

A theory of maternal engagement with public health nurses and family visitors

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Background. Home visiting by public health nurses and family visitors is promoted as an important intervention for enhancing parent and child development. Mothers of children at-risk for developmental delays tend to be the most difficult to access and engage, and commonly drop out of home visiting programmes prematurely.

Purpose. This paper reports a study developing a theory that describes the process by which mothers of children at-risk engage with public health nurses and family visitors in a blended home visiting programme.

Methods. Grounded theory was used to guide the collection, recording, organization and analysis of the data. A purposeful sample of 20 mothers receiving public health nurse and family visitor home visits were recruited from a public health unit in Canada. Data were collected through client record reviews and 29 in-depth interviews that explored participants' experiences, beliefs and expectations about engagement. Data collection and analysis continued until all categories were saturated.

Findings. Mothers felt vulnerable and frequently powerless when they allowed the service providers into their home. Mothers with children at-risk engage with public health nurses and family visitors through a basic social process of limiting family vulnerability, which has three phases: (1) overcoming fear; (2) building trust; and (3) seeking mutuality. The personal characteristics, values, experiences and actions of the public health nurse, family visitor and mother influence the speed at which each phase is successfully negotiated and the ability to develop a connected relationship.

Conclusion. Public health nurses working with families at risk need to identify client fears and perceptions related to home visiting, and to explain the role of public health nurses and family visitors to all family members. Given the importance that mothers place on the development of an interpersonal relationship, it is

important for home visitors continually to assess the quality of their relationships with clients.

Keywords: home visits, nurse, paraprofessional home visitors, high-risk families, grounded theory, engagement

Introduction

To promote child and parent development, the Province of Ontario, Canada implemented the *Healthy Babies, Healthy Children* (HBHC) early intervention programme to support all Ontario families through universal and targeted services. Universal services include postpartum screening to identify risk factors for poor parenting or developmental delays, a telephone assessment conducted by a public health nurse (PHN) within 48 hours of hospital discharge and the offer of a PHN home visit. Targeted services, including service coordination and intensive PHN and family visitor (FV) home visits, are available to high-risk pregnant women referred to the programme or families with children (aged under 6 years) identified by the PHN as being at-risk for developmental delays related to physical, cognitive or social factors. In this blended model of home visiting, both professional and lay home visitors work with families to change parental attitudes, knowledge and behaviours in order to encourage healthy child development. Families that are invited to participate in the intensive home visitation component of the programme also tend to be the most difficult to access and engage, and commonly drop out of home visiting programmes prematurely (Kitzman *et al.* 1997). This article describes the process by which mothers of children at risk engage with PHNs and FVs in a blended home visiting programme.

Literature review

Intensive nurse home visitation programmes targeted at families most at risk due to parental age, low income and/or education levels can positively influence maternal-child health outcomes (Ciliska *et al.* 1999). Children experience improvements in mental development, mental health and physical growth, and reductions in behavioural problems and unintentional injuries; mothers experience a reduction in maternal depression and improvements in parenting skills, quality of social support, maternal employment, education and nutrition (Ciliska *et al.* 1999, Elkan *et al.* 2000). Positive outcomes are most likely to occur in home visiting programmes that offer a minimum of weekly home visits during pregnancy or immediately postpartum and link families to other community supports (Ciliska *et al.* 1999). Despite

strong evidence to support the use of nurse home visitation programmes, many governments and agencies have implemented paraprofessional home visiting programmes or a blended model using both nurses and lay home visitors. Paraprofessional home visitors can positively influence child development and parent-child outcomes, especially when home visits are intense (weekly or bi-weekly), are started during the prenatal period and are part of a multifaceted programme that offers families professional support and links them to other community services (Wade *et al.* 1999). However, in a randomized controlled trial examining the effectiveness of home visiting by nurses and by paraprofessionals as separate service providers working to improve maternal and child health outcomes, it was identified that for most outcomes on which the nurses produced beneficial effects, the paraprofessionals' effects were approximately half the size (Olds *et al.* 2002).

It has been hypothesized that positive maternal-child outcomes are related to the development of a trusting relationship between the home visitor and mother (Weiss 1993, Kitzman *et al.* 1997). In a study examining the nature of health visitor-client interactions, Clark (1985) suggests that the development of the client-provider relationship is necessary because it facilitates ongoing entry into the home when families have not identified a need or desire for health promotion services. Several rigorous qualitative studies describe the home visiting process and identify factors that influence the development of the nurse-client relationship from the nurse's (Zerwekh 1991, 1992a, Chalmers 1992, De la Cuesta 1994, Byrd 1995a) or FV's perspective (Jack *et al.* 2002). In these studies, client experiences and perceptions are interpreted by and described from the home visitor's perspective.

