Identity Dynamics as a Barrier to Organisational Change

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Abstract

This paper seeks to explore the construction of group and professional identities in situations of organizational. The paper considers empirical material drawn from a health demonstration project funded by the Scottish Executive Health Department, and uses insights from this project to discuss issues that arise from identity construction(s) and organizational change. In the course of the project studied here, a new organisational form was developed which involved a network arrangement with a voluntary sector organisation and the employment of 'lay-workers' in what had traditionally been a professional setting. Our analysis of the way actors made sense of their identities reveals certain barriers to change that were significant in this project, and which may relate to other change-oriented situations.

Change in Organisation and Identity

Public health provision has over the last twenty years been the subject of an extended series of change initiatives. While cost reduction and effectiveness improvements have underpinned a number of these[1], many have been aimed towards attempting to tackle highly complex social issues associated with areas of social deprivation such as poverty, drug abuse and domestic violence. In response to these challenges, many governments have employed partnership arrangements across agencies[2] and with external organizations[3]. Coinciding with introduction of these changes it has been argued that, at a societal level, the nature of the relationship between individuals and organisations has altered. Factors such as the rise of individualism in western cultures have contributed to the weakening of individual-organizational bonds and cynicism about the 'company man' perspective in which there was a strong and career-long connection between the individual and employer [4]. Gratton and Ghoshal [5] argue that such changes require new ways of managing, including working across boundaries in order to enhance learning, democratic processes and 'investing in the self' such that there are mutual gains for both individual and organisation. While research on change initiatives within public administration have acknowledged the impact upon role identity [6], there has been little work investigating the role that identity dynamics play in the implementation of changes associated with cross-organizational working. Our research sets out to explore such a setting where innovative forms of employment have been used in order to increase flexibility and effectiveness. Specifically, our aim was to explore the identity dynamics of two groups as they came together in a project that entailed innovative forms of organising.

The public sector has not been immune from the forces for change in organising and increasingly organisations are networking with, and employing, staff from the voluntary sector [7]. The concept behind such approaches does not differ significantly from that identified in commercial companies by [8], as the aspiration is to increase capacity and value for money, enhance effectiveness or, in some cases, reduce costs [9]. It has been argued that one of the factors that impacts on the effectiveness of mergers is identity [10] and we will argue that identity also impacts in looser networking and collaborative arrangements between organizations and between professional and staff groups.

A traditional conception of identity is that it is that which distinguishes the individual from others and remains relatively consistent over time [11]. However, traditional perspectives on identity have been challenged, as it is not clear that identities remain singular and consistent. Bolton[12] highlights the contradictions that often occur as people operate in more than one role simultaneously which is a typical requirement in new forms of organizing. Working across traditional boundaries, for example where employees of another organization are brought into the team structure of a host organization, can have the effect of forcing more established groups to confront the nature of their own, multiple roles. This can induce dynamism in identities that can adapt and change through social processes of interaction [13]. Change in identity can be produced where individuals or groups come into contact with others who differ in their perceptions [14] and where there

is a disjuncture in the 'narrative of self identity' [15]. In some change situations where identity differences became highlighted, emotional responses to the perceived threat to the group can re-emphasise identity and militate against change [16]. However, in other settings, the existence of a distinct identity-group (such as cohorts of new entrants) within organisations has not simply led to opposition between the identified group and others, but has resulted in more complicated processes of adaptation and renegotiation [17].

Whether groups and individuals perceive change and identified-others as threats or opportunities for adaptation will relate to how they attribute meaning to the situation [18]. One key mode of meaning-making is the use of narrative and story-telling [19]. McCloskey [20] conceptualises organisational narratives as ways that people find answers to crucial questions, which have been identified as: Can employees break the rules? Is the boss human? Can the little person rise to the top? Will I get fired? Will the organisation help me when I have to move? How will the boss react to mistakes? How will the organisation deal with obstacles? Such questions are typically not posed and answered in straightforward ways in organisations unless there are exceptional circumstances [21]. Rather, in effect, employees explain the culture to each other through story-telling and the morals of the stories carry meaning-making significance. Czarniawska [22] has shown that the emergence of organisational identities is linked to the nature of narratives that are carried through every-day story-telling by organisation members. Stories can relate to belongingness, differential treatment of one group as compared to another and the partisan intentions of leaders. The moral of such stories will impact on whether or not a particular group perceives itself to be in a position of strength or weakness and will carry messages about the nature of the future for the group. Equally the characterization of those in the story indicate how members of the group should act towards others with these often following patterns of archetypal characterisations[23]. In our research we explored the story-telling within a specific project in order to better understand the identity dynamics and processes that were occurring.

