CHAPTER 3

Skills in working with children and families

Objectives

In teaching and training it is customary to divide the requirements needed to undertake a particular kind of work into knowledge requirements, skills requirements and value (or attitude) requirements. This chapter deals with skills requirements. Knowledge is a matter of what a person needs to *know*

in order to do the work; values or attitudes refer to how the person needs to *feel*; skills are what the person needs to *do*. It is very difficult to learn how to do something by reading a book – practice skills can only come with time and experience – but a book can tell you what types of skills are necessary to be able to undertake effective work. When you have read this chapter, you will not be a skilled practitioner, but you will have an idea of what skills need to be mastered and how you might begin to acquire these skills.

A good starting point is the principles contained in the new government guidance on assessment (Department of Health et al., 2000, p. 10). These principles describe assessment, but they can be seen as underlying the entire process of intervention. The principles require that assessments:

- are child centred;
- are rooted in child development;
- are ecological in their approach;
- ensure equality of opportunity;
- involve working with children and families;
- build on strengths as well as identifying difficulties;
- are inter-agency in their approach to assessment and the provision of services;
- are a continuing process, not a single event;
- are carried out in parallel with other action and provision of services; and
- are grounded in evidence-based knowledge.

The skill is to apply these principles to children in a variety of different situations. The children you work with may be in the 'looked after' system. They may be children in need living with their families in the community. They may be abused children. They may be children being placed for adoption. Despite the children's different situations, many of the skills you will need to work with them are the same. This chapter will deal first with skills needed to work with children, and then consider skills needed to work with families. Obviously these two sets of skills are not mutually exclusive and there will be some overlap.

Skills needed to work with children

Any work with a child must be based on a very thorough understanding of children's development and of the needs of the particular child being worked with. The child's needs will be identified through an assessment of the child's situation (and remember that an assessment is a continuing process not a single event, as indicated in the principles listed above). Then the needs must be addressed through specific activities related to specific goals, and the degree of success in meeting the needs must be evaluated both on an ongoing basis and at the end of the work.

The way you work with children changes depending upon the age of the child. If the child is four, you might get down on the floor and play with a puzzle or a doll; if the child is fourteen, puzzles and dolls are not the way to go. As children grow older, the more the work undertaken with them resembles work undertaken with adults. Adolescents are in the transition between childhood and adulthood, and are usually more interested in where they are going (adulthood) than where they have come from (childhood). Certainly, any indignity arising from a teenager's experience of being treated like a child will interfere with future work. Another general principle is that work with adults is more direct than work with children. You can usually talk directly to adults about relevant issues whereas you might need to communicate indirectly with children through some intermediary device like a doll or toy telephone.

Although communication with children is usually *indirect*, it may be *directive* or *non-directive*. For the most part, work undertaken in social services departments by social workers is directive work. This means that the work is highly focused. It is focused not only in the sense that it has a clear purpose but also in terms of how active the worker is in providing a structure for the child during the session. In directive work, the worker gently suggests moving from one issue to another, from one method of working to another. In non-directive work, by contrast, the worker provides an environment in which the child's natural propensity to play can be actualised, and looks at how the child uses the opportunities made available through play, to find self-expression. In fact, very little work is completely directive or non-directive, and most can be described as a mixture of both with a varying degree of emphasis on one or the other. Non-directive work is usually undertaken by more specialised therapeutic agencies (for example, child and family clinics), but even within the therapeutic services there are debates on the relative merits and efficacy of directive versus non-directive approaches.

Let us now turn to the more specific skills needed to work with children. Some of these are:

- ability to maintain clarity of focus;
- ability to recall the experience of being a child and to relate that to the work in hand;
- ability to get children to talk or express themselves;
- ability to feel comfortable in the presence of children and to have them feel comfortable with you;
- ability to facilitate children's play;
- ability to decentre from an adult perspective to engage the child;
- ability to continue working uninterrupted despite the emergence of painful and disturbing material;

- ability to respond to the different vocabulary, idioms, and expressions of children;
- ability to be the diplomat.

Ability to maintain clarity of focus

There are a number of reasons for undertaking work with children, and it is important to be absolutely clear about what the reason is. Is it to assess the child? Is it to enable the child to express a view? Is it therapeutic? Is it a mixture of these? Unfortunately, these reasons are not always separate and distinct. Assessment is an ongoing process, continually modified on the basis of work done with the child. It may well influence and be influenced by therapeutic intervention, each informing the other as the process unfolds. To take another example, advocacy work undertaken with a young person for the purpose of enabling him to express views about being looked after, may well act therapeutically by giving him a strong sense of personal validation, even if the process is not one that is explicitly intended to be therapeutic. But it would be an unwise advocate who confused her role and began trying to use advocacy work to achieve therapeutic objectives.

Advocacy for children is a field of work that has only seriously begun to develop since the implementation of the Children Act 1989 with its very heavy emphasis on the voice of the child. An advocate's primary objective is to express the words of the child; and, indeed, one might view the role of an advocate as having parallels with the role of a translator. The role of the translator is to aim for the most accurate possible translation across the two languages, without any embellishment or modification, no matter what the translator himself thinks. If the client says something that might be misconstrued, or which, when translated, may go against the client's interests, that is not a matter for the translator.

In advocating for a child, the role of the advocate is to provide information to the child and to convey the child's views to those who are charged with the responsibility for making decisions concerning the child. It is the child's rights and views that are promoted through advocacy, not his or her welfare. Rights and views may be in conflict with welfare. The most obvious example is where a child wishes to return to live with a father who has sexually abused her. She may feel that the disclosure and the open knowledge will be enough to protect her. Professionals may feel concerned that she will continue to be at risk. Here we have a situation of potential conflict between the professionals and the advocate: the professionals may feel that the advocate does not appreciate the harm to the child if she returns home, and is not acting in a way that will promote the child's welfare. It is then the advocate's task to clarify for the professionals the distinction

between their role and his: it is they who are responsible for the child's welfare; it is his role merely to inform the child about the options available and convey the child's views. The advocate may have to make this distinction clear to the child as well. If she erroneously believes that he has the same decision-making powers as the professionals do, she may not trust him enough to express her views truthfully.

