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A hermeneutic phenomenological study exploring the experience health practitioners have when working with families to safeguard children and the invisibility of the emotions work involved

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Abstract

Aim and objective

To explore the emotions work undertaken by practitioners with responsibility for the safeguarding of child wellbeing and establish whether there is a relationship between emotion work, role visibility, professional wellbeing and effectiveness of supportive frameworks.

Background

Protecting children is the responsibility of everyone in society with health, social care and public health services leading this worldwide. To safeguard children effectively it is known that practitioners build relationships with families in sometimes challenging situations which involve the management of emotions. However irrespective of this current knowledge; health practitioners who work in this area suggest that their child safeguarding role is not recognised, respected or valued in professional and societal settings. The purpose of this paper is to report on a qualitative study which set out to explore the relationship between the known relational based emotions work of practitioners' and the reported lack of visibility.

Methods

Hermeneutic phenomenology underpinned the study. Semi-structured interviews were employed for data collection. Ten participants actively working with pre-school children and families in health care organisations.were recruited.

Results

The emotional, relationship and communicative based work crucial to effectively safeguard children may influence the visibility of the role. Poor role visibility influences the morale of practitioners and the support they receive.

Conclusion

In conclusion this study proposes that when there is poor role recognition; there is ineffective clinical support. This reduces professional wellbeing which in turn will impact practitioner abilities to safeguard children.

Relevance to clinical practice

This study highlights that in order to sustain safe and effective health and social care practice, organisational leads require an understanding of the impact emotional, relational based work can have on practitioners and provide supportive frameworks that will effectively promote professional wellbeing.

Key Words

health visitor, health visiting, emotional labour, emotion work, professional resilience, stress, child protection, safeguarding

Summary Box

What does this paper contribute to the wider community?

- The internal management of emotions in the work place is poorly recognised and under-valued

- Poor understanding of emotion based work by managers and wider colleague groups in any health and social care setting will prevent the development and implementation of effective support and supervision frameworks which in turn will influence service quality

Main Document

INTRODUCTION

Promoting and improving the health, development and wellbeing of children, young people and their families is of global importance for the survival of countries and communities (United Nations 2010). This vision has been adopted politically throughout the United Kingdom (UK) with the specialist nursing profession of health visiting viewed as one of the

main services pivotal to its progression. Health visiting services are utilised differently throughout the UK (Hogg et al 2012), however at its core, the health visiting profession has a remit to deliver fundamental universal structures to promote public health; with the notion that by implementing effective support from birth, children, young people and their families will be protected and positively enabled to contribute back into communities (NMC 2004, Royal College of Nursing [RCN] 2011, Scottish Government 2012, DOH&PH England 2013, Welsh Government 2013, DOHSS&PS Northern Ireland 2014).

The centrality of the health visiting service in promoting this political aim has resulted from a longstanding history of health visitors universally and compassionately supporting individuals and communities to safeguard pre-school children (Davies 1988, Luker et al 2012, Smith & Horne 2012). However the role, although recently gaining prominence in public health and child protection arenas (Laming 2009), is not always visible in other quarters (Appleton 2011, Robinson 2012, Peckover 2013).

This paper reports on a study exploring the emotion work of the health visitor (HV) in child care and protection. The study offers insight into the influence emotion work may have on the visibility of the role and explores the impact a lack of role recognition may have on professional supportive infrastructures. To do this the paper will provide information about the background to the study as well as an overview of the analysed results. It will then offer a discussion in the context of current emotion based literature, arguing that undervalued and unrecognised emotion work can influence practitioner wellbeing.

BACKGROUND

Interest in this topic originated from experience of working in health and social care practice and education. As observed, on the one hand senior student nurses question what learning benefits they gain when allocated a practice placement with a HV because '*they just weigh babies and chat'*. On the other hand HVs offer concerns about working with intensive,

unpredictable workloads with inter-professional teams that appear to lack knowledge about their role. Such anecdotal findings chime with UK wide HV perceptions of: poor role recognition, limited professional support, emotional capacity issues, increasing dissatisfaction and feelings of anxiety, '*burn out*' and '*stress*' (Wallbank and Hatton 2011, page 11, Mackintosh 2011).