In summary, the twin challenges of improving cost effectiveness while addressing complex social issues have led to reforms that challenge traditional organisational structures in which role ambiguity was minimised. This raises increased uncertainty of identity as organisations seek to operate across traditional boundaries and the ties between the individual and the organisation are loosened. Therefore it is necessary to understand the organising processes through which people create meaning for themselves and others as it is on the basis of such meaning that they decide how to act. One significant process of meaning-making activity is story-telling, and hence it is important to develop our understanding of the processes and impacts of identity narratives in change-oriented situations.

This paper explores the identity dynamics in a project that involved employees from two organisations – one in the health service and the other a voluntary sector organisation - working collaboratively. The intention was to increase effectiveness of delivery in two areas of social deprivation through this mode of organizing. Prior to the start of the project, health professionals performed much of the work on their own. The introduction of workers from the voluntary organisation had a range of impacts on the way in which

services were delivered. We report here one aspect, identity dynamics, which played a significant role in the project and may be of significance for similar change-oriented situations.

The Starting Well Demonstration Project

Although the United Kingdom's National Health Service (NHS) is talked about as a singular body, responsibility for policy decisions were devolved from central government to the regional assemblies of Scotland and Wales on their formation in 1999. As outlined in the White Paper *Towards a Healthier Scotland,* in November 2000, the Scottish Executive Health Department launched their demonstration projects to pilot innovative approaches to a range of healthcare issues. Starting Well is the national child health demonstration project in Scotland and was initially commissioned with funding of £3.1 million over three years [24]. The project aims to demonstrate that child health can be improved by a programme of activities, which both supports families and provides them with access to enhanced community-based resources as a means of addressing adverse life circumstances (low income and poor skills base). The project supplemented existing staff groupings (such as Health Visitors and GPs) with a new category of lay-worker called Health Support Workers to produce multi-disciplinary teams that would work together to provide care for individual families.

Within these teams, Health Visitors act as both case managers and team leaders, directing the activities of other members of the team, according to family need. A Health Visitor working full-time is typically responsible for eighty to ninety families. They are professionally qualified nurses and have traditionally carried out the role of supporting wellbeing and health in new families without the support of a formally constructed team. Starting Well introduced a new way of working with families and also the new role of Health Support Workers. These workers, who were not professionally qualified, were drawn from the local communities where the project is based and, therefore, had valuable local knowledge and insight into the challenges of parenting in these areas.

In the original project bid, lay-workers were identified as essential service providers within this new team model. The proposal stated: "…The lay members of the team will bring to the project an understanding of the problems of family life in deprived circumstances and the local economy will be enhanced by the recruitment of local people to the project" (Project Proposal, p.27). Following consultation with multi-agency partners (including specialists in education and training), it was agreed that, rather than employ these workers within the National Health Service, this part of the project would be sub-contracted to a voluntary-sector organisation. The rationale for this decision was based on two considerations. First, as an employer, the NHS has limited experience of intermediate labour market programmes and secondly, this employment initiative offered an excellent opportunity for a mutually advantageous learning development between the NHS and the voluntary sector. On the basis of a tendering process, a local voluntary-sector provider (One Plus) was identified. One Plus recruited, trained and continue to manage the lay-workers, now known as Health Support Workers (HSWs). These HSWs assume a wide variety of emotional and practical support roles within the Project.

As noted earlier, there was an explicit recognition that the employment of HSWs would offer both the project teams and participating families a unique blend of empathic and experience-based understanding of challenges to family life in areas of multiple deprivation. There was also an implicit belief that these lay workers, who, by definition, were unlikely to have been socialised into traditional NHS roles would offer a fresh vision and energy to the project teams. The roles for the HSWs were clearly identified in job descriptions and accountability to the project teams was clearly described. However, as the role was innovative, it was also agreed by management and communicated to the project teams, that role development was anticipated and that definite parameters of the role would only emerge over time and experience.