Ability to recall the experience of being a child and to relate that to the work in hand

Most of us cannot recall what it was like to be a child. Certainly we may recall memories of things that have happened to us. We may create a synthesis between what we recall, what we think we recall, and what others have told us, and call it 'memory', but the real sense of being a child is for many a clouded image. Some may recall happiness, others a melting pot of psychological pain, anger, helplessness, sadness, recognised and unrecognised loss, fears of rejection, and a feeling of being misunderstood. These are powerful emotions for a child to have to deal with, and therefore by the time 'normal' people reach adulthood, many of these experiences have been adjusted to in a way that perhaps drives them from memory. Consider the following, for example:

> The truth about childhood, as many of us have had to endure it, is inconceivable, scandalous, painful. Not uncommonly, it is monstrous. Invariably, it is repressed. To be confronted with this truth all at once and to try to integrate it into our consciousness, however ardently we may wish it, is clearly impossible. The capacity of the human organism to bear pain is, for our own protection, limited. (Miller, 1992, p. 1)

Miller is not talking about the distorted, disturbed and disrupted childhood of the abused child, but the powerful emotions behind the ordinary upbringing of the ordinary child in not unusual circumstances. While working with a child who has experienced abuse, the worker may well be confronting ghosts from her own past. It is vital that this is understood, so that the worker does not try to resolve her own problems through the work undertaken with the child. It is not uncommon for workers to be attracted to areas in which they have had some personal experience. A worker who was sexually abused in childhood, for example, may feel that she has much to offer other victims through her personal understanding of their trauma. Convinced that she has worked through her own experience, she will not consciously use her client to benefit herself but, nevertheless, the child's story may trigger a feeling in her which she had not resolved as thoroughly

as she had thought. Supervision and self-awareness on the worker's part are both vital to ensure that this potential difficulty is kept in check.

A second, perhaps less emotionally laden barrier to recalling the experience of being a child is simply the vast distance between the developmental stage of the young child and the developmental sophistication of the adult. The language and thought of the adult are different from the language and thought of the very young child. For infants (for example, those in the Piagetian sensorimotor stage of development), the world is an experience of fleeting images and impressions which may exist briefly in time and space. Trying to recall such experiences is similar to trying to translate the stream of consciousness of James Joyce's *Ulysses* into a more prosaic, structured and grammatical form of text. Even the older child who has not yet developed the mental apparatus to handle concepts of object constancy (in both space and time), may find abstract reasoning, logical thought and reciprocity in relationships very difficult. Helping the child to achieve an understanding of adult decisions, actions and concepts may be enormously challenging. One of the very important examples here is the child's conception of time. Depending upon age, the 'here and now' can be a state that will exist forever, and notions of 'tomorrow' or 'later' may be the equivalent of 'never'.

In this sense, it is useful to be reminded of the totality of experience in very young children. Loss is loss forever, of the other and of a large part of the self. It is not a matter of 'I'll see you later', because for the very young child there is no 'later' and the sense of 'I' and 'you' can still be largely undifferentiated. Anger, on the other hand, is a rage that destroys. The experiences of hunger, frustration and pain are all extreme; they are not experienced as a temporary state that will get better, but rather as 'This is what it will be like forever.'

ACTIVITY

- Consider your first memory. To what extent is it your own recall? To what extent is it the recall of what others have told you?
- Look around the room you are in. Consider the sights and sounds you experience. Then try to imagine how they would appear without the continuity that locates them in time and space. Consider, for example, how it might feel to close and open your eyes with wonderment at seeing the same things? Consider how the sounds might be if you had no previous understanding (through experience) of the causes of those sounds.

Ability to get children to talk or express themselves and ability to feel comfortable in the presence of children and to have them feel comfortable with you

Not everyone feels comfortable around children. Children have a tendency to say whatever comes into their heads ('Mummy, how come that man only has one leg?'). Children do not have adult qualities of self-restraint, the ability to delay gratification, and an appreciation for the needs of others. Children are noisy and frequently destructive. They say the wrong things, cry at the wrong times, and demand almost unceasing attention.

To work effectively with children the worker must be comfortable around children. If this does not sound like you, then you may need to evaluate quite soon whether this is the place for you. Comfort around children can be learned (most parents learn it) but it may take time, and involve a considerable amount of self-reflection. The worker needs to be secure enough in himself that he is not excessively perturbed when the child asks why he is bald, why he has that spot on his nose, or mentions some other embarrassing attribute. To help the child to talk, he needs to relate to the child in a way that is different from how other adults relate to children, and initially at least the novelty of that approach may make the child curious, but in a cautious way. Talking to the child in a way that encourages the child to express a view, that says in effect that the child is worth talking to, and is an important person in his or her own right, may be something the child is not used to.

Getting down to the same physical level as the child, to address the child more as an equal, does serve to reduce the barriers to communication, but it is also something that may strike the child as odd, at least initially. After a time, it may make the child more comfortable, and the child's level of comfort with the worker is a primary factor in engagement.

Because children tend to be more open in their expression of feelings, it is easier for the worker to gauge a child's comfort level than it would be with an adult. However, when the child is uncommunicative, there are other indicators of comfort. Children who are distrustful of the worker, or at least cautious, will keep a safe physical distance. They will only approach the worker or allow the worker to approach if they are relatively comfortable. Another indicator is the extent to which the child engages in, or allows the worker to engage in, dialogue or other types of interactions (e.g., joint play). The worker should be aware of eye contact and other body language here, always keeping in mind that the messages conveyed by body language vary from culture to culture. A third indicator is the degree to which the child is able to stay 'on task' in terms of activity when the worker is present. The child who is excessively anxious is unlikely to be able to continue to play or concentrate on the task in hand.

Children, and in particular younger children, can be quite anxious about people whose appearance is simply different. If they are not used to men with beards, then the mere fact of the worker having a beard may make them wary. Similarly, they may be anxious about an unfamiliar skin colour or any physical peculiarity. Certainly, in time, they will come to adjust (or to use a Piagetian concept, the child will come to accommodate eccentric appearance as part of the way that adults appear), but not before they have mentally struggled unsuccessfully to assimilate it into their existing picture of the world. Some children adjust quickly, others take longer, and the issue for the worker may well be how long he needs to wait for the child to adjust. Patience will usually prevail but in the worst possible case it might be necessary to assign another worker. The bearded and rejected worker must then be sufficiently self-confident to accept that it was his beard that was rejected and not himself.