The aim of this study was threefold: firstly it aimed to establish whether there was a relationship between the communicative role and emotion work of the HV and the lack of role visibility reported, secondly it intended to identify what impact this has on the groups reported professional wellbeing and thirdly to understand if this had an influence on the support they receive.

One driver of the study was the concern that if practitioners feel stressed undertaking a role they perceive as unrecognised, undervalued and poorly supported, surely this increases a potential for risk within children and family health services (Wallbank & Hatton 2011). Although there is little direct evidence in research literature to support this conjecture, it was felt that given the collective indications of long-term stress as detailed below and the knowledge that such symptoms can influence the overall wellbeing of a person's cognitive ability and performance, it is a real concern warranting study.

Collective symptoms of stress:

the response of a person who feels they are in a threatening or difficult situation…associated with physical and psychological factors including anxiety, headaches, recurrent fatigue, depression, reduced self-esteem, poor concentration. . .emotional exhaustion, a decreased sensitivity to rewards and a withdrawal from decision making. . .. manifesting as a lack of involvement with, or sympathy or respect for, colleagues and clients. . .

(Brooker & Nicol 2011,over pages 522–524)

Health Visiting

A review of focused literature confirms that the HV role is founded on communication and professional relationship building (Appleton & Cowley 2008, Robinson 2012, Peckover 2013). Such characteristics are deemed crucial for the recognised sensitive but challenging aspects of the role in relation to the assessment and interventions required to potentially address behavior change and parenting with the aim of ensuring child wellbeing. However although the importance of these individual activities is recognised, there is limited evidence about the collective influence this work has on the professional and emotional wellbeing of the practitioner. According to Davies (1988) and Smith (1992, 2012) psychosocial; caring; relationship dependent and emotion management elements of work are often poorly recognised and significantly undervalued in the workplace. These findings were utilised to underpin the study.

The research question was: How do HVs experience and manage their emotions when working with families to safeguard children? As a theoretical framework for the study, the main concepts from Hochschild's research into the '*emotional labour' (EL)* of employees was utilised (Hochschild 1983, page 7). Hochschild's research suggests that people in paid work environments use internal emotion management systems to disguise internal feelings for external purposes and financial gain. She suggests that these processes are rarely openly recognised but are needed by employees if they are to manage emotions effectively to meet employer expectations in emotionally challenging situations. She coined the phrase EL to explain the challenges that such internal efforts have on an individual. The current study was designed to test Hochschild's theories in the context of health visiting.

The study was also cognisant of the theoretical work of nurse academics that have been influential in the transference of Hochschild's findings into nursing knowledge. Each of the studies utilised illustrate that nurses work with complex emotion. This emotion is either felt personally or is expressed by others when relationships are built or therapeutic interventions

are being implemented (Gray & Smith 2009, Theodosius 2008, Smith 1992, 2012). It was not the aim of this study to replicate these studies undertaken with nurses however the health visiting study was designed with their findings as a guide.

STUDY DESIGN

Hermeneutic phenomenology, as influenced by Heidegger, was adopted as the most suitable methodological approach for this study. Its adoption was aimed at uncovering data about both the obvious and ambiguous experiences of health visitors (Braun & Clarke 2006).

The methodological choice for the study was influenced by the recognised collective expert knowledge the research team had. This was acknowledged as a double edged sword which could present advantages or disadvantages to the study (Kanuha 2000). Adopting Heidegger's philosophical approach to phenomenology, the research team was enabled to utilise their knowledge base as an asset instead of ignoring it as other traditional phenomenological approaches dictate (Connelly 2015). The recognised flexibility of the methodology (Robinson 2002) permitted a reflective governance process to be used during data collection which ensured the explicit exploration of data and not the assumed as pre knowledge can precipitate (Pringle et al 2011). In addition, taking advantage of pre-understanding of the current context of health visiting, emotion work and child protection ensured the most contemporary political, organisational and theoretical milieu was considered during analysis (Alvesson & Skoldberg 2009, Connelly 2015).

Sample

The target study population were experienced HVs currently managing a caseload of pre-school children within two Health Boards in Scotland. Ten volunteer participants were recruited from those who responded to advertising flyers. Any volunteers known personally by the researcher or registered HVs not active in caseload were excluded.