In summary, home visiting programmes have been extensively evaluated and their effectiveness in altering a broad range of maternal and child outcomes has been examined, particularly in the United Kingdom (UK) and the United States of America (USA). While a number of qualitative studies have examined the home visiting process from the viewpoint of service providers, there are few in-depth descriptions of client experiences in blended home visiting programmes or factors which influence their ability to create trusting relationships with and accept services from multiple service providers.

The study

Aim

The aim of this study was to develop a theory grounded in the data that describes the process of engagement between mothers and PHNs and FVs in a blended home visiting programme from the client perspective.

Design

Classic grounded theory (Glaser 1978, Stern 1985) was used to guide the collection and analysis of the data.

Participants

Study participants were recruited from a health unit in South West Ontario between June 2001 and January 2002. To learn about clients' experiences of engaging with PHNs and FVs, a purposeful sample of 20 mothers receiving intensive blended home visits were recruited. Mothers were eligible to participate if they had been identified by the PHN as 'high risk' because of social or economic factors, had received at least one PHN visit and three FV visits, and spoke English. Maximum variation sampling, or the selection of participants who varied on multiple dimensions, was used to select a heterogeneous group of women participating in the HBHC programme (Patton 1990). The benefit of maximum variation sampling is that 'any common patterns that emerge from great variation are of particular interest and value in capturing the core experiences and central, shared aspects or impacts of a program' (p. 172). Variability within the sample was achieved by selecting mothers who differed on the following dimensions: timing of referral (prenatal or postpartum), parity, age, marital status, and household composition.

As data analysis progressed, theoretical sampling was used to guide the collection of further data. Theoretical sampling involves identifying individuals who can provide information that develops and conceptually links emerging categories (Glaser 1978). During analysis, it became evident that client preconceptions and experiences with social and health service providers and the availability and quality of informal supports influenced a mother's ability to engage with home visitors. Therefore, sampling was extended to re-interview or recruit mothers who lived in a rural setting, had past experiences with a child welfare agency, were new immigrants to Canada and/or whose husband or partner also participated in the home visits. Negative cases, or those mothers who were perceived by nurses not to have fully engaged in the home visiting process, were also sought in

order to raise the level of abstraction of the theory and to understand the limits of the variables (Glaser 1978).

Data collection

Data collection and analysis occurred simultaneously. Demographic data were collected using a short, written questionnaire administered by the principal investigator. Contextual data about the home visits were gathered through a review of client records. Each participant's experiences, beliefs, and expectations related to the phase of engagement with their PHN and FV were explored during in-depth, semi-structured interviews that lasted between 60 and 90 minutes. As the core category emerged during analysis, interview questions were added that focused on understanding the dimensions and properties of the category. Participants were interviewed between one and three times. A total of 29 interviews was conducted, 18 in person and 11 by telephone. Permission was granted to tape record 23 of the interviews, which were then transcribed verbatim. Six interviews were not recorded at the participants' requests. Extensive notes were made during these six interviews. Field notes recording observations and thoughts about the emerging concepts were documented immediately after each interview. Fifteen participants reviewed and commented on a summary of their individual interviews. Five mothers could not be located for follow-up. Each participant was given one \$20 gift certificate as a token of gratitude for participating.

Ethical considerations

Approval to conduct the study was obtained from the McMaster University and Hamilton Health Sciences Corporation Research Ethics Board. All participants received a written and verbal description of the study and gave informed consent to participate. Consenting mothers were informed that their participation was voluntary, that they could withdraw from the study without consequence at any time, and that their involvement would not affect their home visiting services. Participant anonymity and confidentiality were guaranteed, with the exception that if the researcher suspected or observed signs of child abuse or neglect during the interview, then participants were clearly informed that she would have a legal responsibility to report these suspicions to the child welfare agency.

Data analysis

Data were analysed using open, selective and theoretical coding (Glaser 1978). Theoretical memos were written at each

stage of coding to capture ideas and hypotheses and to explore the relationship among concepts emerging from the data. Through this constant comparison of data in theoretical memos, codes were verified and saturated, while patterns and themes emerged (Stern 1985). Data continued to be collected until categories were saturated and no new information was emerging. Coding of data and the organization of memos were facilitated through the use of NVivo 1.3 software (QSR 2002).