Ability to facilitate children's play

Play is an absolute prerequisite for work with young children. If a child cannot play, she cannot be helped, and therefore, the first stage with a child who cannot play is to help her to learn how to play. From there the work can begin. There are three fundamental principles underlying using play to work with children. First, play is the child's medium. The child feels comfortable with play. Playing with the child sends the message that the adult values what the child does, and this message empowers the child. Secondly, play, like other techniques, is a method of making the 'inner world' of the child external. It is a projective tool in that it takes what is inside the child, puts it outside the child, and there allows it to be the focus of attention by the child and the worker. It acts as a screen upon which the child is projecting herself. There is nothing the child can create in the context of play that is not a reflection of the child's inner self and that inner self's relation to the world. The child who makes the bear eat up the little boy, demonstrates at the very least an awareness that there are creatures called 'bears', that they can eat people (sometimes a little poetic licence needs to be allowed), and that children are vulnerable to dangers from other living creatures. The worker may be able to take the scenario further, by asking, 'How does that boy feel about being eaten by the bear?'

A third principle of play as a medium of working with children (and this is particularly true in non-directive play approaches) is that it relies on an inner drive of the child to health and reparation. Given a supporting environment that does not direct that certain things need to be done at certain times, the child will use the equipment available to address issues of significance to herself – possibly as a way of learning to understand something she does not yet understand. The worker is thus more of a facilitator and observer of the healing process than a prime mover. It is not the worker that heals the child; the child heals herself, but the worker provides the context in which the healing can occur. Of course, healing may not occur, but at least the opportunity has been provided.

One of the difficulties of working with children is that this is often seen to be the province of experts: child psychologists, child psychiatrists and play therapists all lay claim to the special skills and knowledge that are needed to understand children, and a social worker with none of these specialist qualifications may feel that she ought to leave well alone. It is useful here to make a distinction between play therapy, and direct work with children using play as a medium. Child-welfare workers do not provide therapy in the sense that their primary goal is to reduce the child's trauma. Instead their role is to assess or monitor the child's situation in order to provide the appropriate services. One such service may be to refer the child to a 'child expert' so that therapy can be provided, but meanwhile the worker must communicate with the child in order to find out what is needed. As with all clients, the worker will communicate in the way that is most likely to elicit a valid response, and for a child that way is through play. After all, no worker would hesitate to try to communicate with an adult on the grounds that a psychiatrist is more qualified to do it. Engaging in play as a medium of communication is therefore a perfectly legitimate occupation but engaging in 'play therapy' is not.

As a practical example of the difference between play as communication and play as therapy, we might point to the interpretation of the significance of communications from the child. If a child draws a picture of a person without arms, a worker who is trying to communicate might well say, 'It's hard to do things without arms. How does the person feel about that?' But the same worker should steer clear of interpreting the drawing as a reflection of the child's internal sense of helplessness. That kind of interpretation is the province of the experts.

We see here, again, the importance of clarity of focus. It is the coordination of the efforts from different professionals that is the hallmark of effective practice, but such coordination only works if each professional is clear about her own role and purpose as distinct from the roles of other professionals on the team.

Ability to decentre from an adult perspective to engage the child

Direct work with children operates at the interface between the world of children and the world of adults. We cannot expect children to be eager to talk to us about issues of concern to adults, even if they are also issues of

concern to the children themselves. For children, sitting down face to face with an adult and talking about things that they have perhaps not talked about before is not an easy matter. The interview situation may be familiar to the worker, but to the child it is artificial. It may require social skills (taking turns to talk, waiting until the speaker is finished, using eye contact appropriately) that the child has not yet acquired. It may require cognitive skills (for example, sustained concentration) that the child is still developing. It may require a level of self-denial (or endurance) that the child is not yet ready for. Therefore, above all else, work with children must be undertaken in a way that engages the child. It has to be appealing, it has to be comprehensible, it must be age appropriate, and it must be fun (or at least not excessively tedious). This is not to say that direct work techniques cannot be used to address painful material, but it should be the content that is painful, not the process.

A very good example is provided by Bray (1991) who describes her work as a social worker with Shaun, a child in a children's home. The work gets off to a very unpromising start. Shaun is not around when she visits, despite his knowing she was coming. When he arrives they sit opposite each other in green plastic chairs, and she proceeds to go through the agenda she has mentally prepared, telling Shaun about the threat of exclusion from school, changes in his mother's circumstances, and the forthcoming meeting with his foster carers. Shaun says, 'Can I go now?' and the social worker is left feeling angry and bemused at the lack of connection. For Bray it was the beginning of thinking about how to approach work with children in a different way, how to avoid adult-centred agendas in the actual work with the child, and how to find a different medium for communication in which the child will be engaged. This is not easy and means abandoning many preconceived notions about the importance of getting answers from children about the questions adults want to ask. It means that the worker must meet the child on his own terms, in his own place, using his own language. And for younger children especially, this language is the language of play.

The attitudes of colleagues can make this even more difficult than it is already. It is obviously faster, even if less effective, to have the child talk to the social worker in her place, on her terms, in her language. It is faster still not to talk to the child at all, obtaining the needed information instead from adults who think they are familiar with the child's situation. In a busy social-services child and family team, where there may be great pressure to allocate cases, taking a long time to work with a child, at the child's pace, using methods which may seem slow and unfocused, is not likely to be viewed with favour. Even though more experienced practitioners recognise that direct work with the child is a necessity not a luxury, the worker may

still feel that she has to justify the time spent with the child. From the point of view of colleagues, she could be using that time to initiate other interventions that might be seen as more useful, at least in the short term.

A final point to note about decentring from an adult perspective is the extent to which the child is expected to share everything with the worker. No child, or anyone else for that matter, can be compelled to share information and we should allow the child the dignity of choosing what he wants to share. A more difficult decision for the worker is to what degree she should let the child know the consequences of sharing before the information is shared. For example, if a child says that abuse has reoccurred the worker must take steps to deal with that and a possible consequence may be that the child is constrained. If the worker points out the possibilities, the child may conceal the information and his welfare may be jeopardised. If the worker does not point out the possibilities, she has deceived the child but can address his welfare because she has the relevant information. On the other hand, the child might not trust her ever again. With older children, the worker might decide to be open about the consequences, and trust the child to make an informed and correct decision about what to share. But it is always a difficult situation, and with younger children it is even more complex.

Ability to continue working uninterrupted despite the emergence of painful and disturbing material

The material that children disclose to workers can be very painful and distressing. If the worker is to provide a useful service to the child, she must not be thrown off course by the content of what is said. It is not unheard of, particularly in the early days of interventions with children who had been sexually abused, for workers to require temporary breaks during the sessions, for the purpose of regaining their composure.

