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Establishing Therapeutic Relationships In the Context of Public Health Nursing Practice

by

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DEDICATION

This thesis is dedicated to the beloved memories of my brother, Scott Allan Tyynela, of my mother-in-law, Thelma Grace Porr, and of my father-in-law, Richard Irvin Porr.

ABSTRACT

I employed classical grounded theory methodology to formulate a theory of establishing therapeutic relationships in the context of public health nursing practice. Targeting Essence: Pragmatic Variation of the Therapeutic Relationship emerged as the theoretical model that elucidates how public health nurses develop therapeutic rapport with vulnerable and potentially stigmatized clients, specifically lower income lone-parent mothers. Data sources consisted of interview transcripts and dyadic observations. Public health nurses and lower income lone-parent mothers were the primary participants. During analysis, other sources for data were sought to achieve saturation of conceptual categories and theoretical integration. Targeting Essence: Pragmatic Variation of the Therapeutic Relationship is a six-stage process that evolved from theoretical interpretive analysis of the participants' general pattern of relating. Public health nurses strategically modify the therapeutic relationship during their efforts to ascertain main concerns of mothers within the constraints of contemporary practice. Lower income lone-parent mothers with heightened sensitivities enact interactional behaviours to discern the intent of public health nurses. The study's focused context elicited a nuanced explanation of the dynamic process that builds on the fundamentals of communication. Targeting Essence: Pragmatic Variation of the Therapeutic Relationship has the potential to enhance relational practice capacity, to advance nursing communication training curricula, and, ultimately, to promote maternal/child health and well-being.

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CHAPTER ONE: INTRODUCTION

Background and Impetus

The first nurse theorist to develop a model of interpersonal relationships for practice implicated the salience of messages communicated by verbal and nonverbal behaviours. Patients, Peplau (1952/1988) conjectured, are discerning primarily, "Do you approve of me? Do you think I am important?" (pp. 46–47). How daunting a responsibility, I thought, for the psychiatric nurse, but the tenet also applies to practice contexts that are situated in the community, outside the corridors of the psychiatric institution. The severally mentally ill are just one of several groups considered vulnerable by society and who may possess heightened sensitivities due to stigmatization. People living on public assistance, or "welfare recipients," are another group who might accrue negative social judgments. It behooved me as an advanced public health nurse to critically reflect on the mirrored messages that I had communicated when working with lower income lone-parent mothers who lived on public assistance.

I became curious about the nature of the interaction between public health nurses and vulnerable and potentially stigmatized clients such as lower income lone-parent mothers. I was surprised by the small amount of discussion on the topic in current nursing textbooks, especially given the fact that public health nurses are mandated to establish therapeutic relationships with vulnerable families in the community. It became evident that the requisite models, frameworks, and empirical studies were lacking in the professional literature and that research was warranted. I also wanted to investigate this particular context of therapeutic

relationships because although financial hardship compounded by stigmatization takes its toll on lone-parent mothers with indirect negative effects on parenting behaviours and child development, on the other hand, maternal/child health outcomes have been optimized when public health nurses are able to address psychosocial needs of mothers through the medium of relationship. I set out to theorize how therapeutic relationships are established by conducting a grounded theory study. Targeting Essence: Pragmatic Variation of the Therapeutic Relationship emerged as the substantive theory that explicates the social behaviours enacted by public health nurses and lower income lone-parent mothers during the relationship building process. During the six-stage process these dyad members of public health nurses and lower income lone-parent mothers implement interactional strategies and components that foster relational rapport despite practice constraints. Further description of the research pursuit follows, including the relevant study terms and definitions, research problem, statement of intent, justification, and significance.

Relevant Study Terms and Definitions

Lower Income Lone-Parent Mother

Lower income lone-parent mothers are urban female lone parents (never married, separated, divorced, or widowed, and not living with a legal or common-law spouse) whose after-tax yearly family income is below Statistics Canada low-income cut-off (LICO) for its family size and its community. The LICOs are the threshold incomes below which families spend a greater portion of their yearly income than the average family on food, shelter, and clothing. Income sources

include federal and provincial government tax credits, subsidies, and benefit programs (Government of Alberta, 2004) and/or low-wage employment (National Council of Welfare, 2007). Based on the most recent income statistics, the LICOs for female lone-parent families with four persons is $32,556; for families with three persons, $26,095; and for families with two persons, $20,956 (Statistics Canada, 2006). The mean household incomes for female lone-parent families in 2005 were $41,300 for wage earners and $17,800 for those earning no wages (Statistics Canada, 2007a).

Vulnerability

Vulnerability is a universal human phenomenon. The word vulnerable is derived from the Latin root *vulnus*, meaning *wound* (Aday, 1994). All persons are susceptible to a wounded state, physically, psychologically, and/or socially, as a direct result of the stressors of their complex circumstances. Vulnerability generally denotes the relative risk for health problems associated with insufficient "economic, social, psychological, familial, cognitive, or physical resources" (Horowitz, Ladden, & Moriarty, 2002, p. 316). Vulnerable individuals are more likely to have limited health care access and to be dependent on others for care. Individuals who are new immigrants, substance users, pregnant and parenting teens, severely mentally ill, elderly, disabled, homeless, or living in poverty are examples of groups categorized as vulnerable (McEwen & Pullis, 2009).

Stigmatization

Stigmatization refers to interpersonal situations that create feelings of humiliation, of being reduced to a "tainted, discounted, and discredible citizen"

(Goffman, 1963, p. 3). Stigmatization threatens one's identity or self-concept (van Laar & Levin, 2006) and self-esteem by creating doubt about one's worth and value as a person (Crocker & Garcia, 2006). The lower income lone-parent mother is made vulnerable by economic disadvantage, substandard living, and other correlates of poverty. Moreover, if she relies on public assistance, her state of vulnerability is compounded by a stigmatizing label of "undeserving," "unfit," or "welfare mother" (Hays, 2003; Holloway, Fuller, Rambaud, & Eggers-Pierola, 1997; Ocean, 2005; Power, 2002; Reid & Tom, 2006; Seccombe, James, & Walters, 2005; Wiegers, 2002). The salient effects of stigmatization are mediated through the mother's interpretation of how others view her during social encounters (Major, 2006), including interactions with health care professionals.

Public Health Nurse

In Canada, the core functions of public health are health promotion, health protection, preventive interventions, health assessment, and disease surveillance (Reiter, 2005). A public health nurse (PHN) is a professional under the Community Health Nurse designation who promotes the health and prevents illness and injury of individuals, families, aggregates, populations, and targeted vulnerable groups in the community (Canadian Nurses Association, 2007a) based on a repository of knowledge from nursing and social and public health sciences. Disciplinary values and beliefs stem from the philosophy of primary health care and include individual/community partnerships, caring, and empowerment. One of the five standards of practice is building relationships with the goal of establishing and nurturing caring relationships that preserve, protect, and enhance

human dignity. PHNs practice in diverse settings including community health centres, public health units, schools, street clinics, youth centres, and nursing outposts (Community Health Nurses Association of Canada, 2008; Reiter, 2004).

Therapeutic Relationship

Within the professional discipline of nursing the therapeutic relationship is an interpersonal process that occurs between the nurse and the client. The therapeutic relationship is a purposeful, goal-directed relationship for advancement of the values, interests, and health outcomes of the client (Alberta Association of Registered Nurses, 2005; Canadian Nurses Association, 2007b; Registered Nurses Association of Ontario, 2002).

Research Problem

PHNs are mandated to establish therapeutic relationships as a means to positively influence the health and well-being of their clients. Yet, review of the professional literature indicates that there are few contemporary models and frameworks, and little empirical research to guide their relational practice efforts and to enhance their interpersonal competencies. This is especially true for PHNs working with members of specific groups or populations considered vulnerable to health problems due to insufficient physical, psychological, social, or economic resources. Some vulnerable clients, such as severely mentally ill persons, individuals with disabilities, and lower income lone-parent mothers, present a unique challenge because their vulnerability is often intensified by stigmatization. Negative stereotypes and stigmatizing labels devalue lower income lone-parent mothers, for example, as not being worthwhile human beings and contributing

members of society. Blatant forms of stigmatization toward lower income lone-parent mothers (including demeaning social encounters and discriminatory institutional practices) contribute to their everyday life stressors and may account in part for prevailing levels of psychological distress, hopelessness (Aber, Jones, & Cohen, 2000; Bancroft, 2004; Marshall, 1982; Ocean, 2005; Schein, 1995; Sword, 2003), and depression (Belle, 1982; Belle & Doucet, 2003; Browne et al., 1997; Cooper Institute, 1999; Gucciardi, Celasun, & Stewart, 2004; Peden, Rayens, Hall, & Grant, 2004; Petterson & Friel, 2001; Somers & Willms, 2002). Conversely, several researchers have revealed that these mothers derive significant benefit from therapeutic relationships with helping professionals such as PHNs, including enhanced psychosocial well-being, coping capacity, parent-child interaction, and access to services and resources (Belle, 1983; Berlin, 2005; DeMay, 2003; Heaney & Israel, 2002; Klass, 2003; Olds, Eckenrode, Henderson, Chamberlin, & Tatelbaum, 1986; Olds, 2002, 2005; Olds, Hill, O'Brien, Racine, & Moritz, 2003; Stewart, Reutter, Makwarimba, et al., 2005). Although it is apparent that the therapeutic relationship has the potential to serve as the medium to promote the health of the vulnerable and stigmatized client, the existing literature offers PHNs limited knowledge about the explicit process by which the therapeutic relationship develops (Aston, Meagher-Stewart, Sheppard-Lemoine, Vukic, & Chircop, 2006; McNaughton, 2004; Reiter, 2005; Zerwekh, 1992).

Statement of Intent

The overall objective of this doctoral study was to formulate an explanatory theoretical model that explicates the development of therapeutic relationships between PHNs and lower income lone-parent mothers (who will henceforth be referred to in this document as "lower income mothers" or simply "mothers" or "mother participants"). Lower income mothers is the group selected because I was interested in the challenges associated with the development of therapeutic relationships with clients whose vulnerability is associated with or compounded by stigmatization. They have also been selected from among other possible marginalized populations because the benefits and barriers of therapeutic relationship are expected to be most apparent. I employed grounded theory methodology consisting of the technical aspects as well as the philosophical (pragmatism) and theoretical (symbolic interactionism) underpinnings to elucidate the process. I sought to uncover the thoughts, emotions, and behaviours of interactants, especially of the mothers, and to discern the implications of stigmatization for relationship building. The findings indicate that the PHN modifies the therapeutic relationship to adapt to contemporary practice contexts and to account for heightened sensitivities of the vulnerable and stigmatized mother.

Justification

In reference to broader application, the nurse's ability to form a therapeutic relationship is fundamental to the entire nursing care delivery process.

Regardless of technological advances in diagnosis and treatment, communication and moments of connection are the most significant dimensions of nursing practice and quality of care (Arnold, 2003; College of Nurses of Ontario, 2006; Niven & Scott, 2003; Potter & Perry, 2007; Schuster, 2000). Unfortunately, cost-driven, technocratic care environments often mean less time to establish appropriate competent nurse-patient relationships and result in the deemphasis of interpersonal competence (Benner, 1998; Canadian Health Services Research Foundation, 2001; McCabe, 2004; Tuck, Harris, & Baliko, 2000). Nurses complain about diminishing patient contact, and in fact, the ever-increasing relational distance is correlated with professional moral distress (Austin, Lemermeyer, Goldberg, Bergum, & Johnson, 2005). Patients, too, lament the loss of essential contact with nurses as they believe the nurse-patient relationship is pivotal to their healing and recovery (Shattell, 2005). Despite the brevity of encounters and other barriers in current health care environments, however, nurses can still make meaningful connection (Hagerty & Patusky, 2003; Sundeen, Stuart, Rankin, & Cohen, 1998). The principles of effective therapeutic communication still apply. Nurses are still expected to leave their patients in a better state of well-being through relational interventions designed to develop working partnerships and to maintain rapport and trust (Boggs, 2003). It is imperative in the current system that nurses and other health care providers make the necessary efforts to engage with vulnerable patients in order to better address their needs and to ease their suffering (Bergum & Dosseter, 2005; Craven & Hirnle, 2007).

The importance of establishing therapeutic relationships is also made explicit in practice guidelines for nurses who work outside acute care institutions (Community Health Nurses Association of Canada, 2008). These guidelines are linked to the legacy held by PHNs with respect to interpersonal rapport (Zerwekh, 1990). PHNs are expected to develop therapeutic connective relationships, particularly when working with vulnerable or overburdened families in the community (Potter & Perry, 2007; Reiter, 2005) as the burden of poverty can interfere with maternal capacity to nurture healthy child growth and development. Supportive interaction that addresses maternal psychosocial needs positively influences the child's developmental trajectory (Barnard, 1997, 1998; Berlin, O'Neal, & Brooks-Gunn, 1998; Greenspan & Wieder, 2006; Guralnick, 2004; Letourneau et al., 2001).

This doctoral study is timely given the global downturn in financial sectors. Like a domino effect, the fallout is touching individuals and families where they live and work. Available statistics indicate that 7.5% of Canadian families (Statistics Canada, 2007c) live in a precarious state of vulnerability due to insufficient economic resources and find themselves overburdened with the stress of trying to secure the basic necessities of food, shelter, and clothing. The challenges are particularly apparent among female lone-parent families, who have been prone to economic disadvantage both in terms of incidence and depth (Phipps, 2003; Statistics Canada, 2005). Statistics Canada (2007c) reports a 33.4% probability that children who are raised in female lone-parent families live below the LICOs, whereas the probability or risk of poverty for children raised in

two-parent families is 7%. A mother's low income and lone-parent status also put children at greater risk for adverse developmental outcomes. In contrast to those in higher income families, children raised in lower income homes suffer a disproportionate rate of academic difficulties, emotional and behavioural disorders (National Institute of Child Health and Human Development Early Child Care Research Network, 2005; Ross, 2003; Seguin, Xu, Potvin, Zunzunegui, & Frohlich, 2003), and physical health problems (Aber et al., 2000; Lethbridge & Phipps, 2005). Despite Alberta's economic boom in 2007, 1 in 8 children in the province live in female lone-parent families, whose household median market income continues to decline because of low wages and rising living costs (Edmonton Social Planning Council, 2007). Although statistics are not yet available, it seems likely that as a result of the recent economic decline, the national and provincial prevalence of families living below the LICOs has increased since 2007.

Significance

The significant outcome of this doctoral study is a theoretical model comprising the building blocks, relational components, and interactional strategies necessary for therapeutic relationship according to the subjective perceptions, knowledge, and experiences of both PHNs and lower income mothers. An important secondary outcome is the beginning construction of a succinct, concrete, accessible framework for practice. I was able to use the newly formulated theory as the basis from which to propose a practice framework for PHNs that consists of the explicit communicative behaviours required to convey

the elements identified in the theoretical model. I elaborate on the proposed practice framework in Chapter 6: Discussion.

The theoretical model and practice framework will serve as guides for PHNs seeking to effectively establish therapeutic relationships with mothers made vulnerable by economic disadvantage and whose vulnerability has been intensified by stigmatizing labels and acts of discrimination. The insights gleaned from this research endeavour will also assist managers who are seeking a theoretical foundation for the development of program goals, practice emphases, approaches, and strategies focused on the psychosocial needs of mothers and the relational competencies required to work with mothers to address their unique needs. Interprofessional and interdisciplinary knowledge translation efforts vis-à-vis submission of findings to professional associations, governmental and nongovernmental organizations, and scholarly journals will facilitate discussion of the model and framework, and identification of further implications for policy, practice, research, and professional education.

Dissemination of findings will not only advance novice and veteran nursing knowledge, skills, and training and foster high-quality interaction between PHNs and vulnerable clients but will also serve as a basis and catalyst for similar studies in other health care disciplines. This explanatory study carries broad conceptual application as it is expected that Targeting Essence: Pragmatic Variation of the Therapeutic Relationship and its constructs will provide a solid foundation for an evolving program of research to include similar studies about the development of therapeutic relationships between both PHNs and other

helping professionals, and clients representative of other stigmatized vulnerable populations.

CHAPTER TWO: REVIEW OF LITERATURE

In this chapter I review the pertinent literature. I start with the theoretical orientation of the study commencing with symbolic interactionism and the sociopsychologic perspective of "self," as tenets were drawn from both to guide inquiry and analysis. Social psychologists purport that attitudes, behaviours, and relationships in one's social environment have a pervasive influence on self-concept. Theories based in social psychology such as symbolic interactionism conceive of the self as shaped by social interactions. The research goal was to uncover the nature and process of professional interactions involving clients potentially affected by stigmatization. Symbolic interactionism served as a vital interpretive framework during my investigation of the salience of interactional behaviours exchanged between PHNs and lower income mothers.

Next, I highlight key insights regarding the implications of stigmatization, as social psychologists have also contributed to landmark theoretical and empirical work on the mediating influence of stigmatization on self-concept and interpersonal dynamics. I then shift focus to the communication literature, from which I gained understanding of the fundamental role of verbal and nonverbal communicative behaviours during the relationship building process. I expand discussion to also include the linear and social models of communication that are embraced by nurse educators, researchers, and practitioners. I conclude with critical appraisal of the empirical literature on the topic of nurse-client relationships in the context of public health nursing practice.

Theoretical Orientation

Symbolic Interactionism

> Symbolic interactionism does not merely give a ceremonious nod to social interaction. It recognizes social interaction to be of vital social importance in its own right.
>
> –H. Blumer, 1969, p. 8

Why do we behave the way we do? There is no single answer, but there are several perspectives derived from the study of human behaviour. The psychoanalytic perspective, wherein we act because of complex personality processes of biological impulses and unconscious motives that are pitted against social norms and mores, originates with Sigmund Freud (1859–1939). Proponent of the importance of learning in human development John B. Watson (1878–1958) believed that one learns a repertory of behaviours or habits during childhood from parents, who provide reinforcements or punishments (Shaffer, Wood & Willoughby, 2002). The functionalists conceive of people as cogs in the wheel of a large organism or system called society. People mechanically and passively contribute their part to keeping the system functioning in a state of equilibrium. According to the psychocultural approach, human behaviour and personality are products and reflections of one's culture (Holstein & Gubrium, 2000). George Herbert Mead (1863–1931), founder of social psychology, rejected the explanations of his contemporaries chiefly because they denied the influence of mental events on human behaviour. Watson's (1913) behaviourism, as mentioned above, advocates a dualistic view of mind and body. Human behaviour results from instinctively learning to respond to environmental stimuli. In

contrast, Mead (1982) envisioned the mind, body, and conduct as inseparable human aspects.

Mead (1982) and Herbert Blumer (1969) championed the theory of symbolic interactionism, believing that human beings are purposive agents who interpret their worlds and then act. Psychological factors and sociocultural contexts contribute to understanding why human beings behave as they do, but they are not the major impetus. Human behaviour is instigated by one's interpretation of the meaning of things, or "symbols," and not merely by *automatic* application of the meaning but by one's use of an *interpreted* meaning. Symbols range from physical objects to institutions, persons, ideals, and virtues, and they arise in significance during interaction. It is the interactant's interpreted meaning of these symbols during the process of interaction that forms human conduct, as depicted in the three premises of symbolic interactionism:

1. Human beings "act toward things on the basis of the meanings that the things have for them" (Blumer, 1969, p. 2).
2. Meaning is a social product that arises in the process of social interaction between people. Meanings rest in symbols. Symbols are shared interpretations of one's culture that produce a common response in the individual and in others (Chenitz & Swanson, 1986).
3. Finally, interpretations are modified through the process of interaction as individuals encounter varying social situations. The situation is the concrete, specific, and often familiar configuration of acts and objects about which people have organized their perception, have made sense of

its meaning and are able to act in an orderly fashion. Cognition of the situation is essential.

Mead's (1982) thesis that the self plays an active role in human behaviour had laid the foundation for Blumer's (1969) formulation and premises of symbolic interactionism. Although interpretation derives from and is influenced by the actions of others during social interaction, people do their own evaluating of the meaning of the actions of others as they experience them. During this time, an individual engages in dialogue with him- or herself and he or she "selects, checks, suspends, regroups and transforms the meanings in the light of the situation in which he [or she] is placed and the direction of his [or her] action" (p. 5). I adopted symbolic interactionism as one of the interpretive frameworks for this study because symbolic interactionists espouse a nondeterministic view of behaviour by taking the position that an individual has a thoroughly active self. In terms of studying the professional relationship, I approached my inquiry with the understanding that each dyad member (i.e., the lower income mother and the PHN) is an independent agent in control of her own interactional behaviours and it was my job as researcher to uncover why certain verbal and nonverbal behaviours are enacted. What are the covert "interpreted meanings" underlying their interactional behaviours?

The Sociopsychologic Perspective of Self

Self-Designation

Engagement with others influences human conduct, but before the next social act is decided, there is considerable communication with one's self through

an internal interpretive process (Blumer, 1978). This process of self-designation begins during childhood after the early formative period, when one has the language and symbolic capacity to objectify self and to ascribe meaning to self as one does with any other object, thing, or symbol. Symbols are recognized by language, and reference to self is through language.

> We can name ourselves, think about ourselves, talk to ourselves, imagine ourselves acting in various ways, love or hate ourselves, and feel proud or ashamed of ourselves; in short, we can act toward ourselves in all the ways we can act toward others. (Hewitt, 2003, p. 9)

Self-designation occurs between what Mead (1982) conceived of as the "I" and "Me." If the PHN refuses to accept an invitation to her client's birthday party, for example, the PHN will respond as spontaneous acting subject in the *I* form. She then imagines herself as object in the reflective *Me* form. The PHN will carry on an internal conversation between I and Me about the pros and cons of declining her client's invitation. The PHN begins to imagine the effects of alternative responses in terms of how her client will respond. The PHN is able to exert control over her conduct by responding in accordance with what she anticipates might be the reaction of her client. The PHN has essentially become an object to her own experience as she imagines how she appears from her client's perspective and how the PHN imagines her client will perceive her refusal.

Development of Self

> A self-idea…seems to have three principal elements: the imagination of our appearance to the other person; the imagination of his [or her] judgment of that appearance, and some sort of self-feeling, such as pride or mortification.
>
> –C. H. Cooley, 1964, p. 184

Even though individuals are born into the world with physical and psychological characteristics, they become persons and acquire their personalities through social interaction. First in the family (i.e., the primary social system) and then through interactions with other persons, a child internalizes into her[1] personality aspects of her culture, which manifest in habits, attitudes, beliefs, values, and patterns of response. Language exposes the child to names of things, and through the socialization process she learns how to act in the presence of these tangible and abstract objects, which include persons in her social world.

The child also learns about the meaning of the self as an object through the perspectives of others. With each successive interaction, the child interprets what adults in her immediate social world want, what they expect, and what they think, and she then acts toward her self accordingly. "The child fashions his [or her] own self on the models of other selves.... The child's consciousness of its own self is quite largely the reflection of the attitudes of others toward him [or her]" (Mead, 1982, p. 54).

The self is created and re-created as people act towards themselves and as others act towards them. Social identities such as mother, father, and child are created, which enables individuals to interact as they position themselves in relation to one another, such as a child in relation to her mother. The child's self-image is developed as she thinks about herself during the daily routines and encounters of social life. Her self-image will reflect deeply entrenched cultural

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[1] From this point henceforth I use the pronoun "she"; however, "he" is also assumed.

ideas and inherent understanding of what she should and can be. Self-focused feelings, such as liking or disliking who she is, and excitement or discouragement about her actions or performance, denote self-esteem. Self-esteem captures the affective dimension of self-objectification (Hewitt, 2003). When one responds with a sense of security or fear during interaction with others, one is expressing feelings that are aroused from how she thinks about who she is and how she imagines others see her.

As social beings in society we interact with others, and we take into account the responses of others as a kind of "complicated mirror" (Strauss, 1959, p. 34). Strauss claimed that one sees "himself [or herself] in the mirrors of their judgments" (p. 9). People undergo self-appraisals; arising out of this process of self reflection are new ways of acting as I, and emerging are new ways of viewing the Me. Self-appraisal leads to a new course of action, but the judgments along the way about former gestures, things said, or emotions expressed culminate in questions about the essential self, about the "the self that I believe to be behind or underneath all my acts" (p. 33). At this juncture the self might be re-created and one's overall level of self-esteem altered. However, some persons with whom one interacts bear little impact as their opinions matter little. One also has the option of discounting mirror images when one thinks they are grossly inaccurate and not meeting one's expectations.

It was important that I comprehend what is being asserted here in terms of the deemed pertinence of social interaction for the creation and re-creation of self. I was careful to apply this tenet during the course of studying the interaction

between PHNs and potentially stigmatized clients. I understood that the lower income lone-parent mother's self-view might very well influence her mode and quality of interaction with the PHN. The PHN's gestures, body movements, and vocal gestures would be significant symbols. The mother's *interpreted meaning* of the PHN's verbal and nonverbal communicative behaviours would be filtered through the mother's individual lens, and that lens would be contingent on existing conceptions of self and the weight that she assigned to the responses of the PHN towards her.

Moreover, the mother, like members of the general population, possesses cognitions and feelings about self on three levels: (a) as a person, or the core self; (b) as a subidentity, or affiliation with an institutional domain (e.g., associated with family, religion, or economic class); and (c) in particular roles (Turner, 2002). Where did the mother stake her domain of self-esteem? Was it wrapped up in the imputations of others? Was it directed towards her core self and how she felt about herself as a person? Or did it depend on how others evaluated her performance within a particular role?

Stigmatization and Lower Income Lone-Parent Mothers

What are the sources and manifestations of stigmatization? The stigmatization of lone-parent mothers who live on public assistance stems from longstanding welfare discourse of undeserving dependency. Unlike children, who earn public sympathy as naturally innocent and deserving of assistance, mothers are "assumed to be individuals who should naturally be independent and responsible for their own life outcomes" (Wiegers, 2002, p. 43). The American

public deems welfare dependency synonymous with humiliation (Sennett, 2003). Researchers (Power, 2002; Raphael, 2007) have reported that in Canadian society some believe that social programs and public assistance undermine personal responsibility and erode the work ethic. Such a perspective perpetuates an ideology of blaming the victim and a punitive basis for welfare reforms, whereas recent welfare-to-work programs, which provide transportation, child care, training and education, and other support measures (Bancroft, 2004), *ostensibly* recognize the link between poverty and unregulated labour markets, low wages, and lack of affordable, accessible, high-quality child care. However, Breitkreuz's (2005) doctoral exploration of the experiences of 17 welfare recipients transitioning into labour force attachment in Alberta portrays a very different and disturbing reality. Well-intentioned welfare reform policies did not take into account the everyday actualities of her lone-parent mother participants. Mothers reported many barriers to self-sufficiency. They found that they were juggling unpaid caring work and low-wage part-time work, and ultimately, they did not reap the economic benefits promised.

Social psychologists have advanced our understanding of how negative constructions of welfare recipients at the societal level intersect with stigmatization at the individual level by concentrating on the interpersonal situations, social contexts, and events that mothers appraise as threatening to self (Major, 2006). Debasing stereotypes, prejudiced attitudes, and discrimination are acts of stigmatization. They impute a negative value on a person's social identity (van Laar & Levin, 2006) and can prove deleterious to the person's conception of

self and appraisal of self-worth. However, the degree to which a lower income lone-parent mother is affected by stigmatization is contingent on her level of stigma consciousness, which is the extent to which she expects to be stereotyped or judged based on her group membership irrespective of her actual behaviour (Pinel, 1999).

Qualitative researchers have revealed that discursive interactions within human service organizations are social contexts within which mothers are exposed to condemnation and devaluation. It is not uncommon for mothers to visit public assistance agencies, for example, and be confronted by personnel whom some mothers characterize as nasty, arrogant, uncaring, condescending, and aloof (Canadian Research Institute for the Advancement of Women, 2007; Cooper Institute, 1999; Holloway et al., 1997; Laughlin, McPhee, & Pompeo, 2004; Prairie Women's Health Centre of Excellence, 2007; Schein, 1995; Seccombe et al., 2005; Swanson, 2001). *Toronto Star* columnist Carol Goar (2006) commented about the views of 58 homeless women, which were compiled in a recent city report: "Naturally, the women wanted affordable housing and enough money to live on. But what came through most strongly was a desire to be treated the way the official sitting across the desk would want to be treated" (p. A24). Furthermore, mothers' perceptions of contempt are not confined to their encounters within social service institutions. Researchers have also reported negative interactions and other displays of discriminatory practice within the health care system (Reid, 2004; Stewart, Reutter, Makwarimba, et al., 2005).

