

The Helping Relationship: Understanding Partnerships

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Summary

In this article Professor Hilton Davis describes his Family Partnership Model. In this Model, the relationship between parents and those helping them is a partnership defined in terms of mutual participation and involvement, being parent-led, involving the expertise of both partners, with agreed aims and process, mutual respect and trust, open communication and negotiation. Hilton offers the Model as a guide to service design and development, recruitment, family practice, training and effective supervision.

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Introduction

In this essay I will attempt to explore the nature of the helping relationship in working with families because the nature and quality of the relationship is crucial to beneficial outcomes. I have come to believe that the most effective relationship between service providers and parents is a partnership. I also think that all potential helpers need to understand what this means specifically and must have the skills of putting this into practice. In order to understand the place and function of the relationship fully, it has to be seen within the context of the helping processes overall and this therefore requires an explicit theory to tell us what these are. The essay will therefore:

- give reasons for developing a model of helping
- describe one particular model, the Family Partnership Model, in some detail
- describe briefly the associated training with some examples of how it has been implemented
- give some research findings about the effectiveness of the training in influencing relationships with parents in practice

Background and Context

Relationships with others and the communication to sustain them are not easy and cannot be taken for granted. This is evidenced by the fact that almost 50% of marriages end in divorce, our courts are full of conflicts, and there are wars occurring throughout the world. Relationships are the foundation of our lives, including our work, but are also the source of considerable anxiety and hard work.

Relationships with clients and colleagues are a major source of stress within the caring professions. Service provision is dependent upon relationships. This is evident in the prevention literature from the numbers of parents who refuse to be involved or who drop out prematurely. There is also evidence from the psychotherapy literature that the quality of the therapist-client relationship is one of the best predictors of outcome.

Given these points, why do we not ensure all staff have the ability to relate to others? I have been struck by how infrequently professional staff have an explicit understanding of the processes of helping. Service providers can often feel vulnerable and threatened themselves, may become defensive and may lack a respectful belief in the abilities of parents to be effective. These people may care deeply about the parents with whom they work but, too often, express this by trying to take over from them, trying to solve their problems for them and trying to make everything all right. Instead of working with them, they adopt an expert model, in which they take responsibility for finding solutions and may then feel stressed or helpless when they cannot.

The need for an understanding of how to help first struck me in the early 1980s, when working in the East End of London with families of children with disabilities. I realised that I, and other people, need an explicit model that can guide us as helpers, that can decrease the anxiety involved in helping and make us more effective. My subsequent experience in working in other fields, including general paediatrics, child mental health, specific learning difficulties, war trauma and, more recently, prevention, has only served to endorse this need. The problems as I see them include the following:

1. There are enormous psychological and social needs in families that are not addressed adequately by our services.
2. These issues are not well understood. This includes a failure to understand the psychological and social nature of the helping processes, which begin with a relationship and intimately involve communication.
3. As a result, there is unnecessary parental dissatisfaction with services, particularly in relation to communication.
4. Professionals frequently lack the skills of engaging and interacting with parents.
5. There is usually a narrow focus upon disease or disability and a failure to address the human needs of children and their parents, whose psychological adaptation is compromised by problems in their children, yet crucial to the care they can provide for them.
6. True to an expert model, our services have almost always been designed by professionals and imposed on their clients with little by way of negotiation.
7. Providing services is expensive. Resources are scarce in general terms and, particularly, in those relating to psychological care. As a result, every member of our workforce is required to attempt to provide holistic support that especially promotes the psychological and social functioning of families and prevents psychosocial difficulties.

The following account will help to illustrate these points. I vividly remember in the early 1980s working with a mother of a five-year-old girl, who I will call Sally. She had severe developmental delay and a life-threatening illness. The family were well known to the hospital services through constant and necessary involvement. In a referral to me for a developmental assessment, the paediatrician described Sally's mother as well supported and coping remarkably well. However, by doing the assessment in partnership with the child and

mother and by listening carefully, I discovered that Sally's mother:

- did not know, or had not been told, the nature of Sally's problems
- had denied or otherwise not realised the extent of the delay
- was completely obsessed by caring for Sally to the detriment of her other children, all of whom were showing psychological distress
- felt alienated from her husband and isolated from family and friends because of her preoccupation with Sally
- felt unsupported, even put down, by the hospital staff, and particularly by one of the paediatricians, with whom she felt in conflict
- felt unable to express her concerns over Sally's constant invasive treatments that she thought were ineffective
- was depressed and felt both helpless and ineffective
- knew that her parenting was inadequate and fuelling Sally's behavioural problems

In my experience this is not an isolated situation, as research into family needs shows. It clearly highlights the service problems mentioned earlier, including:

1. Undisclosed parental dissatisfaction with services.
2. Professional failure to communicate effectively with the mother.
3. The lack of the type of relationship with professionals that would enable her to express her problems.
4. A failure by professionals to identify and understand personal and family difficulties. This can:
 - a. have profound influences on the care for and development of the child
 - b. result in a failure to meet the needs of the family or the child
 - c. result in a failure to promote the psychological and social functioning of the family and hence a failure to facilitate the quality of Sally's short life
5. Finally, a failure by professionals to foresee and prevent problems that were not inevitable.