We know from foster carers (Macaskill, 1991) that children frequently do not disclose all of the abuse that they have experienced at once. There is a pattern of disclosing physical abuse before disclosing abuse of a sexual nature, and often there is a progressive unfolding of the extent of the sexual abuse. Foster carers describe the process as one in which the child seems to test you out to see how much you can cope with. If you seem able to cope with what you have been told without being shocked or thrown off course, then later the child may tell a little more. The implications of this for the social worker are self-evident. She needs to be able to maintain equanimity in the face of shocking material. Training helps, and so does the capacity for self-care. It may seem a truism to say that if you can't care for yourself, you can't care for anyone else, but many social workers lose

sight of themselves in other people's traumas, and losing sight of yourself is a sure recipe for disaster. There is a large literature on burn-out, vicarious traumatisation and post-traumatic stress disorder, which describes the consequences of repeated exposure to traumatic experiences, both one's own and other people's. There is not space here to go further into that, but the importance of self-care cannot be over-stressed.

Ability to respond to the different vocabulary, idioms, and expressions of children

As already noted, the language of children is different from the language of adults. One of the areas where this is particularly important is work with abused children. For example, one of the exercises used in basic training to enable people to understand sexual abuse and work with sexually abused children is to brainstorm on the range of terms used to describe male genitalia, female genitalia, and various sexual acts. In part, this exercise is used to desensitise people to the shock-value of the terms used (important in connection with the previous section). However, in part this exercise is designed to familiarise trainees with the wide range of terminology so that they will be familiar with euphemisms and idiosyncratic terms when children use them.

In the same way, it is helpful to be familiar with slang expressions, which can change almost overnight. A word of warning here though. It is one thing to understand slang and quite another to attempt to use it. Children feel patronised by adults who try to 'come down' to their level by using their slang, and they have a very natural tendency to laugh when the adult gets it wrong. It is more respectful to the child and more comfortable for the worker to use ordinary age-appropriate language, with words and sentence structures that the child will easily understand.

Ability to be the diplomat

Children will frequently ask questions which the worker will find very difficult to answer. Why didn't my parents want me? Why was I the one to be adopted when others in the family weren't? Why was it me my father abused? These and other questions can present a dilemma for the worker – not whether to tell the truth (lies are always counterproductive), but how much of the truth to tell at the moment, and, most importantly, how to tell it. The first step is to understand the question. The child who asks why his parents didn't want him is not asking for reasons why he couldn't live at home. The real question behind all three of the questions above is, 'What is wrong with me that ...?' Of course what the child who couldn't live at home needs is personal validation. He needs to feel that despite appearances to the contrary, he is an individual with intrinsic worth and reasons to feel good about himself.

The child who was adopted has the same need. One of the issues for an adopted child is why her parent(s) didn't love her enough to keep her. Strategies for dealing with this frequently tend to emphasise the material circumstances surrounding the parents (they couldn't afford to keep you), or letting the child know that, although she was given up by one set of parents, she was especially selected by others. Both of these strategies have difficulties. The child may know other families living in poverty who do not give up their children. And it is all very well to be specially selected but if you hadn't been given up by your own parents in the first place – the people who are supposed to love you – you wouldn't have been available for selection.

It is usually considered important, when faced with difficult questions by children, to present the information as factually as possible, being careful to avoid any condemnation of the parents. However, one also has to be careful not to go too far in the other direction, or the child may develop fantasies about absent parent figures, or add to already existing fantasies.

Sometimes the worker needs to convey 'bad news' to the child. For example, the parent no longer wishes to have contact with the child; a decision has been taken *not* to return a child to his or her parents; the foster carers can no longer look after the child. Again, in these cases, the worker must not only deal honestly with conveying the information but must be sufficiently skilful to convey the reason for the news in a way that makes sense to the child without being too hurtful. There is no formula that any text can provide to help you here: it is a matter of your own skill, your own judgement, your own human empathy with the child's situation.

Skills needed to work with families

We have deliberately considered the skills of working with children first, for two reasons. One reason is to remind you that the prime reason for intervention in the lives of children and families is to promote the welfare of the child. As stated by the Department of Health et al. (2000, p. 13):

> Working with family members is not an end in itself; the objective must always be to safeguard and promote the welfare of the child.

The other reason is to remind you that, as adults, workers often find it easier to communicate with other adults (the parents), and therefore it is a greater challenge to find and develop the skills necessary to communicate with children and enable them to communicate with you.

Now we will consider some of the skills needed for working with the parents and with the families as a whole. We will look at:

- ability to work in partnership with parents;
- ability to be honest and open even when the information you have to share is unpleasant or painful;
- ability to communicate with adults;
- ability to negotiate;
- ability to provide counselling, warmth, empathy, understanding;
- ability to tolerate people's pain and anger;
- ability to work effectively with groups.

Ability to work in partnership with parents

As we noted in Chapter 1, one of the key elements of the Children Act 1989 is that it promotes partnership between parents and local authorities. In the 1990s, 'partnership' and its companion, 'empowerment' have become buzz-words within social-welfare practice. However, partnership is an ideal, and as such, is unlikely to be totally attainable within practice.

For many, the idea of partnership is flawed because of the very real differences in power between social workers and clients. When compared with parents, who frequently come from the most disadvantaged sectors of the community, social workers have extensive knowledge of the legislative context in which they operate. They have a large-scale organisation behind them providing professional, legal and administrative support. They have several years of training to prepare them for their role, and they are likely to have at least some experience of the matters with which they are dealing. Critics of the concept of partnership claim that even to maintain the existence of partnership is disempowering because it represents obfuscation, an attempt to obscure the very real power differentials in the relationship. Others however (for example, Tunnard and Ryan, 1991), maintain that partnership, as intended under the Children Act 1989, must be redefined in order to change practice. They note, for example, 'For us, partnership is not about equal power, but about people working together towards a common goal' (p. 67). This can be illustrated in the process of assessment. Even where there is conflict, the extent to which social workers and parents work in partnership is based on the degree to which they can reach an understanding about the common objectives of the social-work intervention process, and the role that each should play in achieving those objectives.

The concept of partnership is integrated into many provisions of the Act, and into some of the changes that have been made from previous legislation. The main partnership provisions of the Act relate to the requirements

to ascertain the wishes and views of parents when working with children in need or with children who are being looked after. Colton et al. (1995a), in their study of family support under the Children Act 1989, did just this.

As part of their study, Colton et al. (1995a and 1995b) talked to 122 children in need within the terms of the Act, and with their parents. Many of the parents interviewed felt that social workers were too concerned with the welfare of a single child and not sufficiently concerned with the welfare of the family as a whole; in other words, they were concerned with protection at the expense of family support. Likewise, some parents with disabled children, while grateful for the help they were receiving, believed that this help should be extended to their other children, whose 'normal' lives were being disrupted by their sibling's disability.

