

CHAPTER FIVE

CONFRONTING HIDDEN AGENDAS: CO-OPERATIVE INQUIRY WITH HEALTH VISITORS

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Hilary Traylen's MPhil dissertation (Traylen, 1989) at the University of Bath, from which this chapter is taken, started as an exploration of the nature of health visiting practice in the British National Health Service. An emerging theme in this work was the considerable level of stress experienced by health visitors in the course of their work, caused in part by uncertainty about their role. In the first phase of her work Hilary interviewed a number of health visitors and attended a workshop on the health visitors role. We pick up her story as she reflects on her dissatisfactions with this approach.

As I became more skilled in conducting the interviews I began to pay more attention to the interview process and to the way I was reacting. I began to feel very confused and uncertain about what I was trying to do, and realized how difficult it was to probe into the nature of this relationship between the health visitor and her client. The more I talked to health visitors the more I came to realise that what I was trying to understand was extremely complex. The health visitors themselves were not very articulate in describing their relationships with their clients. There were some similarities in their accounts but they seemed to me to be superficial. There were layers in the relationship. If I tried to probe further, some health visitors seemed to be saying that their relationship was something they could experience but could not fully express. If they were unable to describe the relationship, how on earth was I the researcher going to explain it?

I felt confused not only because I was unable to get much clarity but also because it was an issue for me. I wanted a nice neat definable answer. The experience aroused a whole host of anxieties about me as a researcher. I felt doubt about my own ability to see the research through feeling anxious and powerless in my confusion, my inability to pin down, tie up, package this "thing" called relationships. I felt isolated, as if I was interviewing the health visitors in a vacuum, just two people struggling to articulate and make sense of issues that were beyond resolution.

These issues were not just of academic interest, they were important to me in a very personal way. I began to realize why I had chosen this research topic. When I first started out I had presented myself with all sorts of very reasonable explanations as to why this was the appropriate research to undertake. I had not really taken into account the emotional and psychological implications. In other words I had been pretty naive at the outset. On the positive side the undertaking of such a research project has provided me with an opportunity to grow and develop. Questions have been raised about my own self-worth and have made me look much more closely at "who I am". These deep inner questions of identity, relationship, of facing my own doubts, needs and resistances has helped me to experience a new understanding of myself and I think of others. This

personal process in turn contributed to the research because of my increased awareness and sensitivity.

Living with my anxiety about the impact of my questions on the health visitors was more difficult. The essence of my inquiry felt at times like "twisting the knife" in what was already a raw wound. I felt unhappy about using a method which left these issues unresolved, and it seemed to me that I might be re-surfacing issues for the interviewees. I was for them "here today and gone tomorrow". They were still faced with the day to day task of practising their profession, still tussling with unresolved dilemmas about their practice. I found myself sharing the pain, confusion and dilemmas the health visitors were expressing about their practice, and I was concerned that I might be raising similar doubts and anxieties in them. All the interviews seemed to achieve was an identification of some of the issues about health visiting practice, leaving the health visitors with these issues unresolved. I felt guilty. I was perhaps re-surfacing these issues for them and then just leaving them in a mess. The issues which have emerged from the interview data and the workshop represented in my view serious problems. I wanted to explore a methodology which might reveal a deeper analysis of these problems. From the workshop and the interviews has come a strong impression of the health visitors' isolation, of their need for mutual support and the need to discuss professional practice issues. The health visitors were noticeably anxious about the management structure; they felt there was lack of support from their managers. What I wanted was to look for a different methodology which would be more oriented toward action research. A method that might go some way toward exploring these issues in greater depth.

The co-operative inquiry which followed the interviews provided a significantly different perspective on the issues. It enabled greater insight into the problems and it also led into action research to explore ways to change and develop health visiting practice. This research method was more powerful because I was no longer exploring these issues in isolation, but undertaking the inquiry with a group of health visitors as co-researchers.

The methodology of co-operative inquiry has been described elsewhere (Reason and Rowan, 1981; Reason, 1988). The advantage of this kind of inquiry is that the approach is not simply restricted to my asking the health visitors' to describe their interactions with others, but focuses on their reciprocal interaction with myself, so that we become both co-researchers and co-subjects.

Another key factor in co-operative inquiry is it is person centred, it recognises the potential self determination of those involved. The experience of exploring together in this kind of inquiry would hopefully lead to our own personal growth and development, and to some deeper insight or resolution of the issues of health visiting practice. In addition, co-operative inquiry purported to be a method which could be used by ordinary people, in seeking to change their lives, so that "research" was not just the prerogative of professional researchers (Reason, 1988).

From the literature on co-operative inquiry I gained two strong impressions: first, any individual proposing to use such a method required considerable skills. Peter Reason and

John Rowan (1981) emphasize the need for "High quality awareness"; Heron (1981) suggests that "the discipline and rigour involved in this sort of research is formidable." And Torbert writes "that a person must undergo a to-him unimaginable scale of self development before he becomes capable of rationally valid action" (1976, p. 167). Reason and Heron stress that in order for the researcher to develop and maintain this "high quality awareness" they needed to engage in some therapeutic disciplines or systematic method of personal and interpersonal development such as co-counselling (pp 245-246).

Emphasis was also given to the likely affects such an inquiry can have upon individuals. Peter Reason makes this point when he talks about distress facilitation.

Co-operative inquiry is an exciting business; it can also be an upsetting business. It is my experience that research which authentically challenges the way those involved conduct their lives raises all kinds of emotional issues which are ignored or denied by conventional research doctrine. It is an essential aspect of co-operative inquiry that these emotional issues are addressed... It is therefore a clear advantage if an inquiry group has available to it a degree of emotional competence so that personal distress can be appropriately managed. (Reason, 1988 pp. 28-29)

I felt relatively inexperienced as a researcher and I had little experience of therapeutic disciplines. There would not be time to fit in any kind of co-counselling course or develop the skills which the literature was suggesting I ought to have in using such an experiential method. So the literature really scared me off. Yet co-operative inquiry according to Peter Reason (1988 Chapter 1) was supposed to be a method which ordinary people like me could use.