However, what this case also illustrated was that by simply listening to Sally's mother, by forming a close relationship with her and by helping to create a safe environment in which she could talk openly and explore the difficulties, she felt enormously relieved. In a very short time, she began to feel much better about herself and stronger in facing these various problems. She then began to manage them much more effectively.

Now I am aware of considerable changes in services since those days. Early work by Peter Mittler, Helen McConachie, Cliff Cunningham and others on the notion of partnership has had enormous influence. Such parents as Philippa Russell have taken up these ideas and have demanded and facilitated changes in policy and service ethos and design. There are now many examples of family-centred practice in the UK, including Peter Limbrick's 'One Hundred Hours', 'Face 2 Face' (Scope's befriending scheme developed by Lizzie Jenkins), 'Right from the Start' and many others.

There have been many changes at a policy level, including recognition within the National Service Frameworks of the importance of psychosocial support for the family, the need to work in partnership with them, and importance of promotional and preventive work. Research evaluations have also come to recognise the requirement for intervention to be family-centred for it to be effective. However, in reality the situation may not have changed enough. For example, even though there is a general acceptance of a family-centred approach, it is highly significant that Donald Bailey, in the foreword to a book by Paula Beckman (2000)¹ on

working with families, should observe that (paraphrased):

1. Little time is given to preparing professionals for family-related roles.
2. Most professionals perceive their skills in working with children to be greater than their skills in working with families.
3. There are significant discrepancies between typical and desired practices in working with families.
4. The lack of family-centred practices is attributed to real and perceived administrative barriers, family and professional attitudes, and professional skills.

I often wonder whether these service difficulties derive from our technological world in which it is assumed that everything has a cure, and in which the cure is all-important without taking full account of the means of achieving it – the journey. Such attitudes tend to neglect the all-important human processes involved, except perhaps where marketing and selling are involved. However, whatever the origins of such difficulties, they are compounded by the fact that few interventions are adequately based in theory. Even when a theory is made explicit, it tends to be exclusively related to children's development and techniques for enabling change (e.g. behaviour modification) and fails to acknowledge the importance and functioning of the professional-parent relationship and how this impinges on the implementation of the methods.

We need a model that elaborates all the processes involved in helping, not just those related to the functioning of specific treatments (e.g. drug effects or parenting methods). Without such a model we cannot know what we are doing and certainly cannot conduct appropriate research into what is effective. Our current obsession with evidence-based outcomes will achieve little without equal attention to the processes. This absence of theory at a research level is equally pertinent in practice. We need a model of the helping processes to enable us to improve service design, to select workers appropriately, to provide effective management, training and support for them, and then to evaluate and continuously improve our systems.

The Family Partnership Model

Within the context of these service difficulties, I have been struggling to produce and develop a model that would not only guide appropriate research, but also serve to guide practitioners within all child and family services. The model has become known as the Family Partnership Model (formerly called the Parent Adviser Model). This is described in detail in a book by Davis, Day & Bidmead (2002a). As a model it clearly needs to be valid in being supported by evidence, but equally, for use in practice, it has to be accessible and helpful so that it can be useful to all potential helpers from child care, education, social care and health services. As such, it has to be simple and meaningful. In trying to achieve this, we have expressed it as a diagram showing five boxes contained in an oval, with each of the boxes and the oval containing a small number of specific points. The overall Model is presented in Figure 1. I will firstly indicate what this is intended to convey, before elaborating the specific content of each of the boxes.