Data credibility

To improve data credibility, multiple steps were incorporated into the study design. Data source triangulation was achieved through the use of maximum variation sampling, and method triangulation was done by comparing interview and client chart data. Sampling strategies were also used to identify negative cases or mothers who could provide data to confirm or disconfirm emerging hypotheses. Negative cases were sought out to identify the limits of the variables and to raise the level of theoretical abstraction (Schreiber 2001). To further establish data credibility, two forms of external checks were used: (1) peer debriefing and (2) member checking. Academic colleagues and practising PHNs gave feedback on the emerging concepts and commented on the relevance of the model to nursing practice. Once data analysis was completed, the emerging substantive theory of engagement was validated with eight of the original participants who could be located. They each agreed that it fitted their experiences in the home visiting programme.

Patton (1990) argues that researcher credibility influences confidence in the truth of data. Given that grounded theory is situated in a constructivist paradigm of inquiry where the researcher and participant create knowledge during their interactions (Annells 1996), no attempt was made to separate the researcher from participants. For example, the interviewer (SJ) was open to discussing her personal experiences of pregnancy and parenting knowledge with the participating mothers. To avoid bias in data analysis, she wrote extensive memos describing her professional experiences as a PHN home visiting at risk families and her personal experiences of receiving PHN home visits during a high-risk pregnancy with twins and the subsequent postpartum period. As categories and hypotheses emerged in the theoretical memos, she returned to the data to confirm that these hypotheses were based on participant experiences and not her own. A detailed audit trail was maintained that included a description of all study events and decisions about study design, sampling techniques, data collection and analysis.

Findings

The final sample included 20 mothers who had experienced engagement with both PHNs and FVs. Feeling vulnerable was the basic social psychological problem mothers experienced during the phase of engagement with PHNs and FVs. Mothers expressed feelings of vulnerability and powerlessness because they were aware that they were allowing into their homes service providers who had the power to alter family structure and recommend changes to family processes. As one mother explained, 'I was nervous when [the PHN] was coming over. I always want to say and do the right things in front of her because I'm not sure what will happen if I don't'.

Mothers with children at risk engage with PHNs and FVs through a basic social process of limiting family vulnerability. A mother's decision to participate in a home visiting programme is made by weighing the unknown risks and consequences of participating in the visit with her need for social support, guidance, and information. Those who take the risk of participating use various strategies to protect the integrity of their family and limit their vulnerability. Limiting family vulnerability has three phases: (1) overcoming fear, (2) building trust, and (3) seeking mutuality. These sub-processes are continually negotiated during home visits as the mother allows, first, the PHN and, second, the FV physical entry into her home. This is a circular process, with each phase dependent on the establishment and stability of the other two phases. Fears are overcome once trust has been built, and trust exists only when the mother feels that mutual goals and sharing are occurring in the two different client-provider relationships. At the heart of the process, the personal characteristics, values, experiences, and actions of the PHN, FV and mother influence the speed at which each of these sub-processes are successfully negotiated (Figure 1).

Overcoming fear

Many mothers are ambivalent about accepting initial PHN visits because they perceive that they are coming to 'check up on them' and they fear that they will be judged as inadequate mothers. To overcome this fear, mothers used specific strategies, including 'hiding nothing', 'trying to measure up', and 'protecting self.' The strategy of 'hiding nothing' refers to making a choice to allow the PHN entry into the home so that she can see for herself that her original stereotypes or suspicions may be unfounded. The majority of mothers reported that they purposefully clean the house and make the baby presentable prior to the nurse's arrival. The data suggest that they are motivated by 'trying to measure up' to their perceived ideals of