In the early introduction of the HSWs, specific attempts were made by senior management to ensure that the potentially limiting effects of bureaucratic boundaries, hierarchies and traditional forms of organisation were reduced as far as possible. The project manager attended a series of meetings with the health visiting team and personally emphasised the significant contributions that would be made by HSWs as full and equal members of the project teams. In addition, a series of externally facilitated team building events were held with the project teams in the first six months of the programme.

The introduction of lay-workers into Starting Well has attracted significant local and national interest. There are growing difficulties in recruitment to statutory agencies and an increased recognition of the service requirements of vulnerable children and families. A staffing option that potentially draws on a large and available workforce capable of providing practical and emotional support to families is a desirable option. Within the Glasgow area, two Local Authorities have adapted the lay-worker model pioneered by Starting Well. Within the National Health Service, "skill-mix" models of service provision are increasingly popular.

Methodology

The research presented here was conducted in close collaboration with key members of staff from the Starting Well Project. A research team comprising academics and staff from the Starting Well project undertook research adopting a mode 2 approach [25]. Over time, as the Starting Well project unfolded, the academic researchers and the project managers co-constructed interventions based on theoretical insights. This simultaneous production and consumption of research knowledge is one of the key features of mode 2 management research [26].

We deliberately set out to capture data before, during and after interventions in the project and this meant that in most cases, interviews were conducted before and after key junctures in the project. Data was captured from a range of one-to-one, semi-structured interviews with key personnel together with focus groups with particular professional groupings to establish their views of the project. Finally, we also took detailed field notes and audio recordings at key meetings and events in the project. These data were

then transcribed and treated independently as narrative accounts of the project [27]. These accounts were shared within the research team. However, we were also influenced by Boje's [28] observation that context is essential for interpreting narratives that occur in organizational settings and that without participating in the organization that contextualizes a narrative, meaning is difficult if not impossible to grasp. As we theorized, we also took an active and experimental role in relation to developments in the project working with the managers from the research setting to interpret and re-interpret the dynamics of the change situation.

A great many stories were told in the project and these were categorised into narrative themes. The themes were collated under the heading of questions they were answering [29]. The analysis sought to uncover characterisation [30], narrative structure and style [31]. In some cases, standard character types were used (such as: the mentor, the sorcerer, the hero) but where there was no clear fit between the enacted characterisation and theoretical types, data-driven labels were adopted (e.g. 'accompanying contributor'). The structure and styles of narratives were used to explore the relationships between characters and their expectations of each other. The dominant type was the epic narrative in which a hero undergoes trials and triumphs through his/her special skills. In the outcome of the analysis presented below, a key distinction was between the generic application of this structure and a more restricted local application. The stories used tend not to be of the fully formed fictional variety, but rather are snippets of reported action or attitude that combine to give an overall impression of characterisation, links between characters and a style of engagement. Hence, below we present abstracts from composite narratives in which we summarise the context and display illustrative quotation extracts [32].

Identity Narratives

We have selected three narrative themes to present here. The themes are expressed as questions that the narratives were answering. In most of the narratives the Health Visitors (HVs) and Health Support Workers (HSWs) operate as oppositional pairings.

1. What is our proper relationship to the service users?

The HVs bring particular professional knowledge to the relationship with service users. Their self-characterisation is one of difference from the service users. The narrative structure is based around these differences. So, for example, the service users, or families, are seen as 'needy' and as dysfunctional '…the mother is getting ready for a prison visit [to the father] and she needs someone to look after the children…' The HVs are professionally trained to 'assess needs' and in their talk prominent functions are to 'give advice' based on professional knowledge and to 'co-ordinate' the provision of health and social support. The HVs' perception is that they 'are absolutely responsible for the family and the care for them'. Their purpose in being with the Starting Well project is that they can apply the inclusive 'social model' of health, which is counter-posed with the 'medical model'. The better families are those who receive the advice and act accordingly. The worse ones may fail to act on the advice, or worse, may fail to show up for an

appointment at all. Hence, the families are cast as predominantly passive recipients of a process which they would not be able to develop for themselves.

In narrative terms, the HV's character is akin to that of 'the *sorcerer*'. The sorcerer is a keeper of powerful secrets, which can be translated for others under certain circumstances, but the sorcerer is not part of the same community as those who receive the effects of the powerful secrets. The secrets themselves remain inaccessible to the community.