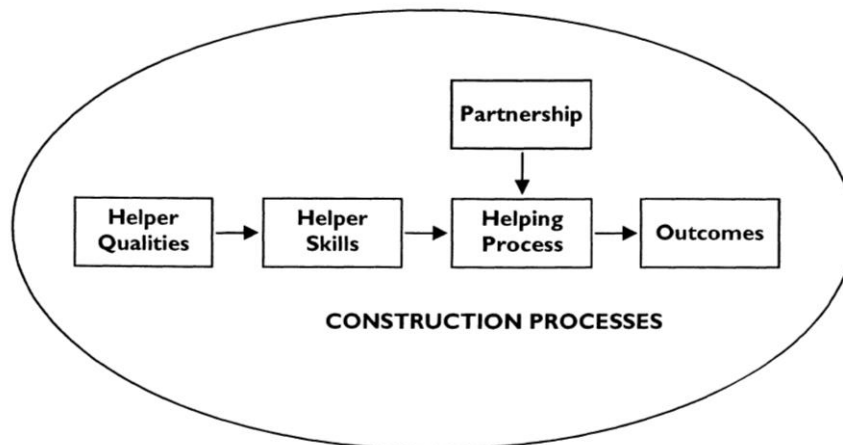


Figure 1: The Family Partnership Model

The diagram as a whole indicates that in order to achieve beneficial outcomes (the **Outcomes** box), the parent and helper have to engage in a process that can be understood as a number of steps, tasks or stages (the **Helping Process** box). These steps are assumed to begin with establishing an effective relationship between the parent and helper and in this Model it is assumed to be a partnership, the characteristics of which need to be defined (the **Partnership** box). It is then suggested that to enable the development and hence the process, helpers must bring a set of personal qualities (the **Helper Qualities** box) and a set of specific communication skills (the **Helper Skills** box). However, these are all enclosed in an ellipse to indicate that the five boxes should be understood in terms of how the helper and parent function psychologically and that this underpins and helps to make sense of all the boxes.

I will now briefly elaborate the Model as a whole by taking each of the boxes in turn and specifying the content of each of them. I am aware that this involves more than the parent-helper relationship, which is the topic of this essay. However, as I said at the beginning, this is so that we can more easily understand the place of the relationship within the context of all the processes involved.

1. Outcomes

Beginning with the box on the right of the diagram, I would argue that it is important to know what outcomes we are attempting to achieve as helpers in order to understand what we must do to reach them. The Model begins, therefore, with an explicit list of anticipated outcomes as in Figure 2. There is not space here to discuss each of these in detail so I will make a few general comments. The first is that an individual should not accept what is written in this list without question. The list is presented to initiate thought and for specific helpers to be clear and explicit about what they think they are doing. Secondly, I argue that all our efforts to help with specific problems or issues should be seen within a broad, holistic and family- and community-centred view. Even if our concerns are very specific, such as prescribing drugs or instituting training, we should still be concerned not to do harm, physically or psychologically, and to enable the family (both parents and children) in terms of their emotional adaptation. For example, their sense of agency or self-efficacy, their sense of control, interdependence and their understanding and abilities. We have included a general concern for social support and community development because these have powerful benefits in themselves and are also the means by which the strength and resources of the family are maintained and developed. We include the outcome of enabling service change or development to make clear that this is not the responsibility of governments and managers,

but of everyone involved in service delivery, with the implication that systems need to be two-way in terms of information transfer and not top-down.

- a. To do no harm
- b. To help parents identify, clarify and manage problems
- c. To enable parents generally including their ability to anticipate problems
- d. To enable them to promote the development and well-being of their children
- e. To facilitate the family's social support and community development generally
- f. To enable necessary service support from all agencies
- g. To compensate for parent and child difficulties where necessary
- h. To change our service systems so they can be more helpful

Figure 2: The Outcomes of Helping

2. The Helping Process

The way these outcomes are achieved can be understood as a process consisting of a number of steps, tasks or stages, each dependent on the steps preceding it. These are listed in Figure 3 which indicates that the helping process must involve both parties and begins with the establishment of a relationship between the parent and helper, and that the nature and quality of this relationship determines to a major degree all that happens subsequently. For example, if this relationship is not based upon trust, then the next stage will fail, as the parent will not work openly with the helper to explore the difficulties they are facing. This second stage is mutual in that it involves the helper exploring and therefore understanding the problem (the third stage), and, more importantly, the parent thinking deeply and carefully about their difficulty. In this way a parent might change by, at the very least, becoming clear about what is happening to them. This might include them realising why the difficulty has arisen and how it connects, for example, to other aspects of their lives. These first three stages are crucial and sometimes they are all that is needed to achieve important outcomes for families. Simply changing from seeing their daughter as damaged to being able to see her as a treasured gift solved enormous problems for one couple. Seeing loving relationships as a major aim in life had similar profound effects on another couple who, previously, were obsessed with finding a non-existent cure for their child's disease. As a parent, coming to see oneself as effective and therefore not as a failure or helpless is also crucial, yet this kind of negative self-view can so easily arise in the face of adversity. These stages are important even in the context of what might be regarded as a simple breastfeeding problem, as the following shows. A mother approached one worker at her local clinic with a feeding problem and was immediately given advice on how to hold the baby differently and then sent away. The mother left feeling very dissatisfied and returned to the clinic again later. This time she saw a different worker who did not immediately tell her what to do but, instead, started by asking her why she was worried. This led within a short time to the mother expressing her underlying fears about the baby having severe developmental problems which, clearly, had very different implications for the help needed.