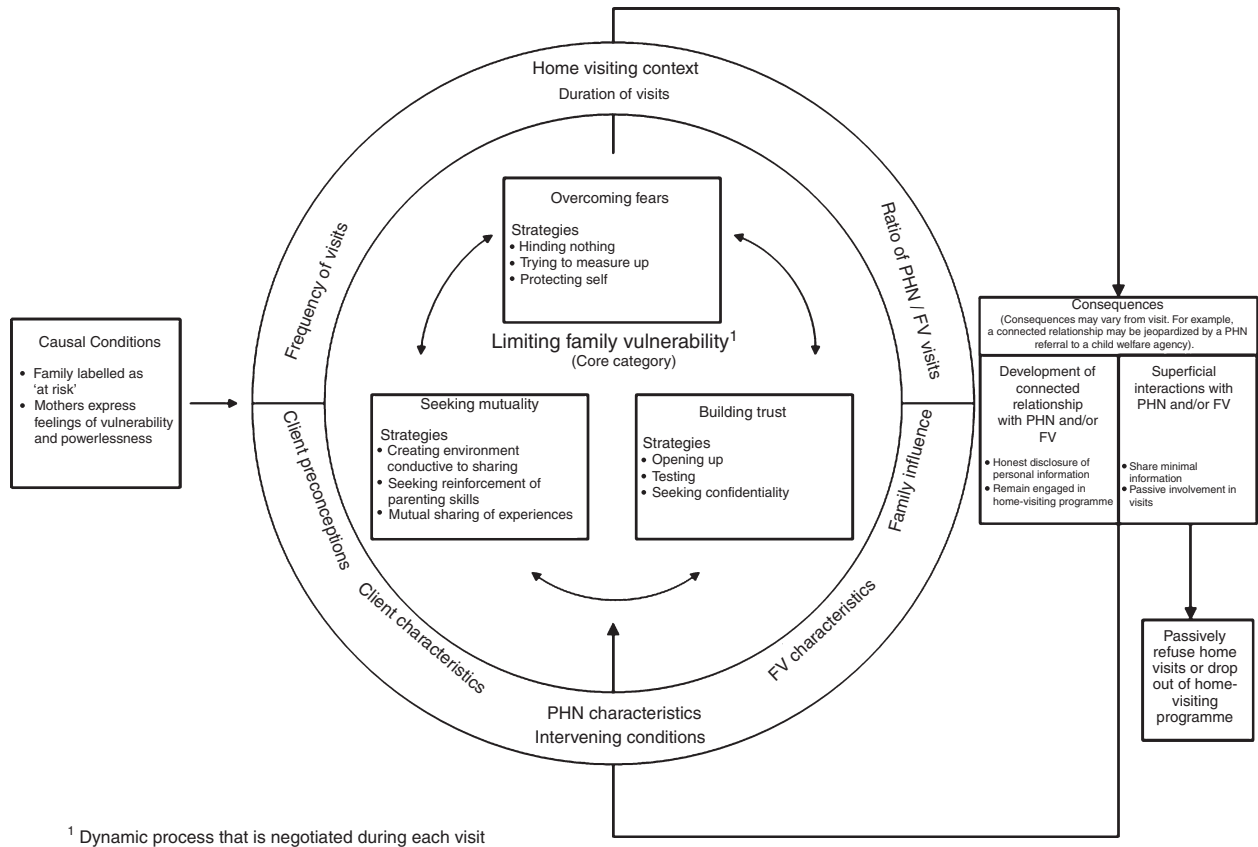


Figure 1 Theoretical model of maternal engagement with public health nurses and family visitors.

being a 'good mother'. They perceive that their level of vulnerability will increase and they risk more invasive agency intrusion if a nurse were to enter their home and observe dirt and chaos. It was common for a spouse, partner or other family member to be present during the initial postpartum home visit. However, for those mothers who were hesitant or unsure of the purpose of the nurse's visit, the presence of another person served the additional purpose of 'protecting self'. Mothers felt safer in the presence of a family member. They anticipated that the presence of the individual would shift the power balance and the nurse would be less likely to judge them or make negative comments. The successful use of these strategies allowed mothers to redefine the role of the PHN from authority figure or monitor to a supportive service provider.

Families who were eligible for long-term home visiting were encouraged to accept referral to a FV. In comparison with their preconceived perceptions of PHNs, most mothers were less fearful of engaging with a FV. Those who had established trusting alliances with their nurses had little hesitation about accepting the PHNs referral to the FV component of the programme. Three hypotheses that emerged from the data to explain this situation were the

following: (1) over time mothers came to trust the PHN and thus perceived her interventions, including a FV referral, as genuine and helpful; (2) mothers had an accurate understanding about the role and purpose of the FV home visits because of detailed explanations from the PHN; or (3) mothers perceived that a FV is 'a mother just like me', had less power than the PHN, and so posed less of a threat to the integrity of their family than did the PHN.