Recent discoveries that "old-fashioned" blatant prejudice is being supplanted by contemporary, more subtle forms, including unconscious responses to members of stigmatized groups (Miller, 2006), are relevant to the aims and context of this study. One might be unaware of harbouring ambivalent reactions or prejudiced attitudes towards stigmatized persons. Moreover, one may behave awkwardly during interactions with others, and nonverbal and subtle behaviours could very well communicate unintended and untoward messages. I wanted to investigate the types of messages that were being conveyed consciously and unconsciously by the PHN. To what extent did these messages influence stigmatization, and what were the implications for establishing therapeutic relationship?

Interpersonal Communication

> Without the ability to communicate, we could not form relationships with others.
>
> –S. Trenholm, 2008, p. 23

The formal study of communication dates back to ancient Greece, where students studied public speaking, oral interpretation, argumentation and debate, and communication theory. Today the field of communication theory is immensely complex and has grown to include multiple forms or modalities from subject areas in mass communication, performance studies, public communication, intercultural communication, language and semiotic systems, small-group/organizational communication, and interpersonal communication (Trenholm, 2008). Interpersonal communication (i.e., two-person face-to-face interaction) was the nexus and domain of this study.

The explicit definition of communication is diverse among scholars, with more than 100 definitions produced in the 1970s. To explore the establishment of therapeutic relationships, I interpreted communicative behaviours from a sociopsychologic approach that excluded examining speech production, linguistics, or other physiological indices (Duncan & Fiske, 1977), and I defined communication as spoken symbolic interaction during which people use words and other symbols to create meaning and to affect one another. I did not want to limit the boundaries of communication to strictly the verbal exchange between the PHN and the lower income mother, so I included in the definition the nonsymbolic the nonverbal interaction that is often unintentional and that enhances interpretation of verbal communication. The above definitions of communication were adopted from Trenholm's (2008) work.

I cannot overstate the invaluable contribution of communication theory to the investigation of interpersonal relationships and the relationship-building process. "Communication *is* the relationship" and is not merely the behavioural manifestations of relationships (Sundeen et al., 1998, p. 82). Relationships are built on communication as there is an inherent symbiosis between communication and relational development (G. Miller, 1976). Communication is fundamental to the nursing role and therapeutic relationships (Antai-Otong, 2007). Its pertinence is clearly evident when nurses interact with patients or clients who are sensitive to how health care professionals respond to them. Communication is ubiquitous; the nurse cannot not communicate. Unknowingly he or she may very well communicate through nonverbal channels certain messages that originate from

undisclosed thoughts, feelings, and attitudes. The PHN, for example, might not be aware that she possesses generalized biases or derogatory assumptions and viewpoints about lower income lone-parent mothers until they surface one day during interaction with her client and subsequently sabotage the connection. Should PHNs be cautioned about certain nonverbal communicative behaviours during interaction with vulnerable and potentially stigmatized clients? Familiarity with a wider spectrum of communicative behaviours and associated meanings enhanced the breadth and scope of my inquiry process and informed my interpretation of dyadic observations and participants' accounts of their relationship experiences.

The communication process is responsible for the transition from mere physical presence to the level of interaction where there is true interdependence or interpersonal communication between dyad members (Berlo, 1960). The criteria for true interdependence are the presence of expressive actions on the part of one or more persons, the conscious or unconscious perception of such expressive actions by the other dyad member, and the return observation that such expressive actions were perceived (Ruesch, 1968/1987b). The developmental approach to the study of interpersonal communication (G. Miller, 1976) explains how an ordinary, impersonal dyadic encounter becomes interpersonal communication. Essentially, the qualitative variation in communication transactions is linked to the reciprocal rules of interdependence that combine persons into an interactive system; that is, "the more any given relationship is characterized by a relatively unique rule structure, the more individualized, the more 'interpersonal' the relationship"

(Millar & Rogers, 1976, p. 86). Rules had been viewed as implicit and explicit directives associated with the roles of the interactants that govern the flow of messages from one person to another (Ruesch, 1968/1987a). In the context of communication research today, rules pertain to the amount of data that communicators have about one another. As the communicators' level of knowledge increases, dyadic communication becomes interpersonal (Trenholm, 2008).

Interpersonal interdependence is achieved when communicators produce and receive messages that carry meaning for both (Berlo, 1960). At this point communicators have entered into a formative process; that is, the message exchange process itself has the ability to affect interactants' behaviours. What happens during the exchange is crucial in terms of relational dynamics. During dialogue, people relate; they do not relate and then talk; they relate *in* talk. "To deny or deemphasize that the message-exchange process modifies expectations and behavioural performances, negates communication as a social science" (Millar & Rogers, 1976, p. 89). The highest level of interactional complexity encompasses a merger of self and the other and the complete ability to anticipate, predict, and behave in accordance with the joint needs of self and other (Berlo, 1960).

Communication-Related Components

I was cognizant during the study that several communication-related components influence the extent to which one is able to affect and to be affected by others during the message exchange process. I address below the most

commonly emphasized communication related components; they are listening, the spoken language, and nonverbal communication.

Listening

Whereas hearing is the body's physiological process, listening is the social cognitive process that engages all of one's senses. Listening entails attending to the message and filtering the sensory stimuli through one's desires, habits, expectations, and experiences to assign meaning. Listening also includes evaluating one's interpretation, responding to the message, and organizing the message for future retrieval. Perception and listening through one's eyes and ears are extremely "subjective and fallible" (Trenholm, 2008, p. 44). PHN A and PHN B, for example, will process messages very differently despite their exposure to an identical message. As a person listens, she forms impressions of other people based on individual mental guidelines or schemata called person prototypes. Person prototypes are global characterizations, personal constructs, and specific descriptors to which an individual resorts regularly to identify and categorize people and which can bias interpretation of others and their messages.

Spoken Language

Spoken language is a rule-governed symbol system. People use spoken sounds to transmit what they are thinking. People also create the sign, or vehicle, for expression. One form of language sign is the symbol. For example "car" represents a motorized vehicle. Car is an arbitrary symbol, because there is nothing car-like about the word *car*, and a conventional symbol, because it has been socially constructed. Words like car are important symbols because they

carry meaning and elicit shared thoughts in the minds of communicators (Trenholm, 2008). Language is our internal, mental knowing and is inferred from our external, physical speech. Coordinated management of meaning theorists study the use of language in social contexts. They believe that to communicate successfully, one must take into account the situation during a given interaction, the relationship (i.e., role obligations), the life script (i.e., one's professional or personal identity), and the cultural norms that one shares with others. To be really effective, speakers have to say the right thing at the right time in the right way (Trenholm, 2008).

Nonverbal Communication

Nonverbal communication is all forms of communication that do not involve spoken words (Hood & Leddy, 2006). Scholars are warned not to separate verbal communication from the critical nonverbal communication component (Giles & Le Poire, 2006). Basic nonverbal codes include body movement and gesture (kinesics), vocal characteristics (paralanguage) (Watzlawick, Beavin, & Jackson, 1967), space (proxemics), facial expression and eye contact, time (chronemics), physical appearance, and object language or displays of material things (Trenholm, 2008). Communicative strands exchange both factual content of linguistic signals and indexical information, defined as information about the speaker that the listener uses to draw inferences about the speaker's identity, characteristics, attitudes and mood (Abercrombie, 1967/1972). Together, nonverbal cues help us to discern the "credibility and approachability of those around us" (Trenholm, 2008, p. 112). Senders and receivers, however, may not be

aware of messages conveyed by their nonverbal acts, as alluded to previously. Validation of nonverbal behaviours is further confounded by the subjectivity attached to their interpretation because the meaning assigned is highly contingent on the unique make-up and experiences of each interactant (Sundeen, et al., 1998).

Models of Communication in Nursing Practice

Nurses use the communication system for a variety of purposes within professional practice. A distinction can be made in the literature between linear communication models intended for goal-directed interactions and social models, which serve as the medium for achieving deeper relational connection.

Linear Models

The linear, commonsense sender-and-receiver model of communication entails individuals exchanging information through the transmission and reception of communication stimuli (Watzlawick et al., 1967). Individuals assume responsibility as senders/receivers for encoding and decoding messages. PHN A has an idea that she encodes and translates into a message for PHN B. The message travels along a channel of transmission. PHN B then decodes the message and sends her reply. PHN A deciphers from PHN B's reply or feedback as to whether communication was successful. To improve communication, senders encode their messages in a clearer and more appropriate way, like a mechanic fixing a broken-down automobile, but the social context in which communication occurs is not taken into account. Messages are treated like physical objects that can be sent from one place to another (Trenholm, 2008).

Linear models, or what has been termed instrumental communication (Swain, 2004), achieve relationship for the purpose of transferring information from the patient to the nurse for screening, assessment, and intervention (Craven & Himle, 2007; Ellis & Gates, 2003; Purtilo & Haddad, 2002) and to affect outcomes (Doane & Varcoe, 2005).

Linear models of communication are prevalent in nursing curricula and are the basis for many teaching-learning scenarios designed to foster therapeutic relationships. Nurses are taught how to interact with their patients in the acute care setting through a skills-based stimulus-response approach. Students are instructed how to encode their messages by focusing on the effective use of nonverbal behaviours such as eye contact and other communication techniques to achieve, for example, therapeutic empathy to accomplish care plan objectives (Morse, 1991). Nursing students are trained to use learned cognitive and behavioural responses to convey understanding of health/illness experiences much like the mechanistic application of a formula. Consequently, they are insulated from emotional involvement that enables enriched insights into patient suffering and effective therapeutic engagement (Morse, Bottorff, Anderson, O'Brien, & Solberg, 1992).

Concurrent review of the practice research indicated that nurse-patient contact was predominantly superficial, task oriented, and perfunctory; nurses seemed to purposely avoid relational depth by not delving into psychosocial issues (May, 1990). According to Morse's (1991) *Negotiating the Relationship* theory, detached connection corresponds with the *clinical relationship*, a mode of

relating that occurs because the nurse is minimally committed and his or her patient requires only routine care. Also included in her typology are the *connected* and *therapeutic* relationship types, which encompass a higher level of nurse involvement and intensity. Doane (2002) has questioned the emphasis in nursing curricula on the acquisition of detached communication skills and rote imitation. "Behavioral skills not only fail to include essential elements of the human, relational process, but override nurses' spontaneous ability to be in caring human relationships" (pp. 400-401). Doane (2002) argued instead for an "awakening of the heart" in students and, like Morse (1991), advocated for meaningful, authentic, relational connection and for a diminished propensity for habitual patterns. Exemplary relational practitioners are those with the capacity of initiative, authenticity, responsiveness and mutuality, and an ability to engage with complexity and to live in ambiguity (Doane & Varcoe, 2005).

Social Models

The social models of communication are founded on the relational tradition of communication, which includes the "report" and "command" aspects of communication. Report is the content. The command aspects refer to how the message is to be taken or interpreted by the receiver. Communication is more than information processing; it carries information/content and, at the same time, it imposes behaviour (Bateson, 1968/1987) through meaning-making. Messages are not benign, because they convey beliefs, attitudes, and values. During the

relational process there is only a minor gap between self and the other:

> All such relationship statements are about one or several of the following assertions: "This is how I see myself… this is how I see you… this is how I see you seeing me"… and so forth in theoretically infinite regress. (Watzlawick et al., 1967, p. 52)

Communication surrounds people. People within social groups use communication processes that reflect languages or symbolic codes, cognitive customs, cultural traditions, and shared roles and rules to generate ideas about themselves and one another, and to make sense of the world in which they dwell. To enhance communication between the provider and the client, we cannot simply focus on individual communicative behaviours and improve skills in expressing and listening to information; rather, we must be sensitive to others and pay attention to the things we talk about and the way we talk about them, being aware of our construction of reality (Trenholm, 2008). Nurse theorists, educators, and practitioners have endorsed the social models of communication (Leddy, 2006; Montgomery, 1993; Sheldon, 2004; Stevenson, Grieves, & Stein-Parbury, 2004) for advancement of the healing, helping therapeutic relationship.

Peplau's Interpersonal Relations Model

Hildegard E. Peplau (1909–1999) was a nurse clinician, scholar, and theorist who introduced the first interpersonal relations paradigm. Levine, Paterson and Zderad, King, Watson, Parse, Leininger and Newman (to name a few) are nurse theorists who have also incorporated interpersonal and interactive concepts into their writings. Peplau (1989) employed a practice-based approach to

develop a theory of nurse-patient[2] relationships by combining her clinical observations as a psychiatric nurse with Harry Stack Sullivan's (1953) interpersonal theory of psychiatry and Sigmund Freud's (1936) theory of psychodynamics. Peplau's (1952/1988) interpersonal relations in nursing theory was considered the crux of psychiatric nursing and the core of all nursing practice, focusing disciplinary attention on the critical therapeutic value of the nurse-patient encounter. She considered the professional interaction as the medium for effective caring interventions and advised a goal-directed, interpersonal process. Her theory consists of a continuum of four phases through which the nurse and patient collaborate to address the "medical problem", including

1. orientation for the purposes of defining the problem;
2. identification, the selection of appropriate professional assistance;
3. exploitation, the process of problem-solving; and
4. resolution, the termination of the nurse-patient relationship (Belcher & Fish, 1995).

Appraisal of the Relevant Empirical Literature

Public health nursing practice originated in Canada in the early 20th century. Civic health departments recruited nurses to deliver health education and preventive programs to combat childhood communicable disease, mortality, and morbidity. The nurses were selected based on their advanced knowledge and their

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[2] I use *patient* and not *client* because Peplau used the term *patient* when referring to the individual in need of health care.

ability to relate to families. The significant benefits of forging working relationships with families in the community have been known empirically since the first ethnographies in public health nursing practice (Field, 1980; Schulte, 2000; Zerwekh, 1990). Experimental and evaluation research that documents PHNs enhancing maternal self-efficacy, autonomy, and independent decision-making report indicators such as APGAR scores, birth weight, and health behaviours that are objective measures. Qualitative investigation of the verbal and nonverbal communicative behaviours exchanged between the PHN and the mother has been overlooked, however. Research is devoid of the messages imparted by the PHN during the process of professional interaction that might have influenced positive outcomes (Aston et al., 2006; Kristjanson & Chalmers, 1990; McNaughton, 2004).

Experimental studies have examined initiatives among at-risk families by employing the PHN-mother relationship as the medium for researcher-manipulated interventions. During the Perinatal/Early Infancy Project, young, lower income, lone-parent mothers were visited regularly by a PHN perinatally and then for the first 2 years of the child's life. Poverty, violence, substance abuse, alcoholism and child maltreatment were manifest among the sample. PHNs provided mothers with emotional and informational support, childcare guidance, and referral to formal services. Compared to the control group, the treatment group evinced fewer maternal and child health problems (Olds, Eckenrode, Henderson, Chamberlin, & Tatelbaum, 1986).

The Perinatal/Early Infancy Project has been replicated in a series of randomized controlled trials with similar favourable results, including aversion against later antisocial behaviour among 15-year-old adolescents. The project has been renamed the Nurse-Family Partnership program and exists in 250 countries. Researchers have reported enhanced outcomes such as decreased substance abuse, better maternal health, less depression, safer home environments, and diminished child abuse and neglect (Olds, 2002, 2005; Olds, Hill, et al., 2003).

The professional relationship enables PHNs to realize early intervention objectives, and there are diverse approaches to attenuating the impact of poverty on child maturation. Early intervention programs might be selectively parent focused or child focused, or provide holistic family support intended to address the needs of the entire family. Early intervention services are provided in the home, within a special centre, or within multipronged intervention systems aimed at modifying several risk factors (Dunst, 2004). Most commonly, in-home interventions are a central component of early intervention during which PHNs strive to address maternal psychosocial issues in order to positively affect the mother-child dyad and to offset developmental problems by providing maternal emotional support and affirmation. Evaluation research indicates that measures to optimize child health and development, regardless of setting, rely on professional-client interaction and rapport and are recognized as some of the most important dimensions of early intervention programs (Berlin, 2005; Berlin et al., 1998; Dunst, 2004; Fuligni, Brooks-Gunn, & Berlin, 2003; Greenspan & Wieder, 2006; Kinney, Strand, Hagerup, & Bruner, 1994; Klass, 2003). I wanted to know what

happens when lower income mothers interact with PHNs in community health centres that are detached from an early intervention mandate. Have PHNs taken the learnings about effectual interpersonal dynamics (acquired under the auspices of early intervention) and applied them in everyday public health nursing practice?

In addition, although we know that the relationship is fundamental to the effectiveness of home visits among lower income families, home-visiting research has contributed little to theoretical, empirical, and operational understanding of the process of relational development (McNaughton, 2000, 2005; Morgan & Barden, 1985; Vehvilainen-Julkunen, 1992). The earliest attempt to analyze professional interaction in the home setting was conducted in 1965 using the Bales' interaction process analysis (IPA) when Conant (1965) studied the role relationships of 12 PHNs and 24 newly referred antenatal clients of mixed ethnicity and lower socioeconomic status. The data comprised audiotaped verbal interaction of 48 home visits. Dyad members provided their perceptions and satisfaction during playback interviews. Although the Bales IPA has inherent limitations in terms of the exclusive categories used for analysis and low scorer reliability, this was the first empirical study to systematically document distinct patterns of interaction between PHNs and mothers. In fact, the analysis was replicated in another study (Morgan & Barden, 1985) two decades later, again examining PHN interactive behaviours and dyadic perceptions of home visits. The sample comprised 18 PHNs and 55 perinatal clients from lower income backgrounds. Some of the findings were consistent with Conant's (1965) results,

which depicted the propensity of PHNs to conduct their visits in a problem-seeking fashion, posing multiple questions, followed by considerable instruction and less focus on socioemotional issues.

In another qualitative study (Kristjanson & Chalmers, 1990) of 5 PHNs and 19 videotaped interactions, gaps in content areas also related to psychological and emotional health counselling. The researchers referred to interactions that lacked depth of information exchanged as ritualistic and socially polite patterned behaviour. In addition, they identified other behaviours during interactional phases (i.e., social, working, and closing) that parallel Peplau's (1952/1988) interpersonal relations in nursing theory, which occurred under the category of "creating common ground" (Kristjanson & Chalmers, 1990). As this was a pilot study, Kristjanson and Chalmers recommended further research to examine more explicitly the components and antecedents of each phase and the processes involved whereby PHNs and mothers interact to create common ground.

Zerwekh (1990) stated that the discipline of nursing possesses a meagre shared conceptual language to describe practice, particularly negotiations behind closed doors in the family's home. Recognizing the paucity of research documenting how rapport is developed, she conducted a phenomenological study to elicit PHNs' stories of successful home visits. After interviewing 30 PHNs, she also discovered groundwork competencies: locating the family, building trust (entailing dimensions of getting through the door, backing off, listening, finding something to hook them, affirming strength, not judging, persisting, and being trustworthy), and building strength (developing client capacity for autonomy and

responsibility). Zerwekh (1992) described her qualitative investigation as a starting point for the articulation of skills, judgments, and solutions to the challenges of developing relational connection. Qualitative researchers have since validated the necessity of trusting PHN-mother relationships and providing positive affirmation within the context of a respectful, nonjudgmental relationship (DeMay, 2003) and have augmented Zerwekh's findings, adding that mothers will voice their discomfort with the paperwork, use of observation tools, and other ritualistic features of the interaction. "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" (Jack, DiCenso, & Lohfeld, 2005, p. 188). Overall, research has generated important constructs of therapeutic rapport such as respect, trust, and positive affirmation; however, without specific behaviours (e.g., how is respect transacted) they are generic elements and facilitators that constitute only one dimension of the complex relationship-building process.

Summary

Professional interactions with lower income mothers influence how mothers think about themselves, their situation, and their parental competence, and have repercussions for maternal approach, patience, and attachment with their children. Opportunities to optimize maternal/child health may be missed if schools of nursing are not preparing PHNs with the theoretical as well as the practical abilities to establish therapeutic relationships with vulnerable and potentially stigmatized clients, as indicated by the dearth of in-depth research

dedicated to the topic. In this inductive qualitative research study I explored the process of interaction between PHNs and lower income lone-parent mothers as a first step in addressing the gaps in our practice understanding.

The sociopsychologic and communication literature provided the interpretive frameworks for the study. Symbolic interactionism for example, was an appropriate theoretical lens because assumptions are rooted in the notion that a person's sense of self is derived from association with human beings and can be shaped by the "solicitations, condemnations and judgments by others" (Blumer, 1969, p. 102). A mother's self-concept as cast by the many "social mirrors" in her life can be a powerful force in relational development. I wanted to know what types of messages were being communicated by PHNs, as perceived by mothers bearing stigmatizing labels, and the implications for establishing therapeutic relationship. The premises of symbolic interactionism coupled with grounded theory enabled me to draw closer to this realm of meaning and interpretation in a systematic way. The study design also incorporated the inextricably linked communicative behaviours of listening, the spoken language, and the accompanying unspoken, nonverbal acts to accommodate the multifaceted nature of interpersonal relationships.

Research Questions

1. What are the characteristics of the nurse-client relationship as described by PHNs and lower income mothers?
2. How does the therapeutic relationship between PHNs and lower income mothers develop?

3. What factors facilitate and what factors inhibit the development of the therapeutic relationship between PHNs and lower income mothers?

CHAPTER THREE: RESEARCH METHODOLOGY

In this chapter I first present an overview of the research procedures and the philosophical and theoretical foundations of the method of grounded theory that together comprise the research *methodology*. Research involving human phenomena is never value free, especially when the researcher is the "human instrument" engaging with participants to elicit perspectives and is entering the field to record researcher observations and impressions. Hence, through researcher reflexivity I also add methodological clarity by attempting to fully address the question, According to what epistemological and ontological assumptions of the researcher was the method carried out? It is imperative that the inductive research process and formulation of the explanatory theory be made as transparent as possible, and to this end I discuss the data collection techniques, data sources, and sample characteristics; clarify procedures for data analysis; and expound on ethical considerations and the evaluative criteria for rigor.

Overview of Grounded Theory

> Grounded theory is a conceptualization of the fundamental patterns that you are looking at when you study an action area of any sort.
>
> –B. G. Glaser, personal communication, February 28, 2007

Grounded theory is a systematic inductive research approach developed in 1967 by sociologist Barney G. Glaser and social psychologist Anselm L. Strauss, when the two social science researchers combined their diverse backgrounds and training to study the social processes experienced by dying patients at the

University of California Medical Center. Their research approach was a departure from the hegemony of positivism in the social sciences, as it was intended for the discovery of theory grounded in data as opposed to the verification of extant theory (Glaser & Strauss, 1967). Grounded theory is generated through direct exploration of how people respond to, manage, and negotiate meaningful events, situations, and circumstances in their natural settings.

For example, Glaser and Strauss did not know what they would find when they entered the hospital institution to investigate how medical and nursing personnel provided care to dying patients (Quint, 1967). The two social scientists relied on their fieldwork observations of behaviours and the subjective experiences, perceptions, and interpretations of healthcare staff, families, and patients to make sense of the dying process within the social context of the hospital. They derived their theoretical formulations from studying terminal patients, watching and interviewing hospital personnel, observing staff-patient interactions, and listening in on conversations held at the nursing station.

Symbolic interactionism is the theoretical foundation of grounded theory methodology. From the outset, Strauss taught Glaser how to conduct sociological fieldwork and how to figure out "what is really going on" at the empirical ground based on the tradition of symbolic interactionism from the Chicago School of Sociology, as learned by Strauss under the tutelage of George Herbert Mead and Herbert Blumer. Glaser, who had studied quantitative analytic methods, aspired to develop with Strauss sociological theory based on real-world situations rather than from conjectural sociology steeped in statistical models of hypothetical

relationships. Glaser learned from Strauss how to find out "the true emergent in the data" (Glaser, 1991, p. 13).

Strauss (1987) also held viewpoints about sociological practice based on the action- and process-oriented philosophical tradition of pragmatism. Pragmatism is the philosophical foundation of grounded theory. Pragmatist philosophy principally connotes action, practice, and practicality. Speculative questions and conceptual disagreements revolve around beliefs and ideas, and one's ideas are really rules for action. The meaning of ideas is only as important as the conduct that it is fitted to produce. "The truth of an idea is not a stagnant property inherent in it. Truth *happens* to an idea. It *becomes true,* is *made* true by events" (James, 1907/1981, p. 92). Strauss was inquisitive about events or action and action schemes in response to problematic situations. He was particularly alerted to the processual nature of events, the impact of contingency on phenomena, and how the consequences of one action sequence influenced the next action sequence (Corbin, 1991). Pragmatism combined with symbolic interactionism underpins the whole thrust of grounded theory: in short, to figure out what is important to people, what is problematic, and what is the process of events or action schemes implemented to attain resolution. I embarked on this study, first, to uncover core concerns arising between the PHN and the lower income mother in developing relationship. Then I strived for sufficient understanding to explain how concerns are "processed" to establish a therapeutic relationship.

Researcher Reflexivity

Critical Realism

I align with a critical realist ontological perspective. Roy Bhaskar fused his general philosophy of science, transcendental realism, with his special philosophy of the human sciences, critical naturalism, to create the hybrid critical realism, claiming that an external world exists and at the same time there is another dimension (Collier, 1994). This other dimension constitutes our socially determined knowledge about reality. All knowledge of a world independent of our human consciousness is conceptually mediated and, hence, is fallible.

Critical realists reconcile the dichotomy of realism and antirealism by purporting that reality is stratified. Reality cannot be reduced to that which is known through our senses. Underlying observable phenomena and events are hidden mechanisms; that is, "the something else occurring below the surface." Health science researchers cannot directly observe electrochemical events of the heart for example, but can detect, manipulate, and experience electrical changes indirectly. Bhaskar's (1989) ontological map consists of three domains; i.e., the empirical, actual, and real. The researcher's electrocardiogram of the heart's activity would be categorized as the *empirical* domain. The depolarization and repolarization of heart musculature and other monitored activities that occur whether the researcher experiences them or not would be categorized as the *actual* domain. The *real* domain would be the deep dimension of underlying pathways and mechanisms responsible for the generation and regulation of heart activity. Empiricist researchers claim that their data arising from the empirical domain are

"factual" discoveries when in actuality, critical realists would argue, their findings represent a very limited, theory-impregnated understanding of the real domain, of the mechanisms producing events in the world (Danermark, Ekstrom, Jakobsen, & Karlsson, 2002).

If the health science researcher were to investigate how a patient recovers from heart surgery following hospital discharge, he or she could move into exploration commensurate with social science research if the object of inquiry is now the person's external lifeworld and human society. Critical realists do not assign less weight to scientific investigation of the deep dimension (i.e., the real domain) of the patient's social reality associated with healing, adaptation, and recovery. There are also underlying mechanisms that ultimately generate and shape patient behaviours and events in this reality. The patient's approach to the phenomenon of recovery is related to many factors, including complex societal structures such as agency services and programs, and the family system as well as conceptualizations of the patient role and normative expectations for self-care activities. The researcher's task is interpretation of the patient's interpretive reflection as to why he or she is choosing to employ certain coping behaviours. Again, the researcher is not immune to the influence of preconception. Additionally, understanding of the real domain is confounded by the influence of societal ideology because the researcher is exploring an "inherently value-charged world of social phenomena, positions, roles, identities and relations" (Danermark et al., 2002, p. 38).

How does critical realism apply to this study of therapeutic relationships? I was seeking to discover a fundamental PHN-client pattern of interaction that exists independent of my knowing, but I was cognizant that there would be limitations to my "discovery." That is, given the complex interpersonal dynamics resulting from bringing together dyad members from contrasting social worlds, identities, and group affiliations, it was understandable that my empirical senses would uncover only a subset of the actual domain, attesting to Bhaskar's (1989) belief that the conceptual and the empirical do not jointly exhaust the real. Furthermore, as researcher I was bringing a preexisting layer of reality with me that would influence my perceptual and conceptual impressions. As much as I wanted to privilege the viewpoints of PHNs and mothers, data analysis would be filtered through my subjective lens of thoughts, assumptions, and experiences.