- a. Establishing a relationship
- b. Helping the person explore their current situation
- c. Helping them formulate a clearer understanding of their situation
- d. Establishing agreed aims/objectives
- e. Planning strategies
- f. Supporting the parent as the plans are implemented
- g. Evaluating the results
- h. End

Figure 3: The Process of Helping: Tasks

It is only when the parent and helper share a clear understanding of the parent's difficulties, that they are in a position to begin problem-solving, which, we assume, has the further stages of agreeing aims and objectives to be achieved, planning strategies, implementing the plans, evaluating the results, and ending the current service involvement when appropriate. These are listed as separate stages because each needs to be enacted in collaboration with the parent. This ensures their involvement, the use of their expertise, their compliance, and an acknowledgement of their role when the goals are achieved successfully. These stages are further elaborated by considering them as a flow diagram as shown in Figure 4. This is meant to summarise what I have said above, but also to acknowledge that the Model is not simply linear in that each stage may relate to all other stages in more complex ways. For example, the development of the relationship may take time and be dependent upon how the helper works in relation to the other stages. There may be multiple problems each requiring a different approach once a successful strategy has been found for a previous problem. It might also be necessary to loop back through the stages to react to a strategy that was not successful initially. This reflection can explore if the problem was understood properly, if goals were appropriate and if the strategies were adequate and implemented appropriately. Necessary changes can then be made at each stage to help ensure success.

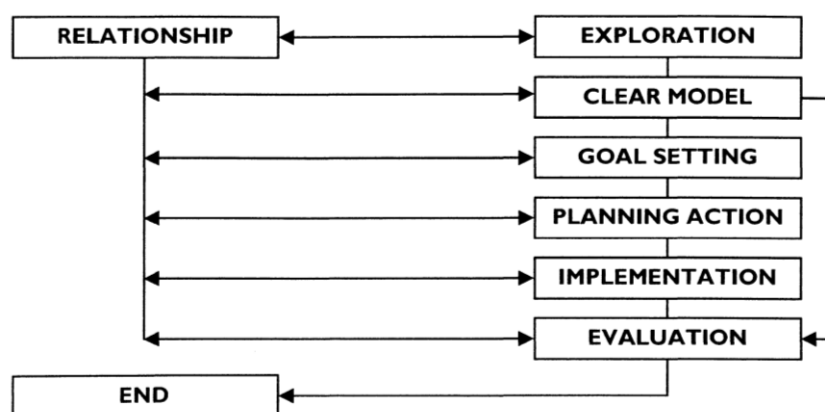


Figure 4: The Process of Helping

3. Helper Qualities

In order to facilitate the processes I have just described, it is assumed within the Model that all helpers require a basic set of personal qualities in addition to the knowledge and skills that constitute the professional expertise of the helper. For the sake of simplicity, the Model includes a set of six qualities that derive in large part from the seminal work of Carl Rogers (1959). I use the word 'qualities', not to suggest that they cannot be learnt, but to indicate that they are internal to the individual and have to be demonstrated to have effect. The six qualities are shown in Figure 5. Each might be seen as a complex set of attitudes, which together determine the behaviour and skills of the helper and in turn facilitate the development of the relationship and the process of helping.

- a. Respect
- b. Empathy
- c. Genuineness
- d. Humility
- e. Quiet enthusiasm
- f. Personal integrity

Figure 5: Basic Helper Qualities

a. Respect. Respect can be understood as care for the person with whom you are working, valuing them as individuals and offering what Rogers called ‘unconditional positive regard’. For me, these come from a fundamental belief in the ability of the person to manage, cope and to change positively. The importance of this belief is that the helper does not have to take over from the person or make up for their shortcomings, but can work with or alongside them.

b. Empathy. Empathy is seen in the Model as the attempt to view the parent’s situation from his or her point of view and not to impose one’s own understanding. This is not to assume either that the parent is correct or that there is only one view, but that the helper must understand what sense the parent is making of situations as the basis for helping them.

c. Genuineness. Genuineness is a complex quality that Rogers related to being able to be open to all experiences, not to distort them and to be as accurate as possible in viewing one’s own and the other person’s experience. Related to this, however, is the notion of being honest, not defensive and not pretending, and as such there are important implications for the parent’s belief and trust in the helper as a whole person.

d. Humility. Humility is also seen as an essential characteristic related to genuineness. It is emphasised here because of the role it gives to the person with whom the helper is working. When the helper has a realistic self-view and an acceptance of their own difficulties and strengths, the parent is encouraged and facilitated to work with them in understanding situations and finding solutions. The parent’s strengths, resources and expertise are to be solicited and used with the helper’s at every point in the process.

e. Quiet enthusiasm. Quiet enthusiasm is included here in recognition of the fact that this is what drives an individual to help another and fuels the great effort needed to engage in the often distressing circumstances of listening to problems and thinking about how they may be managed. It is assumed that it is essential for helpers to be positive and warm in interacting with others as a fundamental ingredient for building the relationship on which the helping processes are built.

f. Personal integrity. Personal integrity is intended to refer to the psychological or emotional strength of the helper and is assumed to be an essential ingredient of effectiveness. People who are themselves vulnerable are unlikely to be effective for a variety of reasons. However, what is fundamental to this quality is the notion that to be effective, the helper may need, not only to hear the parent’s view as in being empathic, but at the same time to be able to think differently, to evaluate alternative views and to offer these if appropriate.