The sample comprised all white Scottish women, aged between 35 – 60 years who had from seven to thirty years' HV experience. No male HVs volunteered. The demographic of the sample was representative of the UK health visiting workforce that comprises 99% female HVs (DOH 2010, Information Statistic Division [ISD] 2014). The national age cluster of the general nursing and midwifery workforce employed by the NHS is 25 – 60 years (ISD 2014) and the majority (83%) of the workforce are recorded as white (NMC 2011).

Ethical approval

Recruitment and engagement processes were authorised by Research and Development Units as part of an established research governance process (Scottish Executive Health Department 2006). Ethical approval was obtained from an academic committee. All participants gave informed consent and were permitted to withdraw at any time without concern of consequence.

Method

In-depth semi-structured interviews were used to generate data. The interviews were approximately one hour long and were aimed at enabling participants to explore the complexities and sensitivities of their work (Scherer et al 2001). All interviews were recorded and transcribed verbatim. Two introductory questions were used: *What aspect of your role do you find the most emotionally challenging? How do you manage the emotions felt during these challenging times?* Other questions were guided by the information shared by the participant.

Analysis

In line with an interpretative approach to phenomenology, transcriptions from each interview were read, re-read and independently considered (Pringle et al 2011). This led to thematic patterns being deduced as guided by the theoretical framework utilised for the study (Braun & Clarke 2006). Using a circular approach (Alvesson & Skoldberg 2009); the verbatim

statements were initially aligned to approximately 30 emergent themes which included: *'emotions felt'*, *'professional confidence'*, *'organisational expectations'*, *'case complexity'*, *'awareness and support'*. The process of interpretation and analysis continually reduced the number of headings that in the context of the literature and the comparative relationship of the data led to two main themes being identified: emotion challenges and emotion management.

Quality Governance

For the purpose of the study the principles of rigour and trustworthiness in qualitative research as proposed by Guba and Lincoln (1989) were adopted as good practice (Higginbottom et al 2013). Although Guba and Lincoln's approach has been criticized in some quarters (Sandelowski 1999) it was employed based on the extensive support it has in others (Robson 2002, Farley & McLafferty 2003, Burns & Grove 2009, Streubert-Speziale & Carpenter 2011). Adopting the principles of Guba and Lincoln has ensured that rigour was considered in terms of credibility, transferability, dependability and confirmability.

To ensure the credibility of the data every endeavor was made to report it accurately. As guided by Guba and Lincoln this was achieved in six main ways which included: having contact with the study context for the length of the study, being open and transparent with all participants about the researchers past experience, carrying out "*peer debriefing"* (p. 237) and "m*ember checks*" (p. 238) which involved peers and participants in the review of the data collected. It also involved the researcher engaging reflective processes which were undertaken and recorded to ensure the accuracy of the report and analysis.

According to Guba and Lincoln (1989) the transferability of a qualitative study is out of the control of the researcher. However a detailed account of the data and the study design has been recorded to assist others in the replication of the study which supports the notion of transferability. To support this and to ensure the dependability and confirmability of the

study, data provided in this paper is an accurate account of the perceived situation for HVs when it was collected. These findings therefore should remain stable and relevant to the profession.

FINDINGS

Theme	Emotion Challenges	Emotion Management
Finding Sub themes	• With families • With partner agencies and managers	• Professional relationship • Support
Discussion sub themes	• Hidden Labour • Impact of undervalued emotion work	• Infrastructures of support

Table 1, Themes

Throughout the interviews the researcher's field notes reflected that participants were able to articulate the complexity of their work and were open about their feelings and actions it generated. The ease with which participants shared their feelings varied. Some were more naturally prone to explain how they were *thinking* within situations rather than *feeling*. Questioning facilitated an exploration of feelings and uncovered the themes and subthemes as highlighted in table 1

Emotion Challenges

Participants reported that they regularly engage with situations that involve emotion and present emotional challenges. When examined collectively the most challenging emotions were felt when working with families, partner professionals and with managers.

With families

The majority of participants reported how challenging they find working therapeutically with families to influence behaviour change in a child-centred way. This was particularly true when working within households where family members have competing demands, such as those affected by mental illness, addiction, homelessness and poverty.