I also found literature very heavy going. I had to learn a whole new language. I struggled through torrid chapters heavily laced with such terms as *ontological assumptions*, *epistemological assumptions* and *axiological assumptions* (Lincoln and Guba, 1985), thinking to myself "I don't even understand what they are trying to say half the time" . This reinforced any foreboding I had about my capability to understand the method, let alone how I could explain it simply to a group of health visitors.

I found John Heron's chapter describing the philosophical basis for a new paradigm (1981) useful, the literature at the time was very thin on practical guidance on how to use a co-operative inquiry approach. (This was before Peter Reason, to some extent at my instigation, wrote chapter One in "Human Inquiry In Action which provides a more practical guide to the co-operative inquiry group.)

To help clarify my mind and identify what I needed to prepare for such an inquiry, I picked out from the literature all the practical hints I could find. I then translated these points into a simple form I felt I could work with and produced an outline of how I might proceed with such an inquiry.

First I sketched out an aim for the co-operative inquiry: *To carry out research into our own health visiting practice and to share that experience with our co-researchers.*

This would lead to a discussion about which aspects of health visiting practice should be investigated. Such an investigation might, for example, focus upon the health visitors' relationship with their clients. Alternatively the discussion might develop into areas outside of my immediate research concern and this made me think through how I might handle this situation if it arose.

Just suppose the group decided to undertake an inquiry which was not important in my research, how would I deal with this situation? Peter Reason sees this difficulty. He suggests that research initiators ask

"Who is this research *really* for?", and "Is there a genuine possibility for co-operative endeavour?" If there *is* an inquiry task around which a group of people can genuinely join to explore, then any problems of initiation, ownership, and power can be resolved through authentic negotiation and confrontation. But if there is no such possibility of a shared inquiry task, then, the group will have been set up on a phoney basis.. (Reason, 1988, p. 20-21)

I was concerned that I needed to provide a forum in which the health visitors could genuinely contribute. I wanted to avoid getting into a position in which the health visitors might only be collaborating to help me in my research. The issue under investigation had to be a matter which was vitally important for the health visitors. One way round this was to set up an introductory seminar in which I could talk about my research and the issues I was interested in investigating further. The participants could then decide for themselves, whether they were interested in the issues and the idea of a co-operative inquiry approach.

The introductory seminar.

I decided to invite the health visitors who I had met at a workshop on health visitor practice. These health visitors had already built up a degree of trust with each other and myself, and from the participants' involvement in the workshop it seemed natural for them to now move towards researching into their own practice. I also contacted some of the health visitors I had previously interviewed and invited them to come along, and I spoke to a number of the managers so that they could pass on the information to those health visitors whom they thought might be interested.

I decided that the seminar would need to be structured and mapped out for the participants. The health visitors would probably be feeling uneasy about the idea of research, especially with the idea that they could "do research". I needed to tailor the

seminar to meet my own and the groups needs, so I drew up an agenda and made a list of points I wanted to cover.

1. Getting to know each other. Some of the participants might not know each other, so time would need to be set aside for introductions .

2. Hilary's research. I would outline the main areas of my research and discuss with them the work undertaken so far. I intended at this stage to share with them the emergent themes and declare my intention of wanting to explore these in greater depth by using a new research method.

3. Expectations. Time would be given for general discussion in order to elicit why they were interested. I also hoped that it might also draw from the participants any burning issues they may want to explore further.

4. What does co-operative inquiry mean ? I would explain in simple terms how we might use this method together. I was not very confident about my ability to do this so I also wrote up a handout for the participants to take and think about afterwards. This would tell them about the method again and the implications of becoming involved in such an inquiry.

5. What am I getting into? This would allow for some discussion about the implications of undertaking such an inquiry. This kind of inquiry would have a direct and personal affect upon the participants. The participants would be probing into, and asking questions of themselves about matters which they cared about and this was likely to cause some anxiety. I was particularly concerned that they should be aware of the likely consequences of research in terms of their own personal distress and how it was intended the group should handle that distress. I would also emphasise that these experiences would bring rewards such as elation, creativity and personal growth.

6. What's next (Contracting). I intended to outline some ground rules for an inquiry group: for example, confidentiality, giving permission for individuals to say "No" if they felt they were getting into issues they were not interested in; time to talk about how individuals were feeling, and roles within the group. I also wanted, if time allowed, to map out how an inquiry might progress, and to end this with a session of brainstorming how they viewed health visiting practice. Participants would then be free to go away and contact me individually if they were interested in setting up an inquiry group.

Of the eight health visitors who wanted to come for various reasons only five were able to attend. I saw the other three health visitors individually, briefed them about the seminar, and about what co-operative inquiry might involve for them.

The seminar was held in the morning and lasted for two hours. I would have preferred longer but the time had to be restricted due to the health visitors work commitments.

We started the morning with introductions, each participant telling the others a little about their previous work experience and where they were presently based. Next we moved on to some flip charts I had prepared and I gave the group a brief outline of my research to date and the reasons why I was proposing an inquiry group. After this session I asked permission to use the tape recorder because I did not want to forget any of their ideas.

Using the flip charts again I started to describe the co-operative inquiry approach. They seemed enthusiastic about the idea of action research and the philosophy of research with people rather than on people. One of the participants was quite taken by the idea of a more holistic approach.

I then showed the participants an example of what we might do by putting up the aim of the inquiry I had previously outlined in my plan, and showing how they might decide on which aspect to inquire into and how they might put this into practice. I could feel at this point they were a bit lost, so tried out a little mapping exercise to see if this would help. This seemed to fit into their culture of "being up and doing". I took *health visitors' relationship* and got them to brainstorm their ideas. I encouraged them to share ideas and these were put onto a flip chart.

Someone offered the idea that the relationship was affected by their "expertness". I was not sure what they meant and after a long silence, bit by bit we made a list of what they thought they meant and through discussion it emerged that all this knowledge was not necessarily known to the families they visited. They suspected that perhaps only four areas of their "expertness" may be known to the people they visited. These were child development, nutrition, immunization, and child behaviour problems. This realisation that families might not know what the health visitor has to offer provoked considerable discussion about how much they were prepared to communicate with their families. Participants varied in how they described their role and their reason for visiting their families. This discussion also revealed that the health visitors varied in how much they would communicate to their clients about their role and reason for visiting. Several other issues linked to the health visitors' relationship were mentioned, and gradually we began to draw various concepts together.