One might perhaps sum these qualities up by saying that success in facilitating the helping process and achieving positive outcomes is to some degree determined by the helper being able to communicate to the parent that:

- they (the parent) can manage and that what they think and believe is of the utmost importance
- that the helper is trustworthy, not all-powerful, cares for them and has the strength to walk with them on their journey, while perhaps questioning the path the parent might choose

4. Helper Skills

For the qualities discussed above to have effect they must be perceived by the person requesting help. The helper has to try to demonstrate these qualities throughout their interactions with the person in all communication. The helper must, therefore, be highly skilled in communicating with the parent, both to demonstrate these qualities, but also to provide the specific skills required within each of the stages of the helping process. I will not dwell on these here because they have been frequently discussed. However, I have included in Figure 6 a list of perhaps the most important skill areas.

- | |
|---|
| <ul style="list-style-type: none"> a. Concentration / active listening b. Prompting and exploration c. Empathic responding d. Summarising e. Enabling change f. Negotiating g. Problem solving |
|---|

Figure 6: Helper Communication Skills

Each of the items in the list implies a set of skills that must be used throughout the helping process or at specific stages. Being able to concentrate completely on the people seeking help is crucial at all stages and is the basis of actively listening to them through all one's senses and attempting to understand completely what they are saying. Prompting and exploration skills (e.g. asking open questions) are the means by which one enables the person to talk about the issues important to them and to explore their situation thoroughly. The skills of empathy and summarising are the means by which the helper attempts to indicate a grasp of what the person means, feels or thinks. These are also the ways by which the processes of change may be initiated and followed up with other methods such as providing new information, tentatively presenting different ways of thinking, or inviting the person to consider, for example, inconsistencies in their views. Throughout the process the skills of negotiating should be prominent to ensure that the person is in agreement with what is happening and to resolve any potential conflicts. And, finally, there is a set of skills required when attempting to consider specific problems and to find ways of managing these. This includes the skills of prioritising, goal-setting and creatively generating strategy options to be evaluated with the person.

5. Construction Processes

Before discussing the parent-helper relationship specifically, I should just like to mention the construction processes that underlie all I have said already and provide some understanding of how people function psychologically. In Figure 1 these are indicated by an ellipse which signifies that the way the parent and helper function in psychological terms is intimately related to all aspects of the helping model presented here. This effort to describe a model of helping assumes, following the work of George Kelly, that we all build a personal model of the world in order to make sense of what is happening to us and around us and thereby

anticipate events and adapt effectively. This personal model, or in Kelly's words, 'construction' or 'construction system', is elaborated on the basis of our personal experience and is unique to each individual, although there are, of course, shared constructions. These constructions serve to guide what we do, although we are not necessarily conscious of them or able to verbalise them. They may be seen as akin to hypotheses about the world that are constantly being tested and perhaps changed as a result of our experiences.

Now, my reasons for adopting this way of thinking about how people function is that it is highly respectful of people in that it applies to both the helper and parent and assumes that both are operating as though they were scientists. Neither is superior to the other and they are both engaged in the process of making sense of their world. However, what is more important for the present purpose is that the whole process of helping can be understood as one in which the helper is attempting to enable the parent to be clear about their constructions and to change them in ways that will be more useful for them in dealing with the inevitable difficulties they face. For example, when a child is diagnosed with a serious condition, physical or otherwise, the parent has to make sense of this and needs to anticipate and adjust to what is happening to the child. However, such profound events are also associated with them questioning all aspects of their lives. In effect they are put into a situation where their previous theory about their world is potentially invalidated, where they do not know whether their existing constructions are meaningful or will allow them to anticipate their situation effectively. Their views of themselves, their relationships, their lives as a whole, their religious beliefs and philosophy may all have to change suddenly. The process of helping is not simply an exercise in problem solving, but a means of enabling a parent to change their constructions where necessary to minimise stress and maximise the meaningfulness of what they are doing.

These ideas about constructions apply equally to all the other aspects of the Model I am outlining here. For example, the notion of helper qualities can be seen as general constructions relevant to helping. Respect is a general construction about a parent being capable of adjusting as opposed to perceiving them as inadequate or as being entirely dependent upon the expertise of another. Empathy is a process in which one person attempts to construct an understanding of the constructions of the other and is fundamental to the interpersonal processes involved in helping.