Moderate Social Constructionism

A critical realist ontological stance fits well with my support of a moderate social constructionist epistemology, wherein I do not believe that an unmediated grasp of the empirical world is possible. Inasmuch as I do not believe that the researcher's mind merely reflects objective reality or truth, I do not concur with "strong" constructionists, who renounce any truth to the matter of interpretation because of the dominating role of discourse and other sociocultural forces. Like the moderate constructionist, I discount the relativist view that any interpretation is as good as another (Schwandt, 2003). Moderate constructionists occupy a middle ground, stating that researcher interpretation within the context of

empirical scientific inquiry is only partly the product of social construction and negotiation (Longino, 1993).

Glaser and Strauss (1967) did not articulate their ontological and epistemological paradigmatic perspectives. Some scholars have stated that their antipositivistic, inductive approach to knowledge generation is consistent with the constructivist paradigm (Wuest, 2007) or akin to an interpretive science because grounded theorists search to understand the inherent meaning of social processes and patterns of behaviour (Rennie, 2000; Schwandt, 1990). Grounded theory methodology was congruent with my ontological and epistemological stance. I could seek out and engage with the social actors, glean their symbolic interpretations, observe the phenomenon of interpersonal communication in the natural environment, and then, based on grounded accounts, formulate some explanation of the impetus and thrust to the interactional behaviours between the PHN and the lower income lone-parent mother. Inevitably I knew that I was formulating *some* grounded theory to explain their trajectory and underlying mechanisms, and it was tenuous at best. However, grounded theory is like a double hermeneutic, such that I was able to capture relationship experiences, interpret those experiences, and then take back my abstract analysis to participants immersed in relationship building for their feedback and refinement.

Data Collection

I began the research inquiry by purposive sampling for PHNs and lower income lone-parent mothers as sources of interview data about their relationship experiences and as targets of dyadic observations. Data were collected

predominantly through face-to-face semistructured interviews. Interviews were 60 to 90 minutes in length (no more than two sessions per participant). Initial questions posed to PHNs included, for example,

- What is the role of relationship in your practice with lower income mothers?
- What contributes to a positive relationship?
- What factors inhibit relationship building?

Initial questions posed to mother participants included, for example, Can you please tell me about a recent visit with a health nurse? Questions were posed during each session to simply steer and maintain participant focus on the relational development process (see Appendix A for the interview guide). Analysis of data from the first few interview sessions compelled new questions based on preliminary hunches or hypotheses. Interviews were recorded electronically and transcribed to facilitate analysis. Second interviews were required only twice, involving two PHNs, to clarify points arising in their first interviews and to address queries that had emerged as the research progressed.

PHNs were recruited according to inclusion criteria that were contained in invitation packages delivered to community health centres and nongovernmental agencies suggested by Alberta Health Services (Edmonton Zone). The invitation packages also contained the recruitment poster (see Appendix B), study invitations (see Appendixes C and D), and information letters (see Appendixes E and F). Inclusion criteria for PHNs were that they speak, read, and write English fluently; maintain current professional registration in Alberta; are directly

involved in meeting the support and education needs of lower income mothers; and, have had more than one year's experience working with lower income families. Oral presentations (of the research goals, procedures, and estimated time and personnel involved) to zone managers (Edmonton Zone, Community Health Services), office managers, and staff PHNs of several interested community health centres also proved to be an effective recruitment strategy.

The criteria for selecting lone-parent mothers included that they are residents of Edmonton; speak, read and write English fluently; have at least one child under 5 years of age and thus have made frequent visits to the public health unit or community health centre for child immunizations and/or parenting education/support; and are living on a low income (receiving public assistance and/or low wages). Flyers inviting study participation were posted on bulletin boards (as approved by owners/managers) at laundromats, restaurants, and grocery stores in addition to each of the participating community health centre sites.

Persons of lower socioeconomic status might require more than the written content of flyers and information letters to commit themselves to a research study (Klass, 2003; Reutter et al., 2005). Thus, I also recruited mother participants by requesting that nursing and support staff members speak informally to potential mothers about the study and endorse the value of the research during centre appointments. Interested mothers contacted me directly by telephone or left their first name and contact information with a community health centre staff member. If respondents were eligible, I then met the participants, reviewed benefits and

potential risks involved, obtained written consent (see Appendixes G and H for consent forms) from those willing to take part in the study, gathered sociodemographic data (see Appendix I for information collected), and scheduled the first interview. PHNs interested in the study were asked to notify me directly by telephone or by electronic mail.

I conducted research interviews with mother participants in their homes. In an effort to reduce the likelihood of attrition, I secured a list of multiple contact telephone numbers and addresses of people who knew the family's whereabouts and could locate the family (Katz et al., 2001). However, I was able to maintain contact with all of the mother participants. Interviews with PHNs took place in the privacy of their offices or in another location that they deemed more suitable.

I was able to augment my interview data by observing PHN-mother dyads in office space and common areas in participating community health centres during immunization appointments and unscheduled drop-in clinics. Written consent was obtained from 4 PHNs and 14 mothers (i.e., 14 dyads) who permitted me to observe their interactional behaviours. Direct observation during the immunization clinics enabled me to experience, for the most part, the types, sequence, pace, and frequency of behaviours of the routine interchange between PHNs and their clients. Only 1 participant (a PHN), among the 14 dyads observed, also participated in an interview. Arrangements were also made for dyadic observations outside the community health centre, but appointments were cancelled because of illness and other reasons.

I manually documented my observations of verbal and nonverbal behaviours, and I was careful to be as unobtrusive as possible. Prior to conducting the study, I had consulted with an expert, Dr. Brenda Cameron from the Faculty of Nursing, University of Alberta, regarding construction of a tool that is specially designed for accurate documentation of nonverbal codes such as space, body movement, gestures, facial expression, and eye contact. Dr. Cameron informed me that accurate inductive observational documentation is best obtained without the distraction of a checklist and advised that as qualitative researcher I should record the most salient actions and responses as they occurred during the course of the interaction.

Data Sources

> A half dozen individuals with such knowledge constitute a far better "representative sample" than a thousand individuals who may be involved in the action that is being formed but who are not knowledgeable about that formation.
>
> –H. Blumer, 1969, p. 185

The grounded theory operation does not permit the researcher to determine a priori the exact sample size; however, it is estimated that 35 to 40 participants generally produce sufficient data units to saturate theoretical categories. My purposive interview sample included 21 mother participants and 15 PHNs (see Table 1 for sample characteristics). I also integrated data pertaining to the nonverbal communication of the 14 dyadic interactions involving 4 PHNs and 14 mothers (comprising 7 mothers of lower income status and 7 mothers of higher income status).

The *purposive sample* met the requirements for the nexus of my study (i.e., the PHN-mother relationship), but to achieve sufficient conceptual and theoretical development, I sought other data sources, referred to as comparison groups (e.g., a family physician, 2 social workers, a pregnancy crisis counsellor, and a hospital labour and delivery nurse) through *theoretical sampling*. The grounded theorist employs theoretical sampling strategies once preliminary conceptual categories and their properties emerge during data analysis. The additional sources and data variation enabled me to address my queries, hunches, and uncertainties; to expand on and refine conceptual categories; and to sort out the temporality of relationship-building.

For example, I learned that the PHNs' ability to care unconditionally fostered rapport among mother participants, especially those mothers who felt guilt and shame about their former addictions to drugs and alcohol and were assuming much of the responsibility for their present plight of poverty: the greater the sense of stigmatization, the greater the need for a caring approach, it seemed. During a formal interview with a volunteer pregnancy crisis counsellor I began to understand why unconditional positive regard was so critical to establishing rapport. The volunteer counsellor explained how some of the young women whom she counselled were experiencing their second and third pregnancies. These girls would appear very defensive because they "desperately" needed someone to show them genuine care, acceptance, and concern as they expressed tremendous remorse over the choices they had made in their lives, including several abortions. From this data source I could also better understand what PHNs

described as “walls of defensiveness” and how these behaviours were displayed and enacted nonverbally.

Theoretical sampling also included several helping professionals. Some of the mother participants spoke about taking private concerns to their family physicians. The mothers felt that their physicians knew them, understood them, and were good listeners. I consulted with a family physician whom I had met at a conference (and whose practice consisted of vulnerable and stigmatized clients) to compare the role, significance, and principles of the physician-patient relationship with the relational pattern and characteristics emerging in my study. The information obtained from the family physician helped to explicate and saturate the category Concerted Intentionality. I also gleaned the expertise of other helping professionals who work with lower income lone-parent mothers, including a labour and delivery nurse with more than 25 years’ experience. Some of the mother participants spoke about negative interactions during labour and delivery and the postpartum period in the hospital. The formal interview with the veteran labour and delivery nurse provided clarity about inhibitors to relationship-building as well differences in terms of the context, conditions, and approaches to professional relationships implemented by acute care nurses.

PHNs introduced me to social workers, one from the acute care sector and one from the community. The social workers proved invaluable in terms of assisting me to further define relational constructs, such as respect, trust, and authenticity, based on their many years of establishing working relationships with young lower income lone-parent mothers representing diverse ethnic

backgrounds. I also achieved sufficient data variation by conducting dyadic observations of PHNs with mothers from higher income groups, in addition to mothers from lower income groups; and elicited PHNs' insights regarding experiences with mothers of higher economic status. Contextual information gleaned from Alberta Health Services documents and through consultation with Community Health Services managers (see Table 2), and immersion in the multidisciplinary literature as certain subject matter surfaced, also contributed to theoretical formulation. The analytic procedures of the grounded theory operation are fully delineated below under Analytic Coding Procedures.

Table 1

Sample Characteristics of Interview Participants

Characteristic	**Mothers**	
Ethnicity	First Nations (6) White Canadian (11) Malaysian Canadian (1) Swiss Canadian (1) African (2)	
	Range	***Median***
Age	22–40	28.3
Years of primary education	8–12	11.1
Years of postsecondary education	0–5	0.67
Number of children	1–7	2.3
Years as lone-parent	0.25–16	3.6
Years on public assistance	0–16	3.0
Total mothers = 21		
Characteristic	**Public Health Nurses**	
	Range	***Median***
Years of relevant experience	3–35	18.0
Total public health nurses = 15		

Note. Primary education combines elementary and high school levels. All years shown in data columns are approximate values.

Table 2

All Data Sources

Technique	Data Sources	Setting/Affiliation	Datum Type
Purposive Sampling	15 PHNs 21 Mothers	Alberta Health Services Edmonton Zone	Transcripts Transcripts
	Administrator	Ministry of Employment, Industry and Immigration	Contextual information
	Coordinator	Healthy Young Families, Alberta Health Services	CHN/PHN standards
	Coordinator	Healthy Beginnings, Alberta Health Services	Orientation content
Theoretical Sampling	Labour and delivery nurse	Hospital	Relational approach
	Physician	Family Practice	Relational approach
	Health For Two nurses	Alberta Health Services	Contextual information
	Peer Counsellor	Pregnancy Crisis Centre	Stigmatization
	Social worker	Nonprofit organization	Relational approach
	Social worker	Hospital	Relational approach
Direct Observation	14 PHN-Mother Dyads	Community Health Centre	Communication

Data Analysis

> Grounded theory methodology enables the researcher to join the concrete visible ground with abstract invisible conceptualization.
>
> –S. L. Star, 1991

Conceptual emergence is the cornerstone of grounded theory (Glaser, 1992). The relational building blocks (conceptual categories and their properties) that constitute Targeting Essence: Pragmatic Variation of the Therapeutic Relationship were inductively extracted from my data and were not deduced from preexisting conceptualizations. I allowed the data to "speak" as opposed to "forcing the data" to fit preconceived notions. Conceptualization was stimulated very early on by the rich perspectives and insights of the participating PHNs and mothers. In adherence with grounded theory's operational procedures, I initiated analysis without delay. I did not wait to amass several interview transcripts before beginning to make analytical sense of what I was seeing in the data. Analogous to a "matrix operation," analysis during the grounded theory project is conducted as a joint process with data collection, and as such, "everything goes on at the same time" (Dr. Phyllis Noerager Stern, personal communication, May 14, 2007). The matrix operation is correctly referred to as grounded theory's constant comparative method because of this recursive overlapping of data collection, coding, and interpretation (Locke, 1996).

Conceptual Emergence in This Study

The PHNs and mothers participating in the study provided such an enormous wealth of information that it was not long before I was able to begin

identifying their basic pattern of relating and possible relational building blocks. I immediately compared the relational building blocks, or conceptual categories emerging within these initial interviews, with incoming data obtained from additional interviews and other data sources. My tentative ideas were then tested, verified, and modified accordingly. This collection-coding-analytic process was repeated throughout formulation of the explanatory theoretical model.

In the next section I outline the explicit analytic coding procedures that I conducted to make the transition from empirical findings to theoretical understanding so that I could join the concrete, visible ground with abstract invisible conceptualization. The caveat to keep in mind is that data analysis proceeded as an iterative rather than the strictly linear, step-by-step process depicted below.

Analytic Coding Procedures

Step 1: Building Substantive Codes

A grounded theorist strives to abstract up and to transcend description of empirical findings of people, place, and time. Grounded theory is "theory about concepts, not description at the substantive level" (B. G. Glaser, personal communication, February 28, 2007). Conceptualization is the chief aim through the assembly of data segments into labelled codes about what one is seeing, hearing, and sensing about the phenomenon under study. Then codes are merged into conceptual categories, after which conceptual categories are integrated into a chain of an emergent theory. The indicators of the fundamental pattern of relating that I had uncovered are considered empirical findings. To make the transition

from the data at the empirical ground (for the furtherance of understanding and explaining relationship building), I had to first *build substantive codes* through *open coding* and *selective coding* strategies (Glaser, 1978).

Open coding. Open coding is the fracturing of data into analytic segments that can be raised to an abstract conceptual level. Beginning with data gleaned from my interview participants, I examined entire interview transcripts, one after another, from a macroscopic perspective to gain some sense of the main pattern or messages about relational development, and then textual data were analyzed line by line as I coded each sentence to extract words from the participants' language (or in vivo codes) that depicted relevant ideas, notions, behaviours, gestures, perspectives, attitudes, or key experiences. For example, in vivo codes extrapolated from interview transcripts of mother participants include:

- They [PHNs] *don't really look at me or nothing.*
- There are *certain nurses there that know us.*
- I think the PHNs *have to know what is going on in order to help.*
- It happens all the time *people judge people every day.*

See Table 3 for in vivo codes from verbatim transcripts of interviews with PHNs.

Table 3

Study Examples of Conceptual Emergence

Procedure	Conceptual Emergence
Step 1. Building substantive codes	
1.1 Open coding	Beginning sense of relational pattern Identification of in vivo codes. Examples from PHN interviews: • The PHN *is conscious that she sounds up* • Mothers *are sensitive to criticism, doesn't take much* • The PHN *puts on a poker face* • The PHN *goes by her gut feelings* • PHNs *keep mothers in the picture so they are not blind-sided* Examples of conceptual categories: • *Strengths-based approach* • *Capacity-building approach* • *Strategic interaction* • *Personalizing the professional encounter* Mergence of conceptual categories
1.2 Selective coding	Identification of core issue and process MEMO July 25 08: CORE ISSUE AND PROCESS *I am concerned that I am not seeing a process of establishing relationship between PHNs and mothers. Clearly though, there is a relationship. It seems how attuned nurses are and the time they take to optimize opportunities with mothers, the greater the PHNs' ability to discern what is going on with the mother, and whether or not intervention is necessary for the sake of the child.* MEMO Aug 17 08: CORE VARIABLE *Rather than capitalizing on the opportunity, I wonder if it is about the PHN capturing the opportunity, not letting go of opportunity, and then lamenting missed opportunity. Thinking about the core variable as optimizing contact or optimizing the interpersonal dimension. Also thinking about the core variable as, rather than capitalizing on the opportunity, it is*

attending to what is most meaningful. There is something about being able to get out the most meaningful in that short period of time. So my core variable is related to attending to the most meaningful under time constraints.

Verification of core variable with participants

Identification of conceptual categories linked to core variable

MEMO SEPT 12 08: CONCERTED INTENTIONALITY
I asked the PHN how she could be so attentive. We talked about servant leadership, humility, selflessness. None of that seemed to resonate with her. "Concerted intentionality" seemed to account for her interactional behaviours. She wasn't to the point of being self-effacing. Is that dropping one's pride? I forget what is meant by self-effacing, seems relevant here for some reason. She wasn't demonstrating humility, but a caring, concerted effort to grasp the story of her client, the mother, and find out what is going on.

MEMO OCT 6 08: POSITIVE ENGAGEMENT
I think "positive engagement" is a description of something. So what is it? How is it? What is it that the PHNs are doing exactly? They are exuding optimism; they are emanating optimism; they are projecting optimism, almost like overcoming or reconciling or accommodating any deficits… . They can't think about anything but projecting optimism. Yes "projecting optimism" is it. It's a gerund and that gets above the descriptive level.

Basic social psychological process relabelled

Verification of core variable and relevant conceptual categories through consultation with participants

Conceptual specification and "densification" of conceptual categories

Verification of analysis through direct observation of dyadic interactions

More densification of existing conceptual categories

Step 2. Advancing abstraction to theoretical codes
Propositional statements of relations between conceptual categories
Conceptualization of how incoming substantive codes relate to conceptual categories
Theoretical chain of conceptual categories emerging

In vivo codes were compared one by one, and also with incoming data codes from other data sources, and then were eventually combined into conceptual categories. Conceptual categories and their properties were generated through constant comparative analysis. As mentioned previously, the conceptual categories are not intended to be descriptive detail of the data themselves, as Glaser and Strauss (1967) inform:

> The analyst will notice that the concepts abstracted from the substantive situation will tend to be current labels in use for the actual processes and behaviours that are to be explained, while the concepts constructed by the analyst will tend to be the explanations. (p. 107)

I also conjectured at this point about intertwining relationships among properties and other aspects of conceptual categories.

Memo writing is a pivotal activity throughout all phases of the research endeavour. The memoranda ignite conceptualization and raise concrete observations to an abstract theoretical level. Systematic memoing in this study included observations in the field as well as incorporating personal impressions, pondering, speculations, and conceptual hypotheses (see Table 3, above, for exemplars).

Selective coding. Selective coding was then implemented to identify the recurring social psychological problem associated with establishing therapeutic relationship as well as the basic social psychological process implemented for resolution of this chief concern (Glaser, 1978). Identifying the "real" interactional concern or challenge of dyad members was an important procedural step. It was through this step in the analysis that I came to the knowledge that professional praxis permits a relatively infrequent and short period of interaction, and that PHNs are persistently struggling to maximize this narrow window of relational opportunity to ascertain burdening holistic health concerns of the mothers. Resolution is through a basic social psychological process that I later labelled Targeting Essence. Targeting Essence achieves relational rapport, mitigates the mother's fears and mistrust, and enables the PHN to identify and then address unique needs. This problem and process of resolution became the core conceptual category, and from this point forward my coding focused exclusively on what is referred to as the core variable, around which the generation of theory to account for relationship building occurred. The emerging conceptual categories were revisited to refine the original list of conceptual categories. Existent substantive codes and conceptual categories were analyzed for their relevance to the core variable and excluded if extraneous. I then concentrated on the constant comparison of incidents and indicators applicable to the now smaller set of conceptual categories. The core variable assumed a delimiting function and became the guide for further data collection through theoretical sampling. Theoretical sampling included the selection of comparative data to further

explicate and expand emerging conceptual categories associated with the core variable.

Step 2: Advancing Abstraction to Theoretical Codes

This next step was to determine how conceptual categories and incoming substantive codes related to each other within the emergent theoretical framework about the process of establishing therapeutic relationships. A higher level of abstraction was conducted as substantive codes were assembled theoretically, using Glaser's (1978) families of theoretical codes (e.g., causes, contexts, contingencies, consequences, covariances, and conditions) as analytic strategies to enhance abstraction. For example, when studying the stages of relational development, the coding families of *causes* and *consequences* assisted with propositional statements about the shape and sequence of stages.

Subsequently, more data were amassed through theoretical sampling to produce the interrelation of conceptual categories and the properties that elaborated them. Theoretical sampling of comparison groups maximized the differences, enriched conceptualization, enhanced saturation of conceptual categories, clarified conceptual boundaries, and extended the scope of the theory (Glaser, 1998; Glaser & Strauss, 1967). I sought the opinion of an acute care nurse (as one source of comparative data) about the significance of my emerging relational concepts for her nursing approach with lower income postpartum mothers. Other individuals who provided data for the purposes of comparison were social workers and a family practice physician who worked with this demographic group. Again I compared my emerging process and relational

building blocks with their reflections of their particular disciplinary principles and approaches.

The repeated process of constant comparison of similarities and differences gleaned from multivariate data sources brought out and focused my attention on other coding families (including potential ranges, continua, degrees, types, uniformities, variations, and structural mechanisms) and promoted further saturation (Glaser & Strauss, 1967). As more conceptual categories and their properties emerged in abstraction, the accumulating interrelations gave rise to the basic shape of the integrated central theoretical model; that is, to the identification of the relational concepts or building blocks of the trajectory and process of the therapeutic relationship.

Rigor

This grounded theory study was not designed to accurately describe and represent participant relationship experiences and perspectives. Rather, the aim was to formulate probability statements about how emerging relational concepts were integrated to form the theoretical explanation of the relationship-building process. The question of rigor pertained to ensuring that Targeting Essence: Pragmatic Variation of the Therapeutic Relationship was well grounded in the data as opposed to demonstrating the reliability and validity of measurement instruments or other research design tools implemented to test or verify preexistent relationship theory. Evaluative criteria drawn from the traditional canons of logicodeductive research are not applicable to grounded theory's

inductive hypotheses-seeking research strategy (Mullen, 1996). The co-originators

> rejected positivist notions of falsification and hypothesis testing and, instead, described an organic process of theory emergence based on how well data fit conceptual categories identified by an observer, by how well the categories explain or predict ongoing interpretations, and by how relevant the categories are to the core issues being observed. (Suddaby, 2006, p. 634)

The indicators of reliability and validity have been tailored to assess grounded theory's generational methodology. Criteria for determining the rigor of the grounded theory study include *fit*, *relevance*, *work*, and *modifiability*, as developed by the co-originators (Glaser & Strauss, 1967) and later adapted by Glaser (1978).

Emergent Fit

I fulfilled the criterion of emergent fit by ensuring that I did not force data to fit predetermined ideas, problems, or solutions. Rather, I enabled emergence of the main concern, the patterned behavioural responses, and the processual elements. I was cognizant of this "emergence, not forcing" principle throughout all phases of the research so that I would not be unconsciously trying to prove my point or deduce my pet theories, as they could slip in insidiously (Glaser, 1992). Through my active, open analytic stance (Morse, Barrett, Mayan, Olson, & Spiers, 2002) I avoided forcing irrelevant assumptions and theoretical claims and allowed the data to dictate. When reviewing my transcribed interviews and other data pieces, I asked myself neutral questions such as, What is going on here? What am I really studying as indicated by the data? Conceptual impressions had to fit all incoming data, and I found myself having to refit generated conceptual

categories with each new participant perspective and other new empirically grounded data.

Similarly, I accessed interpretive frameworks drawn from the sociological and communication literature after I had accrued data. The frameworks served as aids and offered sensitizing concepts to discern not so much what I was *looking for* in the data but helped to determine what I was *looking at* in the data. Trust and respect are good examples of generic relational concepts that are prevalent in the multidisciplinary literature. At no point during my fieldwork did I deliberately look for trust and respect, or attempt to locate them in textual data or prove their existence in the relational development process. My semistructured questions did not include trust and respect or any other relational construct unless they were first grounded in my data and thus had earned their way into the theorizing process and then became part of my inquiry when posing questions to participants to verify hunches and to gain conceptual clarity.

Relevance

The criterion of relevance refers to identification of the core issue and process within the substantive area and to ensuring that the issue and process were allowed to emerge as opposed to deduced from data sources outside the empirical ground (Glaser, 1978). The initial discovery of the core concern (i.e., time-limited interactional opportunities) resonated with the PHNs' everyday practice realities. Targeting Essence is a basic social psychological process that enables PHNs to focus their attention more accurately, to relate efficiently and sensitively, and to ascertain pending concerns of lower income lone-parent mothers. Some of the

core conceptual categories received affirmation with comments, such as, "Yes, I like that," and provided the bridge (Glaser & Strauss, 1967) between what I was thinking theoretically and what the PHNs were thinking pragmatically.

I also aimed to develop a rich, relevant, dense theory through incremental steps of discovery, conjecture, and justification, moving back and forth to incorporate microscopic perspectives of the data and macroscopic insights from the theoretical literature (Morse, Barrett, et al., 2002, p. 2). I first checked for practice relevance by discussing emerging conceptual categories with my supervisory committee members familiar with the theoretical and empirical literature concerning the study's context and sample demographics. Committee members alerted me to other conceptual possibilities that I subsequently pursued. I soon learned that the strengths-based approach (Feeley & Gottlieb, 2000; Leddy, 2006), maternal self-efficacy (Bandura, 1997; Hess, Teti, & Hussey-Gardner, 2004), intuitive knowing (Benner, 1984; Rew & Barrow, 2007, social support (Stewart, 2000), professional boundaries (Boggs, 2003), person-centredness (McCormack, 2003) and health promotion (Pender, Murdaugh, & Parsons, 2006), to name a few, legitimized the emerging conceptual categories and their applicability to the practice knowledge base. Moreover, massive healthcare restructuring and reform, and the climate of fiscal constraint confirm the broader relevance of my study findings. Nurses in both acute and community care sectors have had to streamline their relational practice efforts and downsize services and programs to meet healthcare needs in a timely, judicious, cost-effective manner (Wright & Leahey, 2005).

Work

I presented Targeting Essence: Pragmatic Variation of the Therapeutic Relationship to a group of PHNs, who stated that the model was comprehensive and understandable, and that it merited practical value and application. Hence, the emergent theoretical model passed the criterion for work; that is, I was able to validate that the model could explain and interpret (Glaser, 1978) the interpersonal dynamics between the PHN and the lower income lone-parent mother. Overall, PHNs verified that the model accounted for much of their relational practice efforts to establish therapeutic relationship with lower income lone-parent mothers and indicated that they were pleased that finally there was *explicit* documentation of that which they knew how to do *implicitly*.

The criterion of work was also established by the study's multivariate data sources. Insights from PHNs with various levels of experience and mothers representing diverse demographical characteristics helped to illuminate complex and nuanced facets of the reality of their interaction. My consulting with mother participants along with dyadic observations overcame partiality of the PHNs' interpretations over the mothers' interpretations and served to confirm some of my inferences about their relationship-building process.

Modifiability

The grounded theorist should view generation as "an ever modifying process" (Glaser, 1978, p. 5). Through investigator responsiveness (Morse, Barrett, et al., 2002) I approached the data with openness and flexibility, ready to modify my categorization scheme if my ideas were not well supported. A constant

flow of questions led to my reworking of my assumptions and were the basis for seeking confirmation from additional data sources. Even my research objectives could have been altered. My intent, for example, was to explore the establishment of therapeutic relationships but I was prepared to change my research focus if warranted.

I sought ongoing verification of my analysis of the processual stages of relational development throughout the course of the research study. This entailed seeking out negative cases. For example, one mother participant was indifferent to the second stage of the emergent model, Child as Mediating Presence. She claimed that her appraisal of the visit with the PHN had little to do with how much the PHN focused on her child. This particular mother was born outside of Canada, not living on public assistance, well educated, resourceful, and resilient, and had ample social support. She also did not believe that there was any stigma associated with her status as a lower income lone-parent mother. Another mother made similar comments. Unlike the other mothers in the study, this mother was enrolled in a 5-year early intervention home visitation program and had established a close bond with her home visitor, whom she saw biweekly. The above examples are deviant cases that I had to take into account. I was largely able to explain, for the most part, the apparent inconsistencies; otherwise, I made modifications accordingly.

I expect to continue to modify the emergent theoretical model as I discuss its relevance and application with PHNs during dissemination of my findings. I will be responsive to their recommendations for amendment. Additionally, as I

embark on future research involving helping professionals from other disciplines, new theoretical perspectives and insights will emerge, and I will want to refine the model further to make it more amenable to establishing professional relationships in other practice contexts.

Ethical Considerations

The research proposal was submitted for ethical review to the University of Alberta Health Research Ethics Board. There were some potential challenges and issues that warranted my attention and sensitivity. The main ethical considerations were as follows.