Truancy was a further major concern for a large number of the parents, who were intensely frustrated by the seeming inability of any authority to enforce the law regarding school attendance. These parents were also reluctant to talk to teachers and tended to believe that social workers should act as intermediaries between the family and the school, the police and the school, and the special and local schools. Parents felt in addition that temporary placement in a special school following difficulties in the local school could do more harm than good if gains were not maintained when the child returned to the local school. These gains tended not to be maintained because there was little communication between the special and local schools.

A good deal of concern was focused around the accommodation of children. Some parents confided that children were being returned home from local authority accommodation before parents were ready to cope with the responsibility. The lesson here might be that reunification, though a worthy goal, only works when the groundwork has been thoroughly prepared and the timing is right. It is easy to assume that parents mourn the loss of their children and want them back as quickly as possible; and, for many, this is indeed the case. Others, though, while not wanting to admit it in case they are seen as 'bad' parents, are thoroughly relieved that the rude, destructive, trouble-causing child has gone. They need time to come to terms with their feelings about their child and they need help to cope with the kinds of behaviours they will have to face when the child comes home. No doubt, they need help also to change their own behaviours with respect to the child; and all of this is an inherent part of the reunification process.

Another concern was the relatively high amount of assistance provided to foster parents to care for a child. This was resented by birth parents, particularly when the child spent a lot of time at the birth parents' home. A further cause of resentment was the benefits afforded to accommodated children when compared with non-accommodated siblings. Moreover, children

returning home after being accommodated tended to resent the loss of the benefits they had formerly enjoyed. Social workers here seem damned if they do and damned if they don't. Providing for one seems to lead inevitably to jealousy on the part of the other, yet provision is required under the terms of the Act, and resources do not allow for indiscriminate provision. It is perhaps a case of viewing the needs of the child in the context of the needs of the family and ensuring that siblings and birth parents are not ignored.

Finally, Colton et al. (1995a and 1995b) examined partnership between families and social-work agencies. Most parents did feel that they had participated in decision-making, and two-thirds felt that social services had helped them in bringing up their children, and they particularly appreciated the provision of emotional support. The partnership element most lacking between agencies and families was the sharing of information. Only 29 per cent of the children interviewed felt that their social workers had told them things they needed to know, and only 13 per cent of parents felt that they knew enough about the kinds of services available to help them (from other agencies as well as social services). Social workers tended to provide children only with the kind of information that seemed relevant and beneficial under the circumstances, and withheld information which could potentially be damaging – such as not telling a 16-year-old girl that she was entitled to leave her foster home to move in with her boyfriend. There are echoes here of the 'diplomatic' skills needed to work with children discussed earlier, where the issue was how much of the truth to tell and how to tell it. However one feels about the social worker's action in this particular circumstance, Colton et al.'s study did show that relying on social workers to provide verbal information did not work well overall. The authors' recommendations for more effective dissemination of information included the following:

- Prepare information leaflets for parents, covering such common concerns as: hyperactivity; working without losing benefits; child support; parent support groups; behaviour management; harassment by an ex-partner; personal development programmes for men; entitlements when leaving care; and so on.
- Have social workers distribute the relevant leaflets (including leaflets from or about voluntary agencies and community groups), providing additional verbal explanations where necessary. Such provision of written material often helps to dispel parents' suspicions that information about entitlements is being deliberately withheld.
- Utilize other ways of disseminating information: for example, holding film shows and public meetings, or erecting information booths in public places such as shopping centres.
- Develop a multi-agency strategy on how information is to be produced, publicized and delivered.

Even in child-protection work, the trend has been towards increasing partnership, and one impact of this, as a result of the Children Act 1989, is the greater involvement of parents in child-protection conferences which look at issues of risk to their children. Whilst there have been real problems with the implementation of this practice, it is now generally accepted that parents should participate in child-protection conferences. For some parents, however, participation means little more than physical presence. It is easy for them to be intimidated by the authority figures at the table with them, difficult for them to argue, easy to feel at the end that they were no more than a rubber stamp, called there to reinforce decisions already made. If there is to be any real partnership, the impetus must come from workers who genuinely desire the parents' input and have the ability to make the parents feel comfortable and empowered in an alien setting.

Ability to be honest and open even when the information you have to share is unpleasant or painful

Parents are not always honest with social workers, particularly when there are issues of abuse (Department of Health, 1991a; Reder et al., 1993), but it is important for social workers to be scrupulously honest in all their dealings with parents. Sometimes this is difficult, particularly when sharing unpalatable decisions with the parents, such as the decision to hold a child-protection conference, the decision to place a child's name on the child-protection register, the decision to withdraw, or not provide, financial support for a child to attend nursery (or indeed any family-support service), and of course, the decision to apply for a care order for the child to be removed from the care of the parents. Sometimes other unpleasant information needs to be shared with parents: you haven't been able to secure the service for the parent that you were attempting to get; you haven't been able to do something very important for the parent that you had agreed to do.

Like any unpleasant task, telling the parent this tends to be put off because there is always something more important that you have to do right now. Also, like any unpleasant task, it gets more difficult the longer it is delayed. Honesty with parents includes sharing information in a timely manner, using all the skills you possess to convey what you have to say in the least hurtful and most productive way.

Ability to communicate with adults

We have already discussed the skills needed for working with children, and some of the skills needed for working with adults are similar. However, whereas with children the major obstacles to communication are

developmental differences, with parents the obstacles are more likely to stem from social class and cultural differences. One of the lessons one learns very soon in practice is that there are ways and ways of saying the same thing, and finding the right way is vitally important. A temptation when one has to say something unpleasant is to lapse into jargon. Official-sounding phrases that are usually incomprehensible to the parent can distance the worker from the whole proceedings, allowing her to believe that she has said whatever it was without putting it into so many words. Sometimes, the use of jargon is not intentional: it is just a matter of the worker unconsciously trying to increase her own comfort level by using language that is familiar to herself. But jargon is only communication if it is used as a convenient shorthand with other professionals who know what it means. With parents, it is more often a process of exclusion: the worker is essentially saying, 'I belong to a professional club and you don't.' It is very important, therefore, to use only words that the parent will understand, taking into account the parent's cultural background and social class.