There were several consequences of not being able to overcome fear: hesitancy about accepting ongoing support from the PHN and/or the FV, cancelling or not being present for scheduled home visits, dropping out of the home visiting programme without offering an explanation to the PHN, or choosing not to fully disclose information shared during individual and family assessments.

Building trust

As trust in the home visitor increased, the mother's sense of vulnerability decreased and she was more willing to take a risk and discuss personal, sensitive issues. Mothers referred to this as 'opening up' and being able to 'talk from the heart'.

Being honest and sharing aspects of their lives was easiest when they knew that the home visitor was reliable, would keep information confidential, and would not react negatively to any of the information disclosed.

The ability to trust or 'open up' occurs at different points in time during the process of engagement. The level of trust that is developed exists on a continuum, from no trust, to tentative trust and then strong trust. The speed with which the mother trusted the home visitor was influenced by maternal characteristics and perceptions of the home visitor's role. Those who were open to the relationship, motivated to participate, confident in their parenting ability, and perceived the PHN as a positive source of support were most likely to immediately trust the PHN or FV. Those who came across as defensive, identified that they 'trusted no-one' and were suspicious of the nurses' motives when visiting did not initially trust them and viewed trust as something to be earned over time.

In deciding to trust the PHN and FV, mothers discussed the various ways they 'tested' these service providers. This included using secondary sources to verify information given by their home visitor and testing the home visitor's reliability. Home visitors who were reliable were viewed as more trustworthy than others. Confidentiality was another important component of trust. Some mothers admitted to testing the boundaries of their relationship with their home visitors, particularly with the FVs, to assess how much information they would share about other clients. Home visitors who were perceived as 'gossipy' or willing to talk openly about other clients were not viewed as trustworthy. As a consequence, clients did not trust these providers and engaged in only superficial discussions rather than disclosing sensitive information.

Outcomes related to the development of trust were: (1) establishment of an effective, working alliance; (2) improved communication; and (3) increased maternal motivation to examine and improve parenting knowledge and skills. Mothers who did not trust or who stopped trusting either the PHN and/or FV experienced feelings of frustration, extreme stress and anger. This limited their ability to work effectively with the home visitors, to disclose personal information, and to implement any suggestions or recommendations made by the home visitors. Mothers who did not trust the PHN and/or FV often considered dropping out of the programme, but many were hesitant because they were fearful that such action would result in a telephone call to the child welfare agency. Therefore, the usual response would be to 'play along with them so that they leave me alone'.

In comparing PHNs to FVs, it was not evident that mothers generally trusted one group more than the other. However,

when examining individual triadic relationships, a mother generally placed more trust in either her PHN or her FV because of differences in individual characteristics, such as reliability, genuineness, warmth and ability to be caring and empathetic. As a consequence, one of the benefits of participating in a blended model of home visiting was that mothers felt that if trust was lost with the FV, for example, they could still trust and work effectively with the PHN. Others who were unable to establish trust with the PHN still hesitantly accepted the FV referral, particularly in situations where they were isolated and desperately seeking social support and 'someone to talk to'. The need for companionship and support outweighed the distrust of the nurse. These mothers maintained hope that the next individual they would be referred to would be that special person who could help them.

Seeking mutuality

Mothers attempting to limit their vulnerability do so by seeking mutuality with either the FV or PHN. Henson (1997) defines mutuality as a feeling of being able to connect with or understand another. All of the mothers wanted the PHNs and FVs to be people with whom they could openly share their stories, and who in return would share their experiences and some details about their lives outside of nursing and home visiting. They also desired respect and wanted to have meaningful input into the content, structure, and goals of each home visit.

To promote mutuality, mothers created environments that were conducive to sharing information and reduced the formality of the home visit. They purposefully scheduled home visits at times when outside distractions were reduced and frequently offered refreshments to the home visitor and encouraged a brief social exchange. Mothers also took note of the verbal and non-verbal language that occurred during the visits. When conversations were filled with humour, caring and empathetic responses, respect, and a mutual exchange of ideas, they felt that they were able to deepen their connection to their home visitors. They observed mannerisms that indicated that the home visitors respected them and would not judge them or be 'shocked by anything I have to say'. Mothers reported feeling comfortable engaging with home visitors who smiled, nodded their heads in encouragement, and allowed adequate time for the mothers to talk.