Imposition. Participation in the study could be an added inconvenience for lower income families, whose lives are already characterized as stressful and chaotic. Struggling with chronic financial hardship and possibly consumed with the daily vagaries faced by lone-parent mothers, these mothers might have little capacity to devote to research (Horowitz et al., 2002). All interviews were conducted in their homes to relieve travel and childcare concerns. A $30 gift certificate from a department or grocery store (e.g., Zellers, Wal-Mart, or Save-On Foods) was given to mother participants as a token of appreciation and to thank them for their invaluable contribution to the study. I ensured that the date and time of interview sessions were arranged according to the mother's preference and convenience (e.g., when children were napping or in school). PHNs were given several options in terms of dates, times, and locations of interview sessions.

Participant burden. Lower income families are typically inundated with social services personnel, healthcare providers, government forms, and surveys. I limited my visits to a maximum of two sessions for any one family.

Discomfort. Disclosure of feelings, thoughts, and experiences associated with social interactions and interpersonal encounters within the current healthcare delivery system could evoke untoward emotions. I emphasized with participants that protection of their interests and well-being took precedence over the research and that participants had the right to terminate the interview at any time. I was prepared if problems arose during the course of the interview. I planned to end the session momentarily and was ready to refer the participant for outside assistance. On one occasion I did stop the interview because the mother participant became tearful as she discussed her situation and circumstances. This mother had rated her sense of well-being as "good" prior to the interview and was not under the care of a physician for depression. She reassured me that she generally becomes emotional when discussing personal concerns and was adamant that there was no need to be alarmed. In fact, she stated that she found the interview process cathartic and thus appreciated the opportunity to talk.

Researchers do claim that participants can be richly rewarded by the interview experience (Corbin & Morse, 2003). The mother continued to be teary at times throughout the interview process but stable. I confirmed her status again at the close of the interview and again before leaving. I was also careful not to shift roles and assume the responsibility as practitioner, therapist, or counsellor (Speziale & Carpenter, 2003). I was ready to offer this mother and other mother

participants, if warranted, a list of community services and contact numbers of health and social services professionals for emergency and consultation purposes (Klass, 2003).

Trust. Participant trust is precarious at best, especially if the mother participant has had negative encounters in the past with researchers or has been exploited by other adults in her life (Reutter et al., 2005). Furthermore, research conducted in America indicates that mothers living on public assistance employ silence and guard information related to their lives as coping mechanisms to protect themselves from the scrutiny and suspicions of personnel from social service institutions (Dodson & Schmalzbauer, 2005). It is likely that the level of trust established between the study participants and me determined the extent to which they were willing to share information. Presentation of self as the researcher is the criterion used for evaluation of moral character and trustworthiness (Harrington, 2003). I endeavoured to project caring, respect, humility, and unconditional acceptance and appreciation at all times. Mothers were reassured that this study was in no way connected to or funded and controlled by Alberta Employment, Immigration and Industry; Alberta Health and Wellness; or Edmonton and Area Child and Family Services Authority.

Confidentiality. Confidentiality and anonymity are very significant ethical issues. According to the ethical principle of beneficence (i.e., doing good and preventing harm) participants were reassured that confidentiality would not be violated (not withstanding exceptional circumstances in which professional codes of ethics or legislation required reporting). I clarified at the commencement of

each interview session the measures that were to be taken to protect participants' confidentiality and anonymity by reiterating the written content of the information letter. All participants were reassured that no one (including agency personnel and employers), apart from my supervisory committee, would have access to my raw research data.

Participants' rights. It was critical that all participants be fully aware of their freedom to withdraw. Mothers and PHNs were invited to participate strictly on a voluntary basis. Participants were informed repeatedly throughout the course of the study that they had the right to withdraw at any point without reprisal. PHNs were reminded that their involvement in the study would bear no impact on their job performance and evaluation.

Literacy levels. There is a higher rate of limited literacy skills among members of the lower socioeconomic population (Grenier et al., 2008). With respect to lower income mothers, level of literacy might affect their ability to adequately comprehend information regarding the research goals and process, and mothers might be misled with regard to the nature of the research. Because their right to consent voluntarily or decline participation was a critical ethical consideration, verbal explanations accompanied written material, and all documents accommodated lower literacy levels (Speziale & Carpenter, 2003).

CHAPTER FOUR: THE EMERGENT THEORY

In this chapter I present the theoretical model, Targeting Essence: Pragmatic Variation of the Therapeutic Relationship. Participant quotations (pseudonyms ensure anonymity) and pertinent observational data are interwoven throughout description of the model's six stages to better illustrate constructs and to corroborate inferences and conclusions. There are instances where I insert excerpts from transcripts that include both questions posed by the interviewer and participant responses to fully capture the main point and to avoid partial presentation of the intended meaning. (See Figure 1 in this chapter for a graphical representation of the theoretical model.) A brief synopsis of the model's relationship-building process and its interrelated, interdependent stages is provided in the closing section entitled Summation.

The Therapeutic Relationship in Context

It is important that the reader comprehends the context within which this phenomenon of therapeutic relationship was studied. Who were the dyad members? What were the circumstances internal and external to their interaction and the relationship-building process? One of the premises of this study is that stigmatization can threaten one's sense of self and self-worth. From a contextual perspective, many of these women grew up in homes without unconditional love and acceptance. Judgment did not start with stigmatizing labels as lower income lone-parent mothers but much earlier, as one PHN illuminated: "These people

have people judging them most of their lives." Throughout the course of the research I became aware that the mother participants are very conscious of the self and that heightened sensitivities among this cohort of mothers carries implications for relational development. PHNs, I discovered, have to accommodate and adapt by employing certain interactional strategies. The relational practice efforts of PHNs are also shaped by praxis, with constraints imposing, to some degree, the nature and type of therapeutic relationship established. The ensuing profiles were compiled during the course of my interviews with the dyad members.

Dyad Member: The Lower Income Lone-Parent Mother

When questioned, the participants (i.e., PHNs and mothers) knew of or experienced firsthand the stigma and stigmatizing labels assigned to single mother status and living below the poverty line, especially when the "government" was the only means of financial support. As mentioned previously under Relevant Study Terms and Definitions, the salience of stigmatization is mediated through the mother's interpretation of how others view her during encounters within her social world. Although mother participants acknowledged that negative attitudes exist in society, the extent to which each mother was personally affected varied from one mother to the next in accordance with, among other factors, her level of stigma consciousness (as previously defined in Review of Literature). Some mothers more than others attributed being single and living on public assistance to personal character flaws and felt that people "looked down upon them."

Depending on where they were positioned on a continuum, mothers were apt to put up what PHNs described as “walls” or “barriers” and “shut themselves off.” At the lower end of the stigma consciousness continuum were the mothers who expressed guilt about not always being able to provide the basic necessities for their children but rationalized that circumstances were beyond their control. In contrast, mothers at the other polar extreme were both cognizant of and emotionally distraught about their everyday lives, with intense feelings of both guilt and shame due to their poverty coupled with their history of drug abuse, alcoholism, prostitution, or involvement with Alberta Children and Youth Services. Interesting is the notion that guilt “ ‘says that I made a mistake’ and shame ‘says I am a mistake’ and that I am ‘bad’… ‘rotten’… and ‘inadequate’ ” (Whitfield, 1987, p. 26). I surmise that the “walls” were more permeable in the former group, in which mothers referred to a type of circumstantially based stigma, than in the latter group, in which mothers spoke more of a shame-based stigma.

Another contextual feature worth mentioning is that PHNs were doubly challenged when initiating rapport with mothers who had suffered and/or carried negative stereotypes as members of not one but multiple marginalized groups. Consider, for example, the following interview excerpt, which is a mere glimpse into the complex life stories of the mother participants. Kelly is a single Aboriginal mother with two young children. She is living on public assistance and has a congenital illness and a learning disability. She is also an adult child of an alcoholic. Kelly describes a recent visit with her neurologist:

Interviewer: You need to go to school and need to work? What do you think about that?
Kelly: Um…[3] I'm trying to get on AISH too so I could get a little bit more money so I won't have to work but like I said I could still go to school. And the doctor's kind of giving me a hard time about that. It seems that they don't really believe me.
Interviewer: Believe that you have…
Kelly: … that I have… the things I tell them.
Interviewer: So you go to the doctor and what does he say or she say?
Kelly: Well he… they don't really say anything; they just give me some medication. Like I told… I don't know it seems they don't believe me.
Interviewer: So, you… tell me about the last visit you had with the doctor.
Kelly: I went to the [names place] the neurologist, he checked, um, like because I have neurofibromatosis, he gave me some kind of test with this nerve machine and he just didn't believe me that I told him how much in pain I am and that they could be removed. And he said, "No there are too many of them [nodes] for me to remove," and he just didn't want to do it. So that kind of made me feel bad.
Interviewer: Oh… so you were feeling bad? Just what, what were you thinking that he was thinking about you?
Kelly: I just think that they don't believe me. I think maybe because I am a Native and maybe he thinks I just want pills or something?
Interviewer: Um… so what has being Native got to do with it?
Kelly: Well just the way he looks at me sometimes…
Interviewer: How did he look at you?
Kelly: The just I-don't-believe-you kind of look.
Interviewer: Um… so it is a… can you talk about that look?
Kelly: No. I don't want to.

In light of Kelly's many personal characteristics, the PHN would have benefitted from being able to anticipate prior to interacting with Kelly (and other mothers sharing similar profiles) that her level of stigma consciousness might be influenced by her identity as a single mother in poverty and, in addition, stem from the cumulative effects of being affiliated with several socially disadvantaged groups (e.g., bearing sensitivities arising from her parents' alcoholism or

[3] Ellipsis points (...) within participant quotations indicate pauses in speech, not missing words.

associated with her Aboriginal status and/or from dealing with a learning disability).

Finally, I uncovered one more confounding contextual piece. Although stigmatization can be devastating, many of these women, regrettably, were predisposed to conditions during their childhood such that poor personal judgments may have been established long before they became mothers. The majority of the mothers interviewed spoke about their dysfunctional families and/or their current estrangement from family members. Some had been "motherless" children and went from foster home to foster home until they lived "on the streets" and had to fend for themselves. Most disturbing is that the majority recounted experiences of socioemotional deprivation, physical and/or sexual abuse, and were children of drug addicts and alcoholics, suggesting perhaps that their self-esteem was not nurtured and that, rather, the converse was true: Their primary social systems contributed negative attributions of the self.

Dyad Member: The Public Health Nurse

Public health nursing practice has changed from the more generalist role a decade ago to the departmentalization, or siloing, of professional expertise, knowledge, and skill sets. Moreover, with the demand for cost containment and healthcare sustainability, changes have meant the loss of contact hours with clients. PHNs recall how (in the past) they were responsible as generalists for a caseload of families and were afforded time to establish rapport and maintain continuity. In contrast, PHNs in current specialty roles and designated capacities must fulfill responsibilities and new mandates within a relatively limited time

frame. Time allotted for families during child immunization clinics, for example, range from 20 to 60 minutes per family. PHNs are expected within short blocks of time to inform parents of the risks and benefits of vaccines, administer several vaccinations, evaluate child development, teach preventive measures, and ascertain need for intervention/referral. Some practice settings allow PHNs the discretion to follow up with families after the immunization clinic if issues have been raised, typically with a telephone call or through drop-in appointments. Home visitation is much less frequent, but all postpartum families receive a routine visit from the PHN shortly after birth. Again, if the PHN suggests that further support is warranted for the mother and her newborn, the PHN can resume contact by telephone and (depending on the site's policy and protocol) could address the family's needs by visiting in the home setting. However, the telephone call in most cases has replaced the follow-up home visit because of staffing and time constraints.

Some PHNs are also seconded to federally and provincially funded programs and nongovernmental community organizations specially designed to accommodate the complex needs of at-risk (e.g., economically disadvantaged) maternal/child populations. These programs and services facilitate greater opportunity for engagement with clients formally and informally and on individual and group levels. PHNs working within comprehensive community-based initiatives for at-risk perinatal women, for example, are allotted much more face-to-face contact with clients either in the health centre, home, or agency settings.

The PHNs who participated in my study represented all of the delivery orientations mentioned above. The constraints notwithstanding, within this overall practice context I discovered that therapeutic rapport for both PHNs and mothers was no less significant or meaningful but that the nature of the relationship demanded a particular set of interpersonal dynamics. It required that PHNs be relationally efficient and strategic so that they could adequately focus on individual needs of lower income lone-parent mothers.

Targeting Essence:
Pragmatic Variation of the Therapeutic Relationship

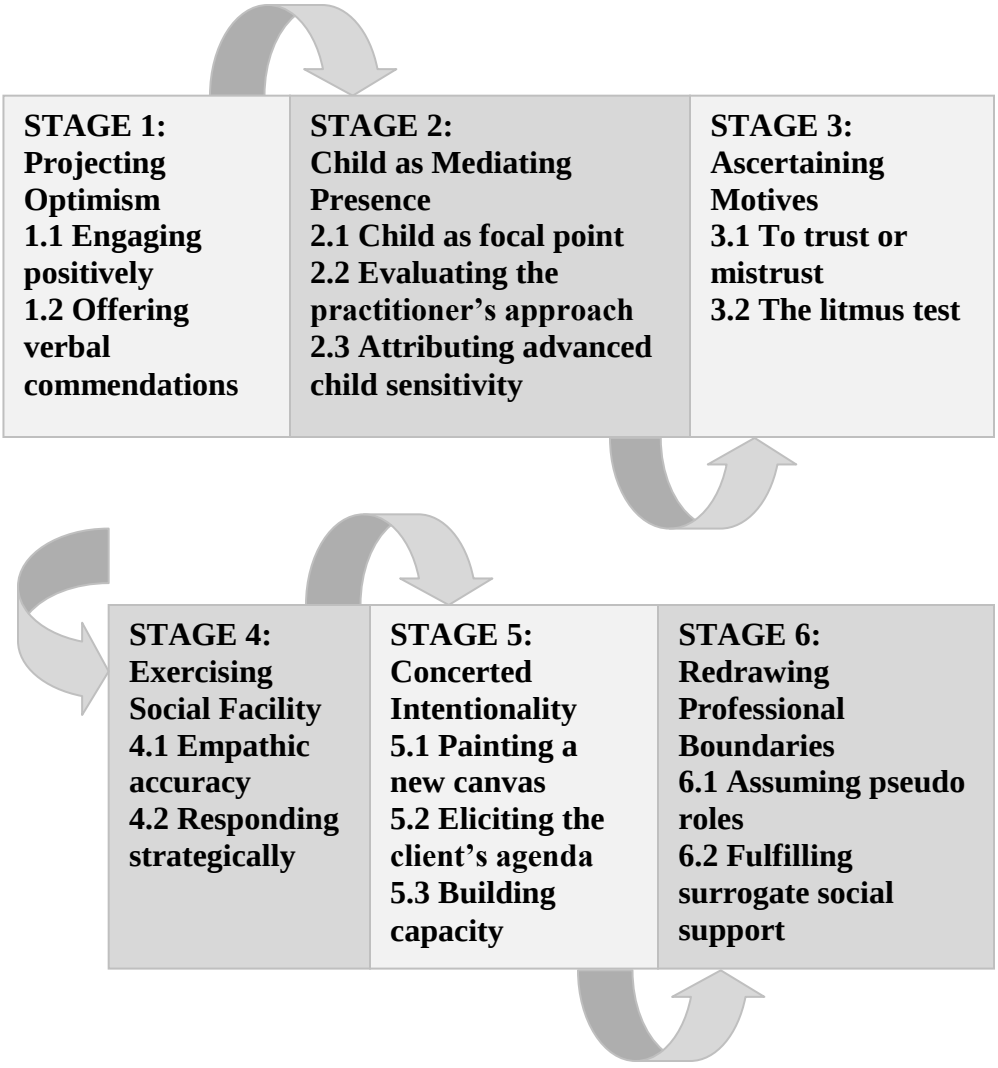
Preamble

Fundamentally, I detected a general pattern of relating between the PHN and the lower income mother. The PHN exudes a positive disposition from the outset, raises maternal self-efficacy, is focused on the child, makes known that she is "not here to judge," identifies appropriate relational strategies, fosters autonomy by positioning the mother in charge of agenda priorities, and maintains contact. The lower income mother is calmed by the "warm" approach, gauges level of interest in her child, senses parental competence affirmed, judges intent, decides that there is no threat, vents needs, and anticipates future connection.

Further analysis in conjunction with observation of PHN-mother interactions indicated that the general pattern just described is actually a situation-specific modification of the therapeutic relationship due to the fact that professional praxis permits limited opportunity for rapport and relationship building. PHNs modify the therapeutic relationship to accommodate a relatively

infrequent and short time period of interaction. Consequently, the main issue confronting the PHN is her ability to maximize this narrow window of relational opportunity with this vulnerable and potentially stigmatized client to identify real and potential maternal/child holistic health concerns. Resolution is through a basic social psychological process that I have labelled Targeting Essence. Targeting Essence achieves relational rapport chiefly through mitigating the threat to self and enables the PHN to pinpoint the mother's unique needs. Targeting Essence encompasses six interdependent stages: projecting optimism, child as mediating presence, ascertaining motives, exercising social facility, concerted intentionality, and redrawing professional boundaries. All dyads do not proceed through the six-stage process in a linear sequential pattern, as the model in Figure 1 portrays. The interactional strategies and components contained within each stage might take on greater or lesser emphasis, require longer or shorter duration, exist concurrently, or be repeated. In the end, the process resembles more of a dialectical synthesis of the back-and-forth actions and reactions of dyad members. Targeting Essence: Pragmatic Variation of the Therapeutic Relationship, as explicated below, is the emergent theory explaining the mode and adaptation of the therapeutic relationship established between the PHN and the lower income mother.

PUBLIC HEALTH NURSE:
Exudes positive disposition from outset - Raises maternal self-efficacy - Focuses on child - Makes explicit "not here to judge" - Identifies appropriate relational strategies - Fosters autonomy by positioning mother in charge of agenda - Maintains contact



MOTHER:
Calmed by warm approach - Gauges level of interest in child - Senses parental competence affirmed - Judges intent - Decides no threat - Vents needs - Anticipates future connection

Figure 1. Graphical representation of the emergent model, Targeting Essence: Pragmatic Variation of the Therapeutic Relationship.

Stage 1: Projecting Optimism

Projecting Optimism is the crucial first stage. The PHN sets the tone and "breaks the ice" with two interactional strategies: Engaging Positively and Offering Verbal Commendations. The well-known maxim of communication "It's not what is said but how it is said" is never more applicable than during the initial moments of the encounter between the PHN and the lower income mother. It is not the word spoken but all the unspoken communication, including posture, gestures, facial expression, and voice inflection. Engaging Positively addresses the immediacy and critical nature of first impressions, specifically the mother's first impressions of the PHN. The other substage interactional strategy, Offering Verbal Commendations, is less focused on the unspoken communication and more focused on the verbal exchange as the means to establish rapport.

1.1 Engaging Positively

The potential for interpersonal connection is contingent on the PHN's nonverbal communicative behaviours. Just as the PHN is looking at the mother, at the same time the mother is looking at the PHN. From the outset it is imperative that the PHN exude what mothers describe as a "peppy" and "chipper" disposition. All mothers interviewed explained that the happy, friendly demeanour puts them at ease and contributes to their sense of comfort in the presence of the PHN. "Friendly" is exhibited by the nonverbal communicative behaviours of the smiling face, eye contact, relaxed body posture, and gentle warmth denoted by paralanguage such as a soft voice quality as opposed to loud, harsh, or stern. Betsy, a 27-year-old single mother of a 5-year-old, explained that

her comfort level depends on "how friendly they are"; "if they are very serious" and "all uptight," she stated, she does not "like that" as it is "not very welcoming." Betsy prefers people "who are easy going… they can laugh" and "not make it so nerve-wracking."

Friendly cues are also conveyed by the PHN's general appearance. PHNs told me, and I observed, that they dress in civilian, or "street," clothes rather than "sterile" starched uniforms or professional business attire. Most appealing to mothers is the "hippie, down-to-earth" look. Belinda, a 31-year-old single mother with four children, added,

> I think I liked Laverne because she was friendly like she really, to be perfectly honest, had this thing about her that reminded me of an old hippie woman. And I really liked that. I liked her because she was laid back and friendly, she had long… she didn't dye her hair, she just let her hair be a natural color. I liked that whole thing about her. And she was always positive.

The PHN's aim and hope during this crucial first stage are that the mother will infer by virtue of the PHN's uplifting approach that the PHN is genuinely pleased to see her and her child. When Belinda (as mentioned above), who had just given birth to her fourth child, was asked what she thought was the role of the PHN with mothers like herself, she replied,

> I think a big part that health nurses have to play especially with extremely low-income moms, is try to, possibly, is to give a lot of positive reinforcement because that's the thing I can always say about Jessie. Jessie is always trying to be upbeat and everything like that and I think she even sees it as her role to be a positive influence on the moms, to help them be excited about their babies. And letting them know that their babies are a unique beautiful little jewel that they have to take care of that they have.

Especially when first experiencing the transformation from woman to mother, participants were not unlike other new mothers, for whom "mothering awakens

the moral impulse to be with and for the child" (Bergum, 1997, p. xiii). Sheila is a PHN who has continued to witness the euphoria over the birth of a new baby during her 10 years of experience in the field of maternal/child health:

> Absolutely it doesn't matter whether you are single or what your status everybody is excited about this baby. And whether it was you were unsure about wanting this baby, unsure you wanted the pregnancy. Whatever it was, you've got this baby now and it's part of you, and they're so excited.

Mother participants were made to believe that the PHNs truly celebrated their transition to motherhood and wanted to share the joy over their newborn.

However, an essential property is that the PHN's enthusiasm be authentic, that there be no what Grace, a 27-year-old Rwandan single mother of a 5-month-old, referred to as "crocodile smiles," suggestive of insincerity. Ramona, a 23-year-old single first-time mother of a 6-month-old, commented about her visits with the PHNs: "I love their expressions on their faces when they see Darren and how big he is getting. He looks so great and smiling. That just makes me feel good." It is important for soliciting engagement that the PHN's overall mood reveals a joyful attitude that is congruent with her facial communicative displays of happiness and her verbal enthusiasm regarding the presenting mother and child.

1.2 Offering Verbal Commendations

Engaging Positively is coupled with Offering Verbal Commendations. Offering Verbal Commendations is another important substage interactional strategy, but unlike Engaging Positively, the focus is primarily on the spoken word. Offering Verbal Commendations reflects a strength-based orientation during which the PHN attempts to draw out and verbally acknowledge the mother's capabilities, skills, or competencies in whatever form and measure they

happen to appear or which the PHN can discern. “I really try to see the positive, what people are doing is good and try to work it into our conversation,” commented Patty, based on her 30 years of public health nursing experience. She further explained how she calls forth strengths to aid relationship building; she would tell mothers, “This is the most important job in the world raising this baby… this is huge. This is a big job. And it’s really a special job. You are the only mom.” Then Patty would point out that “not just anybody can look after this baby.” Her commendations might be what she observes in terms of maternal-infant bonding, the “little connections” that are “positive strokes but that the mom may not even notice.” For example, she might affirm mothering behaviours by saying, “The baby already knows you. Look how well you cuddle that baby, boy she settles down when you pick her up.” Similarly, Julie, another 30-year veteran, stated that she constantly tries to identify “maternal successes,” big or small. “And when they do something that is positive, notice it,” Julie suggested, by acknowledging, for example, “That was a really a nice way to talk to your baby you know… oh she sure likes that.”

Offering Verbal Commendations is an effective relational tool because it addresses the mother’s motive to enhance her sense of self. As alluded to earlier, presaging any present-day feelings of low self-worth associated with the stigma of being lower income lone-parent mothers are possibly their years of negative beliefs about themselves rooted in much earlier parental and social relationships. Mother after mother disclosed stories of deprivation, abuse, and rejection, leaving little reason to believe that they came away with high appraisals of themselves;

more accurately, their formative years taught these mothers that they were not loveable, "contributed little," and would amount to nothing. Patty (the PHN cited above) advised that the PHN has to "sort of pat them on the back" because

> a lot, especially young moms or single moms, they think the whole of society is looking down their nose at them like, "How stupid are you why did you get yourself knocked up? Why are you having this baby? What do you have to offer?"

Patty continued: "Mothering a baby well might be the only thing they've done right in their eyes, in society's eyes." Verbal Commendations are the practitioner's "language of gifts," claimed Jasmine, who after only 3 years as a PHN can attest to the impact of compliments when bestowed on mothers who are seeking and needing self-affirmation that they have never or otherwise might never receive. The mothers are made to feel self-conscious in a positive way, which replaces, if even for a moment, negative self-conscious emotions derived from criticism in former social interactions and contexts. "It feels good when you get compliments. I used to be just put down and you feel like you are nothing," confirmed Lana, a 32-year-old single mother with two young children.

By relating to the woman before her as a mother and, notably, a capable mother, the PHN enhances the mother's sense of self. In accordance with my analysis, it appears that the mothering role and maternal self-efficacy may very well have become the domain (Crocker & Wolfe, 2001) on which many of the mothers have staked their self-esteem. Consequently, the mother's view of her value and worth depends on perceived parenting successes or failures via introjections of the PHN's reactions towards her. By honing in on and identifying positive parenting behaviours, the PHN is affecting the mother's cognitions and

feelings about her self in the role of mother, with implications for enhancing her core self and overall sense of self-worth. In fact, when the identity of mother is firmly attached to her core self, she has a stronger sense of pride and feelings of happiness when the PHN draws correlations between her child's healthy weight gain, for example, and other milestones, and effectual mothering, which is essentially verification of her identity as a competent mother. Witness Ramona's response when questioned about her conversation with the health nurse during a recent visit with her son to the immunization clinic:

> Yes, um, that I'm doing good great with Darren; that he's looking great. He was taller than any of his... percentiles. He was tall because he's 26 inches right now for being six months and she's like, "That is really, really good." He's 19 pounds right so she'd be like, "That's awesome." So she said that I'm doing really well with him because she knows that I take care of him most of the time right, so, and the situations that I've been in. And that was really nice to hear because this is my first child and I don't know if I'm doing good right? So it's nice to hear when someone says that you are doing a great job with the child.

Ramona was able to *see* and *hear* the PHN verify that she is a "good mom." Addressing Ramona's salient need for self-verification instils in mothers like Ramona, who are young, single first-time mothers, the feelings of being "proud" and "very confident." At the same time, the PHN is cultivating rapport and placing before the mother a stepping stone to further engagement.

Verbal Commendations are most effectual for cultivating rapport when the PHN's praise does not take the form of superficial flattery, such as "Your baby has pretty eyes," per se but, rather, (to the extent possible) is more in keeping with concrete measures or manifestations of quality parenting practices (e.g., maternal-child interactions, feeding choices, play activities, and so forth). Verbal Commendations works in synchrony with Engaging Positively when that which is

transacted and perceived is in the PHN's message to the mother: "I am excited for you as a mother and I acknowledge your capabilities." Furthermore, praise, compliments, or commendations accompanied by clear directives as to the appropriate mothering behaviour not only are affirming but fulfill the mandate to teach mothers child developmental needs, management, and parenting skills, as depicted in one of Patty's (a PHN cited above) annotations:

> And I think that it is helpful to moms to know how to read their babies and pay attention to cues. And sometimes I will point out to mom, "Look what he is doing what do you think he wants?" Or he'll be… mouth wide open, "I want food," right" Or he's pushing away like even when I'm doing blood work on the baby's foot and he's kicking and I say, "He doesn't like this, good for him, he shouldn't like this, this is a good, healthy, normal response. Nobody wants somebody holding their leg and poking their foot." So, just some of those things that are normal kid behaviours. You know, it is like a two-year old coming in and, "Ugh [shrugs her shoulders]. That's normal. He's asserting his independence. That's a normal milestone kind of thing." I think some moms think he is just being a brat, "No, this is normal, it's healthy."