This exercise seemed to work extremely well as it helped to get everyone involved and yielded a lot of rich data which had not emerged earlier in the research. For example, it was the first time I had heard the health visitors talking about manipulating their clients, of being devious and having hidden agendas (by this they meant that they did not give the client the real reason behind why they were visiting them.)

After this exercise I moved on to describe the processes involved in this kind of inquiry. I introduced them to the idea of cycles of inquiry. This would involve taking an aspect of health visiting practice and deciding what method would be appropriate to explore it, for example, questions and discussion. Then trying this out, and coming back to the group to re-examine their original ideas in the light of their experience. This might result in changes being made, and new ideas tried out. This re-cycling may occur several times.

Briefly I covered some of the ground rules an inquiry group should consider - issues of confidentiality, permission to say "No" and time to be given for checking out how people felt. However when I started to mention validity procedures I could see that individuals were looking a bit lost, one or two people looked puzzled. When I checked this out, one of the group confirmed she felt confused. The group, I felt, were not all that interested in the process of inquiry, rather they were much more keen on "doing something", never mind the processes involved. This experience was to be repeated several times in the course of the co-operative inquiry.

I returned to the brainstorming exercise and more issues were raised. Doubts were expressed about their role such as "Why do I visit?"; "Who am I now? So many things to so many people"; "What am I doing?"; "How well am I doing?". These problems of feedback about themselves and their practice were a recurring theme already raised by the interview respondents and in the workshop.

After the two hours were up several of the health visitors wanted to meet again as soon as possible and another date at the end of June was arranged.

Co-operative Inquiry In Action.

The inquiry itself spanned a period of eight months and during this period went through a number of different phases:-

Phase 1: Identification of the issues to be explored.

Phase 2: Convergent cycles of inquiry in action.

Phase 3: Engaging in chaos.

Phase 4: Communicating the research.

Phase 1: Identification of the issues to be explored.

Over the period June to September the group met twice. and settled to a core group of five health visitors with myself making the sixth participant. All the sessions were tape recorded and many of the ideas explored by the group recorded on flip charts. Many of the themes and issues about relationships, support, role conflict, and evaluation had already been raised in the interviews and workshop. In this account of the co-operative inquiry I intend to recount only those themes which the inquiry explored through action research, and to explain the inquiry process the group undertook.

My role within group. In these first two sessions I worried quite a lot about my role within the group. I saw myself initially needing to help facilitate the group but I did not want to get caught in this role. I was concerned that the facilitator's role might become that of leader with the group no longer authentic co-researchers. I hoped it would be possible for this role to be shared, so that others within the group would also act as facilitators.

This did not happen in the early stages of the inquiry and on reflection this was inevitable. The group members were new to each other, we needed time to get to know each other and to feel safe with each other. In my role I realised that I needed to nurture and educate participants in using a method they were unfamiliar with. Whether I liked it or not in these early stages I was seen as some sort of expert in co-operative inquiry.

The first meeting. The group spent the first session getting to know each other, sharing views about health visiting practice, and identifying possible areas for the inquiry. From these discussions we began to focus on three key issues which the group found difficult to manage in their practice. Through discussion we came to realise, that these issues were inter-related. These we called *Feedback*, *Hidden Agendas* and *Confrontation*.

Feedback concerned evaluation: How do you find out whether you have been effective? Are there any methods or techniques you can use that can give you this feedback? From this exploration came the link with *Hidden Agendas*: How much do we discuss with our clients, particularly highly sensitive issues such as child abuse, incest, drug and alcohol abuse and poor relationships? One participant recalled a visit in which she felt the mother had a poor understanding of what to expect of her children. The health visitor was finding it difficult, saying, *I can be open about some things, but it is actually quite difficult to confront her and say, "Look you are having some difficulty in relating to your child."*

Thus feedback and hidden agendas linked with *confrontation*: several found confronting clients a big problem. Some described themselves as skirting around the issue rather than being directly honest.

We all recognised that some of the visits were superficial, not tackling the fundamental concerns we held about some families. If we were to be effective as health visitors these sensitive areas needed to be explored further. The group concluded that in order to assess how they were doing with families, they needed to be more open and honest, to confront them with the real reasons for visiting: "No hidden agendas". They also needed to seek families' views about their visits to them to gain feedback.

Was this an issue the group wanted to inquire into? It seemed at first that the answer was, "No", and we all slid away and "skirted around the issue". Just as we had identified a core problem with visits, the group moved away from this sensitive question and started to explore around about the issues again.

This second exploration led us to probe into why feedback, hidden agendas, and confrontation were such problematic areas for us. This discussion unearthed a lot of underlying anxieties. Some of the group felt they did not have the courage or the strength to get into these issues in their day to day practice. Some described themselves as having "chickened out". One explained how she felt *I have this big dread about that day I have to visit a certain family, and all you do is bury it. You think "I will visit them and get it over with" and you know there is a whole host of problems, but you don't go searching for them..*

Others worried about whether they could cope if they "unearthed" families' needs. question arose such as "How do I cope with the consequences of that confrontation, do I have the skills?" Issues were raised about *"How much are you responsible for actually digging around for what's going on ?"* All this imagery of burying, digging, and unearthing conjured up in my mind images of graveyards in the dead of night and childhood stories of unimaginable goings on. We were all fearful of what might happen, of getting out of our depth, of making things worse.

One group member got angry, she felt so frustrated: *Here we are talking about something we all feel quite passionately about I think. This is something we need help with. It's the first time it's (she was referring to the problems about confrontation and feedback) been discussed with me.... this is still a big problem with me, but this is the nitty gritty of health visiting I feel... I just feel that somebody up there (she meant managers) should be looking at what I am doing and asking why I find health visiting difficult. "Why haven't you visited this family ?" I need help with that.* It was in circumstances like these that I saw that the help would come from the group, from sharing these experiences together and by exploring together how we might manage these issues.

The second meeting. The group spent a lot of time in the second session circling around these problems and others in health visiting practice. I think this was because we were feeling at a loss about how to tackle the issues and in particular the issue of confrontation. The group continually sought sanctuary in talking about *content* rather than tackle the problem of *process*. In other words, how are we going to deal with this issue? At this stage I felt the need to help move the group on. We were all hovering on the brink. All that was needed was just a little nudge to get us into trying to work out together the processes involved in confrontation.