Therapeutic reciprocity, or the 'mutual exchange of meaningful thoughts, feelings, and behaviors' (Marck 1990, p. 52) is an important property of mutuality. In their interactions with the PHNs and FVs, mothers wanted to

know more about the people they were working with and so they asked their home visitors questions about their personal experiences, beliefs and practices, especially related to child-rearing. When a mutual exchange of information occurred, mothers felt less vulnerable in answering personal questions related to such topics as their histories of depression or experiences of domestic abuse. They described experiencing a sense of relief when they realized that the PHN or FV struggled with the same issues that they encounter on a daily basis.

Mothers also sought to create mutuality by creating alliances with their home visitors. It was common for many to be berated by their partners or parents. Often the baby's father would be overly critical of the mother's parenting methods, especially when these 'new' ways were contradictory to his cultural beliefs or to traditional ways of parenting. These mothers often sought reinforcement from the home visitor. Together they would present a common front; often with the PHN praising the mother's parenting abilities in front of the father.

Mothers placed a high priority on collaborating with the home visitors to define common goals for the home visits. Mutuality was reduced when home visitors did not identify or ignore mothers' priority needs and instead established their own agendas for what should be discussed during a visit. It was more common for FVs than PHNs not to provide this aspect of client-centred care or to 'lecture' the mothers. One exasperated mother stated:

I don't want the family visitor to get in my face about my daughter. Don't tell me to do things that I am already doing! Instead, start by asking questions to find out what I am doing and why I am doing it.

Some mothers felt disconnected from their PHNs if they entered the home and mechanically collected family assessment data and did not spend time interacting with the child or engaging in some social conversation. Seeking and finding mutuality in a relationship with either the PHN or the FV was an essential condition to remaining engaged in the home visiting programme.

Discussion

The use of home visits in early intervention programmes is a key strategy to promote optimal child and parent development. Public health nurses and FVs seek entry into private homes to provide support and information to parents of infants and young children at-risk. Mothers attempted to cope with feeling vulnerable and powerless through a circular process of engagement identified as 'limiting family vulnerability'. Successful engagement with home visitors was

evidenced by creating a connected relationship built on a foundation of overcoming fear, building trust, and seeking mutuality. This grounded theory provides new insight into the experiences and thoughts of mothers who accept home visits. It moves us towards a more holistic understanding of the home visiting process, which, in the literature, has been predominantly described from a nursing perspective only. The findings are clinically relevant because they provide insight into why mothers participate or withdraw from home visiting programmes.

Engagement with home visitors can be inhibited if a mother feels vulnerable and hesitant about allowing the visitor access into her home. The fears that mothers expressed in this study about being judged and monitored are not unfounded. Peckover (2002) confirms that some mothers perceive home visits as form of surveillance. Cameron (1994) explored client perceptions of home visits conducted by health visitors and, in a representative sample of 45 primiparous mothers, one-third of mothers perceived that it was the role of the health visitor to monitor for child abuse. Nurses recognize and struggle with balancing their role of providing support with that of policing families (Zerwekh 1992b, Peckover 2002).

The most important home visiting outcome to mothers was the development of a connected relationship with one or both home visitors. Pearson (1991) confirms that during prenatal and immediate postpartum home visits, clients tend to place an emphasis on the establishment of a client-provider relationship, whereas health visitors are primarily focused on the identification of health problems. In order to access and offer health promotion services to families with young children, home visiting nurses have consistently identified the importance of developing nurse-client relationships built on trust and collaboration (Chalmers 1992, De la Cuesta 1994, Byrd 1995b, Paavilainen & Astedt-Kurki 1997). There is some evidence that if a therapeutic relationship is not established during the engagement phase, it may result in clients prematurely withdrawing from the service (Bachelor & Horvath 1999). From my study of maternal engagement, vulnerable mothers who did not feel that their needs were being met or who judged the quality of the client-home visitor relationship as poor were most likely to resist help or withdraw from the home visits. In addition, examples of disconnected relationships were exemplified by PHNs acting in a bureaucratic manner during home visits and FVs 'lecturing' or being paternalistic towards clients.

In their interactions with home visitors, mothers wanted to feel respected, have opportunities for input and to feel that they were making meaningful contributions to the relationship. Most important, they felt less vulnerable when

What is already known about this topic

- Professional and paraprofessional home visiting programmes targeted at high risk families can improve multiple maternal and child health outcomes.
- Families most at-risk are often the most difficult to access and the hardest to engage, and many home visiting programmes report high rates of attrition.