Social class is a delicate area. It is easy to pretend that social class does not exist, that we are all equal as people and class distinction is something that is better ignored. However, class distinction does exist. It is one of the realities that affect all other aspects of client's lives, and to ignore it does no-one a service. A worker might well be seen as hypocritical if she tries to pretend to a client – whose awareness of the social hierarchy is probably acute – that they are both on the same social level. Most often they are not, and this is something that must be dealt with honestly, and without patronising the client. Again, there are no formulae to help you here. It is your own skills, your own personal qualities of warmth and empathy that will count.

Another point to be aware of is that much of our communication with each other is not verbal at all but comes through body language. If you are assuring your client that her situation is immensely important to you whilst backing towards the door, you are sending mixed messages, and the message which will come across with most force is your desire to escape. Be aware of your body language, and do your best to ensure that your tongue, your eyes, your hands and your feet are all saying the same things.

This is particularly important when you need to confront or challenge people. Issues about non-compliance or disguised compliance (Reder et al., 1993) must be addressed, not swept under the carpet, and they must be addressed clearly so that there is no possibility of mistake. A good example here is work with sexual abusers. The worker often needs to confront abusers who deny what they have done or the extent of the abuse. If the client has lied, the lie needs to be pointed out, but the focus of the worker's remarks should be this particular lie, with no implication that the client is,

in general, a liar. This may seem a subtle distinction – a liar, after all, is a person who lies – but it is very important to distinguish the person from the act. A child who has done a bad thing must not be labelled as a bad child. Similarly, a client who has lied must not be branded as a liar but is simply a person who, in this particular instance, has told a lie.

Being willing to confront does pose certain risks for the worker, even if done with the utmost care and discretion. Even the most skilful worker may at times trigger an extremely aggressive response, and it is a matter of judgement to be able to predict when a client might pose a personal danger. If there is a possible danger, it is not brave to confront it alone: it is just foolhardy. Take another worker with you or ask for the protection of the police. If you are alone when the situation arises, leave as rapidly as possible. At all times, consider your personal safety first when dealing with potentially aggressive clients, remembering that you can't look after anyone else if you can't look after yourself.

Ability to negotiate

One of the very curious aspects of working with children and families is the success of the family therapist. Almost any family therapist will tell you that when families arrive, it is very rarely family therapy that they are looking for. They expect that their problem will be fixed, and the problem, in their eyes, is usually the family member who is causing all the trouble: the 8-year-old who will not go to school; the 13-year-old who stays out all night; the 14-year-old who is involved with drugs. The other family members expect that their role in the 'fixing' process will be to provide the therapist with the necessary information and possibly provide moral support to the one who is being fixed.

The first job of the family therapist, therefore, is to persuade the family that it is the family system that needs to be addressed, not the behaviour of the offending member. Perhaps this idea will be introduced gradually, but if the therapist cannot negotiate with the family about what needs to be done, nothing will be accomplished. The fact that something often is accomplished says much for the negotiating skills of family therapists. Other social workers too experience similar problems. We know from research (see, for example, Mayer and Timms' classic work *The Client Speaks*, 1970) that a mismatch between client and worker expectations leads to poor outcomes. Perhaps the client expects material assistance while the worker hopes to increase the client's ability to cope with the situation as it is. Unless the worker is able to negotiate with the client what result can be expected from their work together, the worker will be frustrated, the client disappointed, and nothing will be done.

Negotiation is a vital skill for social workers. They do not need to be Henry Kissinger, but they do need to understand the importance of trying to find ways out of an impasse that allow the other party dignity, and a feeling of having achieved their goals. A very interesting story is told about two sisters who both wanted the same orange. They could not agree over who should have the orange and so, in a spirit of compromise, they cut the orange in half and divided it equally. One sister then went home, squeezed the juice from the orange and threw away the peel; the other went home, used the peel in a cake she was baking, and threw away the rest. Although the division was fair, had the sisters been able to negotiate the outcome with reference to their needs, they would have both had twice as much.

The important phrase here is 'with reference to their needs'. When there is conflict, it is vital in negotiation to identify clearly your own needs, interests and expectations and to help the other parties to identify theirs. Sometimes, the conflict will turn out to be about means rather than ends, and then the process can be addressed rather than the objectives. Even when the conflict concerns the objectives, there may be some overlap, where common action can be mutually beneficial.

Objectives (or interests, needs and expectations) should always be expressed specifically, avoiding generalisations. For example, the worker should not say to a parent that she wants what is best for the child. This does not specify what the worker thinks is best (which is probably the nub of the conflict) and, worse yet, it implies that the parent does not want what is best for the child. Similarly, a worker who proclaims that 'the child's welfare is paramount' will probably produce defensive parents who believe that the worker thinks she has more of an interest in their child's well-being than they do.

Having noted the pitfalls, let us now turn to the principles. The following are some principles of negotiation from Fisher and Ury (1991) that lend themselves to working with parents.

1. Participants are problem-solvers.
2. The goal is a wise outcome reached efficiently and amicably.
3. Separate the people from the problem.
4. Be soft on the people, hard on the problem.
5. Proceed independent of trust.
6. Focus on interests, not positions.
7. Explore interests.
8. Avoid having a bottom line.
9. Invent options for mutual gain.
10. Develop multiple options to choose from; decide later.
11. Insist on using objective criteria.

12. Try to reach a result based on standards independent of will.
13. Reason and be open to reason; yield to principle, not pressure.

Of particular interest here is the emphasis on negotiation as a creative process. Fisher and Ury describe negotiation as a problem-solving process; they suggest *inventing* options for mutual gain and *developing* multiple options. Creativity is not an attribute that tends to be emphasised in social-work training, but there is no doubt that the ability to find creative solutions to problems is a major asset for a social worker.

Another point of interest is the recommendation to proceed independent of trust (principle 5). Social workers tend to believe that trust is paramount and nothing can be accomplished without it. Doubtless it is paramount and it should always be aimed for. On the other hand, it is not always present (in international negotiations it is almost never present) and it is quite possible to negotiate in good faith without waiting for a trusting relationship to be established. Principle 12 suggests that agreements may be reached about specifics if there is agreement about the broader principles (for example standards) underlying the issue. This then makes the discussion one of trying to reach agreement about how to operate on the basis of standards about which there is agreement. This may also de-personalise the issue from an 'I want, you want' position, moving towards a 'we both want'.

Ability to provide counselling, warmth, empathy, and understanding

There are other situations in which a counselling approach is required. The provision of rapid support, advice and guidance when parents have just received the news that their child has a disability ('early counselling') may be a very useful way of helping them to cope. When parents have experienced the loss of a child, a counselling approach is likely to be beneficial, perhaps provided by a specialist counselling service. Marital counselling may be provided by organisations such as Relate. You will be able to think of many other situations where counselling is appropriate.