The breakthrough came when I asked each of the participants to describe a hidden agenda, a problem which they felt unable to discuss openly with the mother of a family they visited. Each problem was explored in depth, and we found that often the individual participant felt unclear about what was going on, and the joint discussion enabled us to be clear about the area of concern and to get some idea of the possible reasons why the health visitor thought her client was behaving in a particular way.

From these discussions various suggestions were explored with the individual health visitor until an outline strategy was worked out. For one participant the suggestion was that she should make a clear offer of counselling to one of her mothers which would be

absolutely confidential, just between the two of them and no records made. Another idea involved rehearsing how the health visitor might confront the mother: what sort of language should be used? How direct should the confrontation be? Is this the right time and in the right circumstances? What do you do if having confronted you get a complete denial or you "open up a can of worms"? The group explored each question in depth and tried out various actual words and sentences.

By the end of this second session a contract was agreed. Each of the co-researchers would try out various ways of confronting the problems we had discussed. They would experiment with ways which would help them to achieve a more open and honest relationship with their families. They would try to explore ways in which they could begin to probe into the more sensitive areas and share those concerns with their families. The methods to be used in recording progress was only very lightly touched upon and was left to each individual to decide. All the group felt anxious about the decision but at the same time they were determined to try out some of the ideas we had discussed.

Reflecting afterwards on this second meeting I was quite frightened by what the group had agreed. What they were proposing to do meant confronting themselves, their fears about their skills, of the danger of causing damage and getting it wrong. This was a highly risky undertaking for them and their families. The group might experience adverse reactions which could destroy their newly found confidence. Perhaps we had taken on a too difficult issue for the first cycle of inquiry. I was so worried I telephoned each of the members and shared my concerns. I thought it was important that individuals should feel free to go at their own pace. One of the members I talked to did feel she needed more time before she could handle some of the issues. Others were more confident and seemed determined to pursue some of the ideas.

Phase 2: Convergent cycles of inquiry in action.

Over the period October to mid-November the group met three more times. During this time the group was deeply immersed in the action of the inquiry, each session being spent on hearing each other's experiences, refining the research methods and going back into action again. The third meeting was tense and full of expectation. Each of the group gave an account of how they had tried various ways of being more "open" during their visits to families.

One of the participants had followed the group's suggestion and offered counselling to one of her mothers. The offer had been made on the understanding that there would be absolute confidentiality. This had been accepted with alacrity, which both pleased the health visitor but scared her too: *Oh my god what do I do! Do I have to read up something, do I have to sit passively?... Are you going to help me or not?* meaning the group.

We spent a long time talking through the next steps of how she might manage the first counselling session. Much of the facilitation came from the group member who was undertaking a counselling course. Key counselling concepts were explored with suggestions being made such as *Go at the pace of the client, let them tell you what they want to tell you... There are ways of letting them know you are there, you are following what they are saying, reflecting back or summarising what they have said...*

Time was spent encouraging, supporting and helping the group member come to terms with guilt feelings she was now experiencing about this particular mother. She had visited this mother over several years and was feeling bad at not having *picked up signs*, not having realised what this mother might have been going through. Offers of support were made so that as the group member moved into the next cycle with this mother she would feel supported.

Another member gave an account of a visit to a mother who had recently given birth to her first baby. Her hidden agenda was *that she suspected there was something going on* and it was connected to the episiotomy the mother had sustained during the birth. The health visitor suspected the mother was anxious, but was uncertain how to raise the problem. She described to us her previous visits: *I was going in to do my weekly visit, thinking "I am not absolutely sure where we are getting here" because she talks an awful lot, and she's always very jolly, and I felt useless there. As if I wasn't getting anywhere...*

The key which opened up the underlying problem was the health visitor's decision to ask a direct question about how the mother felt about her episiotomy scar. This opened up a *whole load of stuff*. The mother started talking about how she had frantically been doing exercises to *get it right*, her fear of being examined post-natally and how *she would happily leave her sex life for another two years*. She complained of feeling tight and uncomfortable. Other issues emerged about how long they had tried to have a baby and how her previous pregnancies had ended in miscarriages.

Reflecting back on this visit the health visitor felt quite brave at having tackled the problem. She had felt that she might have got out of her depth and could have easily avoided the underlying problem. The group reflected on this experience and made various suggestions were made about how the next visit should be managed.

The next participant described what happened to her on the very day we had all decided on the contract. She explained *I was really spent by four o'clock and someone came into the clinic, one of my priority families and I thought I just don't want to see this lady. So I avoided her because I really couldn't cope. But she heard my voice and had me out... "Can you come round?" I said, "No I can't"... She burst into tears on me... So I went round (to her house) and I was there for two hours, and it was the best two hours I have ever spent with them.*

The first thing I said when I walked in (because my temper was short) was, "I have nothing to offer you, I am here to listen, I can give you no money. The only support I can give you is for the next hour". I put a time limit on it. I was really very very cross and

they could see I was. So they made me a cup of tea and made me sit down and they just talked to me for two hours. They were so HONEST because I had been very honest with them. It was GREAT. It REALLY WORKED. I just felt very strong from the morning... My honesty just produced a lot of honesty with them. We had no hidden agendas... We talked all about child abuse and wife battering and his illegal drugs and how many times he breaks into the meter, and it was INCREDIBLE... It had been a GREAT RELIEF and its really really REDUCED MY STRESS. That was my main thought when she came into the clinic, "I cannot cope with them because my stress would be too high". So that was very very useful.

Another health visitor concerned about a mother's relationship with her new born baby tried a more direct approach too: *I can't quite remember the exact words but I think I said something like "Am I right to think you don't feel close to your baby?" I had been dreading this question...* She got a very honest answer to this question which confirmed her assessment. The mother openly admitted she did not love very small babies.

One of the group had kept notes on six visits where she had tried this more direct confrontational approach. She found the responses very positive. In her experience she found she had made far greater progress in getting someone to change. For example, one of her mothers kept failing her appointments and when she challenged her, she was able to get at the underlying problem. The result was that she was able eventually to get the mother to keep her appointments.