What this paper adds

- Mothers with children at risk of developmental delays assess the risks and benefits of participating in a home visiting programme prior to accepting visits.
- To engage with home visitors, mothers use multiple strategies to overcome their fears, build trust, and seek to establish mutuality with their home visitors.
- Mothers identify the development of a connected, trusting relationship with a home visitor as the most important outcome of a home visiting programme.

PHNs and FVs treated them first as people and second, as clients. Morse (1991) labels this a connected nurse–patient relationship. Mothers felt that the power differential decreased when the PHN or FV took part in a reciprocal exchange of information and was willing to disclose personal information about her life and parenting experiences as they related to client issues. Chalmers (1992) discusses the process of ‘giving and receiving’ that occurs in home visiting and identifies how clients give personal information in exchange for professional nursing services, such as education, advocacy or referrals. The findings from our study indicate that nurses should also consider different ways of relating to their clients such as ‘giving’ some information about themselves.

Mothers’ descriptions of trusting, mutual interpersonal relationships also give insight into their preferences for either a professional PHN or a lay FV. Recognizing that most PHNs represent dominant, middle class values, many home visiting programmes instead hire paraprofessionals or lay people who share similar experiences, values and beliefs with the families they visit. This ‘shared culture’ is believed to facilitate entry into the home and promote the development of a trusting relationship (Wasik 1993). Findings from our study indicate that shared experiences do facilitate the process of trust building. However, the mothers’ data suggests that the variable most likely to influence successful engagement is not the provider’s demographic background but rather her skill and ability to develop rapport and mutuality.

Implications for practice and research

Knowing that mothers were initially hesitant to open up to nurses and fearful of full involvement in the programme, it is imperative that nurses identify client fears during initial visits. To reduce such fears, PHNs and FVs have a responsibility to define their role for the family and identify those conditions under which child welfare involvement may be necessary. Most important, mothers who remained engaged in the home visiting programme did so because they trusted and felt that they had established a connected relationship with the PHN and/or FV. Creating mutuality may be difficult for PHNs or FVs who choose to focus exclusively on the client during a visit and decide not to disclose any information about their personal experiences. Mothers noted that the power differential between provider and client was reduced when PHNs or FVs made appropriate personal disclosures while maintaining professional boundaries. This served to reduce their feelings of vulnerability. Given the importance that mothers place on the development of an interpersonal relationship, it is important for PHNs and FVs to take time to assess the quality of their relationships with clients.

The primary limitation of this study is that only mothers who agreed to participate in the home visiting programme were interviewed. Therefore, future researchers should identify strategies to locate and interview families who have refused referral to public health services or who have refused to allow a PHN to visit, so that potential barriers to the engagement process can be identified. Given the importance of developing and maintaining a connected relationship, there is a need to develop and test tools that measure the quality of this relationship.

Conclusion

After considering potential risks, many vulnerable mothers are willing to participate in home visiting programmes with PHNs and FVs. To establish a connected relationship, they must first overcome their fears, build trust and seek mutuality with the home visitor. Therefore, it is imperative that public health managers recognize the importance of allowing home visitors flexibility in deciding how many visits are required during the early phase of engagement. It is difficult to predict in advance how much time is needed to develop a good working relationship with mothers of children at risk. To increase client use of and satisfaction with home visiting programmes, and to develop appropriate home visiting outcome indicators, it is vital to understand and incorporate mothers’ perspectives.