In each interview, examples of challenge were readily offered and participants stated that hearing their work reduced to tangible tasks, such as measuring a child's growth or assessing their development, was *'professionally belittling'* with no consideration given to the emotional investment that engaging a family in complex, holistic, psychosocial assessments or interventions requires.

Each participant illustrated that the complexity of their role has grown over the years. They suggested that this is due to the unique universality of their service which is provided to each child born in the UK until the age of 5 years, irrespective of socioeconomic background or history. As such they work with both children and the majority of the population of child bearing age. In this position they, and midwives, are often the first people to identify concern with an adult's behavior as it relates to the current or future care of a pre-school child. On the whole participants reported that they can find this emotionally challenging, however at the same time they feel they have learned to cope with it as an expected part of their job:

> *"….I've been doing this since I was 17 (years old), working as a nurse for a long time and I've had to deal with people's emotions and feelings all my life as part of my job and it's something that you have to learn to deal with, you just get on with it…it becomes kind of second nature…."(p2)*

What they found more challenging is the feeling of professional isolation that can occur. As a universal service they are often expected to manage complex issues alone. This tends to

occur when concerns within a family are difficult to define in terms that relate to admission criteria set by specialist services. One practitioner explained what it was like to work with one very challenging client with volatile moods and behaviour reflective of personality disorder:

> *"….they've (parents) never seen a psychiatrist, very seldom seen a GP (General Practitioner), but their manipulative behaviour and the way they present is very, very difficult and these have been the ones I have had difficulty getting social work involved because they can present as coping…."(p1)*

With partner agencies and managers

Throughout the interviews professional isolation and a lack of recognition from partner agencies and line managers presented challenges for which HVs were less prepared for than those presented by families. All practitioners reported times when they felt professionally undermined and prevented from arranging effective interventions for children. This occurred when the child's requirements were beyond the HVs scope of expertise and referral information was not accepted by specialists:

> *"….sometimes the frustration around having experience and insight and the ability to assess the situation in a family and perhaps not being listened to by Social Work. That our experience and input is sometimes dismissed if it (our assessment findings) does not fit the criteria (for admission)…"(p5)*

Similarly participants report that they find it difficult to work with managers when there appears to be a lack of recognition about the complexity or the emotional pressures impacting on their role. Comparable to the encounters with partner agencies, HVs find dealing with managers challenging as they believe they can present obstacles to care delivery:

"…. trying to maintain the standards that you set for yourself professionally and personally in the face of staff shortages, lack of leadership and working with people (managers) who don't understand your role…"(p3)

Participants were open about the stress and fear they feel when their work expectations become overwhelming:

"...you can't get on top of things, you fall behind and that becomes more stressful. You don't get your paperwork done which is quite stressful because you need to…"(p4)

In each work based scenario offered, all participants were aware of their emotions and described a range of feelings. The main words used were, '*anger, frustration, sadness, fear* and *happiness'*. Negative feelings tended to be related to situations involving managerial discussions about workload as well as those concerning parental behaviours. However, there was a sense of positivity when change for the wellbeing of children was evident e.g. when difficult child protection case decisions appear to result in an observable improvement to a child's health and wellbeing.

Emotion Management

Throughout the interviews participants were open about the feelings they experienced when at work, however they disclosed that they did not always express these emotions readily in the workplace. When questioned *why* they managed their emotion to prevent expression; participants reported that they do this to promote professional relationships with families for the purpose of intervening therapeutically and to sustain a professional image:

"You would never go into a family and be angry but you would come out being really annoyed….you can't do anything about it…., that's unprofessional…."(p4)

"…you do feel it internally but….I don't think that would really get you anywhere being angry with someone… I think we try all ways round, sometimes you can try a bit of humour,…not make a joke of it, but try and…make it a wee bit more upbeat…to maybe try and change things….you know like some people I could go into and think there's absolutely no way, if I say the one thing out of line I will be put out of the house…."(p2)

Professional relationships

To sustain relationships, HVs believed that they have to take a "*measured approach*" in how they expressed their internal emotions with families. They report that this supports them to manage their emotions to prevent over involvement and to uphold the purpose of their role:

"….you have to keep your emotions in check to remain professional and to remain…objective….having a balance between caring for a family and caring about the welfare of a child, but also then not getting too emotionally involved as well."(p10)

This quote aligns with the findings from all participants who reported they manage their emotions with the aim of working effectively with families by displaying empathy and compassion whilst at the same time working hard to ensure that the understanding they have for a family's situation, or the negative emotions they feel towards the adults within the household, does not interfere with the child-centred requirements of their work.