She found too that she had been worrying unnecessarily about some families and this greatly reduced her stress. In some incidences she had also saved herself some work by checking out with families whether she needed to continue to visit them. Another time where she had been visiting weekly and feeling she *wasn't getting anywhere* she had asked *What do you expect from my visits?* and she actually got some feedback: *She gave me lots of positive things about how much she valued what I had said... When I went back this week, she had a whole list of questions for me. She had actually thought out what she wanted to ask and I felt she had changed a bit of emphasis there. Instead of me questioning her, I had made her think, so she could then ask me things and that it was alright for her to do that..*

Another family where the child was possibly at risk from abuse was challenged by this health visitor. She said *I feel you resent me visiting you.* I said that as soon as I got over the doorstep because I was in a fighting mood. She was taken aback. She said *No, it gives me status,* that's more or less what she said, *You are seen to be doing your job.* She explained that on the council estate where this mother was living, there were frequent allegations of child abuse made against her. The fact that the health visitor visited tended to stop the allegations. So *She does not resent me visiting, she likes me going in fact!* She admitted later to the group that the mother was moving and it was this fact which had given her the courage to confront. She knew that if it went wrong it would not matter as she would be no longer responsible for visiting her.

On one occasion things did go wrong. She had gone to visit an elderly person and her daughter. She had suggested to the daughter that she felt she was very very burdened by her mother. *That was a big mistake... she was really angry with me and she was quite abusive... she said she did not want anyone interfering with her mother, and, yes, she was a burden, but what could I do about it?* The daughter went on to vent her feelings... *I don't know anything about the family background, I don't know anything about the family feuds that go on. How can I make statements like that when I have only been two times. I have talked more to her mother than to her.... I write all these things down and then I go off and DO GOOD. How do I know how she feels when she is stuck at home and her mother is moaning all the time...*

This incident had caused the health visitor a lot of stress. She had felt very uncomfortable and she felt what she had done was dangerous. On further questioning it felt dangerous because she was getting quite upset and stressed to the extent that she knew she could not handle it. She did not feel strong enough to stay and talk through the daughter's anger. The group spent some time in giving support and encouragement which ended in the health visitor agreeing to go back. *Oh well I will try and follow her up then at our next meeting. If I come in a heap you know what's happened... or if I don't arrive!*

Reflections upon the inquiry process. Looking back over this time the group went through three cycles of inquiry. Each session would start with each of us checking out how individuals were feeling and spending time on those issues. Each member gave an account of the progress they had made since the last meeting and these were discussed in detail, ideas refined and developed for the next cycle of research.

During this period the group was almost solely pre-occupied with action and were not the least bit interested in the process of the research. This need to make progress was a powerful influence and its parallel can be seen with the health visitors wanting their families to move on too. Reflecting back over this period not to progress might have represented failure to the group. Although I raised the question several times that perhaps we should spend some time reflecting on the research method, the group were much more interested in exploring and reflecting back on the research material.

Quite early on one of the group members had asked *Where is the research part going to come in?* What was being proposed did not fit in with her ideas about research. She had been on a research appreciation course and she had never heard of a research method such as co-operative inquiry. How could this be research? There seemed to be a considerable culture gap. They were more familiar with traditional methods and felt unclear about this new method. In some way too this discussion was connected to what I suspected were doubts about their ability to undertake research in their own right. The group during this time tended to avoid the issue of identifying how we did it.

My role within the group underwent a number of changes. Earlier on in the inquiry I had worried that I might have got stuck in the leadership or facilitator's role. This in itself raised questions about whether this could be a full blown co-operative inquiry. If I got stuck in these roles, how could I be a participating member of the inquiry group? In the

early part of the inquiry it was important that I should undertake these two roles. The group members needed to get to know each other and to feel safe before they could move on into deciding what they wanted to do.

I shared with the group my concerns about my role. I was different from other members of the group. I was not a practising health visitor, so how could I become an equal participating member of the inquiry group if I was not going out with them to explore these issues? Paradoxically the answer came to this question when I found myself exploring these issues in relation to my relationship with the participants.

This happened during the first feedback session, when they were giving an account of their experiences. I was worried that one of the group members might have gone into the inquiry over-enthusiastically. I felt uneasy, as she talked I could feel aggression. I felt uneasy about how outspoken she had been with the families. She was making statements like *I was in a fighting mood*. I felt puzzled as to how I could broach this with her. So my "hidden agenda" was *concern that this member had gone off at full steam and needed to slow down and reflect a bit more on her experiences*. I found myself pre-occupied with the question of *how do I confront her without causing distress?* Another group member needed to be challenged about something she had said. All through this period I found that I was conducting the same inquiry as the group, but in parallel.

During this phase of the co-operative inquiry the group experienced intense excitement. We were focussing on an aspect of practice which we were particularly anxious about. There was a lot of risk taking involved for all of us and despite the fears, each member of the group had succeeded in breaking through into a deeper understanding of their practice. These personal accounts were full of life and energy, almost effervescent, and it gave everyone a tremendous feeling of confidence. There was general acknowledgement that these experiences were helping them to feel stronger and more confident, not only with their families but in their personal lives too.

I became deeply immersed in the research to the extent that I started to have dreams. One morning I had woken early from a dream which had a nightmarish heavy quality about it. The dream had centred upon the group member who had offered counselling to one of her mothers.

There was a lot of noise in the dream which prevented me from hearing what was said properly. (This probably represented my fears of not understanding the research material). People were hovering out of sight in the wings. I think they were the "managers". (I saw them as being a possible threat to myself and the group).

The group member in the dream was very upset because she had been faced with something indescribable, mad and out of control. I recognised that in the corner of my left eye lurked something equally as nasty and was connected to the group members distress.

Reflecting back on this dream it made me think again about the issue of distress which is involved in this kind of inquiry. In the heat of the inquiry, with the group so fully committed to action, the group's anxiety may not have been sufficiently explored in the sessions. I decided to check this out with the group in the next series of meetings.

Phase 3: Engaging in chaos.

From the end of November to mid February the group met another three times. By this time the group had been through a number of cycles of the research. We had first tested out ways in which group members could confront their clients in order to facilitate and open up underlying issues, and experimented with ideas which would help achieve a more open and honest relationship with clients. These research cycles involved the group taking these ideas several times round the cycle of reflection and action. However the balance between action and reflection tended at this time to be much more weighted towards action. The group realised that the inquiry would be coming to an end since two of the members were due to leave in February. So in the last three meetings the group concentrated much more upon reflection, sense making and evaluation in order to create a better balance between action and reflection.