The third element of a growth-promoting relationship is empathic understanding. This relies on the ability of the worker to imagine what the client may be experiencing, relating it to her own nearest experience to that of the client. Empathy also draws on the ability of the worker to be an active listener. This means fully hearing what the client has to say, relaying what one has heard back to the client for clarification and confirmation, and not jumping in prematurely with answers and solutions. Empathy can be a suspect concept from the point of view of the client, on the grounds that 'you can't know what it's like until you've been there'. For example, workers are frequently asked by parents, 'Do you have children?' The implication here

is that, if you don't, you have no right to be telling me how to bring up mine. Workers should not become defensive – it is not a sin to have no children – and the question, anyway, might provide a good lead in to having the client tell you how *she* brings up children.

Ability to tolerate people's pain and anger

Responding to another's pain and sadness is not easy. There is sometimes a tendency to do anything to get away from the experience: bring the interview to an end; suggest a cup of tea; change the subject; heartily tell the client not to dwell on it. Another temptation is to try to 'fix it': suggest things the client might do; promise to do something yourself. The most difficult thing to do is to sit in silence while the client cries. Allowing a client to feel what she is feeling without trying to move her on to something else is a very important skill. You must be able to contain your own pain in order to allow your client to experience hers.

Loss of a child is a particular example. People who have experienced such a tragedy may well find that others around them are ready to move on long before they themselves are ready. Even those friends who were most supportive during the weeks following the loss may reach a stage after several months when they are no longer comfortable hearing the person talk about the lost child. 'It's time to move on with your life,' they say bracingly, and it is most important that the worker does not convey, implicitly or explicitly, the same thing. The clients themselves are the only judges of when it is time to move on.

Coping with a client's anger is also a difficult task. Despite their best intentions, social workers do things that make people angry. It is no use thinking that because a difficult decision was justified and the justification was explained to the client, the client will not be angry. A decision to remove a child, for example, even when made and explained with the utmost care, sensitivity and fairness, is likely to make the parent extremely angry. As with pain and sadness, the best approach is to allow the parent to experience her anger. However, there is a world of difference between anger and aggression. Physical and verbal threats and menacing behaviour should not be tolerated and, as previously discussed, the worker must be aware of any risk to her personal safety.

Ability to work effectively with and in groups

It is important to feel confident about working in groups and with other professionals. Most child-care social work is delivered by social workers operating in teams. These teams may be more or less specialised, but they

will generally adopt a coordinated approach to assessment and intervention work. During the last quarter of a century, there has been a much greater emphasis on working together with other professionals in a range of children's services. Teamwork is no longer the exclusive prerogative of child protection (if indeed it ever was) and many of the decisions to be made will be undertaken by a group of professionals coming together to develop a coordinated plan. These professionals may come from different agencies and represent several different disciplines.

A good example of this kind of inter-agency and multi-disciplinary working is the case conference. Case conferences to consider the situation of all children who are at risk of abuse were recommended by the report into the death of Maria Colwell (Department of Health and Social Security, 1974). In the case of Maria Colwell, it seems that there were a number of professionals who each held a different piece of information about the situation, but no-one understood the situation in its entirety because there was no mechanism for putting the pieces together. The case conference constitutes the required mechanism, and its purpose is to make mutual decisions about what should be done next, to ensure the welfare of the child. This is not as easy as it sounds. Consider two of the barriers.

First, meetings involving a number of professionals are expensive. The time spent needs to be justified, and therefore the purpose of the meeting must be clear. It is generally accepted that case conferences – and committees in general – should *coordinate* work, not undertake work. Much of the work (for example, risk assessment, locating a foster home) needs to be done outside the committee, and the role of the committee is primarily to decide which tasks need to be undertaken, to allocate those tasks, to monitor progress on the tasks, and to ensure that new plans are made when the tasks are either not being achieved, or are unachievable.

Secondly, professionals have different backgrounds and approach issues in different ways. The most conspicuous example of this is the difference between the social and medical models of disability or illness. A physician treating a child with diabetes, for example, is treating the diabetes and does so by prescribing diet and medication. A social worker, working with the same child, is treating the whole child in the context of her family and may be more concerned with the effect of the diabetes on the child's and the family's life. Both of these perspectives are quite legitimate and, if the social worker and physician can respect each other's views, their cooperation will be fruitful. Perhaps the social worker can persuade the child to follow the diet when her friends are eating sweets; perhaps, on the social worker's advice, the physician can modify the insulin injection regime to fit more conveniently with the child's routine. If, on the other hand, the social worker believes that all physicians are only interested in diseases, not in

people, and the physician believes that social work is a waste of time, it is the child and family who will suffer from the conflict.

Another area of conflict can arise from the different perspectives of social workers and the police. In a situation of alleged sexual abuse, for example, the police focus is to gather evidence that may be used in laying criminal charges. The social worker's focus is to protect the child. It is very difficult to achieve both ends at the same time (in a joint investigative interview, for example, involving both the social worker and the police) and the result may well be mutual recriminations, with both parties feeling that the other has intruded on their turf and prevented them from carrying out their function.

Turf and territory tend to be important considerations for professionals. Psychologists might argue that only they have the skills and training to administer and interpret pencil-and-paper measuring instruments (to measure such things as marital satisfaction, for example). Nurses and social workers might both argue that it is only they who ought to be doing discharge planning for patients coming out of hospital.

Terminology is another bone of contention. Social workers might say that the word 'patient' is disrespectful, implying that the person is an object with no control over his or her own life or treatment (and that medical staff use that word because they do, in fact, see people that way). Physicians might counter that the word 'client' is hypocritical. 'Clients' in the world of commerce are people who pay for services, and social workers' 'clients', who often do not pay, are not clients at all but rather consumers of services. A social worker's real 'client', is the funding body or the taxpayer, and (our hypothetical physician might say) social workers would do well to remember that.

What is to be done about all this? How do we remove the barriers of jealousy, resentment and misunderstanding so that professionals from different disciplines can work together in ways that are beneficial to children and families?

Education is one way. First, students who are being taught within their discipline should be taught the functions and perspectives of other disciplines in a manner that allows them to respect and understand what other people do. Next comes joint training. Professional development training in sexual-abuse investigations, for example, might include both social workers and police officers. So might training in how to handle situations of domestic violence. Training in the medical examination of a woman who has just been sexually assaulted might include physicians, social workers and the police. Through joint training, professionals can learn each other's perspectives, goals and problems. If they work together after the training, and if they are given time to debrief and discuss, they might even grow to like and respect one another.