PHNs recalled encounters with mothers who appeared guarded, detached, stoic, sad, or sullen. They remembered feeling perplexed regarding underlying factors. One would expect that interactional behaviours are altered to focus on, address, or accommodate the mother's presenting affect; however, this is not the case. PHNs advised the opposite; that is, not to hesitate, not even for a moment, from entering into Projecting Optimism and beginning to build that relationship, nor get distracted and take a different course from implementation of the interactional strategies Engaging Positively and Offering Verbal Commendations. The intent is not to dismiss or treat lightly the presenting emotions; however, the PHN must not divert attention from the goal of relationship building to focus on these primary emotions (i.e., fear, anger, depression, and satisfaction) that are

typically longstanding (Hewitt, 2000) and constitute the mother's wall or defensive stance (as opposed to the emotions of pride, shame, guilt, love, and gratitude, which are episodic and arise from shared social experiences). The wall does come down eventually, and few mothers remain closed, even if "they are a little cold towards you," Maude, a long-time PHN commented reassuringly. "As the visit goes on, they kind of relax and warm up to you, and know that we are there to help and provide the best resources you know for their family." Mothers demonstrate that the ice has been broken by the way they "become more open, more talkative," and "start smiling a little bit."

Nevertheless, there are contingencies. If the mother is extremely downcast, dejected, or feeling less than for any one of a myriad of reasons, PHNs cautioned that spirited enthusiasm from the outset without concrete verbal commendations could appear superficial or spurious, or be too overwhelming and not have the impact intended. Jasmine, who has claimed to have interacted well with lower income mothers during her short tenure as a PHN, stated that she "holds a personal belief that everybody has strengths in certain areas," and much of her communication is directed towards those strengths and "building on them, whatever any little thing she [the mother] does towards the baby." However she also warned,

> I think that [strengths] has broken a lot of ice for me, not just being upbeat and optimistic, because I don't know if that works for everybody especially for those who aren't feeling too optimistic themselves… that can also be a barrier sometimes or they will shut you off, "Your life is perfect have fun with that."

The PHN, under these circumstances, may have to gauge the overall tone of her nonverbal communication and verbal praise and move more quickly into

succeeding stages, as described below, where focus can be directed exclusively on the child and/or until reaching the stages wherein which there are mechanisms in place for the PHN to make explicit her care and concern for the mother.

Summary

Projecting Optimism is the first stage of establishing therapeutic relationship. The substage interactional strategy Engaging Positively entails PHNs taking advantage of all channels of nonverbal communication to ensure that first impressions project the PHN's genuine delight in visiting with the mother and her child. Mothers begin to relax their stiff postures in response to the PHN's warm, welcoming approach, and then tensions are further reduced by the PHN's language of gifts in the form of praise of the mother's parenting abilities. These verbal gifts of maternal affirmation are the key ingredient of the second substage interactional strategy, Offering Verbal Commendations, which further enhances rapport as mothers react positively to the PHN's efforts to boost maternal self-efficacy. For those mothers whose "walls" continue to remain impermeable, Child as Mediating Presence is a necessary second stage in establishing therapeutic relationship.

Stage 2: Child as Mediating Presence

Following closely or, with some mothers, even concurrently is this second stage, Child as Mediating Presence, during which the PHN's verbal and nonverbal communicative behaviours converge to focus on the child. For mothers with heightened stigma consciousness, shifting focus off them and onto their children mitigates any threat or discomfort and in some cases serves as another vital

icebreaker. There is no stigma attached to mothering a child well; quite the contrary, transition into motherhood and being able to showcase a healthy child can be seen as normative and equalizing. The child then becomes the bridge or mediator between initial moments of the encounter between the PHN and the mother, and the promise of establishing a therapeutic relationship. Child as Focal Point, Evaluating the Practitioner's Approach, and Attributing Advanced Child Sensitivity speak to the mother's presupposed expectations of the interaction with the PHN.

2.1 Child as Focal Point

Acting on the assumption that a mother's love for her baby is "universal," the PHN adoringly attends to the mother's new pride and joy regardless how unfavourable the lower income lone-parent mother's circumstances might appear. Julie (a PHN cited previously) pointed out that all mothers want to do what is best for their baby. Referring to her clients who are former prostitutes, she stated, "You know what, they all care"; despite what Julie described as their "bad" lifestyle choices, "they all still want to be a good mom to that baby like there is still that maternal piece." Jenna, who has been working with lower income families for two decades, reflected on a typical scenario as a PHN:

> Of course in your mind you have all these thoughts, "Oh my God I didn't know people live this way. Where am I going to find a spot on this couch where do I dare sit down?"… Ninety per cent of the time the reason for my home visit is to see a new baby and one thing that is really nice about that, is, it doesn't matter what the background… everybody is in a state of euphoria. It doesn't matter how wealthy you are or how poor you are you love your baby the same. And so you are seeing them probably for the most times in a really good situation. Even if the situation is not a good situation their feelings about their baby are the same.

Especially among the mother participants who had poor role models, whose own mothers were absent, neglectful, and abusive, there were frequent references to their determination to parent differently, to parent better, and to protect their children from similar exposure. Macy, a 34-year-old single mother of three, remembered how her mother was both an abuser and a victim of abuse as an "abused girlfriend" and that her mother would "get beat up" and Macy would "be dragged along." Macy was adamant that her children's lives would be different as depicted in the following:

> There is no way in hell at all that I want my kids to see me sitting there drunk or seeing me get beat up or have to have them run from a house to another house just to make sure they are safe so they can sleep. You know I don't want that. And they never see that anyways… so I know because of the way that I was brought up and it was rough back then. I don't know my mom had different priorities.

So poignant and telling was Macy's remark:

> I make sure I have a good home for them and I make sure they have and they can go out and play on their jungle gym if they want, you know, and they know where their stuffed animals are or their nightie is.

There are other forces, I discovered, beyond the instinctual maternal-infant bond that have caused mothers in this study to make their children so central in their lives. Some mothers stated that prior to having their children, they had no real aim in life and that it was their children who provided a reason for living. Mandy, a 23-year-old single mother of a toddler, spoke about how her life *before* comprised "going from job to job" with "no direction." She lamented, "Like I'm not doing anything, and [it's] useless, going here to there and not really contributing." She described her life *after* quite differently:

> I felt at least after I had him at least I had a purpose and I was doing something. So, I don't know it's kind of just like, "Hey it's time to grow

> up and just get my life together and do something now because I have to care for him." I think it was a good thing.

Esther, a 34-year-old single mother with a history of substance dependency, disclosed that she underwent detoxification after discovering that she was pregnant. Once Iris was born, Esther explained, she no longer needed drugs to fill the void, numb her feelings, and console her pain: "All I have to do is hold Iris and I feel complete."

Echoed several times was the notion of the child as the embodiment of life, of a "fuller life," claimed Theresa enthusiastically. Theresa, a 26-year-old single first-time mother, also has a history of substance dependency but had been extremely despondent about life and ambivalent about proceeding with her pregnancy. It has been Theresa's 1-year-old child who has inspired her fresh new lease on life:

> He's the best thing that ever happened to me. Like my outlook on life, I love life. I don't feel depressed, I feel sad about things but not depressed. I look at him every day, he's the best thing, I love him… hope is looking at him every day. Before, I hated life. I hated everything. I never looked forward to anything… I look at him every day. I love him so much it hurts.

Several mothers had been or were in the midst of custody battles with Alberta Children and Youth Services. Diane is a 27-year-old single mother of four. She made it clear that she believed that her ex-husband had falsely accused her of child abuse. The threat of her children being apprehended was the basis for Diane's contention about a mother's love:

> My kids are my life. My kids are my life. Nothing is better than a mother's love, no one can give a mother's love unless it is the biological or adoptive mother because once you see your child or have your child it is unconditional love for them.

Similarly, Donna, a 33-year-old single mother of five, spoke of her fierce maternal love when she was threatened by Alberta Children and Youth Services because of her ex-husband's improprieties:

> Because I seriously… my family has known all these years that if they took my kids they took the air I breathe… I shouldn't be saying it but I would collapse and I wouldn't wake up. I would not wake up. I wouldn't get up off the floor I wouldn't hurt myself… I'd just. And my aunt and uncle said if that happened, 'we would come there pick you up and take you home', but I wouldn't do anything. She's like… she understands now how much I'd fight for my children; my whole family knows how much I will fight.

Mothers spoke of their determination, motivation, hope, and also strength being rooted in and derived from their children. Cassie, a 27-year-old single mother of three, has overcome substance abuse and her children are no longer in custody but back under her care. She commented, "My strengths are my kids now more so than anything." Similarly, Ramona (already mentioned) stated, "I wanted to keep the family together for Darren. Darren makes me strong and I want to do better." When Betsy (already mentioned) was asked what made her strong, she responded, "My son. I just get lots of strength from him because he is part of my life. I wouldn't have it any other way." Her son was the impetus for Betsy's return to school, and when some of her teachers were not encouraging her to pursue nursing, rather than give up, Betsy thought about Craig:

> See at first I was really mad. You know what I was pretty [explicative] off but then thought about Craig and said, "No, I'm not quitting." So yah, I stayed, like I'll just bring my nursing degree to them and I'll show them when I'm done.

2.2 Evaluating the Practitioner's Approach

With so much focus on her child, it was not surprising, then, to discover that the chances of developing a therapeutic relationship were largely the outcome of the mother's evaluation of the PHN's approach with her child. More often than not, what was deemed a satisfactory visit with the PHN depended on the mother's assessment of the quality of the interaction between the PHN and her child, and how much effort was put forth "getting to know" her child. Benchmarks included the extent to which the PHN "cared" about her child, displayed interest in her child, "played" with her child, made her child "feel comfortable," "talked" to her child, "explained things," and "remembered his name." For example, Ramona (a single mother already mentioned) was pleased with the PHN because

> she was very good with Darren and he really, really enjoyed her company and he'd smile and giggle and then even after his needles that could be a great ordeal for a baby, she would play with him afterwards and he'd be fine and it would be okay perfect.

Betsy (a single mother already mentioned) recommended,

> Smiling's nice, and just you know, telling him, "It will just be really quick; it's fine you will be okay" and kind of explaining what's going on to him. And just make sure you smile and just look at him. Don't just look at your chart, "Okay we are going to do this Craig and then you're out of here." You know what I mean... you have to communicate and smile.

Shelly, a 34-year-old single mother with seven children, was equally vigilant during the home visit in terms of monitoring how the PHN attended to her children:

Interviewer: Is it important how you see the health nurses working with your children? You know what I mean like how they approach your children? [Baby crying and toddler wanting the microphone.].
Shelly: Yah. Barb was really nice with the kids. That is important to me because… [Shelly trying to console the crying baby.]. Barb was really nice with the kids. Like if I got occupied with him [toddler] crying or something, and she [baby] started crying, Barb would pick her [baby] up.
Interviewer: Oh yah. Some moms that I've talked to say it is really important that the kids feel comfortable around the person…
Shelly: Oh they have to, with me it has to be, because if that person is going to be around my house have to be trustworthy with my kids too.
Interviewer: It's almost like the child, if you were to see a new health nurse now for example, and then the health nurse is talking to your child it would be like…
Shelly: I would be standing there on kind of guard because I don't know the person.
Interviewer: And just watching and judging to see if she is trustworthy?
Shelly: Yah.

Rapport is described as connection that feels "pleasant, engaged and smooth" (Goleman, 2006, p. 29). When the PHN behaves in a perfunctory, impersonal manner and ignores the child, she sabotages opportunity for rapport. Linda, a 22-year-old single mother of a toddler, recalled with more than a little acrimony the visit with the PHN at the immunization clinic when her child was 2 months old:

Linda: Each nurse was different like the first one was not the greatest… like she explained it but she didn't come back and check up on him or anything like that. She was just trying to doing her job.
Interviewer: Tell me more about that.
Linda: That one was, she was like, uh, pretty much, she explained it, all about what she was doing, what shots he was getting, what the symptoms were, she went through that and then afterwards when Henry… like she didn't make him smile, or say too much to him. Like I had to fill out a survey about postpartum and uh, pretty much, after when we left she didn't say anything else.
Interviewer: And what did you think about that?
Linda: Ah that experience wasn't the greatest.
Interviewer: How did it make you feel?

Linda: Pretty much like just there trying to do their job and they are waiting for another patient.
Interviewer: So what would you have wanted her to do better?
Linda: Like talk to Henry. I know he was only two months but actually talk to him because he could still hear your voice; he's still a person. And like explain to you more of the procedures and everything like that cuz it's like more… cuz there is more stuff do with their job than just a job because you have to interact with your patients too.
Interviewer: And what do you mean when you say they should interact with their patients?
Linda: What I mean by that is communicate with them, not just, they're just doing it for the money, basically. They should care and go out and actually be helpful to their patients and make sure everything's okay and that they are well taken care of.
Interviewer: So when you say they should care for Henry, can you tell me how they should show caring towards him?
Linda: Like uh, cuz they didn't really communicate with him or say much to him. They just look at him. They're like, "Oh"… they're like they grabbed his arm and said, "We're going to just jab the needle in" and then he started crying they didn't say, "He'll be fine" or talk to him while they were doing… they just basically stuck it in and didn't say anything else.

Verbal communication with her son, Henry, was important to Linda. The PHN may have opened her visit with Linda in a warm, smiling, enthusiastic manner; however, her subsequent approach with Linda's child and initial projections were contradictory, in Linda's mind. Linda's expectations for the interaction were not fulfilled; the PHN should have devoted more of her attention to talking with Henry, and what occurred was a "disruptive event," destroying the likelihood of rapport and severing connection. Subsequently, the interaction came to a "confused and embarrassed halt" (Goffman, 1967/2005, p. 12).

2.3 Attributing Advanced Child Sensitivity

Linda's statement in the above transcript, "I know he [her son, Henry] was only two months but actually talk to him because he could still hear your voice; he's still a person" and comments such as "He's not just a number" were widely

prevalent and suggested that mothers wanted to defend the personhood of their children. Linda, along with other mothers, expected the PHN to engage in full verbal face-to-face interaction with their children regardless of whether the child was 5 years old or still an infant. Additionally, mothers assigned advanced acuity to their children by stating that their children were "smart" and that their children chose which PHN to like or dislike. Belinda (a single mother already mentioned) commented,

> Oh yah she [the PHN] was even commenting when Joey was grinning at her, "Oh he is doing that really early" because he was grinning at her just under two months. Grinning on purpose because that is someone he liked to see. He's a pretty advanced baby because he enjoys seeing Jessie.

Ostensibly, children signalled to their mothers which PHNs were not caring and simply "doing their jobs." "My kid really likes her," claimed Susan, a 23-year-old single mother of a 4-month-old. "He can tell whom I'm comfortable with." Children were attributed advanced sensitivities to discern the uncaring professional and the reactive tensions present in their mothers, as depicted in the following:

> *Interviewer:* It sounds like from talking to moms it's really important how the nurse interacts with the child.
> *Betsy:* It is because if the child… because children, people think that children are just stupid. Not everybody but you know what I mean though? They can tell. They read the body language they can tell you know they're smart. Children are very smart. They read off you. They can feel you if you are all tense they can feel that. If you are upset they can feel that. Craig does all the time if I'm upset, I don't even have to say anything and he can come up to me and he knows that I'm upset.
> *Interviewer:* What does he do?
> *Betsy:* He rubs my back, "Are you going to be okay mommy?" And I don't even say anything he can just tell my facial expressions and my body language. And they, lots of kids, all the kids, they can tell. So if they come in there and they can feel the nurses just oh, "I just want to give this needle to him and get him out of here and I just want to continue with my day"; they can feel that. Just as long you are friendly and you interact with them and you are nice to them makes it a lot easier for them.

Summary

The mothers in this study introject the PHNs' care vicariously through the manner by which PHNs approach their children. Substage components and interactional strategies Child as Focal Point, Evaluating the Practitioner's Approach, and Attributing Advanced Child Sensitivity attest to the fact that the child is central in the mother's life and the etymological roots of the word *mother*, "hysterical passion" (Skeat, 1963), might very well ring true as the descriptor of the mother's love and affection for her child. Moreover as *mother* in Latin is translated "materies" or "trunk" (Bergum, 1997), with the analogy being that a mother is a source of life, in the context of this study the child, paradoxically, is a source of renewed life for the mother.

Stage 3: Ascertaining Motives

If the mother has been rewarded for her mothering capabilities and her child has been the centre of attention, then relationship building is propelled forward to this third stage, Ascertaining Motives. However despite the PHN's perceptions that she has successfully upheld the identity of mother for her client and believes that she has raised maternal self-efficacy appraisals, the PHN cannot rest on her laurels, not yet. Among mother participants was a predominant propensity for mistrust, and thus it takes more than smiles and verbal praise to assuage the mother's fears and to convince her that the PHN can be trusted. Mothers during this stage are afforded an opportunity to impute the PHN's "real" intent. Ascertaining Motives allows mothers to sort out their interpretations (i.e., distilling the real from the imagined) and to get past those perceptions and

attitudes that stifle relationship building. The mother decides her next act (i.e., to communicate or to not communicate meaningful information) once she is satisfied that the PHN's intentions are "pure," and the mother gains this knowledge by conducting her own motivational assessment of the PHN's actions. Ascertaining Motives is a critical juncture in the overall process of establishing therapeutic relationship, and mothers are again the audience and judge of the PHN's actions, as discussed next under the component, To Trust or Mistrust, and as made evident during the substage interactional strategy The Litmus Test.

3.1 To Trust or Mistrust

Most of the mother participants learned to mistrust human service workers, agency personnel, and police officers when they were very young. Diane (a single mother already mentioned) remembered her siblings and her being told as children to "be scared of social workers or cops and stuff like that." When the PHN showed up at her door on a routine postpartum, visit Diane was fearful: "I was really, really nervous I thought she was there to try and take my baby or see if I was a bad mom." Mothers like Diane, who as children were taken out of their family homes and placed in care learned that the world was not a safe place, and if people in their nuclear families and in systems of authority were unpredictable and undependable, who could be trusted? Shelly (a single mother already mentioned) explained that she also "was nervous" when the PHN came to her door because she "didn't know what to expect. Just the way I grew up. I just don't trust people." Shelly told me that she "blames the system" for "letting her down." Her childhood history included living in the system's social network of group

homes and foster homes, being adopted more than once, and being repeatedly rejected and abandoned. Unfortunately, mothers perceive the PHN or any professional stranger as perhaps representative of or responsible, too, for all of the injustices inflicted on them by the "system" or by their family members. Macy (a single mother already mentioned) is one of the mothers who spoke about this fear being so deeply ingrained that it had become instinctive:

> *Interviewer:* So if I said this to you tell me if this makes sense to you and this is about how you think it happens between you and a health nurse. So if a nurse comes into your house or you are at the clinic you would be trying to check out the nurse who is a stranger…
> *Macy:* Yup right away.
> *Interviewer:* … and see what she's like?
> *Macy:* Yup… right away.
> *Interviewer:* You're judging her to see…
> *Macy:* Because it is my first instinct…
> *Interviewer:* First instinct is to judge and see okay can I be safe with her?
> *Macy:* Yah exactly that's me because of the way I was brought up right…
> *Interviewer:* You were brought up… you are just not quite sure…
> *Macy:* I'm just yah… to have somebody come close to my kids I don't want them sitting there screaming at my kids for some reason or you know…
> *Interviewer:* On guard?
> *Macy:* Yah of course because that's the way I was…
> *Interviewer:* So when the nurse is pleasant and friendly to you and warm you kind of can calm down?
> *Macy:* Yup it kind of makes me at ease a little bit but I am still on guard right until I know and then when I know and then she kind of reassures me just by the way she acts. Like you know if you build a rapport with the same one then that's… that's why I like to have the same nurse if I could but I can't by chance. If I phone and I ask, "Okay, well is she available" and she's not, "She's not at this location" because they jump from different ones so.

In response, mothers "watch"; they "watch what they do and how they talk," informed Lillian, a 23-year-old single mother of an 8-month-old. Martha, an outreach worker and formerly a lone-parent mother who had lived on public assistance, concurred:

> I'm saying be open-minded and nonjudgmental but these ladies are judging too, right? They are very judgmental and so they will read you as soon as you walk in the door. You know… where you are, where you have come from, what you do… whatever.

Diane (a single mother mentioned above) avowed, "I'm going to look at your body language right away and I'm going to look at you and get your personality and see what kind of person you really are." Lillian, Martha, and Diane referred to the reading, watching, and judging of information about the PHN from which to draw inferences about her attitudes, attributes, and mood for the purposes of deciphering, Can I trust this PHN? More precisely, mother participants wanted to ensure that the PHN could be trusted not to render judgment. When asked how she could tell when someone is trustworthy, Shelly replied, "For me it usually it takes a while… uh, if they can help me out and not judge me for being low-income and stuff." Kelly (the single Aboriginal mother discussed under the section heading The Therapeutic Relationship in Context), when asked how she was made to feel at the community health centre, said that PHNs made her "feel comfortable" by treating her "like everybody else."

Among the mother participants was this compulsion to assess and verify that the "strange" PHN at their door or the new PHN greeting them at the community health centre was not about to render judgment. To Trust or Mistrust revolved around this salient dimension because judgment by strangers in society was not uncommon; in fact, it was a regular occurrence. Theresa a single older mother already mentioned) told me that she wears a ring when she is out in public because she knows from experience that one's *married* status meets societal norms and approval. Without the ring, Terri stated, people are looking at her with

her son and looking at her "bare finger" and "judging me because I got pregnant out of wedlock" and inquiring about the father.

Perception of judgment is particularly pronounced among the younger mothers. Lillian has been mistaken as a teen mother because of her youthful appearance, and she, like other young mother participants, has experienced the "weird," "disapproving" looks of strangers like mirrors of judgment. Under those circumstances Lillian reacts and thinks, "I am too young, that individual really doesn't think much of me or respect me as a competent mother" because, as she explained, "It's just a lot people define young mothers [as they] don't know what they're doing." Lillian and other young mothers described the images reflected in the mirrors of judgment as "rude," "snotty," "snobby," and "ignorant" and made by individuals who, Lillian claimed, "thought they were better than me."

The PHN's caring approach had much to do with assuaging the mistrust. The mother's personal conviction that the PHN "cared about her" consolidated the PHN's trustworthiness and dissipated fears of foreboding judgment. Shelly stated that she trusted her PHN because "she wants to help me. She's caring. Barb's a really caring person, to me anyways." Watching for nonverbal behaviours that depicted caring attitudes was reiterated by Cynthia, a social worker, who, from her experience working with lower income lone-parent mothers for more than two decades, surmised that mothers are watching for "people who really do care." Macy's remaining comments from the excerpt above exemplify this point. She said she would feel comfortable enough to "open up" with the PHN if "she is there to help me and my kids." Shelly also felt her PHN

was emulating true virtuous caring by providing immediate tangible assistance (e.g., transportation, housing, and legal services). Evelyn, a 35-year-old single mother with a toddler, spoke of the PHN's "genuine care" when she mobilized various agencies to provide Evelyn with diapers and a washing machine. Evelyn concluded that the PHN "really liked her job" and was "caring" and "nonjudgmental," and "just wanted to help."

3.2 The Litmus Test

If the meaning of the PHN's acts are still uncertain or for some reason obscure in the mother's mind, she will continue to ponder: What are the PHN's unspoken words telling me? What are her innermost feelings concerning me? Do I really want to talk to her? Do I want to share anything with her, or do I just want to tell her what I think she is looking for and then leave? Lacking sufficient information, the mother relies on cues, hints, and expressive gestures as substitutes for factual knowledge about the PHN's thoughts and feelings. However, the cues are inadequate as predictive devices, necessitating that mothers implement the Litmus Test to judge the PHN's motives accurately. The Litmus Test entails the mother's posing certain benign questions to the PHN and then evaluating the PHN's returning verbal and nonverbal communication. If the PHN met the mother's expectations, then the mother was more apt to delve into topics of a personal nature and engagement would proceed with far more real disclosures on the part of the mother than polite, conventional discourse because she could trust that the PHN would not judge, reject, or dismiss her. For example, when Belinda (a single mother already mentioned) was asked to reflect on her sense of

pejorative attitudes when visiting with the PHN ,she responded, "With Jessie I really don't get that feeling, like when I told her I was postponing vaccination, she just gave me information on that and didn't push too hard." She added, "It makes it so I can go back to her when I have other concerns." Betty (a PHN already mentioned) recounted an incident in which she was "tested" during a telephone conversation:

> The moms that are phoning asking you something but you know that's not what they want to ask you. But they are asking you something. "Okay we will talk about the belly button today… You are going to call me back and then you are going to tell me what's really"… and then they do, "I'm not sleeping that well. Oh tell me about this… how long has"… it never fails it's like a gut feeling you know what I get, the feeling you are not calling me for that.

Betty shared another anecdote about a mother who "admitted" that she had started her child on solid foods pretty early, and then the mother stopped abruptly and told Betty, "Oh I wasn't going to tell you that." Betty then told the mother, "You've got the information and you have made a decision… and that's okay." Later the mother sought Betty out again because, according to Betty, she was thinking, "You know what you listen, you hear. I have the information. I may choose to follow that, I may not, but you are supporting me either way." The mother was convinced that Betty was not going to condemn and judge her; that is, Betty had scored high marks during the Litmus Test.

Sometimes it takes perseverance on the part of the PHN to endure the Litmus Test, as Alana, an experienced PHN who has worked with lower income lone-parent mothers both here and abroad, enlightened:

> It is layering things time after time you know that you see someone, basically recognizing even if you see someone on a weekly basis for an hour that's only an hour out of their lives each week and they are only going to give you the information they want to give you and that's fair enough… I can be caught out a little bit [laughing]. Somebody will tell me something one week and then the next week they will tell me something that is contradicted something. And you know I'm thinking, "It doesn't matter I'm still going to come and see you and still help you out whatever." And I think if they see that over time then you will build up that relationship with them that you are just there to try and help them out [laughing] in any way, in any way that you can and you are not trying to trip them up or judge them. You're just trying to work out what is going on.

When the PHN "failed" the Litmus Test, mothers were less talkative, and the relational walls and barriers were erected or remained up and/or the window of opportunity was closed permanently. Julie (a PHN already mentioned) warned that the PHN might have access to only a few windows and that there are no second chances when working with mothers "on the streets":

> The other thing that I find is so important… to keep flexible: "Are you going to hang for another hour can I come?" If I don't come I don't connect because I'll make a plan to meet them and they're not there. They don't show. Their lives are really chaotic. You've lost your window of opportunity. Um… if I can drop what I'm doing and go and even if it's like ten minutes, they've got a face-to-face and I hopefully haven't threatened or made them feel guilty about some of the things they are doing… Sometimes it's to ask you for something really concrete, "Oh you know what, you're applying for… I'll get you a letter." And get the letter don't ever not do what you say you are going to do because um, as soon as you don't do what you say you're going to do, you've lost them.

Summary

The PHN's optimism in the first stage, Projecting Optimism, and her undivided attention towards the mother's child in the second stage, Child as Mediating Presence, are claims of the PHN's sincere interest, and it is during this third stage, Ascertaining Motives, that the mother has been allotted an opportunity

to ensure that the PHN has not been "leading her astray." Hopefully, the mother is more certain now that she can find a safe haven in the presence of the PHN. If this is the case, their encounter is ready to evolve from a superficial impersonal exchange of ritual behaviours between strangers to interpersonal connection. The mother permits herself to be open and receptive to the PHN's invitation to share, question, and disclose private matters. How does the PHN engender and retain the mother's positive feelings to establish rapport? The next stage, Exercising Social Facility, unveils the social intelligence capacities of the PHN.

Stage 4: Exercising Social Facility

The PHNs who could relate effectively with lower income lone-parent mothers knew what to say, how to say it, and when to say it. Although participants could not articulate how they knew what to say, and some alluded to a "kind of sixth sense," their communicative behaviours were conscious and deliberate and not purely instinctual, routinized, or incidental. It became apparent that the PHNs had acquired an advanced skill set that I believe parallels social intelligence competencies. This fourth stage, Exercising Social Facility, accounts for the PHN's astute detective work; that is, she is able to read the nonverbal signals of mothers and then use this information to determine when and how she will state her next comment, pose a question, or decide whether it is necessary to provide further reassurance. Exercising Social Facility comprises the substage interactional tactics of Empathic Accuracy and Responding Strategically, which enable the PHN to manoeuvre her way through the interaction in such a way that

she can proceed to probe more deeply and, simultaneously, not threaten but protect the mother's sense of self.