In the first of these three meetings I proposed to the group that we should spend some of the time hearing from each other about our experiences and part of the time discussing the research, defining and recording what we had achieved so far. There was general agreement and a time agreed for feedback and time to deal with the process of the research.

The group member who had offered counselling to her mother, now recounted her first counselling session. The meeting took place in the mother's home. She had arranged for the husband to take the children out for the afternoon so they would not be interrupted. Significantly the mother had suggested they should talk in the dining room, a room she had never been in before having always talked to the mother in the lounge. She realised the symbolic reason for this suggestion. The use of this room made the distinction between her former relationship with this mother as her health visitor and her new relationship as her counsellor.

The mother poured out her feelings of resentment she had held against her third male child. Taking the health visitor back to the beginning of the pregnancy and how desperately she had wanted a girl, she explained how she had felt, from hugging the child in desperation, to losing control and hating the child. She talked about an incident with the child *screaming so much, that she started shaking him, and shaking, and shaking him. The husband came in. She was screaming, the baby was screaming, and he hit her to stop her from doing it. In retrospect she knew that something terrible could have happened.*

The mother could not talk to anyone about these feelings for fear of being labelled as a child abuser. This was why she had not taken up the health visitor's previous suggestion to seek help from a private counsellor, and why she could not talk to the health visitor about these feelings. It was not until the health visitor made the offer of absolute confidentiality and no records kept, that she could feel safe to reveal this burden she had carried for so long.

The health visitor was aghast. She had no idea in the many months she had visited, that this mother was suffering in this way. On reflection there were signs which she had failed to recognise and this made her feel guilty. Before the session ended the mother checked again and asked *Are you recording this?* The Health visitor replied, *No, That was part of our agreement, there is no record of it at all.* They agreed to meet again.

This incident provides a different insight into the issue of child abuse for parents. Here was a mother who desperately needed to talk through her feelings and dared not, because she was haunted with the fear of being labelled a child abuser.

Other group members fed back their experiences. One of the members had experimented with being more assertive and more open with one of her mothers. This mother did not attend clinic despite repeated invitations. There was been a history of cot death and some evidence of a poor mother-child relationship with the eldest child, now five. The health visitor had received a copy of a report recommending that all babies should be weighed regularly if there had been a cot death in the family.

The health visitor was getting fed up with going in to weigh the baby when the mother could come to the clinic. *I told her quite bluntly why I wanted him weighed...* What happened next *amazed* the health visitor. She was taken into another room and out came the photograph album and she was shown pictures of a ten month old baby who had died (cot death syndrome) six years ago. The five year old child had very similar looks to those of the dead child and from this discussion the mother was able to talk about why she felt so ambivalent towards the child that replaced her dead baby. This simple direct explanation on the part of the health visitor seemed to be the key in moving towards a more open relationship which allowed these issues to be explored.

Out of this discussion one consequence of labelling families was revealed: the health visitor had held a strongly pre-conceived idea, reinforced by other health visitors that the family was hopeless. Statements like *You can never do anything with this family* had been made. The health visitor was highly amused to think that she may have succeeded where previous health visitors had failed.

The last member of the group to feed back had some tragic news and was clearly upset. The news concerned the mother who had recently given birth to her first baby and had revealed she was worried about the episiotomy scar. The health visitor had been back several times and gradually it became apparent there were sexual problems. On the last occasion they had talked about miscarriages and death. *I spent a long time there and she*

was able to talk about how she couldn't believe the baby was there. Yes couldn't believe the baby was actually there and then the baby died. Sudden Infant Death.

Everyone in the group were shocked to hear this news. The health visitor had visited the day after the baby died and had subsequently spent a lot of time listening and supporting. She was thankful for her earlier frank discussions. She felt this had helped deepen the relationship and provide support through the parent's bereavement. The experience had upset her because she felt helpless, she had experienced the feeling of wanting to "make it better" and she knew she could not. This incident reminded us all of similar feelings when faced with dying patients and the group spent some time dealing with this distress.

Reflections and sense making.

After the feedback session the group moved on to start to identify the processes involved so far in the research. We started by focussing first on what the experience had been like and these collective statements were recorded on flip charts. Reflecting back on these statements we came to realise that the main method of inquiry had evolved from storytelling, from telling the story of their experience with particular families, or by recounting a visit which enabled us to analyse and understand what was happening. Except for one group member who kept a diary of the visits where she had experimented, the remaining group members recalled from memory. From these statements came a clear message of "what it felt like" and I shall call this "personal process".

Personal process.

All of the group at the start of the inquiry had felt anxious and talked about *needing to feel good, getting the time right, feeling strong and having the courage* to go and try out new ways of developing a more open and honest relationship with their families.

Given these initial feelings the group work prior to each inquiry cycle was seen as essential: the group was seen as an empowering agent. One member told us this story. *I was quite assertive, far more than I have ever been in a case conference... I felt good about it and my clinical nurse specialist was quite amazed at my reaction. I then had to explain, "I have just come from this meeting (meaning the co-operative inquiry group) and power is coming out of my ears"!!*

Having experimented with being more open with families the group members experienced increasing confidence. They found out that they had worried about situations quite needlessly and so experienced considerable relief. Their stress levels reduced and they found they could work more effectively. They found themselves tackling problems they had shied away from in the past. For example, one group member got fed up with the way she was being manipulated by social workers, so she told them how she felt. Another group member experienced changes for the better in her personal life. Others had found they had had an affect on work colleagues, one of whom had confided to a group member that she felt she was not coping with her case load; the group member talked to

her about the work of the co-operative inquiry group and now the colleague too was trying to be more assertive and open with clients and finding it worked for her.

Next the group moved on to consider the original contract. At the beginning the group had concluded that in order to assess how well they were doing with families they needed to inquire into a number of areas:

They needed to be more open and honest. To confront clients/families with the real reason for visiting, have no hidden agendas. They needed to seek clients'/families' views about their visits to them, to get feedback.

The group's next task was to see if we could identify the process which enabled us to explore these issues.

This identification went relatively well at first. The group had found the most helpful method was to get each other to talk about particular families. This was because we were uncertain of what was happening within the family or we were perplexed about how to manage the situation. Then through discussion and mutual support we ended up with different strategies to suit particular situations.