To manage emotions for these purposes each participant stated that they are able to do this through the development of personal strategies. These are established through experience, learning and education and by having supportive colleagues. HVs reported that *how* they manage their emotions is dependent on the situation.

Support

The majority admitted that in relation to work challenges they were more inclined to express feelings of frustration and anger openly and directly to managers and inter-professional colleagues (within the scope of organisational dignity at work policies); whereas families were, on the whole, exposed to professionally expressed emotions. Participants described that true feelings of anger, frustration and sadness are contained during family contacts and only expressed remotely. Remote expression would include: crying in their car and engaging in independent and facilitated reflection with supportive colleagues in their office. All participants reported that they depend on these activities to remain professionally safe and to prevent stress.

Every participant in the study received formal clinical supervision facilitated by their employer; but not one participant shared this information spontaneously. This was only revealed when asked about it directly by the researcher. Instead each participant emphasised that they used the external support received from colleagues to manage their emotions.

They expressed that interactions with *"trusted"* colleagues were invaluable in supporting them to "*normalise"* their emotions and affirm decisions taken.   They highlighted that they seek this from colleagues due to their timely availability, perceived credibility and the understanding they have about the pressures and complexity of the job:

> *"So I come back in and sometimes feeling rather exasperated and kind of need to talk about it quite quickly to somebody to…share the frustration"(p6)*

> *"….it's a very different conversation that you have with someone who does understand the role of the job when you're discussing the pressures, stresses and emotional demands of the job. It's a very different conversation that you have*

compared to having a discussion with someone (manager) who doesn't understand, who has no experience and understanding of the job and the role."(p3)

Clinical Supervision practice on the other hand was seen by the majority of the participants as organisation led and not for their emotional support. All of the participants agreed that clinical supervision has a place in health visiting in providing the time for reflective discussions relating to caseload management and case decisions.   However for all participants, with organisationally allocated supervisors who were either a child protection advisor or team leaders; the perceived credibility of the supervisor influenced the benefits they got from it:

"At the moment we get clinical supervision which to be honest ….where I am at the moment is not helpful at all….it's not purposeful to me, it's going through the motions. It's very difficult with clinical supervision, it comes from the top down and we're being supervised by managers or individuals who have no direct experience of health visiting."(p5)

"…you feel very, very alone as a health visitor….. we get…Child Protection supervision which is to go through each case regardless of the level of risk and the level of involvement with them, which on the whole is not particularly helpful…. it feels very much the organisation is protecting itself by very much a task orientated approach of you know; are you following the guidelines…"(p10)

One practitioner shared a story involving an injured child to justify her intense feelings about the lack of emotional support offered by her employer. On notifying her team leader of the incident she was questioned –*'when did you last see the child? Is your paperwork up to date?'* At no time was she asked how the child was or how she was. This led to reduced

morale as she felt her value within the organisation was belittled to tangible tasks. All participants reported that such situations influenced the levels of *"stress"* experienced.

Stress mainly occurred when they found it difficult to cope with the unrecognised demands of their job. For each practitioner this corresponded to times when trusted colleagues were also feeling overwhelmed, were not at work or had retired. In all reports this led to needing *"time out"*. One HV had been through this recently. Her descriptive account demonstrates the influence this had:

> *"I wasn't going to get upset (crying), but I do because I was really stressed, I wasn't sleeping very well at all, and my kids as well there's been an impact on them definitely…. you're still thinking about work…you're not really totally focused on them, it takes you a long time to switch off, and then you're dreading going back to work….. Over-whelmed yeah…you think aw I've got this to do, I've that to do, but in health visiting the job is never finished, you've always got something else to do, but it is actually just the sheer amount of work, with no back-up. You were saying, to managers, phoning them and saying this is unsafe, and we're over our limit for child protection and then getting told to take on cases just from another area, and I thought I need to leave, or I will be off ill, or something is going to happen"(p9)*

DISCUSSION

The findings portray health visiting as a complex, emotionally challenging job. As the data suggests the role is variable and unpredictable due to the universality of the role; with emotion management involved in a large proportion of the work. This emotion work ranges from supporting a new parent with anxiety about the care needs of their child to one of managing distress. It is evident that with increasing frequency health and social care practitioners are required to work in complex, emotionally charged and potentially volatile environments to safeguard children (Brandon et al 2010, Vincent & Petch 2012). Such

practice requires abilities and attributes to effectively manage erratic and irregular behaviour of others (Laming 2003, Scottish Government 2010).