4.1 Empathic Accuracy

Empathic Accuracy is a combination of the PHN's spontaneous or intuitive ability to detect the mother's fleeting expressions, to sense her emotions, and to be cognitively aware of what the mother is thinking and feeling. Esther (a single mother already mentioned) believed that the PHNs who have contributed to her mental well-being were those who could "actually read people if the person is not looking themselves." She explained, "If their facial expression looks different then they [PHNs] will ask them what's wrong, if they want to talk about it they are there to listen." For this reason, Esther added, "they are very helpful people." Julie (a PHN already mentioned) alluded to her reliance on nonverbal cues when deciding how to pursue connection with the transient mother:

> *Interviewer:* What works for you in terms of establishing rapport?
> *Julie:* Listening and watching body language. You find that um… it's hard to know how you do it because you just do it right? But you kind of have to sit back and… I can tell when I'm getting… I've asked too many questions and I just say, "Have you had enough? Do you want to go on or do you want to do this"… "Oh no I got to get going. I got to get going."
> *Interviewer:* So they get restless?
> *Julie:* They get restless, or they get antsy or you can tell that they're… not really wanting to answer the question or you are sensing that it's not a true answer. So I just say, "You got some chits, you got your milk, so do you want to meet up again?"

Julie is also proficient distinguishing facial communicative displays of fear or apprehension, which enabled her to decide whether to proceed with a line of questioning that might prove threatening:

> I know when I've asked enough questions like I just sense that they don't want to answer anything anymore. And I can also tell whether I can go forward and ask questions like about drug use or like I probably won't do that on first contact.

In so doing, Julie is also demonstrating another important interpersonal competency and consequence of Empathic Accuracy: what social psychologists refer to as saving face. The "face" is the person the mother wants represented publicly. Posing questions about the mother's former life of prostitution or substance abuse might threaten exposure of her inner self, which she may want to be kept private and separate from her public identity. She may be the mother whose new identity as competent mother has been afforded positive social value by society, and thus it is this public identity that she wants to maintain as it is self-enhancing. Responses to those questions, exposing her identity as former substance abuser, on the other hand, are a threat to face and a threat to self.

Sheila (a PHN already mentioned) detected the "thinking" inherent in a teen mother's spoken word revolving around the teen's hesitation to join a mothers' parenting group. The teen mother, Sheila recounted, posed the following questions: "Is it going to matter that I'm single?" and "Is it going to matter if I don't make very much money?" Sheila relayed what she sensed were the teen mother's thoughts and feelings:

> I think that sometimes within themselves they kind of set up those barriers, "Oh I shouldn't go there because they will look at me differently." So I don't necessarily always say that to moms, "You know what just because you are young or single that I look at you any different" but I think it is how you portray it and how you ask the question.

Jasmine (a PHN already mentioned) identified what she believed was a mother's state of exhaustion when Jasmine was visiting a new mother who was

raising a newborn in social isolation, with no one to relieve her so that she could get some much-needed reprieve.

> She seemed tired and exhausted and almost shut off from the safety messages that you give and the health assessments that you give and you know, discussing that sort of thing. Almost shut off because she has probably heard a lot of that before. I think overall just seemed very tired and closed to those things until we build a bit of a rapport and it was a bit of a wall to get through for a while.

Ostensibly the mother was manifesting physical exhaustion, or perhaps it was depression or some other motivational state. Jasmine had been able, possibly, to discern something more than tiredness, rather something akin, perhaps, to low motivation or despondency, which is significant, because either emotional state could be tied to the mother's conceptions of self, which "shape the person's disposition, level of anxiety, moods of depression or elation, feelings of joy or sadness, and sense of competence or incompetence" (Hewitt, 2003, p. 120). When I asked Jasmine to describe the "wall," she was able to identify verbal, nonverbal, and attitudinal attributes:

> Kind of averting your gaze, very short answers, just short and brief, can't think of the word to describe it, just a very flat affect. And not even seeming to care, not seeming distracted about the things we would normally be distracted about. You know TV on, kids running around everywhere, dog barking that sort of thing, just kind of going over her head as well.

If the PHN cannot discern initially, then she is left with a bit of a conundrum. Does she acknowledge the mother's alleged tiredness by carrying out her nursing agenda quickly and then leaving so that the mother can rest, or does she focus special attention on boosting conceptions of self by offering maternal affirmation? Jasmine demonstrated both her capacity to recognize the mother's exhaustion and, more important, I contend, her sensitivity to the mother's

despondency by taking time to step back and interpret the mother's nonverbal emotional signs. Jasmine did not leave but remained with the mother and was able to break through the mother's wall. As she described and, I surmise, with Empathic Accuracy, Jasmine ultimately moved possibilities for future engagement onto fertile ground.

The conundrum mentioned above points to the fact that although intuitive, the ability to discriminate among several possibilities what a mother might be experiencing on an emotive level requires concentration or attunement, which is the PHN's communication skill of attending or visibly tuning in. The PHN must be consciously *attuned to* the mother, which is more than *thinking about* the mother, to decode nonverbal signals and capture emotions. Jasmine (the PHN mentioned above) offered reflections about her relational strategies, illustrating her attunement:

> I don't know if I use a particular model… I can't describe it any more than taking a step back and observing and not being so prescriptive and having my own agenda but taking a step back allowing moms to be distant for awhile, allowing her the space to get comfortable with you. You can't force people to warm up to you.

Empathic Accuracy entails capacity to identify emotions and become aware of underlying thoughts and feelings. It requires that the PHN attunes to the mother with her eyes and her ears. Allowing mothers their "space," as Jasmine remarked above, is an opportunity for PHNs to visibly tune in and to also *mentally* tune in, to listen to what mothers have to say. Jasmine may have detected the emotional state and, moreover, been able to understand what the mother was saying both directly and indirectly by listening deeply to her story. Listening goes hand in hand with attunement as an important communication skill that enhances

social cognition of what mothers are thinking and feeling. Listening takes on the dimension of entering the mother's private perceptual world with sensitivity to her changing felt meanings. Such listening attracts mothers and is instrumental to the relational development process. I noted during direct observation of PHN-mother dyads that PHNs were very adept at "stepping back" and consciously exerting the mental effort required to listen *with* mothers. I also recorded that kinesic behaviours or body language, such as an open posture by facing the mother squarely, avoiding crossed arms and legs, and leaning forward slightly, strongly intimated the PHN's involvement. Maintaining eye contact was another well-known kinesic emblem that signalled the PHN's attentive presence and interest and invited mothers to speak.

Jessie (a PHN already mentioned) indicated that she reflects-in-practice by asking herself during interaction with the lower income mother, "What is she really saying, and what do I need to draw out of this?" Jessie shared that the PHN "just needs to listen" and to listen closely "with her ears and her eyes." For example, she stated that she would ask mothers, "How are you doing today?" Mothers sometimes concealed true emotions by responding with the socially acceptable, "Oh fine." Jessie informed that the PHN "has a choice to choose to accept the fine or pick up on the tone of voice that's not so fine and ask the mother, 'Something else going on?' " Jessie employs active listening to clarify not so much what the mother is saying verbatim but what Jessie is deciphering from the mother's facial display. Again, as another example, Jessie would proceed by clarifying: "[You] sound a little unsure about that today. What's happening in

your house today?" Jessie has "heard" the mother's emotions with her eyes and now uses clarification as an active listening technique to gain a sense of what the mother is feeling and thinking behind both the mother's facial and verbal expressions.

There are important antecedents to Empathic Accuracy in terms of what equips Jessie and other PHNs with the powerful capacity for intuitive recognition and visual and mindful attunement. Sensitizing and supporting their abilities are multiple layers of learning that, I infer from my data, have much to do with the PHNs' exposure to the day-to-day lived experiences of lower income lone-parent mothers. Having gleaned insights into the range of possible challenges, PHNs have learned firsthand what mothers might manifest emotionally and what might be the continuum of their thoughts and feelings.

Through the mothers' stories, PHNs, first, recognize that mothers come with a complex history and, second, appreciate that the mothers' background, coupled with their current situation of poverty, shape the way they think, act, and feel. Mothers' stories tell PHNs not only what they experience but what they think about those experiences, how they manage, and how they are impacted in terms of their feelings, emotions, and moods. As Cynthia (the social worker already mentioned) aptly stated regarding her relational competencies, "I am able to read what I know and understand"; the PHN, too, can decipher messages transmitted by the mother's analogic communication, and the PHN's empathic accuracy is honed by each new story. PHNs are grasping what they are seeing and, in addition, *why* they are seeing it; that is, they can impute underlying motives for

presenting emotions because they have stepped outside their subjective worlds into the subjective worlds of lower income lone-parent mothers.

Sheila (a PHN already mentioned) had learned over the years that the mothers' daily strife fuelled their guarded or angry defensiveness:

> I find they set up their own barriers because they've been treated poorly before, always had to fight with the foodbank, maybe having to fight with the landlord, so then it's like, "What do you think you are going to offer me?" So I think it's very much an open approach. I know I've had some moms say, "Well I'm not giving up the baby so don't try and talk me into that" and there has been nothing alluded to that, so whatever history happened before me, who knows.

Equally empathic was Jasmine (a PHN already mentioned), who knew the mothers' plight in terms of the bombardment of agency personnel "knocking on the door and wearing that professional badge," pronouncing claims about the mothers' parenting, and thrusting anxious mothers into despair. Donna (a single mother already mentioned) felt like she was suffocating under the burden inflicted by agency personnel:

> *Interviewer:* So I guess it is fair to say that when you are feeling all these layers that you were feeling pretty… what, how would you say you were feeling about yourself as a mom?
> *Donna:* Well when Children's Services was involved I felt like I was failing as a mom and I was trying so hard to get through that barrier that held me down. Every time I would feel more confident the support worker I had, made me feel like I should be put back on the shelf and I would keep trying to squeeze out of there. I felt like I couldn't breathe because there was so much being attacked on me.

Such unannounced intrusions evoke mistrust, fear, and suspicion and precipitate much of the mother's defensiveness, as depicted in Jasmine's further comments: "Social services is there for a reason. They take kids away for a reason but when parents get exposed to that sort of thing they get more defensive." The unannounced visit is not uncommon according to the mother participants. Diane's

account of the social worker's visit to her home illustrates the pervasive force that Alberta Children and Youth Services personnel can have in the lives of lower income lone-parent mothers:

> You don't come across as if you are there to do them wrong. They are already in a bad situation. They already feel bad about the situation or whatever the situation may be. And you are coming in there to help them feel bad about themselves. You are not supposed to do that if somebody's kids are taken away or if they've placed their kids with their father, they don't have their kids. Their heart isn't with them. How do you come and tramp on somebody like that how do you do that? You can't.

Patty (a PHN already mentioned) could understand the salience of an unforgiving world of judgment and rebuke in terms of its psychological effects on the teen mother and subsequently she did not misinterpret, as do some professionals, the teen's flat affect as careless apathy:

> Everybody wants you to do well with this baby. Everybody does, really. And I don't think that they really believe that. You know they think, "Okay I've got Child Welfare breathing down my neck you know. My parents think I can't handle this you know. I'm young and everybody on the bus is looking at me like what are you doing?" And I think they get a little bit of a crust: "How am I going to manage?"

4.2 Responding Strategically

Confident that she has accurately perceived the mother's emotions, thoughts, and feelings, the PHN must now decide how she will respond which is the core objective of Responding Strategically. Responding Strategically involves fine-tuning nonverbal behaviours to ensure that they are appropriate and effective. For example, consider the PHN's strategic response to a mother's angry outbursts. What transpires, Nancy, a PHN who has been working with lower income families for more than a decade, informed, is the PHN's immune, nondefensive response because the PHN has not personalized the mother's anger and does not

seek to avenge hurtful feelings. On the contrary, she appeases and addresses the mother's anxiety and distress behind the anger and agitation, first by responding with a calm demeanour and listening, and then by gently expressing care and concern for the mother's welfare by simply stating, "We're here to help you. What do you want? How can I help you?" Nancy cited an incident with a mother during which she was able to exercise Responding Strategically and assuage the mother's anger:

> She was very defensive, agitated, a lot of tears… um… but then she was just more relaxed even her crying was different, crying and screaming part just relaxed through time, was trusting of the information, not here to judge her but to help her.

Empathic Accuracy had primed Nancy to be mindful of the mother's emotions, thoughts, and feelings. By building on what she had learned through Empathic Accuracy, Nancy reflects-in-relationship as she sees herself through the eyes of the mother and responds to accommodate the mother's apparent and potential sensitivities. As mentioned, the antecedents to Empathic Accuracy include the PHN's comprehension of the mother's multifaceted lifeworld, taking into account her contextuality and appreciating her challenges as she interacts within her social environment. The antecedent or prerequisite to Responding Strategically is respect. However, I am referring to a broader conception of respect than what convention dictates or what is designated by the ethical codes of professional conduct. I have unveiled that *earned* respect inspires and motivates PHNs to serve the best interest of lower income mothers. Participants seemingly possess a personal and professional responsibility beyond codifiable rules and obligations to emulate respect by directing their full attention to the unique needs

of lower income lone-parent mothers. The task is not a difficult one, for these PHNs are decidedly respectful because they know of the hardship and stressors that mothers must overcome to do better and to be better for their children. The mother's endurance, perseverance, and resilience earn the PHNs' respect, as revealed in Jessie's (a PHN already mentioned) anecdote of awe and amazement:

> Well you know I think often people think if they would just get a job… if they would just work harder. … Now I realize how complex it is, it's not a single issue thing… You look at families and there might be mental health issues going on there. They might have grown up in a family that never knew any different than this. How do you get beyond and how do you get a job when your housing you know… You're here telling me you don't have food today… You have to go to the food bank and that will take all day. You have to organize housing… and then you've got little children, whose going to take care of them?... I didn't realize how many layers were beneath the poverty.

The mothers manage, Jessie believed, with "resourcefulness," "resilience," and "strength."

> You know, they will tell me all this stuff that is going on, "Wow, you are amazing look at this baby he's delightful." I have a great deal of respect. And how do they get up every morning and do it again?

Patty (a PHN already mentioned) had deliberated over the years about the mother's facility to manage finances:

> Well respectful of where they've come from and how difficult it was or still might be… how they've survived… I mean some of these moms that live on a low low income are economic majors. They juggle the bills; they know exactly where the pennies are going and how they are going to manage. And to me they are geniuses some of them… that's not easy. It's easy to pay the bills when you've got a steady income not so easy when you don't. Figuring out, "Where am I going to move to? How am I going to pay a damage deposit when I can't? How am I going to get by? Where am I going to get food?"

Cynthia (the social worker already mentioned) conceived of respect as something that practitioners offer to mothers, much like the language of gifts of

commendations identified previously in the first stage, Projecting Optimism. She considered the gift of respect, along with understanding and compassion, a key ingredient for developing relationship with lower income mothers, in particular Aboriginal mothers.

> You know if… like there's people who will say, "Oh I know how they are," or want to lump them in one sum and "That's how they all are." I mean, like everybody is different right and even though we are different from everybody else we are still the same. But I think it is that understanding, and knowing, and really the respect that you can give them that they are going to appreciate that more.

Without a doubt, what is of great consequence for relationship building for all the mother participants that I have uncovered is the practitioner's/PHN's suspension of judgment that is embedded in the gift of respect.

Suspending judgment is very much a part of the PHN's respectful approach. The PHN's desire and affinity for refraining from judgment in the presence of lower income mothers is carried out with ease. Earned respect gained through knowing and understanding their vulnerable and potentially stigmatized clients provides PHNs with a vantage point. Chiefly, earned respect keeps PHNs from becoming "jaded," as Sheila (a PHN already mentioned) enlightened:

> I've kind of learned that there is the one side that you can jump on, that you can be like, "Well, if she tried she could get off social assistance and maybe the addictions" and that kind of thing. And that's the kind of jaded side and on the other side there is well: "You know what, maybe no one has given her information, and maybe she has tried addictions seven times and it hasn't worked."

Perhaps PHNs who embrace earned respect do not readily heed and adopt society's stereotypical views and labels concerning lower income lone-parent mothers or are not as willing to "lump them in one sum," in accordance with what Cynthia alluded to above. Stereotypes are preconceived notions that enable us to

make sense of what seems unfamiliar and uncertain; however, they are dangerous when applied as sweeping generalizations. Stereotypes can very quickly shift to prejudice, which are negative social attitudes if members of the "in-group," for example PHNs, have never attempted to validate prejudices held against members of the "out-group," such as lower income mothers (Trenholm, 2008). Effectual PHNs in this study are possibly not ready to jump to conclusions; rather, they are more open minded by considering possibilities other than what appears on the surface through direct contact with members of the out-group. Very simply, perhaps there is less need to suppress distorted information, pejorative thoughts, or discriminatory tendencies through coming to a greater realization and conviction that these mothers are to be respected. Thus, the PHN, Sheila confirmed, possesses the ability to interact "without preconceived ideas," and when she "goes out to the house," she "goes nonjudgmental."

Sheila's reference to going "nonjudgmental," or suspending judgment, falls within the realm of the PHNs social capacity for self-presentation and what symbolic interactionists would describe as possessing consciousness of the self. Presenting one's self effectively is a major facet of Responding Strategically. PHNs have mastered control over emotions that begin preconsciously as impulses. For example, when the PHN "goes out to the house," she is able to govern those impulses and conceal if needed, any facial displays of shock, dismay, or disdain regardless of what she sees and hears. PHNs have learned to hold up a "poker face," a particular contrived persona, to avoid exposing impulsive expression or unintentional emotions in response to what they see, be it

"cockroaches" or the "mess" on the floor in "untidy," unkempt homes. Cognizant that mothers are "reading them," PHNs put on the poker face to project an attitude of indifference: "All people live like this." Shelly's (a single mother already mentioned) PHN had perfected self-presentation, as depicted in Shelly's statement: "Yup, she never minded my house being dirty and messy, that's not that easy to keep clean with that many kids, so she wasn't judgmental at all and that's what I liked." In the same way, PHNs shared that they exert deliberate control over their emotions to appear "neutral" when told about histories of drug abuse, prostitution, crime and violence, or current atypical problems as nothing could "shock" them.

The desire and capacity of the PHN to view herself from the perspective of the mother and to alter her own forthcoming act perpetuates positive interaction and conversation, including those conversations when the PHN must pose seemingly invasive questions. PHNs must elicit sufficient information about the mother's needs for efficacious referral and intervention. Betty admitted that broaching certain topics was awkward for her at first:

> [The Community Health Centre] was very valuable I learned that if there was a history of alcohol or drug abuse, I could ask it. I was never offending them. I was always worried before about offending. It never offended if anything it opened a door and then they were free to say what they wanted to.

Such subject matter could be potentially threatening or embarrassing, but the PHN is able to monitor the mother's reactions and respond in a manner that safeguards the mother's overall conception of self. Patty (a PHN already mentioned) informed that her role is to ensure that mothers have the means to meet their tangible needs, even needs at the most basic subsistence level. She was adamant

that the PHN cannot "skirt around" certain matters: "You need to know, 'Can you afford to buy the formula? Can you afford to eat so you can make milk… Can you afford your rent or where are you going next?' " Patty's social competence ensured that mothers did not "feel like I'm just picking." She advised, "Sometimes too many questions and the manner that you do it can be almost like… they put up a wall for that, for their own reason, like, 'The nurse doesn't think I know what I'm doing.' " Julie (a PHN already mentioned) concurred; the PHN has to be strategic about how she puts topics "on the table." She stated,

> I might ask them, "What do you need right now? Do you got a place to live? Are you safe? What's happening?" I might give them the opportunity you know, I probably would, I'll give them milk if they've got a place to keep it or I'll give them options how they can keep their milk.

Summary

To sum up this fourth stage, emotional states expressed by mothers instigate responses in the PHN, which enables the PHN to accurately decipher nonverbal communication, in particular facial expressions such as anger, sadness, anxiety, and embarrassment. Exercising Social Facility encompasses the reliable social radar referred to as Empathic Accuracy. Although Empathic Accuracy is primarily intuitive, PHNs attain capacity to perceive emotions, thoughts, and feelings incrementally as they become well versed in the daily hardships of lower income lone-parent mothers and are able to listen intently and to understand with both their ears and their eyes. Responding Strategically, the other substage interactional tactic of Exercising Social Facility, builds on Empathic Accuracy and entails PHNs suspending judgment attitudinally, affectively, and

behaviourally. Consequently, the PHN mitigates threat and is able to pose personal questions and not sabotage chances for rapport.

Exercising Social Facility is the fourth relational building block but is clearly instrumental to the PHN's communication competence and her ability to achieve relational goals. Situating Exercising Social Facility as stage 4 in Targeting Essence: Pragmatic Variation of the Therapeutic Relationship might lead one to believe that the stages, as alluded to earlier under Preamble, follow a serial pattern when in fact, depending on the PHN-mother dyad, the interpersonal competencies depicted in this fourth stage are likely apparent and interwoven iteratively throughout the process. However, I argue, based on my analysis, that even the less socially astute practitioner could progress through the first two stages (i.e., Projecting Optimism and Child as Mediating Presence) successfully and invite engagement with mothers, and even possibly the third stage (i.e., Ascertaining Motives), although advanced social skills might be the leverage needed to pass through the Litmus Test. Notwithstanding, I reason that high social intelligence is the platform necessary from which to transition into and to sustain meaningful connection, which call for stages 5 and 6 (i.e., Concerted Intentionality and Redrawing Professional Boundaries), so I have deliberately positioned Exercising Social Facility as the fourth stage in the overall relationship-building process.

Stage 5: Concerted Intentionality

As the PHN has broken the ice during the first stage, Projecting Optimism; attended to the child as is expected throughout the second stage, Child as

Mediating Presence; fulfilled the mother's criterion of trustworthiness in the third stage, Ascertaining Motives; and anticipated and reacted with wisdom to emotions, thoughts, and feelings for the duration of the fourth stage, Exercising Social Facility, her relationship with the lower income lone-parent mother, progresses to this fifth stage, Concerted Intentionality. Concerted Intentionality is the "meat and potatoes" of Targeting Essence: Pragmatic Variation of the Therapeutic Relationship.

By this point in the overall process, relations between dyad members have changed and the transaction is undoubtedly more than the sum of their actions. The seemingly intense work of interaction has meant sufficient interrelationship and has facilitated "genuine evolvement or development" of the relationship (Strauss, 1959, p. 62). This realignment of the relationship permits the PHN to concentrate less on her self-presentation or the indexical information put forward (i.e., attributes, attitude, and mood) and to focus more on the cognitive or factual information exchanged. Much is realized through the interactional strategies, Painting a New Canvas, Eliciting the Client's Agenda, and Building Capacity, in terms of finding out *who* this mother is and what she needs and wants to fulfill her mothering responsibilities.

5.1 Painting a New Canvas

The PHN moves now from universal understanding of a mother in poverty to this *particular* mother and person before her "like starting with a new slate." The PHN directs her attention to this particular mother in her particular situation and distinguishes her from all the other mothers. She may see this mother

extraspectively, meaning that she possibly sees her as anyone else would, as a member of a group in society with a certain social identity, but this is not the introspective view. The social identity (i.e., lower income lone-parent mother) might be only one aspect of the mother's introspective view. To explain, the mother's introspective view (Jenkins, 2007) gets at *her* construal of self in the world. What is the mother's *personal* identity? The personal identity is created by the mother and is separate from what is assigned to her as a member of a specific homogenous group in society. She is at liberty to modify what she has created as she wants. Mothers talked about PHNs, for example, who sought to know them as persons behind, above, and beyond the demographical and diagnostic profiles contained in their medical charts. Mothers appreciated being recognized and known by their real or new identities.

As a case in point, PHNs ensured that Esther (a single mother already mentioned) was no longer affiliated with her assigned identity of substance abuser by professionals and agency personnel but known as devoted parent, the personal identity Esther had created. Esther exclaimed,

> They don't see me as an addict. They see me as a person who is really trying. They see me as a mother who is trying. They gave me as much information as I need with parenting and that. They point me in the right direction. They don't see me like I said before as an addict… As to where [names site] knew I had an addictions problem and it seemed like they see me as a total different person. Like they see me as that addict, as to where [names site] they just see me as a normal person.

Similarly, when Cassie (a single mother already mentioned) was asked how she wanted health professionals to see her now, she replied, "As a person. I don't know, like… I come a long ways, so." She recommended that PHNs pose questions "like how am I doing today," implying that the PHN should concentrate

on the Cassie of today rather than "judge" Cassie for "stuff" she has "done in the past." Cassie reflected on her labour and delivery experience, during which some healthcare providers, Cassie thought, did not see her past their myopic views and Cassie's *real* personhood was sadly overlooked:

> When you are going in to have a baby they have all these questionnaires. And what I find I don't like you know when they ask you have you used drugs and blah, blah, blah and they have all this on record. I don't like that. I don't like it when they judge me for my past like for when I had my girls they asked me a lot of the same questions from when I went into have a baby and stuff. But when I answered them like even I would have done drugs years and years before and they held me to that, the things that I've done in my past, and I don't like that.

One way PHNs seek to personalize generic services delivery and to *know* mothers is by simply posing the question, How are you? Jasmine (a PHN already mentioned) commented that she has become increasingly intentional about "acknowledging them as a human being first… like sort of tapping into the emotional part of it because sometimes it can be forgotten or just used as a question for us to check off on our little checklist." I was surprised to discover that some mother participants confided that they had never been asked "How are you?" and actually have someone care enough to listen for the answer. Mothers, I learned, desperately wanted to be asked about life on the home front. They sought the permission of PHNs, possibly the only positive adult influence in their lives, to be able to talk, to share, and to vent their personal coping concerns.

Although Diane (a single mother already mentioned) preferred her privacy as depicted in her statement, "I'm a really, really personal person… don't let people come in or let alone explain my situation or how things are doing… I've been like that my whole life," she benefitted from visiting with the PHNs, who

made her feel comfortable enough that she would return several times on her own volition. “I never wanted to be alone,” she disclosed. “Fear of being alone… getting it out sometimes what you are going through,” she shared.

> If you have nobody to talk to and somebody asks you a question, just even get out what’s on your chest at the time, that makes you feel so much better, rather than coup your feelings and not talk to anybody about them.

Mothers like Diane stated emphatically that it helps to vent but generally waited for the PHN to initiate discussion, as Ramona (a single mother already mentioned) indicated:

> She would give me alternatives, not like just ignore it. If I ever needed to talk I could phone there and next time she saw me she would want to follow up on it and she would ask first. I didn’t have to go, “Oh, guess what happened, so everything in our house is crazy.” She would take the initiative to talk about it first.

Grace (a single mother already mentioned) appreciated the PHN who inquired about her as a *person* with particular psychosocial difficulties because Grace felt the stressors of her single motherhood could affect her well-being as a mother and the welfare of her child. Grace felt it was reassuring that there was someone who “knew” her and to whom she could turn. For Jessie (a PHN already mentioned) the immunization clinic provided the open window to the unique social and psychological worlds of lower income lone-parent mothers and served as the “jumping off point” from which to ascertain their burdening issues. She would inquire of the mother, “It sounds like there are more things going on in your life, maybe you would like to come and talk to me and we can find ways to support you.” Moreover, Jessie and other PHNs have been discovering that the mothers’ readiness to divulge private, “touchy,” “emotional” matters is not always stifled

by the short timeframes within even the very narrow windows of relational opportunity.

5.2 Eliciting the Client's Agenda

I draw from my findings that PHNs aim to facilitate what appear to be autonomy and self-regulation during their working relationships with lower income lone-parent mothers. I also infer that the PHNs align with the philosophy that mothers, not unlike the general population, have certain goals, make certain choices, and behave in certain ways to lead a more productive life, and therefore person-centredness within the helping relationship (Rogers, 1989) should foster and advance their independent decision making. Hence, Eliciting the Client's Agenda is focused on discerning the mother's prioritized needs and her proposed solutions. The PHN subjugates her professional agenda for the moment to determine the mother's personal agenda. Betty (a PHN already mentioned) believed that the topic of the agenda and when and how it was to be handled was the mother's prerogative. Betty explained, "We all have our agendas" but said that she would impart to the mother, "But that's not my priority; you are." She reiterated, "We are client-focused. I truly believe client-focused. Yes I have all this on here but that's not important." She would say to the mother, "It's important, but it's not what's important right now. You tell me where you want to go. You tell me what you need to know or what you need to have done." Betty also wanted to tell mothers, "This is your life, not mine, and I am here if you want me to be. If you don't want me to be that's okay and if today is not a good day that's okay too." Alana's (a PHN already mentioned) practice approach

exemplifies the crux of Eliciting the Client's Agenda. She told me that she strives to "service" the mother's self-defined needs and wanted mothers to know,

> If you've got something else going on that's fine… Pick me up and put me down wherever it is you want me and that I'll be as useful as you want me to be when you want me to be.