These discussions helped in a number of ways:

Increased our knowledge of the particular families we discussed.

Increased each other's knowledge about our practice.

Helped us in deciding how we would manage our next visit to this particular family.

Explored various key words or sentences to help facilitate a more open and honest discussion with our families.

Helped us to come to terms with our anxieties and through mutual support give us the confidence to go out and explore.

This process was repeated at each group meeting.

From these discussions we began to learn that a number of strategies seemed to work. Direct questions which focussed on the area of concern were a good way of getting feedback. For example, the health visitor who asked one of her mothers what she expected from the visits; and another who asked a direct question about how the mother felt about her episiotomy scar. These direct questions seemed to be a key factor in moving towards a more open relationship which allowed these issues to be explored.

Health visitors experienced what they called *a better quality, deeper, closer, more equal relationship*, with their families.

Another strategy which appeared to help involved the individual becoming more assertive and being more open about how they felt about a situation or a particular client. For example, the health visitor who told one of her mothers that she felt she resented her visits. The same health visitor made it clear to one of the social workers that she felt she had been manipulated. Another health visitor who pointed out to her client that her failure to attend for her appointment resulted in her missing her lunch. She received an apology from the client.

Others made it more clear to some clients the work they were prepared to undertake with them. For example the health visitor who offered counselling to one of her mothers. Others made it clear what work they would not undertake, such as lend them money or deal with their rent arrears.

Chaos.

While identification of these particular strategies was successful, when we came to link this with what we were trying to do as health visitors, the group started to get confused. The same old issues came up again: what are Health Visitors' aims? What are we doing as health visitors and what is our role? The group struggled with the formal statements which are made about health visiting aims, such as "prevention of ill health and promotion of good health", trying to see how such a broad concept be applied meaningfully to actual health visiting practice. One member described her feelings: *I am quoting aims that have been quoted at us, and I no longer believe in them... Sometimes I go in and waffle on about preventative health, but what the hell does that mean? They look baffled and I feel baffled, it doesn't mean anything really.*

Just when we were feeling so confident the group was thrown into confusion, uncertainty, and depression. In a way we had been deceiving ourselves that we were doing all right: this discussion stopped us in our tracks. Everyone knew intuitively that the group had to address this more fundamental issue about our practice. We were swamped by the enormity of the task and scared about whether we would be able to make sense of it all. This first session in which we had set aside some time for reflection proved to be the most distressing period the group went through. The group had found that once they had got up the courage to move away from doing the research, that identifying the process we had used had gone reasonably well. But the group's pre-occupation with action had, I think, something to do with avoiding the key issue of our lack of clarity about the health visitor's role, which had always been present hovering in the wings. I had no idea how we were going to address this, all I could hang onto at this stage was the thought that if the group could hold this chaos for long enough perhaps something would emerge. We agreed to do some thinking and writing before we next met.

At the second reflection session we spent quite a lot of time dealing with how badly we felt after the last session, dealing with feelings about adequacy, competence and

articulation. Despite these feelings each of the group had done some thinking or writing as agreed. Everyone had experienced some difficulty, mainly because they found themselves getting stuck every time on the issue, *what am I doing and why am I doing it*. We shared what we had, and gradually we began to identify factors which seemed to cause us the most difficulty and these we called our sticky areas.

We needed first to sort out what we meant by "health visiting aims", and we found a typical formal statement from the Council for Education and Training of Health Visitors: "planned activities aimed at the promotion of health and prevention of ill health". From here we were able to identify why we felt stuck.

This aim was too big for us to handle. One member put it this way *It's all encompassing, we delve into so many areas of life. Not just the healthy parts of people's lives, it impinges on the social, the physical, the mental welfare, everything... Perhaps that is the problem, it's not specific enough; its all too general, we can't define it and it needs to be more specific*. This aim was too broad, too enormous for us to put into practice as a health visiting aim, and we felt this lay behind the group's inability to answer the questions *what am I doing and why am I doing it?*

To help us to move on we brainstormed on flip charts what we thought were the specific sticky areas of practice. This helped, because we were able to focus much more sharply on the health visitor's aim, our role and how this related to the people we visited. After lengthy discussion the group experienced a breakthrough. We had struggled with this idea about health we asked ourselves *what does this mean to the families we visit?* Gradually we began to talk about the idea of health as being a sense of "well being". The role of the health visitor was to help families maintain an equilibrium and quality of life which contributed to this sense of well being. One of the group began to see the implications of this idea and how she could relate to this concept. *If people feel better, then isn't that linked into feeling stronger, confident and in control. Isn't that what we are trying to get families to be? If you are feeling ok, you can tackle the more important problems in your life. If you don't feel ok, you never get round to dealing with it because you don't feel strong enough or confident enough.*

The group began to see the parallel of this idea to the work they had been doing earlier with some of their families. Had we not talked about *needing to feel good* before we could go out and try out new ways of developing our relationship with our families? The health visitors realised they could act as a catalyst in helping families to cope or to move on in their lives.

A new cycle of research began to be formulated around the idea of how we could communicate this health visitors' aim of "well being". How to explain to clients what we were trying to do and the kind of service which was available for them to use in achieving this aim. We began to identify factors which were likely to influence client families' equilibrium, such as the birth of a new baby or illness or death. The role of the health visitor in these circumstances would be to help explore these potentially stressful areas with their clients. The ante-natal visit was seen as an ideal opportunity to start

exploring possible issues which might be around the birth of a baby. For example, the physical, emotional and psychological impact of a new baby, as well as the practical problems of infant management and feeding.

Key questions such as *What do you think ?* and *How do you feel?* were seen as helping to facilitate this exploration and at the same time inform clients about how the health visitor could be of use to them. One member started to laugh with relief at the idea of asking such a simple question. She explained *It applies to everything, when you do a bereavement visit, you say "How do you feel?"... The child playing up, "How do you feel!"* Another member reflected about the mother who for three years had hidden her negative feelings towards her third baby. *Maybe if someone had asked her very early on "How do you feel?" that might have opened that up for her..."*

This discussion seemed to clarify some of the sticky areas which had got everyone so blocked. Somehow the idea of well-being seemed tangible to us. We experienced an *intuitive knowing* even though someone outside of the group, might well interpret this concept, as being just as broad as the standard health visiting aim mentioned earlier.

