You need to know what to do to manage children in a positive way, and you need to actually put it into practice, parents need support."

They are hoping that the conference can be used as a platform to launch a multidisciplinary group called the Bath Positive Parenting Forum.

The role of the group would be to give ongoing support and information to those who are interested in positive parenting.

In the long term, as Robyn Pound says: "What children really need is a warm encouraging environment with firm, enforced guidelines, and fewer punishments of any sort. This requires a change in children's status in our society."