Promoting a client-focused, client-driven agenda means providing suggestions and letting mothers decide. The PHN is not the "boss"; nor does she act "bossy" or "nursy," as made explicit by Jenna (a PHN already mentioned)—"You work in collaboration… [you are] not the big boss or the keeper"—and echoed in Barb's (a PHN already mentioned) comment about her relationship with her young mother client: "This is not about me telling her what to do." Mothers, I infer, are made to feel perhaps that they "hold the reins." Again Betty shares a common scenario from practice about a conversation over the telephone:

> I have had moms crying on the phone on the first visit or crying when I'm phoning, and they say, "I offered formula." "Tell me about that." "I was really busy and I was tired. It was nighttime when I did this." "Did you get some sleep?" "Yah." "Good for you. So tell me what your plans are? What did you want to see done? What did you want to [see] happen?" "I want to breastfeed." "Okay how can I help you with that? What can I do?" That might be nothing and that's okay.

PHNs in this study aligned with a practice ethos that fosters self-management. Patty (a PHN already mentioned) spoke about putting "mothers in charge." She informed that she might tell the mother,

> "This is your baby and you're doing a really good job and you know there are some things that could help you if you want. I can make some suggestions if you are interested." And if she says, "No, I'm fine. I've got it all figured out," Then, "That's fine," right?

Although Patty's clients might require services and might want to take advantage of certain opportunities, she advised that PHNs should "give a little bit of information" and then the mother "makes up her mind."

Mothers do not want to be and do not benefit from being denied their control over the decision-making process. Cassie (a single mother already mentioned) reflected on "what could have been" had she been able to collaborate with a PHN on identification of issues and then, too, on the options for resolution. She confided that she never benefitted from physician referrals and "expert" solutions that typically meant medication. The drugs prescribed interfered with her parenting abilities and did little to address the "real root" of her problems and change her situation, and subsequently Cassie never followed through. She would have preferred that the PHN had referred her to "a place where it does help people, as a person." She expounded further:

> Like I'm stressed. I feel stressed out and stuff about… had to get my girls home and I'm in the process of moving on with my life where it comes to their dad coming into our lives you know… I got to a point where I am just fed up with the way things are with him and uh just have somebody to talk to like you know so that they can point me in right direction rather than send me to a doctor who is going to give me pills, you know what I mean, prescription for pills?

She also put forth recommendations:

> What they could have done, what they should have done?... Uh… Well maybe be there, and give me the information about these counselling and stuff, and have information about this counselling centre rather than just sending me to some place, you know what I mean? Then I had this one nurse who I was talking to about my problems wondering if I had postpartum depression and she's trying to link me up with some kind of person. And it's hard… because… like a counsellor or something or somebody… but it's hard because I'm like doing all this other stuff… Maybe it's not hard but for me it feels like it is hard to talk to somebody when somebody is like on the other end phoning me to like how many days later questioning if you got in contact with that person.

Recommendations included the PHN taking the initiative to be determinedly inquisitive and supportive at the same time to elicit Cassie's core concerns:

> I did need help but I didn't see that I needed help, I thought I could do it on my own, couldn't do it on my own, every day was a struggle and it was harder. I was very aggressive towards my kids. I could have been better at raising them when they were smaller, better parent, if set in the right direction. Because having babies and stuff there is that chance that you could have that postpartum depression and I'm not too sure if I did go through that with my girls and I'm not sure that is what it was. I remember being given a prescription for those antidepressants and it could have been their dad too [I] went through a lot of [explicative] with him, you know, it was a lot to deal with. I guess, um, to have a nurse and stuff to ask me questions about where and how I am feeling and stuff, asking continually, 'are you okay today? How are things going? How have things been going?' If they could have helped me and pushed me in the right direction it would have been more helpful.

Yet when the PHN refrains from being "gung-ho" and "prescriptive" and is present with mothers like Cassie, mothers are able to actualize their agency and control through telling their stories and telling their version of their unique story, including how it should unfold. Cynthia (the social worker already mentioned) expresses this principle eloquently while imparting her narrative as a former lower income lone-parent mother: I have been a single mom. I've been on income support. I've been in abusive relationships. I've been in the shelters, one shelter [laughing]. So I know where they are coming from and I know how important it is for you to have respect for these moms, to understand that they might tell you a story that… you'll think well you should know the answers to them. But until they are given the knowledge and information to get to where they want to be you just have to be patient and understand and respect that they are individuals, and everybody has their own story to tell. Yet we all want to… we want to be in a

better place… to understand that their stories are their stories. And to just support them in any way that you can and that's not by telling them this is what you need to do and this is how you gotta do it.

Building Capacity, as explicated below, sustains relational engagement through equipping mothers with the beliefs and skills to tell and to live out their stories well.

5.3 Building Capacity

Within the context of this study, maternal capacity is the mother's self-view that she is and can be an effectual parent. Mothers early on in the relationship-building process will have been recognized, to some extent, for their strengths in terms of maternal competencies (see first stage, Projecting Optimism). Building Client Capacity brings forward those earlier allusions of maternal self-efficacy to enhance and to optimize her competence and positive functioning through extending the strengths-based approach by becoming more tailored to accommodate her personhood and unique circumstances. Moreover, in addition to *maternal* capacity, what transcends is *wider application* of capacity, referring to the "power, ability or faculty for anything in particular" (Simpson & Weiner, 1996, p. 857). Building Capacity comprises steps and properties that instil in the mother her sense of mastery over her "knowing" and coping abilities as well as hope and optimism that she will possess the necessary fortitude and skills for what may lie ahead.

The PHN begins with small incremental steps. Over time, with each encounter these small steps have a cumulative effect, culminating in the mother's

efficacy beliefs. For Lorraine (a PHN already mentioned) the incremental steps within this stage build on the objectives of the previous substage interactional strategy, Eliciting the Client's Agenda. Lorraine poses questions that promote the mother's sense of control. She explained that she might tell the mother, "We just want to support you as much as you feel you need. What kinds of supports do you need?" and "There's lots of support out there would you like me to get you some information?" Lorraine will start with questions about topics that may seem minor, such as "Are you going to be able to afford diapers and wipes?" However, they are key necessities in the everyday lives of these mothers, and their accruement is a feat in and of itself. Shelly (a single mother already mentioned) was beaming with pride when boasting of her resourcefulness in terms of her ability to obtain the basic supplies for her seven children. "I know of probably everywhere in city to get stuff, I know where to get free furniture, food bank, clothing for kids, school supplies. I get everything. One way or another I find a way of getting it."

Patty (a PHN already mentioned) ensures that her "nursy," "bossy" hat is removed, and then, armed with the conviction that the mother is in charge and responsible for her own health and the well-being of her children, she also poses questions. Her questions also pertain to choice about matters that at first are largely incidental. Offering mothers choice about something as simple as their preferred location for blood work, followed by "It's up to you," engenders a sense of control, especially among the "young mothers." Moreover, providing mothers with the opportunity to demonstrate their autonomy and giving them the

knowledge necessary to secure material resources changes their state of powerlessness, Patty asserted, to one within which "the mother has got some power":

> They don't have any power [and they] have everybody looking down on them. [They] had to fight through the pregnancy to maintain it [and now] that they are mothers and they have a baby, all of a sudden they are put into that role.

Often it is during this time that family members and strangers in society mirror back an unfavourable picture of helplessness and dependency.

Mothers in this study endured, it seems, through their growing sense of personal power, which is gained through knowledge. Knowledge is power. Esther (a single mother and former substance abuser, already mentioned) has two children in the care of Alberta Children and Youth Services. She has been sober and dedicated to her third child, who has remained in her care since birth. Esther conveyed her eagerness to get her hands on all the available parenting manuals, and it was apparent that she was excited about this growing knowledge base. "I found they were much helpful with breastfeeding, immunization, how to brush my daughter's teeth, like gums, age to start feeding her table food and what age to start feeding her baby food." Esther was appreciative of the parenting instruction provided by PHNs at her local community health centre.

> They've just… with parenting they ask me what I want to do with parenting and they gave me so many pamphlets on [Agency A], and um what I should watch out for in the daycares at [Agency B] or [Agency C], which signs I should watch out for if she starts choking like… just very useful information.

Conversely, Esther was critical of PHNs who were not as forthcoming with information and who did not provide her with material resources about child

safety or related topics. Mothers like Esther would seek out PHNs who "treated them like they know something." Cynthia (the social worker already mentioned) was insightful about the benefits of the PHN's knowledge-enhancing sessions with Aboriginal lower income lone-parent mothers:

> She [the PHN] can help them through the time that they need her help and refer them on to any other services. Always that little bit of friendship, trust, relationship that is being built right? And the more knowledge that they get, the more broader they will expand whatever they are needing.

The PHN's humility and honesty about what she knows and does not know about a mother's circumstances, concerns, or pending situation confirms for mothers that there is nothing kept hidden. All the available information is there for them to master control over their lives and the decision-making process. Alana (a PHN already mentioned) would tell a mother involved with Alberta Children and Youth Services,

> "I'm going to let you know what they say to me. You might get a visit you might not but I'll let you know the information they give to me because I am going to carry on working with you after… whether the children have to be removed I'm going to carry on working with you." It is that openness because if you think that you are the professional, if you feel awkward and difficult about it, you think about how those parents feel about it. And I think it is facing really difficult situations and being open and truthful about it and if you are not sure about how things are going to go you say that, but you also say what concerns you have. And just being truthful, being truthful about that.

Julie (a PHN already mentioned) also stated that she is

> very up front about the Child Welfare thing. I said… "You know if that's your goal to get to keep that baby then you know there's going to be some red flags when you go to the hospital… What can we do to so they know that you are making some really good choices… and you're ready to move ahead and parent?"

Mother participants stated that they felt empowered through professional supportive, helping relationships; sometimes it was the PHN, sometimes the

social worker, and sometimes the home support worker. The PHN builds the mother's capacity incrementally along many dimensions, from providing information about tangible supports or material resources to enhance her parenting skills, to posing questions to perpetuate a sense of control and autonomy. PHNs also explicitly and implicitly build the mother's hope. Betty (a PHN already mentioned) would converse with a mother about her drug history with future aspirations in mind:

> Oh I see there was some drug use. Tell me what's happening for you now. Where are things at? What is your hope? What is your dream for that? Is it to be drug free? Is to cut down? What is your dream? What's your hope?

The mother's perception that there is someone backing her puts her at ease disclosing her story. In so doing, the mother uncovers other elements of her powerful capacity, and hope for the future. Cynthia captures well the essential aspects of Building Capacity:

> Like I think a lot of them know... and they are trying to reach out knowing that they can reach out. And just to give them back that autonomy that they've lost or was never passed on to them through their parents…. Many of them get afraid when speaking to professionals so to speak. It's like they've been in a situation where the rules haven't always been followed, and um, so when they run into agencies that they are not familiar with or professionals who think they have all the answers for them I think they kind of get afraid of that not knowing that they have all the power within them to have a voice to anything they need to speak to, whether it's poverty, whether what they want for their children, and saying it in a way that they will be listened. So I think it gives them a lot of long lasting, not superficial, encouragement and hope… They're identifying things that you know, just in speaking. It's not at the forefront of their minds, but they actually have a lot of skills and tools that they can use and do use but they don't identify as something that could get them places.

Summary

Concerted Intentionality comprises substage interactional strategies that together extend therapeutic rapport. This fifth stage embodies the PHN's desire to discriminate "what is really going on" and not so much to complete a generic client assessment form but derives from the PHN wanting to magnify her lens to see the mother as unique human being. Building on all that has been gleaned from preceding stages, the PHN poses more questions and probes effectively and efficiently to hone in on the mother's chief concern most often by simply asking, "How are you?"

Painting a New Canvas encompasses the PHN's "digging deeper" rather than deciding without validation, "Okay you're fine, mom, I won't pursue." Verbal commendations from the first stage are carried forward, and the mother is motivated by the PHNs reassurance, "I know you can do it." The PHN continues to foster the mother's self-enhancement through Eliciting the Client's Agenda and Building Capacity. In very tangible ways the PHN draws out and directs the mother to broader areas of power, abilities, and faculties and in so doing sustains the mother's full engagement.

Stage 6: Redrawing Professional Boundaries

The sixth stage is not the final stage or considered the termination phase of the therapeutic relationship. There is no clear demarcation indicating termination or closure of the PHN-mother relationship. The door to the community health centre is left open. The telephone lines remain accessible. While the child is young, there are still immunization clinics and drop-in appointments and, under

the guise of weighing the child or checking out a skin rash, the conversation with the PHN commences and the mother reveals what is *really* bothering her. The PHN leaves the window of relational opportunity wide open. When the PHN is contacted again, therapeutic relationship is reestablished, and it resumes without formal closure. PHNs spoke about mothers calling them several months and even years later just to talk and pose "a question or two."

Redrawing Professional Boundaries explicates the roles of the PHN, particularly in the eyes of the mother; hence the *pseudo* roles. The PHN has taken on, and continues to take on, different roles than that of professional nurse, according to the mothers. Assuming Pseudo Roles speaks to the PHN's continuance as mediators between the broader social network and resource access, and the unique needs of the mother as a kind of social worker, advocate, mentor or coach. Then, unbeknownst to the PHN, the mother also sees her PHN as a substitute friend and confidante, and mother, as part of Fulfilling Surrogate Social Support.

6.1 Assuming Pseudo Roles

Interaction with lower income lone-parent mothers involves considerable focus on ensuring that basic physical needs are addressed before pursuing professional teaching objectives. Julie (a PHN already mentioned) believed that she assumes the role of *social worker* because

> with this job you need some health background but… and certainly I try to keep a health focus probably more than… well depending who you talk with, but you have to look at health in that bigger picture, all the determinants of health. And if someone has no food and no place to sleep it's really hard to get them to think about the other pieces of health. So you

> have to look at health in a really bigger picture in terms of how do you keep someone healthy.

Jessie (a PHN already mentioned) told me that she refers to "Maslow's [1970] hierarchy of basic human needs" of food and water, safety, love and belonging, esteem and self-actualization, as she pointed to a copy of the seminal theory pinned up on her office wall. She asserted that Maslow's progression of human priorities is readily apparent and is often her foray into her working relationships with lower income mothers. Jessie stated that instrumental to her effectiveness is her ability to address their basic human requirements first, before anything else. In fact, other PHNs advised that efforts to fulfill the professional agenda are futile and that all their teaching "goes out the window or down the drain" if the mother's problems at the subsistence level are not addressed beforehand, especially when it is not uncommon to discover that the mother's "resources are slim to none" or that the mother is undergoing intense psychological strain over inadequate housing or food insecurity. PHNs check and confirm with mothers, especially the new mothers, that they "have enough diapers" and that they are not "watering down the [infant] formula because they cannot afford to buy more."

PHNs told me how they certainly feel like a social worker addressing this liminal space between the mother's intrapsychic world and outside society and that a large component subsumed under the role of social worker is advocacy. As *advocates*, PHNs liaise and "partner" with personnel from the food bank, nongovernmental organizations, alcohol and drug rehabilitation centres, healthcare institutions, and social assistance agencies to assist mothers to "access"

a wide assortment of programs, services, and resources, including safe, affordable housing, transportation, job training, education, and financial benefits. Advocacy includes making appropriate referrals for mothers. However, some mothers cannot simply be given a name, telephone number, and office address on a piece of paper. Most helpful is when the PHN and agency personnel can speak together with the mother to arrange that first visit through conference telephone. This arrangement promotes the likelihood that the appointment is kept, eases the mother's apprehensions, and satisfies the PHN's knowledge that the mother will have this aspect of her life taken care of. Having established the bond with her PHN, the mother trusts the referral to another human resource yet for several reasons is reluctant to go alone, and more often than not referrals are not followed through on. As Jasmine (a PHN already mentioned) informed,

> Sometimes it just takes extra encouragement and sometimes [it] takes four phone calls instead of the first home visit to actually have a mom engage in one of these resources that I would like her to try out. It takes more reinforcement and more affirmation and things like that.

Depending on the mother's "level of confidence" and "social skills" and nature of the situation or crisis, the PHN might be requested to "pave the way a little" and provide extra support by accompanying the mother to the appointments and/or speaking with agency personnel on her behalf; hence, emulating the etymological roots and definition of advocate, someone who is " 'called upon' to plead" (Skeat, 1963, p. 7). Belinda (a single mother already mentioned) shared how her PHN

was in her "corner."

> I actually talked to Benita, she used to work at [Agency D]. I talked to her a lot for help. Actually that was a time I had a lot of help because Child Welfare was very interested in how I was taking care of the kids and everything because I came from a very dysfunctional family. So Benita was kind of a person in my corner who would help me tell Social Services, "No, leave her alone she's sorting it out, everything is going okay."

Then the PHN must reconcile her expected responsibilities and purview as a PHN with her desire to stretch the scope of her mandate to address the diversity and immediacy of presenting needs. Jasmine acknowledged that occasionally she struggles, because, she explained, "You want to be doing everything for some of these moms at least trying to help them out as much as you can. Your role only goes so far." She found it difficult at times to keep that line drawn and straight between PHN and advocating as social worker because "with some of these moms" she wanted to "offer them more resources, more tangible things" that extend beyond her "bounds as a PHN."

Julie's (a PHN already mentioned) "training" activities and instruction with her perinatal clients are consistent with those of a *coach*. Julie prepares her mothers-to-be (who, for the most part, live on the margins of society) for what they will encounter in the physician's office and at the hospital in terms of the expectations of "conventional" healthcare providers. Julie wants her clients to put their "best foot forward" so that they can keep their babies and avoid involvement with Alberta Children and Youth Services. She advises and cautions them on how they should conduct themselves to align with what is normative and what is characteristic of mainstream discourse:

> Because I can't take away the red flags but I know that there are some better ways to dealing with it then showing up without any prenatal care because that, right there, that's a red flag. If you show up at the hospital and you haven't had any prenatal care they're saying, "Well, she didn't care about her baby. Yet we know you did." I said, "That's just how that's interpreted." And I try to interpret some of the mainstream, how they interpret behaviour, like what will happen.[4]

Betty (a PHN already mentioned) felt she was a coach guiding mothers through decisions:

> The thing that really gets me with a lot of singles moms: grandma's living elsewhere; daddy finds out they are pregnant, and are gone. They have no supports. They have nobody that backs them. They hear something or they get something from a doctor they have nobody to run it off with. I've had moms phone me and say, "What do you think about that?" I turn it back, "Well more importantly what do you think of that. You've called me now, so that tells me you have an idea… tell me what you are thinking? Tell me what's going on? Yah" it's like, "Yes I agree, or why don't we get a second opinion?"

In addition, Betty described her role as *mentor*, as she often tries to model for the mother effective parent-child interaction:

> We want to role model, mentor… when I go there [the home] I play with the kids, I dress the kids. I've had little ones take me by the hand I want to show you this. Is that okay Mom? Is it alright if I do that? … I've talked to little ones as they are being looked at and they are responding to me and I'm saying, talking to the parents, saying you know, "They love your voice; they are listening to mine because I am here but they love your voice. Have you done this before? Have you done this before?... This is something you can do at home. Just talk. They want to know all about you. Your voice is the one they want to hear. They are hearing mine but they would love to hear yours.

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[4] A caveat is warranted; when lifestyle choices pose risks for the child, Julie and other PHNs would be open about issues and report their suspicions to authorities.

6.2 Fulfilling Surrogate Social Support

The services and resources provided by the PHN as pseudo social worker, advocate, coach, or mentor are not unlike the hats worn by PHNs working with other client groups; however, the benefits for these mothers are felt deeply. The PHN is addressing concerns and filling a void, perhaps, that just as well could be or should be carried out by the mother's partner, family members, or friends. Consequently, some mothers perceive their PHNs in a different light than perhaps another client would. What culminates by this final stage is the mother wanting to resume contact with her PHN under a different pretence. Mothers identify their PHNs with whom they have established rapport as the "health nurse" and more, some seeking to fill a social support void of friend and confidante or surrogate mother, requiring PHNs, again, to revisit, to refine, or to redraw, their professional boundaries.

Mother participants confided that the dream of raising their children with the fathers is gone. Although mothers "grew up" and faced their responsibilities, the boyfriends did not, and mothers felt like they were "abandoned." Isolated and caring for their children, their lives are almost bittersweet, for they have been given reasons for living but, on the other hand, life is very different now with the demands of raising children alone. Some mothers were disheartened as well by the rejection by their parents and the loss of contact with friends. Their friends "were fair-weather support, not there for the long haul," and thus once they "no longer had anything in common… they stopped coming around." Under these circumstances, mothers indicated, they "need somebody, if it's not a relative or friend, somebody that they could turn to and confide in and stuff."

The majority of mother participants were estranged from family and friends, and when asked about their neighbours, they told me that they preferred "to keep to themselves." Often neighbours were a negative influence, and the mothers wanted to protect themselves and their children from exposure to drugs, alcohol abuse, and violence. It was not surprising, then, to learn that professionals such as PHNs may be one of the few sources of positive adult influence from their social network, and as such, the PHN's presence leaves an impression in the minds of some mothers. After ruminating over the hardships of her experiences as a first-time mother, Diane (a single mother already mentioned) described the PHN who knocked at her door for a routine postpartum visit as "an angel in disguise":

> I mean as soon as the health nurse comes to your house and you don't have anybody to talk to and you are a single mom, you don't have anybody to ask certain questions to. And I think that that is awesome. If they could do that have an open ear to listen that would be awesome because there are so many moms who need that who don't have it and for me from my own experience I was so blessed that she [the PHN] showed up like I said, she was an angel in disguise.

Trusting few people, and having few friends and little to no family support, the mother deems the friendly supportive relationship with her PHN as a special relationship, as a *friendship***.** More than one mother in the study echoed Shelly's (a single mother already mentioned) comments:

> She [the PHN] was somebody to talk to for me because I barely get out of the house. I don't have much friends…. She was a counsellor, a friend. She… was someone who I could count on to help me.... [She] took a lot of stress off my shoulders.

In contrast, Evelyn (a single mother already mentioned) did not consider the PHN her friend. She was one of the few mothers who had a healthy, functioning social support system that served as her source of both instrumental

assistance and emotional affirmation. Evelyn spoke about returning to her Edmonton "friend circle support":

> Then I moved back here mid-December because my support systems is here. I wasn't relying on governmental support. I was relying on my friend circle support. One friend of mine enabled me to sleep on her couch. Another friend helped me to write a resume to cooperative housing. She helped me to write a really good application so I could move in here. Some other friends were feeding me on a regular basis. When I did get this place another friend got the truck and helped me to move in. There was a whole bunch of help.

The experience of "friendship" is not mutual; it is not the perspective held by both dyad members. There was no indication from PHNs participating in my study of their overinvolvement or violation of professional standards or code of ethics. I never gained an impression of an extension of the professional to personal relationship, meaning transition to a socially determined emotional friendship. Although PHNs were cognizant that with some mothers "there were no boundaries," the PHNs clarified their position as was necessary and went to efforts not to share their personal information. When mothers offered gifts, the PHNs responded with appreciation but explained that their kind gestures could not be accepted. PHNs had to be insistent that they could not see mothers after work hours under the auspices of a social gathering or social function but were not always direct. They often made up excuses with each invitation extended that they simply had prior commitments. Lorraine (a PHN already mentioned) revealed:

> You have to watch that fine line that they [the mothers] don't think they're your friends because I have had clients that you follow for a year and said, "Do you want to come to our daughter's first birthday?" Well, so, that's… I mean that they made this really rapport to me. That's nice. I feel flattered but you can't cross that line of professional-client relationship. But then you've connected with the client.

It was not surprising to learn from mother participants that they perceived some of the PHNs as older wiser women who reminded them of *mothers* whom they wished they could adopt. Rose is an African single mother with one child whom I interviewed. She is one of the few participants who is in close contact with her mother. She told me that she enjoyed visiting with the PHN because her age, manner, and approach reminded Rose of her own mother, and for a little while Rose felt like she was "talking to her mom."

The younger mothers were especially interested in establishing a relationship that resembled a kind of mother-daughter bond. Betty (a PHN already mentioned) recalled how one teen mother told her, "I wish you were my mom." Another teen mother brought Betty her baby and asked Betty to take care of him, stating, "You are the only person I trust him with." Betty reflected, "That tells me about more work that may need to be done. 'I'm honoured to hear that but I can't do that.' " Belinda (a single mother already mentioned) believed that PHNs should assume a motherly role or that of "aunt":

> I think a big role of health nurses especially in a low income community is probably, as a, kind of a surrogate mother even if their own mother is there, or not a surrogate mother but maybe a surrogate aunt. Then an aunt is even less judgmental than a mother and more unbiased information you can provide.

Summary

Frequently, the mother's informal social network does not offer trusting interpersonal relationships and social intimates. Although the PHN's enthusiasm, genuine interest, and friendly manner have been pivotal to sustaining deep connection with the mother, and targeting the mother's *real* burdens,

paradoxically their relationship could be considered problematic if there is transition into a mutual friendship. The PHN, however, safeguards her professional boundaries.

This final stage brings the description of Targeting Essence: Pragmatic Variation of the Therapeutic Relationship to a close. However, as mentioned previously, the mothers and their PHNs will seek each other out once again somewhere down the road.

Summation

The research intent was to investigate how therapeutic relationships are established. However, the contours of the study changed slightly when I uncovered that the goals of the PHN during interaction are actually twofold; that is, although the PHN is striving to achieve relational goals, her attention is focused on the goal of ascertaining the concerns that are foremost in the minds and hearts of her client. Targeting Essence is the basic social psychological process implemented to accomplish her goals within the context of systemic practice constraints and heightened sensitivities of the lower income lone-parent mother. Targeting Essence is the basic social psychological process that enables the PHN *to know essentially* (with a certain degree of astute accuracy) what this mother wants and needs, and permits the mother an opportunity *to know essentially* that this PHN can be trusted not to render judgment.

Targeting Essence: Pragmatic Variation of the Therapeutic Relationship is the explanatory theory of the relationship-building process between the PHN and the lower income lone-parent mother. The first two stages, Projecting Optimism

and Child as Mediating Presence, are the icebreakers; that is, the PHN's buoyant approach and verbal praise break through the mother's walls of apprehension and defensiveness and propel dyadic exchange to the third stage, Ascertaining Motives. During Ascertaining Motives the potential for relational development is tested when the mother assesses the authenticity of the PHN's nonjudgmental approach. The mothers' confirmation of the PHN's trustworthiness is the catalyst to the next stage, Exercising Social Facility. This fourth stage demonstrates the PHN's advanced interpersonal competencies, including the PHN's ability to detect the mother's overt and subtle nonverbal cues. The PHN gauges how she will respond next according to these visible acts of meaning emanating from the mother. Exercising Social Facility is the other catalyst of the overall relational development process for it is the foundation for the final stages, during which the PHN and mother engage at a deeper level of connection.

The final stages, Concerted Intentionality and Redrawing Professional Boundaries, are the sustainers of the relationship, chiefly because the PHN makes a deliberate effort to know the mother's personhood and also directs her professional efforts to enhancing her client's capacity. The PHN and mother have established a therapeutic relationship and for an indefinite period of time. Neither dyad member needs to plan for a termination phase for there is no formal closure. In fact, the mother readily anticipates future contact with this PHN not only as her professional "health nurse" but perhaps as her advocate or friend.

CHAPTER FIVE: DISCUSSION

In this chapter I discuss the new insights gleaned from the study and the distinct contribution of the emergent theoretical model, Targeting Essence: Pragmatic Variation of the Therapeutic Relationship. I begin with the PHNs' nuanced use of the communication system for establishing therapeutic rapport in the section entitled Revisiting Nursing Communication. Their advanced social competencies are powered by a collective force of intuition, experience, and cognitive insights. These three components work together to equip PHNs with the abilities and sensibilities for effectual relationship building when working with lower income lone-parent mothers. Second, I compare the Targeting Essence model of relational development with Peplau's (1952/1988) seminal work and extant models derived from Canadian contexts. Third, I summarize the essential ingredients for establishing therapeutic relationship in the context of the professional encounter with the lower income lone-parent mother. Finally, under Barriers to Therapeutic Relationships, I discuss inhibitors to establishing therapeutic rapport that were uncovered during the course of this investigation.