6. Partnership

There are many implications of the points I have been making about creating constructions which are highly relevant to the understanding of the parent-helper relationship. Constructions are the basis of all relationships. The constructions the helper and parent create of each other form the foundation of their work together. If the helper is viewed, for example, as uncaring, not to be trusted, or not understanding, then their work together will fail. If the parent views the helper as all-knowing and themselves as relatively insignificant, the outcomes discussed earlier of enabling parental self-efficacy will not be achieved and they will not derive the strength that would otherwise be an option for them. I hope these points illustrate the importance of the relationship for the success of the helping process. I have described relationship-building as the first stage of helping, as influencing the subsequent steps, and I have just given an indication of how the outcomes may be determined by a parent's constructions of the person with whom they work. Given their centrality, it is crucial to define the exact nature of relationships that are likely to be most productive in facilitating the tasks of helping and in achieving successful outcomes. Following the work of Peter Mittler, Cliff Cunningham and others in the disability field, I should like to suggest that the most

effective parent-helper relationship is one characterised as a partnership. This is a term that has become common parlance throughout service policy and design, yet its meaning remains unclear, as the definition of 'partner' in the Short Oxford Dictionary indicates. This includes:

- A person who takes part with another in doing something
- A person who is associated with another in carrying on a business with shared risks and profits
- A person accompanying another
- A companion
- An accomplice

I would argue that these are too vague to act as a guide to what is the most crucial element of helping. I want to suggest that we need to be very clear about the characteristics of a partnership, because only then can we know what we are trying to achieve in terms of relationship development, to know whether and when we have been successful, and to understand the effects it might have and how. I should like to suggest that the attributes of a partnership are those listed in Figure 7.

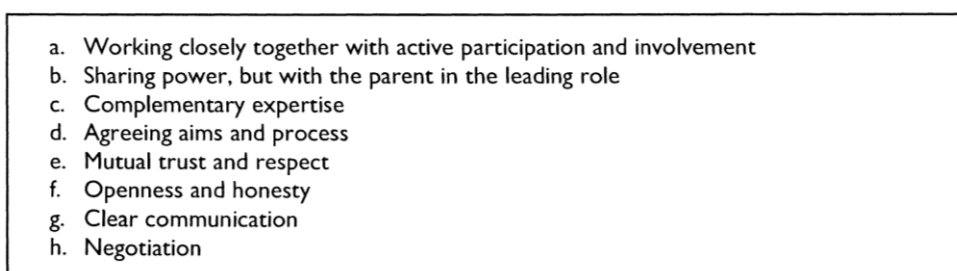
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- a. Working closely together with active participation and involvement
 - b. Sharing power, but with the parent in the leading role
 - c. Complementary expertise
 - d. Agreeing aims and process
 - e. Mutual trust and respect
 - f. Openness and honesty
 - g. Clear communication
 - h. Negotiation

Figure 7: Characteristics of an Effective Partnership

An effective helping relationship requires the active involvement of two parties working together, not one person working on or for the other. Although the notion of power is complex, I assume that the parent should lead the process and that the power in the situation should be shared for their benefit. This includes the helper's expertise. The helper has expertise, and must provide it as necessary, but this would be impossible without the expertise of the parent. The parent's knowledge and skills are vital and must be acknowledged. In essence my expertise as a professional helper is only of benefit if it adds to the expertise of the parent and is applied appropriately in relation to the information they provide. The expertise of both are equally important and, to be of value, must be allowed to complement each other. A relationship cannot be considered a partnership if there is no explicit attempt to reach agreement either about the aims and objectives of what they are doing together or about the means by which these outcomes are to be achieved. This requires the development of mutual trust and respect founded on honesty and achieved through clear, open communication and constant negotiation. This is particularly true when there is disagreement or potential conflict. If one defines partnership in this way it becomes clear that it is not a relationship that can be assumed to develop quickly and naturally, but that it requires time, effort and skill. Partnership may not be achievable in all cases and at all times because it is dependent upon what each brings to the situation. Some people may not want or be able to work with others in this way. Nevertheless, this definition may serve as a guide for what one is attempting to build because of its consequences for the processes of helping.