The HSW perspective contrasts with that of the HVs. HSWs' authority is based on a direct form of experiential knowledge. The HSWs were drawn from the same communities as the families and often had relevant experience that they could bring to interactions with them. As a HSW put it, she could relate to the families '…with my own knowledge and my own personal experiences because then you've been there and you've done things that most of these families need guidance on. Where you can use your own life experiences as a reflection which is really, really good because a lot of, like care workers and things like, haven't had the experiences that they have as mothers and things like that.' Their talk is characteristic of *mentoring* narratives. In traditional mentor narratives the mentor is a 'substitute father' for a hero who has to undergo a trial. The mentor cannot take the trial for the hero, but can offer support and a perspective from experience. Mentoring roles are typically reflective and are focused on enabling the central character to take more thoughtful action themselves. There is a degree of shared understanding between the HSWs and families, and the HSWs valued this highly in their talk.

The difference between these characterisations highlights divergence and the potential for conflict between the HVs and HSWs because different relationships to the service users and different processes of engagement are assumed to be proper. In the HV narrative structure the key activity is advice-giving by the HV, and the degree of separation is high: the HV has separate and inaccessible knowledge (gained through professional qualification) and comes from a different community. Conversely, in the HSW narrative structure the key activity is action by the family and the degree of separation is low: there are similarities in experience, accessible knowledge and they come from the same community.

2. What is our proper relationship with each other?

The HVs spoke of themselves in what can be regarded as a *parental role* to the HSWs. The HVs felt that they had all the responsibilities, and that if they did not arrange everything it would grind to a halt. HSWs were cast as well meaning but somewhat fallible children. When they were good, they were good. But they could not always be relied upon to turn up, to carry out instructions properly or to effectively support the HV. 'If I'm at work, I'll go and do it, but if I'm not at work it doesn't really matter' (HVs on HSWs). The HSWs were perceived not as fellow professionals but as another responsibility for the HVs to manage: 'I think having nine health support workers all land

on your desk in one go was quite difficult…you know they were kind of dragging their heels and not being busy for a while', or as another HV put it: 'we are used to being solely responsible for the one family and all of a sudden you are having to also be responsible for what somebody else is doing with the family and trying to keep on top of all that'.

The HVs saw HSWs as having relevant personal experience, but this was regarded as low status, and the main purpose of the HSWs was to free up time for the HVs to apply their specialist professional knowledge. 'Some of them [HSWs] have got…previous life experiences that are really helpful for some families. They have maybe had experience of women who have been in domestic violence or maybe there is drug problems and things like that. So there is quite a lot of personal experience that is quite useful. Even if it's only in a support role for the grandparents. Sometimes, even just to sit and say "yes, we understand how that feels"'[HV]. 'There seems to be quite a lot of them doing things like school runs…helping kids get out to school in the mornings…sit with the baby and allow the mother some time just for a sleep or a bath or something' [HV]. 'Like in the hospital the patient may relate to the cleaner, where she's maybe got a wee bit of time, whereas the nurse [HV] is seen as different…[where we are] going into one family we have a slightly different relationship, and we discuss it as slightly different' [HV].

The HSWs, by contrast, saw themselves as *accompanying contributors*. They had significant local knowledge and could contribute to the care process. For example, the families would be willing to divulge personal information to the HSW that they would keep hidden from the HV because of the empathy and time spent with them. This sort of input should be valued in managing the cases and should be given a fair hearing. They did not feel that this was always the case. '…We've got the knowledge of what's going on in the community that we can actually go and we can say to the health visitor that we think that such and such could be doing with the help from a specific agency. We've got the ability…we know what's going on' [HSW].

In addition, HSWs thought that they were able to get to the heart of what the Starting well project was intended to do – which was to build competence and confidence in the families, in line with the 'social model' of health. '…they [HVs] deal with the medical issues that we're not qualified to deal with and they support the family on a medical basis but I think we as support workers do all the mental support and the family support…' [HSW]. In this quote, the technical/medical skills are acknowledged as important but not as important as the 'mental stuff' on offer by the Health Support Workers. Interestingly, and perhaps ironically, HV practice within the project has deliberately sought to break away from a "medical model" focused on illness and remedy, to a more holistic 'social model' of care and support.