Our data suggests that to do this effectively, the main skill required in child focused practice is the ability to assess, recognise and respond in contentious situations. This involves emotion work to manage, deescalate and maintain work with families which promote positive outcomes for children while avoiding emotional responses that would jeopardise professional relationships and personal safety.

Participants' accounts demonstrated how they used EL (Hochschild 1983) in their health visitor practice. However, in contrast to Hochschild's findings, it appears that HVs regulate and manage their emotions beyond the expectations of their employer. Instead, emotion management is linked to professional identity and professional relationship building.

These findings correspond to studies by Smith (1992, 2012) and Theodosius (2008). It is apparent that when considering the care needs of others, internal processes to manage one's own emotion are more complex than a one process action. In health visiting, like nursing, EL practice involves in-depth processes to both internally contain personal emotions, while at the same time externally assisting others to explore their emotions (Ruch 2008, Karimi et al 2014). This becomes increasingly complex when also maintaining professional standards of empathic, compassionate, respectful and human valuing healthcare (NMC 2015).

It is evident that for HVs to do this effectively, they utilise a variety of skills and attributes that can be aligned to a number of theoretical constructs. According to Douglas (2007) this is not an uncommon finding as professionals who work with children and families are often influenced and guided by a number of theoretical principles due to the competing demands within each family.

Hidden labour

The study data illustrated that practitioners require a level of professional agility to navigate, address and manage complex emotion work (Douglas 2007, Harlow & Smith 2012). There was evidence that each interviewee was confident in their ability to manage their role intricacies. However it was clearly believed that the complex nature of their role was not recognised by others. This causes disparity in role understanding between those aligned with the profession and those experiencing the profession.

In the UK academic, political and expert developments provide evidence about the actions undertaken by the HV (Cowley & Frost 2006, Laming 2009, Appleton 2011, RCN 2011, Scottish Government 2012, DOH&PH England 2013, NNRU 2013). However there remains a mismatch of understanding about the level of complexity the HV deals with. This lack of visibility could be attributed to three factors. Academically it can be attributed to the lack of research on the specific child protecting role of the HV (Harlow & Smith 2012, NNRU 2013). Sociologically it is proposed as an outcome of the historical design of health visiting, with the role previously promoted as a *'mothers friend'* (Davies 1988, page 49) to covertly disguise their societal monitoring role (Peckover et al 2013). Or finally, the suggestion that there is a lack of value given to communicative, emotion work which leads to a lack of work recognition (Davies 1988, Gray & Smith 2008, Smith 2012). The limitations of this study cannot confirm or deny all three points, but it does highlight that internal emotion management in health visiting does contribute to this situation.

Impact of undervalued emotions work

The impact that this lack of visibility has on HVs was initially ambiguous throughout the data with contradictory evidence apparent. In essence it parallels Hochschild's (1983) findings. Hochschild's suggests that regular engagement with emotion work in familiar circumstances

increases work competence. This was something HV participants' confirmed by initially expressing feelings of competence and resilience to the emotional challenges of their role (Rutter 2007). However as is evident in this study and Hochschilds, the ability to cope in challenging situations falters when feelings of unrecognised or undervalued work, poor support, professional isolation and a loss of workload control emerge.

In Hochschild's study participants complained about stress when employer expectations increased. This was referred to as '*speed up'* (Hochschild 1983, page 21) and aligned to an analogy of a factory conveyor belt that as it increases in speed; it escalates expectations from workers and reduces their ability to cope. Examples of when this occurs are during times of organisational restructure or staff shortages. These examples align with the findings of this study, with HVs relating their feelings of stress to times when they have reduced control and support. Polk (1997) suggests that to remain resilient, individuals have to feel supported, in control and able to access resources (Polk 1997), something that is absent in the findings of this study.