These consequences include facilitating the subsequent stages of the process and achieving desired outcomes. To illustrate this, one can argue that the nearer one comes to a partnership, the more involved and open the partners can be in exploring the parent's difficulties within

their personal context. This in turn increases the likelihood of achieving an understanding of the situation that may be helpful in itself and also serve as the basis for the processes of problem management (i.e. setting goals and planning strategies). The more honest they are, the more likely it is that they can address difficult issues and hidden concerns and then a greater probability of achieving clarity and change in a parent's constructions. The more control a parent is accorded within the relationship, the more their self-efficacy may be enhanced. This in turn can enhance their confidence and independence. A parent's self-worth will be increased as a function of the power they have within the relationship and their future ability to cope will be enhanced by their understanding of the helping process that may arise from these being explicitly discussed and agreed. A final and perhaps most powerful effect is that such a relationship may overcome previous beliefs about how to relate to others and may actually provide a model of how to behave in partnership with others, including partners, friends, family and children.

Implications of the Family Partnership Model

Having elaborated the Model above, I should like to mention here a few implications of it. Clearly each person has to think about what I have said and explore what application it might have for their practice. It is not presented as the truth, but as a model which attempts to make explicit the ingredients of effective practice and the ways in which they work. It is not a final product, but perhaps it is a vehicle by which we can think more clearly about effective helping and hence further develop the clarity and usefulness of the Model. However, if these constructions about helping have any merit, then there are a number of important implications to be noted. The first implication is that all interventions as well as our system of care as a whole must be designed to take account of the processes described. For example, the assumption that one can conduct effective interventions in ten-minute interviews without causing potential harm is to be questioned. Allowing a limited number of hours of treatment for families, particularly the most vulnerable, does not make sense when the time allowance may not even be sufficient for them to develop trust in the helper. The second implication is that all workers should be selected as much for the helping qualities and skills described in the Model as for their qualifications and technical expertise. This is generally not the case now in any systematic way and suggests that there may be people in our current services who do not match up to the requirements of the tasks they have to undertake. The third implication is that all people working with children and their families should have training to enable them to have a clear and explicit understanding of the processes involved in relating to their clients, to develop their personal qualities and to acquire and hone the skills of helping. Finally, given the importance of these processes and the difficulties of maintaining effective relationships, I would argue that all workers require support in this work. By this I mean ongoing supervision provided by competent and trained people. Supervisors must be able to understand the processes of working with others and have the skills and qualities to be effective. In effect, the processes of supervision may be seen as the same as those of helping.

Family Partnership Training Programme

Because of these implications, with many colleagues over the years I have been trying to develop an effective training programme for all those working with parents and their children, whatever the nature of their problems. Our core training has been published in an extensive manual (Davis, Day & Bidmead, 2002b) which accompanies the text that elaborates the Family Partnership Model. The course design is based on the Model and therefore reflects or demonstrates the approach in its format and style. It is intended to help participants understand the processes of helping and to develop the necessary skills and qualities. It does

this by using adult learning methods that are interactive throughout. Facilitators are trained to help participants learn by using the same skills and qualities, and involving them in the same processes including the formation within the group of relationships that have all the qualities of a partnership as defined above. In parallel with this programme are courses designed for supervisors and facilitators which are also based upon and which reflect the model of helping I have been describing.

Implementation Examples

The Family Partnership Training has been used over many years to train people from all the disciplines and agencies working with children and their families in the UK, as well as in other countries (e.g. Australia, Finland, Greece). Participants have included health visitors, paediatric and school nurses, nursery nurses, other early-years staff and teachers in primary and secondary education, as well as those working in special needs settings. We have trained psychologists, paediatricians, physiotherapists, occupational and speech therapists, social services staff, people from voluntary agencies and parents themselves. A proportion of those trained have gone on to become facilitators and are now training others in this model of helping. Those trained have used the Model in the development of services for families of children with all kinds of disabilities (e.g. Davis & Rushton, 1991), those born with very low birth weight (APIP, 1998), and those with emotional and behavioural problems (e.g. Davis & Spurr, 1998). Exciting recent developments have included programmes specifically designed to prevent a range of psychological and social problems in children (e.g. Davis & Tsiantis, 2005), including child abuse. These begin in pregnancy and the post-natal period (e.g. Barlow et al, 2003). At least one programme has made the approach central to a project which involves parents in their children's schools, provides adult education facilities for them, and a tiered support system including home-visiting. The project has been developed entirely on the basis of what families thought would help them and has clearly been effective in developing close links between families in the community (Davis, E. 2005).

Research Evidence

Further references in relation to these service developments can be found on the website for the Centre for Parent and Child Support, an organisation set up to research the approach further and to disseminate the methods via training and consultancy (www.cpcs.org.uk). Over the years we have used research to evaluate the Family Partnership Model's effectiveness in both training and intervention. We have conducted a number of studies that provide support for the Model in terms of the benefits of the training for professionals and of the effectiveness of their work with families. Details of these studies can also be found on the website. I should like to pick out a few of the research results that are particularly relevant to the development of the parent-helper relationship – the focus of this essay. The general research question here is whether the training of helpers has effects on their relationship with parents and whether this brings the associated benefits predicted in the Model. For ease of reading I will not present all the detailed methods and statistical information related to these findings, but instead refer those interested to the relevant publications.