In these character constructions there are certain areas of cue and response incompatibility. The parental role expects to be able to issue instructions, to be listened to and to be regarded as being responsible. However, the HVs did not always receive the paired expected response. Rather they experience HSWs as people who wanted to talk and not receive instructions and who would not necessarily carry out instructions and

problems of communication. Conversely, the HSWs found that they were not 'allowed in' to the conversations at the appropriate level and that there was a steep hierarchical divide between them and the HVs. They felt that the HVs believed that the role of the HSWs was to support HVs, rather than to support the families, which was the HSW perception. Both sides believed in a differentiation, but they differed over the value of experience in the community as a status-giving rhetorical resource when compared to professional qualification.

3. *Who presents obstacles, and who overcomes them?*

For the HVs most other parties presented obstacles. Everyone expected them to be able to do everything with no resource or time. They typified themselves as 'constantly juggling' many competing demands, and those making the demands appeared to be unaware that they were being unreasonable: 'everyone thinks you can do everything'. Service users were not always in for scheduled appointments, and the HSWs were an added responsibility (they were another example of what could be 'landed on your desk'). Rather than necessarily reducing the workload, at least initially, they increased it as, like clients, they had to be looked after. Management were also an obstacle to an extent as they were perceived as 'distant' and lacking understanding of the clinical practice issues involved in supporting families. Management was also seen as fairly autocratic and poor at communication. The belief was that things would work out if 'senior management got off your back for a wee while and let you get on with the job' [HV].

In short, the HV narrative structure has themselves as the central active agent with all other actors and 'the system' providing (to greater and lesser extents) obstacles that they have to overcome themselves. Little gratitude is expected to be received for this struggle. This perception is typical of epic narrative structures. The HVs narrative is *generically epic* in that they are the prime custodians of good and effective action and all others, to some extent, and often unwittingly, contribute to the difficulties inherent in the system.

HSWs also felt that they were battling against the system at times. For example, they told stories of having to wait in the rain and catch a series of buses to get to an appointment with a family, who would then be out, and they would have to retrace their steps on a fruitless journey. In such stories, management were implicitly at fault for not having devised a better solution to the logistical problems (suggestions such as buying a mini-bus were thought to have been ignored), the bus service was at fault (almost as an undeniable truth that all would naturally agree upon) and the service users were at fault for being disorganised. The HSWs perceived the HVs in much the same way that HVs perceived management, for example, as lacking in compassion and being too dictatorial. Further bite was added to these criticisms when the HSWs commented that these attitudes were often mirrored in the way that the HVs would interact with families.

The HSWs' narrative structure is also epic, although not exclusively focused on their own character as central – they acknowledge the roles of others in solving problems and making contributions. In this sense the HSWs narrative is *locally, rather than*

generically, epic. They make their own local contribution, but these contributions fit into a generic system that is controlled by others who also can be forces for the good.

Both narrative structures that answer the question of who presents and who overcomes obstacles are in the epic narrative form [33] in which the hero struggles to overcome trials. However, the HV narrative is a form in which they see themselves as battling alone against the total system. Conversely, the HSW narrative is more diffusely epic, in which a number of characters are needed to combine their localised efforts in order to triumph overall.

Discussion

In conducting this research, we have focused on the Starting Well project as an example of organisational innovation and have attempted to explore the identity dynamics involved implementing change. In the Project, an inter-organisational network arrangement was implemented between the health service and a voluntary sector. This introduced ambiguity into management structures and organising practices (incorporating One Plus, the Starting Well management and primary health care trusts). The managers did put considerable effort into fostering cross-boundary learning and development with attention paid to two-way communications, team building and democratic processes such as allowing HVs and HSWs to set the agendas for meeting with managers. These practices would conform to the desired approach exemplified by [34].

The perception of those in the situation is that there have been significant improvements in the service offered to families, but there is an underlying difficulty which was not fully realised at the beginning of the process, and which could impact on future change situations such as this one. The organisational changes had implications for the identities and the identity dynamic processes [35] of those involved. We suggest that one way to understand these identity processes is through exploration of the narratives through which people attribute meaning to themselves and others [36]. Following Martin et. al. [37] , we regard one of the functions of identity-narratives as answering key questions which enable actors to position themselves in the situation. These social positioning devices have impacts for whether or not people will be supportive of, or averse to, change.