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References

- Annells M. (1996) Grounded theory method: philosophical perspectives, paradigm of inquiry, and postmodernism. *Qualitative Health Research* 6, 379–393.
- Bachelor A. & Horvath A. (1999) The therapeutic relationship. In *The Heart and Soul of Change: What Works in Therapy* (Hubble M.A., Duncan B.L. & Miller S.D., eds), American Psychological Association, Washington, DC, pp. 133–178.
- Byrd M.E. (1995a) A concept analysis of home visiting. *Public Health Nursing* 12, 83–89.
- Byrd M.E. (1995b) The home visiting process in the contexts of the voluntary vs. required visit: examples from fieldwork. *Public Health Nursing* 12, 196–202.
- Cameron S. (1994) *First-Time Mothers and Their Health Visitors: Perceptions of a Home Visit*. Unpublished PhD Thesis, Edinburgh University, Edinburgh.
- Chalmers K.I. (1992) Giving and receiving: an empirically derived theory on health visiting practice. *Journal of Advanced Nursing* 17, 1317–1325.
- Ciliska D., Mastrilli P., Ploeg J., Hayward S., Brunton G. & Underwood J. (1999) *The Effectiveness of Home Visiting as a Delivery Strategy for Public Health Nursing Interventions to Clients in the Prenatal and Postnatal Period: A systematic Review*. Effective Public Health Practice Project, Hamilton, ON.
- Clark J. (1985) *The Process of Health Visiting*. Unpublished PhD Thesis, Polytechnic of the South Bank, London.
- De la Cuesta C. (1994) Marketing: a process in health visiting. *Journal of Advanced Nursing* 19, 347–353.
- Elkan R., Kendrick D., Hewitt M., Robinson J.J.A, Tolley K., Blair M., Dewey M., Williams D. & Brummell K. (2000) The effectiveness of domiciliary health visiting: a systematic review of international studies and a selective review of the British literature. *Health Technology Assessment* 4(13), 1–339.
- Glaser B. (1978) *Theoretical Sensitivity*. Sociology Press, Mill Valley, CA.
- Henson R.H. (1997) Analysis of the concept of mutuality. *Image: Journal of Nursing Scholarship* 29, 77–81.
- Jack S., DiCenso A. & Lohfeld L. (2002) Opening doors: factors influencing the establishment of a working relationship between paraprofessional home visitors and at-risk families. *Canadian Journal of Nursing Research* 34(4), 59–69.
- Kitzman H.J., Cole R., Yoos H.L. & Olds D. (1997) Challenges experienced by home visitors: a qualitative study of program implementation. *Journal of Community Psychology* 25, 95–109.
- Marck P. (1990) Therapeutic reciprocity: a caring phenomenon. *Advances in Nursing Science* 13(1), 49–59.
- Morse J.M. (1991) Negotiating commitment and involvement in the nurse–patient relationship. *Journal of Advanced Nursing* 16, 455–468.
- Olds D.L., Robinson J., O'Brien R., Luckey D.W., Pettitt L.M., Henderson C.R., Ng R.K., Sheff K.L., Korfmacher J., Hiatt S. & Talmi A. (2002) Home visiting by paraprofessionals and by nurses: A randomized, controlled trial. *Pediatrics* 110, 486–496.
- Paavilainen E. & Astedt-Kurki P. (1997) The client-nurse relationship as experienced by public health nurses: toward better collaboration. *Public Health Nursing* 14, 137–142.
- Patton M. (1990) *Qualitative Evaluation*, 2nd edn. Sage, London.
- Pearson P. (1991) Clients' perceptions: the use of case studies in developing theory. *Journal of Advanced Nursing* 16, 521–528.
- Peckover S. (2002) Supporting and policing mothers: an analysis of the disciplinary practices of health visiting. *Journal of Advanced Nursing* 38, 369–377.
- QSR (2002) *NUD*IST Vivo (NVivo) 1.3 Software*. Scolari Software, Thousand Oaks, CA.
- Schreiber R.S. (2001) The 'how to' of grounded theory: avoiding the pitfalls. In *Using Grounded Theory in Nursing* (Schreiber R.S. & Stern P.N., eds), Springer, New York, pp. 55–83.
- Stern P.N. (1985) Using grounded theory method in nursing research. In *Qualitative Research Methods in Nursing* (Leininger M.M., ed.), Grune & Stratton, Orlando, FL, pp. 149–160.
- Wade K., Cava M., Douglas C., Feldman L., Irving H., O'Brien M.A., Sims-Jones N. & Thomas H. (1999) *A Systematic Review of the Effectiveness of Peer/Paraprofessional 1:1 Interventions Targeted Towards Mothers (Parents) of 0–6 Year Old Children in Promoting Maternal (Parental) and/or Child Health/Developmental Outcomes*. Effective Public Health Practice Project, Hamilton, ON.
- Wasik B.H. (1993) Staffing issues for home visiting programs. *The Future of Children* 3(3), 140–157.
- Weiss H.B. (1993) Home visits: necessary but not sufficient. *The Future of Children: Home Visiting* 3(3), 113–128.
- Zerwekh J.V. (1991) A family caregiving model for public health nursing. *Nursing Outlook* 39, 213–217.
- Zerwekh J.V. (1992a) Laying the groundwork for family self-help: Locating families, building trust, and building strength. *Public Health Nursing* 9, 15–21.
- Zerwekh J.V. (1992b) The practice of empowerment and coercion by expert public health nurses. *Image: Journal of Nursing Scholarship* 24, 101–105.