However, effective interdisciplinary work is not just a matter of cooperation between individuals, necessary though that is. It is something that needs to be structured, paid for and valued by the various organisations and agencies for which the individuals work. Attitudes need to change, in short, from the top down as well as from the bottom up.

As well as working *in* groups, workers need to be able to work *with* groups. The last thirty years have seen the expansion of group work from an extremely specialist method of working, undertaken only by a small number of specially trained professionals, to a method that is considered to be in the repertory of every qualified worker. Groups are very powerful tools, now used in a wide variety of situations, with a wide range of client groups. Consider the following examples:

- group work with abusers, to mobilise peer pressure to acknowledge denial and minimisation;
- groups for parents of children with a learning disability;
- groups for mothers of sexually abused children;
- groups for children who have been sexually abused;
- groups in family centres, for a wide range of practical activities;
- groups for victims of domestic violence to share their experiences;
- groups for parents of teenagers;
- parenting groups.

One of the main purposes of the more therapeutically oriented groups is to break down the isolation that people often feel. For the sexually abused teenager who, in the context of the secrecy surrounding sexual abuse, has felt that she is alone in this terrible experience, it is often astounding to find that others have been coping with similar experiences, and remarkably, have been experiencing similar consequences. Another positive impact of groups is that people who have felt extremely damaged by what has happened to them (for example, being abused, losing a child), begin to realise that they have something to offer others who are in a similar situation. They begin to find a capacity for growth, and their self-esteem is enhanced when others respond positively to their experience and perhaps their advice.

Of course, any group situation can also have negative aspects: faction formation, scapegoating, groupthink, domination by some group members, and dismissal of the opinions of others. The group facilitator must watch for these and use the most appropriate means to ensure that the group process is one of empowerment, not one of compounding the disempowerment its members may already have experienced.

We will leave the discussion at this point and move on to talk about the distinction between prevention and protection. In this chapter, we have looked at the skills needed to work with children and families. In the next chapter, we will consider prevention and family support.

Case examples

Case example 3.1 Helping troubled children

There follows a number of scenarios in which children may experience adjustment or personal difficulties. For each of them, consider the following:

1. What emotional difficulties might the child be experiencing?
2. How might the child, directly or indirectly, be helped?
3. Are there any particular means of communicating with the child, or methods of working that might suggest themselves in this particular situation?

(1) Paul is 6, and is the youngest of three children. His mother and father have just separated, several months previously. It is an acrimonious parting, and Paul has not seen his father since the separation.

(2) Kylie is 12, and is the oldest of three children. Her father comes home regularly in a drunken condition, and frequently (at least once a month or so) assaults her mother. Her mother has considered moving, but feels afraid to do so.

(3) Richard, who is West Indian, is 8. He has been fostered, on his own, with a white family for two years, in an area where there are very few other black children. It has always been planned that he should move, and now it is suggested that he should go to live with a black family in a more culturally diverse neighbourhood.

(4) June (7) finds it difficult to make friends at school. Her father left home when she was 3 years old, and she has regular contact with him. Since last September, she has complained most mornings of stomach ache so severe that she does not feel she can go to school. On the few occasions when her mother has kept her home the stomach pains have apparently subsided in a few hours.

(5) Michael (11) has just transferred from a very small rural primary school to an urban secondary school because his family relocated. Over the course of his first term in secondary school, a gang of boys have been intimidating Michael, and taking his lunch money off him. He has been afraid to tell anyone about it.

(6) Andrew is 5 years old. His concentration is very poor and at school his temper tantrums are so severe that the school is considering exclusion. His older sister no longer enjoys playing with him, and his parents are finding it difficult to deal with his behaviour.

Case example 3.2 Overcoming barriers to working with families

There follows a number of scenarios in which parents may experience difficulties in working with social workers. Consider what those barriers might be, and how they might be addressed in work with the family.

(1) Mary is 17 and has a child, Paul, aged 18 months. She is a single parent, and is still under a care order, which will lapse when she is 18 years old. She has been provided with housing through a supported housing scheme, and she has found the support provided very helpful. Recently there has been concern about her care of the child, and her social worker is calling around to see her.

(2) Mr and Mrs Anthony are a West Indian couple living in a London borough. Mr Anthony recently used a belt on his 13-year-old son for 'cheeking' him. The school reported the welts, and a social worker, who is white, is calling around to meet with Mr and Mrs Anthony to discuss the incident. Mr Anthony does not understand what the fuss is about; he experienced the same type of discipline when he was growing up in the West Indies.

(3) Anne (23) is a single mother, living next door to her own mother in an English village. She has been in an escalating cycle of drug usage, and is now regularly injecting. She is involved in prostitution to support her drug habit. Whenever she takes the drugs, she ensures that her son Dean (3 years, 6 months) is with her mother next door. Her mother doesn't approve, but is glad that she has enough control of the situation to leave her son there; but she is uncertain whether the drug usage will remain under control. The health visitor has referred Dean to social services.

(4) Megan (38) and her husband have a child (Sian, aged 2) with Down's Syndrome. The health visitor has referred them to the social services for respite care, as Megan is occasionally very tearful, and generally is very tired and run down. Both Megan and her husband are Welsh speaking; the social worker calling to see them doesn't speak Welsh. He is going to be discussing the provision of respite care, and other possible services that might help Megan and her husband.

(5) Mrs Ali has left her husband with her three children aged 3, 5 and 7 to go into a refuge, following his continued violence towards her over the

last five years. Her command of English is very limited, and most of her dealings with people are undertaken through her oldest child. The workers at the refuge are concerned about the impact of the domestic violence on the children and wish to discuss this with Mrs Ali.

Case example 3.3 Working across professional and disciplinary boundaries

Mrs Jones is 25 and has a six-week-old baby boy. He is her first child. She lives with her husband. They live in Grangetown, Cardiff, in a modest, privately-owned, small terraced house. The health visitor has been to see her and using the Edinburgh Post-Natal Scale considers that she is at high risk of post-natal depression; the Health Visitor has shared her concern with the GP to whose practice she is attached. The GP feels that the Health Visitor should strongly advocate medication, which he would then prescribe. The Health Visitor believes that there is time to explore the benefit of post-natal support networks and weekly support visits from herself before embarking on chemical treatment.

1. How might the different professional backgrounds influence their perceptions as to the causes and remedies of post-natal depression?
2. How might their different roles influence their perception of the difficulties associated with becoming a parent?