In our research three central questions emerged: What is our proper relationship to the service users? What is our proper relationship with each other? Who presents obstacles, and who overcomes them? We believe that these add to Martin et.al.'s [38] original list of story-telling questions. It may be that the additional questions we found arise because of the nature of the organisational setting. In Martin's work the research was conducted within single organisations, whereas our focus was on a setting that was new for the participants and which entailed working across traditional organisational boundaries. Hence, there may be less focus on issues such as rule breaking and how the boss will react in less defined settings. Here people appeared to be asking more fundamental questions relating to their own identity, that of others and how the various groups would interact.

Some have argued that such social processes can operate as forms of control in which individuals are socialized into particular ways of being [39], whereas others, such as Coupland [40], have argued that the processes can offer the opportunity for negotiation and interactive settling of identities. In our research, there was evidence of disagreement in perception between the parties. The HVs were perceived by the HSWs as more powerful, but nonetheless the HSWs did attempt to undertake some negotiation of role: in making inputs to conversations about appropriate plans for the care of families and in sending messages to management in team development activities. It is too early to say whether or not such attempts to negotiate roles will be successful in the long term, but it is fair to say that it is a contested terrain.

It is important to note, however, that if left unattended, the differences between the identity constructions could be a significant force against effective progression of change in the project. We have illustrated differences which are summarised in table 1. The professional/group identities of HVs and HSWs have different and sometimes incompatible answers to the narrative questions. They have different views of how one should interact with families. These views are not necessarily incompatible as complementary parts of an overall system. It would be appropriate to have some advice-giving and other mentoring roles. However, it could be problematic when value-judgements are attached to these modes of engagement. So, for example, when HSWs regard HVs as having an inappropriate approach to families that is not compatible with the principles of the social model of care then conflict, either overt or covert, is likely. Similarly, the differences in the perception of the proper nature of the relationship between the two identity groups is likely to lead to conflict. One side expects to be able to run things efficiently with the other side fitting in. The other side, however, expect to be able to shape and alter things, and to have a high degree of value associated with their experience. In so doing, they fail to put as much emphasis on professional education as others would. Lastly, there is a difference over whether the solution to problems is allowing HVs to have freedom to make things happen as they want, or whether it lies in a more communal approach in which different roles have influence.

[Table 1 about here]

We would argue that there is a need to facilitate the meaning-making activities of the professional-identity groups such that these differences can be addressed. We would propose the following: 1. The questions need to be made overt with the groups. 2. Arenas of transparency for negotiation need to be provided in relation to these questions. 3. This needs to be an iterative cycle in which gaining a degree of agreement at the outset is regarded as the start of a process that will be revisited, rather than regarding it as closed. 4. These steps need to be taken in a way that it not time- and resource-intensive. Where possible, activities could be linked to normal team development, training or communications activities. However, we believe that this activity does need to be given some distinct space in which all parties focus on it.

Conclusion

Our purpose was to explore the identity dynamics of two identity groups as they came together in a longitudinal project. Through the use of narrative analysis we identified various dynamics that could militate against effective change processes in the project. In doing this, there are areas of addition to theory. Whilst Gratton and Ghoshal's [41] prescriptions may be desirable, cross-boundary learning and flexibility does not occur naturally or easily in all situations, and an analysis of identity processes can throw light on some significant barriers. Specifically, the research has identified certain identity- and change- related questions that operated in this inter-organisational setting. In terms of practice we have outlined some ideas for the implementation of concepts emerging from the analysis. We have argued that unless the nature of the interaction of the forming and re-forming roles is recognised and made overt, then barriers to effective working are likely to emerge. Consequently there is a need for managers and others to be aware of the characterisations in use and the tendency of these to harden into positions that hinder further dialogue [42].

Finally, we should acknowledge limitations with this study. The use of narrative analysis is only one mode of engaging with qualitative data and it focuses on stories, characterisation and narrative structure. Other modes of analysis would reveal other insights and whilst we would argue that narrative analysis makes a contribution, it does not seek to encapsulate a total explanation of the situation. This type of research does not seek to produce fully generalisable results, but we envisage this analysis being additive to others of a similar approach.

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43.

Narrative Questions	Health Visitors	Health Support Workers
What is our proper relationship to the service users?	Advice-givers 'sorcerers'	'mentors'
What is our proper relationship with each other?	Parent-child	Accompanying contributor
Who presents obstacles, and who overcomes them?	All others Health Visitors (specific epic)	The system A combination of characters (generic epic)

Table 1: narrative questions and answers associated with HV and HSW professional identities