Firstly, in a study that trained community paediatricians and health visitors to work with families of pre-school children with emotional or behavioural problems (Davis & Spurr, 1998), the parents rated the staff involved very positively. For example, on a set of rating scales concerned with the characteristics of the helpers (e.g. warmth, honesty, enthusiasm, interest in the mother) the average rating given by the mothers was 3.34, where the most positive score was 4.00. In a similar way, mothers' ratings of the extent to which the

relationship with the helper was a partnership were 3.00 on average. They were also asked to rate the extent to which the helpers made them feel respected, understood and listened to, and the average rating was 3.04, again with 4.00 as the most positive. Unfortunately this study did not include a comparison group. However, in a recent multi-national study of mothers who were involved in a prevention project in which nurses began working with them during pregnancy to help prevent the development of child mental health problems (Davis et al, 2005), a similar measure was used for both mothers who received the intervention and for those who received the usual services. As predicted the staff trained in the Family Partnership Model were rated more positively across the countries involved (i.e. Cyprus, Finland, Greece, Serbia and the UK).

This study also suggested clear benefits of the training in terms of the nurses being more sensitive to the needs of families (Papadopoulou et al, 2005). Those trained were more than twice as likely as the untrained to identify families as having problems that might be related to the development of psychological and social problems in their children. The fact that the risk factors on which they based their decisions (e.g. marital difficulties and personal emotional problems) could only have been identified through improved communication and were unlikely to be mentioned unless the mothers felt safe with the health visitors, strongly suggests that the training had led to improvements in the nurses' communication skills and the relationships they were able to establish with the mothers. In addition, further evidence was available to indicate not only that the trained nurses were more sensitive to such problems, but that they were more accurate than the untrained nurses in their judgements.

In another study involving the support of parents of children with severe and multiple disabilities, the mothers' ratings of professional support increased very significantly as a result of working with a helper trained in the Family Partnership Model, compared to mothers who received the usual services and whose ratings actually decreased. Given that the support via home visiting was intensive over many months (about 17 months on average) we were also concerned about whether maternal dependence on the helpers would increase. It was reassuring to find no significant change over the duration of the service. On the contrary, we found significant increases in the self-esteem of the parents, indicating that the helper was enabling the parents' own confidence and independence, as predicted, rather than creating dependence (Davis & Rushton, 1991).

Finally, in a study of the prevention of abuse and neglect, clear evidence of effects upon the parent-helper relationships were derived from a qualitative study in which very vulnerable women were interviewed after intervention which involved health visitors trained in the Family Partnership Model (Kirkpatrick et al, 2007). Even though many of these women entered the service with initial reservations about working with professionals, their first impressions were very positive and became more so as the service continued. They described how the relationship developed and deepened to the point of them clearly feeling that the helper was there for them and cared. They described a number of benefits including increased confidence, feeling more in control and being more able to parent their children. It was particularly interesting to find that their attitudes towards relationships with other professionals had also improved.

Conclusions

I have argued that the nature of the relationship between parents and those helping them is crucial to the whole process of helping and, therefore, to the range of outcomes that might result. In order to understand how this works, I have suggested that there is a need to define

the nature of the relationship clearly and to see it within the context of the helping process overall. I have explored this by describing a model of helping, in which the relationship is a partnership defined in terms of mutual participation and involvement, being parent-led, involving the expertise of both partners, with agreed aims and process, mutual respect and trust, open communication and negotiation. This Model, now called the Family Partnership Model, is an attempt to provide a relatively simple and accessible guide to service design and development, recruitment, family practice, training and effective supervision. Various research studies have indicated the value of the Model in terms of the effectiveness of the training and subsequent practice, but I have focused in this essay on evidence relating to the effects upon the relationship. Although there is much to be done in research terms, the findings suggest that the training improves the ability of service personnel to communicate and the relationships they establish with parents.

However, without disputing the need to provide evidence for the effectiveness of the Model, I am concerned that we have been seduced by our technological world into looking for cures and thinking of the content of what we do, the techniques and methods, as opposed to the process and style. I should like to suggest that support is not just derived from information and techniques, but also from the human qualities of the person with whom parents work. Whether or not there is evidence for the Family Partnership Model, as an individual, I actually want to live in a world that treats all people with dignity and acknowledges the importance of relationships in all our lives. This is illustrated graphically by the lines below that were given to me by a friend, Brother Francis. Although there may or may not be answers or solutions, the power of relationships, human or spiritual, should not be forgotten in our suffering.

***Suffering is not a question that demands an answer.
It is not a problem that demands a solution.
It is a mystery that demands a presence.***

(Anonymous).

Editorial note: Since this essay was written there have been further developments in the Model.

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