These discussions also partly answered other sticky areas concerning the role of the health visitor and feedback. The job seemed less broad because we would be focussing in on how client families wanted to use the service. This in turn would determine to some extent priorities, because it would be family-led demand for the health visiting service rather than the other way round. *Not what we want, or what we think they ought to have. It has to be directed and led by families* was the way one group member put it. Feedback was improving as the group became more practised at asking the right questions and being more open about the issues which concerned them.

At the end of this session the group had contracted to explore ways in which they could communicate this aim of "maintaining and enhancing individuals' well being" and at the same time inform individuals about how the health visitor could be of use to them in achieving this aim.

For my part I agreed that I would draft a paper which would begin to draw together an account of our research. We all agreed it was important to try to record the work we had undertaken in order that it could be shared with colleagues and their managers. We hoped that by presenting a paper that this would be more influential than just talking about the inquiry.

Phase 4: Communicating the research.

Prior to the third reflection session, I sent a draft paper to group members which started to give a brief account of the groups' research. This session was entirely taken up with discussion of the paper which had been circulated and there was no time to explore the last cycle of inquiry and how they had got on with our idea of health as well being. The

group was coming to an end and communicating the research now was a more important priority for us.

My paper was discussed in detail, with the group feeling that the language needed to be made more simple and straightforward if the paper was aimed at other health visitors. After a lot of debate I agreed to redraft the paper for our last meeting at which I presented the group with a re-written draft of the work which included the changes agreed. The extracts from the transcripts were the same as those I have used throughout this chapter. They were chosen to illustrate the various methods the group explored in trying to achieve a more open relationship with their families. It was left to individuals to decide how to use the report with their colleagues.

Ending

At the final meeting the group reflected back on their personal experiences and concluded they had experienced changes in their personal and professional practice. They were continuing to explore and develop the issues we had identified. Some of the members were sharing these experiences with their work colleagues, or in peer support groups, much in the same way as we had done in the co-operative inquiry.

My main regret in looking back through the inquiry was that the group ran out of time at what I think was an important breakthrough in our thinking about health visiting practice. Towards the end of the inquiry we had been confronted with chaos, confronted with the issue of what is the role of the health visitor. From having struggled through our own anxiety and confusion, we had generated for ourselves some sense out of the vagueness of the health visitors role. Health as "well being" gave a much sharper focus than the rather vague definition of "prevention of ill health and promotion of health". "Well being" felt like completion of the project, it seemed to pull everything together for us but unfortunately we had no time to really test out the idea.

So what did this inquiry achieve and to what extent did it adhere to the key features of co-operative inquiry?

In my opinion the experience of exploring together did lead to personal growth and development. The group members found themselves growing in confidence and able to be more assertive, particularly in situations where they felt they were being manipulated or devalued.

The group did I think achieve considerable autonomy and the choices made about the directions of the inquiry were reached on a co-operative basis. The inquiry very much developed as we went along and roles within the group were constantly changing. There was some tendency to collude over getting into the action rather than reflecting on the processes of the research and the meaning of our work.

We got excited, depressed, and distressed at various times. We argued and disagreed, we used the devil's advocate role (Heron 1989) to confront, especially when we were trying to escape from coming face to face with health visitor aims. If we had not been able to confront each other, but only our clients, then there would have been something very wrong with the validity of the research. We supported each other and gained strength to carry on. The group itself became an empowering agent.

There was full and authentic participation in all stages of the inquiry except in the writing up of the inquiry. I initiated this development and did most of the writing. Although I checked out with the group about the content, I suppose it could be argued that I shaped the final account of the inquiry and therefore deviated from the idea of full participation. "Ideally" there should be co-operative reporting. In practical terms the group members did not feel able to write and looked to me to act as their scribe and to write on their behalf a collective account of what we did. They shaped the account and made sure that it would resonate with their culture. The group were tough critics and made sure that what I had written was valid.

The process of the research as experienced by the group did, I think, lead to gaining valid practical and experiential knowledge. At the beginning the research method was challenged by one of the members when she asked *is this really research?* I think we progressed from this point to learning about how to do experiential research. At first this was intuitive and then gradually the group began to identify the processes involved. The group undertook a number of convergent cycles of research, each cycle added to and deepened the ideas we were developing. At one stage the group were too much into action and it took some time get a balance of action and reflection. When we started to review our work and ask the question *we know how we did the research but what does it mean to our practice?* we descended into chaos and were faced with the dark side of health visiting, the key issue about the role of the health visitor. This was a major challenge to the validity of the research: the group could have colluded and avoided the issue, but managed to stay with the confusion and out of that experience we created the idea of well-being.

We began to develop some propositional knowledge. For example, simple direct explanations from the health visitor about why she was visiting or what she wanted seemed to be a key factor in moving towards a more open therapeutic relationship in which important issues for the individuals concerned could be explored. Confrontation, feedback and contracting with their clients helped the group members move towards greater autonomy with their clients/families.

We also learnt that practising health visiting was a frightening and confused experience. The co-operative inquiry had created some degree of support and structure about how to tackle the issues mentioned above, but there still remained the fundamental issue of uncertainty about their role and the enormity of the job they were expected to do.

Conclusion.

At the beginning of my research I was looking for a way which would enable me to develop sensitive and revealing method of inquiry. As my first research tool I interviewed a number of health visitors and this revealed that there were major problems facing the respondents including stress and lack of support within their organization. These issues were to weave their way through all of the subsequent research, the key issue to emerge over and over again was the dilemma and ambiguity the respondents experienced about their role as health visitors.

The co-operative inquiry proved to be the most significant of the three research methods I had used. The inquiry enabled me to evolve questions and answers as a shared experience with a group of health visitors as co-researchers. The group discussions facilitated self-awareness and greater articulation of the key issues in a way which had not been possible earlier. Not only did the inquiry enable greater insight into the problems it also led to action research which specifically focussed on some of those professional issues. The group had a unique opportunity to explore, and experiment with ideas which might resolve some of the problems for themselves. The action research helped the health visitors not only to express what they felt about their real problems but also to move towards a more open and constructive relationship with their clients, with each other, other agencies, and with their managers. It provided the health visitors with a means of finding a better and more effective way of practising as health visitors.