Such findings fuel concern that a lack of role recognition and support may impact on a practitioner's ability to work effectively to protect children. Although further research is required to qualify this, it is evident that this is something participants are aware of. They appear mindful that a lack of concentration, engagement or sensitivity on their part could have irreversible implications for children, families and communities (Laming 2003, Brandon et al 2010, Vincent & Petch 2012).

In the first collective audit of significant case reviews in Scotland, Vincent and Petch (2012) imply that employers are not connected with the emotional needs of practitioners. They record a lack of information about the emotional wellbeing of professionals involved with children who either died or experienced harm. Such findings correspond to the study data.

According to practitioners, the structured supervision they receive does not consider their emotions or recognise a relationship between these and their professional wellbeing needs.

Infrastructures of support

This evidence is significant, especially as both study areas were evidently investing in supervisory frameworks. Unfortunately current supervision arrangements were perceived as inadequate. This was attributed to the belief that supervisors have a superficial understanding of the role and focus solely on protocol adherence. This approach appears not to provide a safe '*backstage*' area where HVs are comfortable to remove their professional mask and attend to the emotions they feel in practice (Hoschchild 1983, page 118).

Undeniably, organisationally driven supervision is essential in child protection services (Laming 2009, Beddoe 2010, Harlow and Smith 2012). However the governance needs of the organisation should not be at the expense of supervision styles required to sustain emotional resilience (Ruch 2008, Wallbank and Hatton 2011). For this practitioners require access to supervision sessions with a neutral, non-managerial figure whose attention is their emotional wellbeing (Ruch 2008).

Several study participants referred to the supervision that social workers (SW) receive as exemplary. However, although supervision frameworks are more established in SW services, SWs report similar experiences to HVs (Winstanley & White 2003, Beddoe 2010). SWs also believe that their supervision is solely for governance purposes (Adamowich et al 2014). According to Beddoe (2010) this situation is a symptom of the litigious condition of society; with insecure employers being so concerned about practice scrutiny that they overlook positive ways to sustain practice.

Study Limitations

This study obtained data to answer its initial question however two main limitations are evident with the study. Firstly, the study focused on one main theoretical framework. It would be of interest if other communicative theories were explored in relation to HV practice. Secondly there is a lack of sample diversity. Although the study sample was representative of the general population of HVs in the UK, a comparative study with ethnic and male gender HV groups within each of the four countries of the UK would add to the findings.

Recommendations

As a result of this study it would be recommended that:

- Employing organisations' examine the supervision and support infrastructures that are in place in relation to practitioners who frequently have to manage of emotions

- An exploration of theoretical frameworks that influence practice in child focused services e.g. emotional intelligence (Goleman 1999); the use of 'self' within the therapeutic relationship (Adamowich et al 2014); containment theory (Bion 1962, Ruch 2008, Douglas 2007) and professional expertise (Benner 1984, Benner & Wrubel 1989) is undertaken

- A practitioner led campaign to increase people's awareness about the complexity of the child safeguarding role

- An exploration into the emotional experiences of diverse groups undertaking this work

- An exploration into the impact the management of emotion can have on practice within child safeguard and protection services with a specific focus on assessment abilities.

CONCLUSION

The study has explored the emotion work and emotion management processes of the HV. It has evidenced that this type of work is emotionally complex; with its main role and function

one of communication.   This communication is aimed at assessing and addressing challenging, emotive behaviours, with the focus of working with families to provide a safe and protective social, emotional and domestic environment for children. In conclusion this study has provided evidence that although health visiting is recognised nationally within policy as the profession able to identify and address need as well as co-ordinate services to safeguard and protect children, there continues to be a lack of visibility of this role by professionals and managers. This hidden role is detrimental to the professional wellbeing of the practitioner and in turn could impact on the wellbeing of children services.   Without a clear understanding of a professionals role and full acknowledgement of the emotional aspects of the work; supportive organisational infrastructures will be inept and could result in practitioners with limited resilience and high levels of stress and burn out. It is proposed that the findings of this study can be transferred to several areas of health and social care where emotion management expectations are high.

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