Revisiting Nursing Communication

Underlying this research study was acknowledgment of conventional forms of behaviour that exist implicitly in most social relationships. Not examined were the taken-for-granted relational norms that are based on mutual sociocultural expectations. Conventional interaction includes customary facial expressions,

courteous greeting rituals, body movements, and appropriate distance between interactants (Strauss, 1993). For example, institutionalized forms include the ways one behaves with a retailer in a department store, how one sits in a restaurant and waits to be served and then courteously orders food from the waiter, and how patients and their family members conduct themselves in a hospital setting. The interactional behaviours between PHNs and their clients are not unlike other professional dyads involved in an institutionalized interchange. However, my research findings indicate that specific processual elements are involved in the establishment of therapeutic relationships between PHNs and lower income lone-parent mothers.

The PHN must engage at a level beyond conventional representations of the correct facial expression and body posture. What is evident from the stages of Targeting Essence: Pragmatic Variation of the Therapeutic Relationship is the PHN's *strategic* interaction in response to the cues of her vulnerable and potentially stigmatized client. There is an inherent understanding of the symbiotic relationship between the mode and frequency of communicative behaviours exchanged and opportunity for relational connection and development.

The PHN uses all channels of her communication system (Ruesch, 1968/1987a) to transmit and to receive messages and simultaneously, to do what she can to promote and to preserve the mother's positive sense of self. Mothers defend their self-views, at first, through erecting "walls" and "shutting themselves off." I inferred that the wall is indicative of the mother's level of stigma consciousness and represents one of the self-protective mechanisms learned over

the course of previous social interactions. The PHN is able to employ purposeful communicative acts to break through the psychological walls. Her icebreaking strategies, for example, located in the first two stages (i.e., Projecting Optimism and Child as Mediating Presence), are deliberate but genuinely nonthreatening and serve to penetrate the mother's initial defensiveness. The PHN's projection of zeal and keen interest in the mother and child, coupled with uplifting verbal praise aimed at promoting maternal self-efficacy appraisals, effectively moves interaction beyond institutionalized routine and conventional discourse involving two strangers to a more intimate level, where interactants begin to demonstrate mutual interest. In the parlance of symbolic interactionism, the interaction becomes more than just two lines of action occurring side by side (Blumer, 1969).

The Immediacy of Face-to-Face Interaction

> Our nonverbal behavior has a way of "leaking" messages about what we really mean.
>
> –G. Egan, 2007, p. 87

Heartfelt values and attitudes will colour our behaviours whether we want them to or not. Psychologists inform that we might not even be aware of our ambivalence, discomfort, or depreciatory thoughts. One might inadvertently communicate what was unintended (C. Miller, 2006). I learned that the PHN has to be especially incisive and cautious about the kind of indexical information (Abercrombie, 1967/1972) she conveys because the lower income lone-parent mother will use it (i.e., behavioural information that denotes the speaker's biological, psychological, and social characteristics) to draw inferences about the PHN's attributes, attitudes, and mood. Mothers seek, especially, the personal

conviction that they can trust PHNs not to threaten their self-identity. That which the PHN projects, consciously and unconsciously, is introjected by the mother, and for many, positive reactions of the PHN are their sources of self-verification and bolster their self-esteem. Conversely, perceived negative attitudes of judgment can result in lowered self-esteem. The PHN's caring trustworthy attitude must be translated and taken up early in the interaction.

The "direct, personal, immediate [and] spontaneous" characteristics of face-to-face interpersonal communication compound the challenges of establishing therapeutic relationship (Trenholm, 2008, p. 141). Psychiatrists claim that emotions about how we truly feel are communicated within microseconds, and unconsciously, before our rational mind sets in (Ekman, Friesen, & Ellsworth, 1982). Hence, we cannot not communicate. While the PHN is reading nonverbal signals of the mother, the mother is watching for cues of the "real" motives of the PHN. Is she friendly? Approachable? Authentic? Just as the PHN can detect fleeting expressions in the mother, the mother is as equally astute at recognizing affective signals of the PHN.[5] It is important that internal attitudes be congruent with what the PHN intends by her external behaviours (Egan 2007). More than one PHN admonished during the study that the PHN has to be on her "social toes"

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[5] Noteworthy is what appears to be the leading role of the PHN in the succession of stages of the study's emergent model when in reality it is misleading to think of the stages as instigated solely by the PHN. While the PHN is pursuing relational goals and believes she has mitigated mistrust, assuaged fears, and brought down walls of defensiveness, the mother will implement strategies (e.g., The Litmus Test) to judge the PHN's motive, attitude, and approach, as is evident in the third stage, Ascertaining Motives.

because you “cannot fool these mothers or pull the wool over their eyes. They will figure you out pretty quickly.”

Study Illustrations

Incidents recorded in my study data reflect the immediacy and sometimes precarious nature of face-to-face interaction between the PHN and the lower income lone-parent mother. I purposely extrapolate direct quotations from my transcripts of two mother participants to illustrate my point. Lillian is a young first-time mother of a toddler. People have mistakenly identified Lillian as a teen mother. Esther is an Aboriginal mother with one child who has a history of substance dependency and has two older children in the care of Alberta Children and Youth Services.

The first incident involves interaction between Lillian and a PHN during a scheduled immunization clinic. Lillian characterized the quality of their interchange as poor, detached, and dismissive because the PHN did not maintain eye contact. Lillian felt as though the PHN was averting her gaze. She stated that the PHN “was looking down on her” because she was a young mother who will probably need to surrender “her child to foster care like all the other young moms.” Lillian was convinced that people in society judged her as an immature and incompetent mother.

Lillian and other mother participants demonstrated a tendency to misinterpret seemingly “innocent” cues to fit their deeply rooted interpretations of themselves, something referred to as the self-perpetuating self-concept (Cochran & Cochran, 2006). Mothers would see and interpret the PHN’s interactional

behaviours and responses towards them according to their own persistent assumptions. In light of the discussion above, Lillian was projecting onto the PHN attitudes of negative judgment when more than likely no evaluative messages had been conveyed through word or deed. Lillian did not think to attribute the PHN's conduct to perhaps the busy schedule of the immunization clinic. This incident with Lillian is an example of the self-perpetuating self-concept and an important factor that contributes to the fragile nature of the professional interaction involving young lower income lone-parent mothers.

The second incident involves Esther, who had been seeking refuge from partner abuse at the time of the delivery of her third child. Esther remembered an unpleasant postpartum visit with the PHN, who saw Esther and her newborn at a women's shelter. Esther labelled the PHN's rushed, routine, distant manner as "racist." The fact that the PHN quickly carried out the newborn assessment was a sign of racism, according to Esther, who felt that the PHN showed "a lot of tension, she just didn't want to be there. She just wanted to get her job done and over with" and "she wasn't very verbal." When asked to clarify what she meant by racist, Esther said, "I think she just got lazy at her job… she just seemed like she didn't want to be at work." She interpreted that the PHN was inattentive and believed that the PHN was signalling that she did "not want to touch her daughter" because "my daughter is… like she is dark… she just grabbed her foot, poked her and she's like, 'Take your baby.' "

As Esther watched the PHN, she remembered feeling "a little upset." When I asked Esther what she believed it meant to be racist, she explained,

"Usually it means they are either disgusted at the person or disgusted about the surroundings the person is living in." Despite how fleeting an alleged look of disgust on the PHN's face might have been, mothers like Esther, who have been repeatedly exposed to negative discursive interactions, will identify disgust and disdain immediately, or watch for them expectantly. In addition, Esther's drug-related history might incite tremendous guilt and shame, which only magnify her negative beliefs about self (Ehrmin, 2001) and cause an increased propensity for personalizing negative cues.

Strauss (1959) described face-to-face interaction as a "fantastically complex web of action and counteraction" (p. 61). Sometimes interactants move in rhythmic psychological ballet, and sometimes they "fence." With respect to what transpired during the incidents above, how do PHNs and mothers from diverse sociocultural backgrounds and experiences establish therapeutic rapport? When two people who come from different walks of life converge, how do they know how to relate beyond institutionalized conventions, professional display rules, or "Communication 101"? How is it possible that the PHNs who volunteered to participate in my study, and who for the most part have never walked in the shoes of lower income lone-parent mothers, are able to relate so effectively with mothers like Lillian and Esther, to enable rapport to blossom? Are their advanced interpersonal communication competencies the product of "gut feelings" or nursing gestalt (Pyles & Stern, 1995), intuition (Epstein, 2008), tacit knowledge (Polanyi, 1966), or perhaps something else?

The Social Intelligence Spectrum

I continued to ponder and search for answers until I had a "eureka" moment while attending a convention of the Sigma Theta Tau International Leadership Academy. The president-elect mentioned the term *social intelligence* during her maternal/child health presentation, and then during our subsequent conversation, she encouraged me to consider the PHNs' advanced social skill set as a manifestation of their level of social intelligence. I then began reading Goleman's (2006) social intelligence thesis originating out of the field of social neuroscience, as additional data, and began comparing his work with my substantive codes and emerging conceptual impressions.

The fourth stage of the emergent model, Exercising Social Facility, best demonstrates the high levels of social intelligence that foster therapeutic rapport among study participants. I propose that the PHN resembles an astute social detective with her abilities to read nonverbal cues sufficiently to determine the appropriate timing, mode, tone, and message of her next act and, simultaneously, not threaten but preserve and, at times, enhance the mother's sense of self. The PHN's manoeuvrability with the vulnerable and potentially stigmatized client relies on two substage interactional tactics, Empathic Accuracy and Responding Strategically. Goleman's (2006) social intelligence research has provided insights about the neural mechanics that might drive the PHN's social decisions and behaviours. I surmise that my study findings indicate that "social brain" processes account for Empathic Accuracy and Responding Strategically.

How to Account for Empathic Accuracy

Empathic Accuracy is a combination of the PHN's spontaneous *intuitive* ability to

- detect the mother's fleeting expressions,
- sense the mother's emotions; and,
- be cognitively aware of what the mother is thinking and feeling.

Although PHNs whom I interviewed recognized that they could detect subtle facial cues, they were unable to articulate *how* they knew what mothers were expressing and feeling. Some described their keen practice sensitivity as their "sixth sense." Investigators of expert performance in medicine and nursing describe this procedural knowledge that cannot be made verbal as intuition. Intuition draws on the tacit dimension that seemingly cannot be taught or explicated, and is acquired exclusively through real-life experiences (Patel, Arocha, & Kaufman, 1999). I am not entirely convinced that the sources of the PHNs' intuition (i.e., her implicit interpersonal performance knowledge) defy explicit explanation after immersion in the new social intelligence research.

I infer that the PHNs' social skill set depicted in Empathic Accuracy parallels components within Goleman's (2006) social intelligence spectrum and can be interpreted with the assistance of recent neuroscientific discoveries of the human social brain. Neuroscientists would posit that gut-level, low-road "mirror" neurons in the PHN's temporal lobe enable her to read emotions as well as mimic the mother's social neural activity. Mirror neurons fire in the PHN's brain as she observes the mother's emotional aspects emanating from the mother's tone of

voice, facial display, or posture and trigger identical brain areas to those active in the mother. Biological psychologists refer to the alteration of the PHN's brain induced by such external experiences as neural plasticity (Rosenzweig, Breedlove, & Leiman, 2002). Essentially, the PHN witnesses the mother's emotions, and then her own social brain circuitry senses the mother's emotions and feelings. Empathic Accuracy, as adapted from Goleman's (2006) social intelligence spectrum, lends understanding and credence to major aspects of the PHN's interpersonal communication competence.

How to Account for Responding Strategically

Whereas Empathic Accuracy involves predominantly low-road unconscious social brain pathways, Responding Strategically, the other system in the spectrum of social intelligence, relies on the slower high-road neural circuitry to modulate and fine-tune nonverbal behaviours and to ensure that they are appropriate and effective (Goleman, 2006). The PHN, for example, is able to strategically respond to angry outbursts (see the scenario discussed on page 94 to illustrate this interactional tactic) and other client emotions without sabotaging relational opportunity.

Responding Strategically might very well account for the mechanisms (or the social mechanics) of symbolic interactionism such as beliefs that interactants perform strategic assessments and focused actions during the process of interaction. To explain, in terms of the angry outbursts scenario, symbolic interactionists would postulate that interactants (e.g., PHNs) are capable, in such a

situation, of determining what line of activity would fit with the actions of others, in this case, lower income lone-parent mothers. Blumer (1969) asserted,

> The activities of others enter as positive factors in the formation of their own conduct; in the face of the actions of others one may abandon an intention or purpose, revise it, check or suspend it, intensify it, or replace it. (p. 8)

Accordingly, the PHN would have been constantly taking into account what the mother is doing so that she could anticipate what the mother will do. Then the PHN directs her own conduct in synergy with the actions of the mother, actively conferring with self to formulate her plan of action.

New discoveries about social neural dynamics suggest that the full spectrum of social intelligence necessitates more than "high-road" social cognition (i.e., the ability to behave according to unspoken protocols and norms that govern interaction). Intuition, or the "low-road" noncognitive abilities, such as sensing nonverbal emotional signals and sharing the feelings of others, is also critical for strategic navigation through social encounters (Goleman, 2006). Furthermore, the low-road noncognitive abilities of Empathic Accuracy are not entirely spontaneous and incidental because of the extensive repertoire of factors and layers of learning undergirding this intuitive ability to discern emotions, thoughts, and feelings. I assert that Empathic Accuracy is founded on the PHNs' intentional efforts to understand her client in conjunction with diverse personal and professional experiences.

For example, the PHN's heartfelt attitude of earned respect for her clients, as opposed to her adherence to the mere conventional polite forms of discourse such as the Golden Rule ("Do unto others as you would have them do unto you"),

avert unconscious untoward responses. The PHN strives to treat each individual mother in accordance with how the mother wants and needs to be treated and can muster more than a mechanical, forced expression of respect. She can maintain an authentic neutral position and exude what psychotherapists refer to as unconditional positive regard (Rogers, 1980) because she has come to appreciate her client's struggles and endurance through adversity.

Empathic Accuracy and Responding Strategically are analogous to the two low-road and high-road systems of aptitudes in the full spectrum of social intelligence and work in parallel as "necessary rudders in the social world" (Goleman, 2006, p. 100). The point that I want to emphasize is that we need both the intuitive and the cognitive systems to form therapeutic relationships in the context of public health nursing practice. Johnson and Ratner (1997) asserted that nurse scholars have tended to view the nonrational, intuitive processes of knowledge use in practice as completely independent from the rational, deliberate processes. I contend that intuitive knowing and cognitive knowing need not remain in binary opposition; rather, they should be recognized as two interdependent dimensions. The PHN's advanced social skill set combines the autonomic-affective pathway (that is constantly active and firing) and the controlled-cognitive pathway (that becomes available as required). This discovery is compelling and, in conjunction with my study findings, legitimizes a threefold necessity of intuition (low-road social brain neural pathways), experiential knowledge (real-life training coupled with understanding of client), and technical rationality (high-road social brain neural pathways).

Emotional intelligence, which predates social intelligence, is germane to continuing nurse education and professional development as a field of study, especially within the realm of leadership and administration (Williams & Davis, 2005). It encompasses one's intrapersonal skills, such as being able to form an accurate picture of one's self. It is also referred to as a form of *internal competence*: skillful management and regulation of one's emotions (Albrecht, 2006). However, here I am referring to the PHN's advanced perceptiveness in terms of her ability to detect *another's* emotions and to respond in synchrony to what is before her. Social intelligence, with its broader focus, captures the PHN's *externally oriented competencies* more so than emotional intelligence, taking into account the relational capacities that are so vital to interpersonal success. Regardless of setting, a nurse's control and wise deployment of her emotions and her capacity to understand emotive displays of those in her care are fundamental to therapeutic interaction. I concur with McQueen (2004) that we can anticipate that the spectrum of social intelligence will enhance practitioner ability to better target needs and concerns, and ameliorate suffering. Incidentally, if Peplau (1989) were alive today, I believe that she would be interested in pursuing social intelligence as part of interpersonal communication training for nurses.

Peplau's Seminal Relationship Phases

> Interpersonal theory is a body of knowledge that can assist nurses to observe more intelligently and to intervene more sensitively in nursing situations.
>
> –H. E. Peplau, 1989, pp. 7-8

Although there has been extensive theoretical literature pertaining to various facets of the professional nurse relationship, I proceed to compare the study's relationship-building process with Peplau's (1952/1988) interpersonal relations in nursing theory. Despite the fact that Peplau's theory was derived from her clinical observations in the psychiatric institution, her model has been adopted into practice within the community setting. It is also noteworthy that during Peplau's era, nursing practice was very much embedded in a biomedical paradigm, with focus on the patient's medical problem and his or her adjustment to the hospital setting. Some believe that Peplau held a narrow perception of the patient's socioenvironmental context because nurses at that time had little understanding of the external influences on mental processes, healing, and recovery (Belcher & Fish, 1995).

Nonetheless, Peplau (1989) contributed rich disciplinary understanding of the influence of the patient's immediate social environment, in particular the potential impact of face-to-face caring relationship on the patient's self system of feelings, ideas, and actions. Peplau incorporated postulates arising from investigation in the field of interactional psychiatry. She was intrigued with the work of Sullivan (1953), wherein he attributed the perpetuation of mental illness to inadequate and anxiety-provoking communication processes within two-person

relationships during formative and life-long development of the self-system. Peplau (1989) came to appreciate the vulnerable and malleable nature of the self system and believed that the nurse could improve negative aspects of the patient's self system in the context of responding to illness, through the medium of therapeutic presence and rapport.

Several of Peplau's (1989) theoretical propositions about the nurse-patient relationship strike a chord with relational goals and constructs embedded in Targeting Essence: Pragmatic Variation of the Therapeutic Relationship. I portray the points of comparison in Table 4. I list tenets from Peplau's theory in the left column and pertinent discoveries from the study's six-stage relational development process in the adjoining column.

Table 4

Points of Comparison between Peplau's Theory and the Study's Emergent Theoretical Model

a. *The intrapersonal dimension*. Nurses need to be cognizant of the influential role of intrapersonal thoughts and feelings during the nurse-patient interaction. Each interactant will have expectations, preconceptions, wishes, desires, and feelings about the other. Words and behaviours exchanged between the nurse and her patient ask something, they tell something, and they evoke feelings.	PHNs are both cognizant and accommodating of client sensibilities as depicted in the first three stages of the Targeting Essence model. Stage 1: Projecting Optimism • PHNs forge through walls of defensiveness by conveying authentic interest and enthusiasm. • PHNs raise maternal self-efficacy appraisals. Stage 2: Child as Mediating Presence • PHNs assuage threat by shifting gaze off mother and on to child. Stage 3: Ascertaining Motives • Mothers "test" the PHN's "real" intent. PHNs are aware that they have to adjust to the mother's constant evaluation.
b. *The subtle nonverbal cues*. Nurses often overlook subtle patient cues of distress, concern, worry and other "interpersonal events" because nurses are preoccupied with their professional agendas. Patient needs go unnoticed and unattended.	PHNs possess high levels of social intelligence competencies. Stage 4: Exercising Social Facility • PHNs can detect dissonance between the mother's verbal and nonverbal behaviours and probe deeper when verbal reassurance (i.e., "I am fine") is incongruent with facial displays. • Mothers may hide their true feelings. They especially will not express emotional needs over the telephone.

c. *The contextual aspects*. Human problems are greater in complexity than a cluster of personality traits or medical diagnoses and descriptors (e.g., the "overactive patient"). The nurse must consider the patient's contextuality including reciprocal relations within his or her social world, through application of biological, psychological and social science theories.	PHNs appreciate the unique interconnectedness of client's presenting concerns and her socioenvironmental context. Stage 5: Concerted Intentionality • Mothers may share the experiences of financial hardship but each has a unique story to tell. • PHNs move from universal understanding to this particular mother. PHNs strive to paint a new canvas of each mother, to understand her particular social world, and her heartfelt concerns arising from her circumstances and stressors.
d. *The reciprocal meaning of communicative behaviours*. Clinical nursing situations involve generic roots to nursing, and patient patterns of behaviours. Nurse-patient integrations embody meaning and purpose. The nurse must seek to understand underlying structural aspects and delve into concepts that will address the dynamics of professional relatedness.	PHNs have come to know and to understand their clients and to respond strategically. Stage 4: Social Facility • PHNs attune to the mother's cues and learn how to respond appropriately. • PHNs imagine themselves from the perspectives of the mother • PHNs are mindful of the mother's thoughts, emotions and feelings. • PHNs suspend judgment. • PHNs manage their emotions and impressions. Stage 5: Concerted Intentionality • PHNs realize interactional behaviours are motivated by several underlying factors and resist defensive replies.
e. *Nurse composure*. The nurse requires directional concepts to move her in proximity, contact, and deeper connection with her patients, especially when confronted with unpleasant situations or the	Home visits are sometimes sites of practice incidents that may evoke the PHN's negative feelings and emotions. Stage 4: Exercising Social Facility • PHNs do not offend but

"untouchness" of nursing.	circumvent negative feelings and control facial displays (e.g., the poker face).
f. *The health-enhancing effects of therapeutic rapport*. Showing interest is just one of the powerful growth-provoking interpersonal competencies that nurses possess. Nurses can contribute to the patient feeling understood, respected and valued, and as someone with whom the nurse cares to relate. Nurse-patient contacts enable nurses to actualize the goal of nursing; that is, to know the patient as a human being experiencing difficulty, and to extend his or her capabilities and to exercise innate capacities.	Several stages of the Targeting Essence model convey the PHN's caring interest and facilitate enhancement of the mother's sense of self and capacity potential. Stage 1: Projecting Optimism • PHNs convey confidence in mother. Stage 2: Child as Mediating Presence • PHNs admiration of child promotes maternal pride. Stage 3: Ascertaining Motives • PHNs exude trustworthiness. Stage 4: Exercising Social Facility • PHNs emanate respect. Stage 5: Concerted Intentionality • PHNs demonstrate interest in the mother as a worthwhile and capable person. Stage 6: Redrawing Professional Boundaries • PHNs are willing to go the "extra" mile.

Note. The content in the left column is drawn from Peplau (1989).

Peplau's tenets, portrayed in Table 4 (i.e., the intrapersonal dimension, the subtle nonverbal cues, the contextual aspects, the reciprocal meaning of communicative behaviours, nursing composure, and the health enhancing effects of therapeutic rapport), certainly apply to relational practice efforts outside the hospital milieu. However, I have noticed discrepancies between the results of my

research in terms of how to establish therapeutic relationship and documented reports of how Peplau's phases of the nurse-patient relationship have been adapted for community health nursing practice (McNaughton, 2005). As previously discussed under Review of Literature, Peplau envisioned the nurse-patient relationship as a sequence of overlapping phases (orientation, identification, exploitation, and resolution). These phases have since been collapsed into orientation, working, and resolution phases (Peplau, 1952/1988). I have come across professional literature wherein the three phases have been operationalized much like a mechanistic guide that is not entirely amenable to establishing therapeutic rapport with vulnerable and potentially stigmatized mothers.

For instance, during initial moments of the home visit (i.e., Peplau's orientation phase) PHNs are directed to search the home for hobby items and other objects which might serve as topics for social chit-chat. Mothers interviewed during my study voiced intense displeasure with the behaviours of social workers and paraprofessionals when they "showed up at their door" and proceeded to look around their home, stopping and staring at pictures on the wall. Mothers were adamant that "looking around" should be strongly discouraged. According to participants, these seemingly innocent behaviours are acts of scrutiny that only serve to perpetuate fear and mistrust.

Mothers stated that they would prefer that professional healthcare providers or personnel from social services maintain direct eye contact and shift their professional gaze only to focus on the child. From the mother's perspective,

looking around the room during the first few moments in particular is considered an act of "snooping" and "arrogance." Above all, mothers felt like they were "under the microscope" and that the professional, as one mother indicated, "was really there to check up on me." The PHN must also set out to forge through the mother's defensive stance, and the strategies involved in this are unrelated to "coffee table" items or other sources of conversation openers. Important for breaking ice and inviting the mother into interpersonal communication and relationship are the PHN's abilities to observe and either to praise positive transactions between the mother and child or to use her language of gifts to compliment any other manifestation of maternal competency.

In addition to searching for conversation openers, the PHN would also be directed, in accordance with Peplau's (1989) orientation phase, to complete a full client assessment. The PHN would be expected to solicit copious details from the mother to advance understanding of potential health concerns. Under the auspices of the Targeting Essence model, the PHN delays information gathering until the PHN has taken opportunity to mitigate threat by boosting maternal self-efficacy appraisals. The gradual focus on personal data and at a pace the mother controls is far less threatening. In addition, when the PHN demonstrates her pleasure and interest and offers verbal commendations, seeds are planted for rapport and inevitably the PHN is in a better position to meet professional agendas.

Unlike Peplau's (1989) model, there are no lengthy introductory and working phases depicted in the Targeting Essence model, and the stages do not necessarily follow a linear, sequential pattern. Some of the interactional

behaviours of the stages of the Targeting Essence model will occur more frequently or for longer duration or will reoccur. Temporality of each stage is determined by intrapersonal aspects of each dyad member and then the evolving characteristics of their dyadic interpersonal exchange. The stages are not mechanistic; rather, their dynamic and relational development is contingent on their succession, which is subject to the mother reaching that state of comfort and ease with meaningful disclosure.

Sometimes that level of readiness occurs quickly. PHNs stated that some mothers do not hesitate to divulge "touchy" issues early in the encounter. This finding is shared by other nurse researchers, who have indicated that clients will voluntarily express pent-up emotions irrespective of the length of time spent with PHNs (Aston et al., 2006). If early disclosure were to happen, the PHN would be pursuing relational goals and simultaneously working through problem identification, intervention planning, and monitoring the effectiveness of community referral and resources (i.e., the inferred objectives of Peplau's [1989] working phase). However, again, the very act of approaching the mother with questions would still be disconcerting, not so much because the PHN has not accommodated the mother's heightened sensitivities initially but because the mother would find the PHN's need to inquire about her health, and so forth, a reflection of an expert-driven agenda and a dismissal of her self-determined concerns. This sentiment is congruent with findings from the empirical literature (Jack, 2003).

The absence of a resolution phase in the Targeting Essence model is another divergence from Peplau's (1989) model. One will not find a resolution phase with a synopsis of what has transpired during the interaction between the PHN and the lower income lone-parent mother even after thorough open dialogue. There is no official scheduled termination phase, just as there are no predetermined meetings over the course of their relationship. Mothers anticipate future contact with the PHN, if praxis permits, either during drop-in appointments or over the telephone. This dissimilarity was also noted by McNaughton (2005), who, after testing Peplau's theory among PHN-antenatal dyads, concluded that Peplau's termination phase is not applicable to today's practice approach of "leaving the relational door open."

In a few words, Peplau (1952/1988) ascribed a step-by-step relationship-building process; however, she also envisioned a dynamic narrative between the professional and person under his or her care. If PHNs follow the more formulaic approach to professional relationships without comprehension of Peplau's founding tenets, they might overlook their need to be fully attentive and responsive to the mother's sensibilities and, in addition, might thwart their potential for affecting the mother's self system and mental well-being.

Extant Models

Some nurse scholars might draw parallels between the interactional thrust and strategies of the Targeting Essence model and the relational stance taken with families in the field of family nursing. The two family nursing approaches that I refer to below were developed in Canada.

The McGill Model of Nursing

The McGill Model of Nursing was inspired by nurse researchers based at Montreal's McGill University, most notably Canadian nurse leader Dr. Moyra Allen. The researchers state that in retrospect, the McGill model is a misnomer, for their "model" is, more accurately, a philosophical approach to practice that has been adopted by McGill's Faculty of Nursing (Gottlieb, 1997; Kravitz & Frey, 1997). The McGill model has attracted wide-spread attention.[6] Community health nursing students across Canada integrate the model's strengths-based approach, as opposed to a deficits-based approach, into their practica experiences. Students are instructed that it is the nurse's responsibility to build on individual and family innate and potential strengths within collaborative partnership relationships to achieve better health.

The first stage of the Targeting Essence model is Projecting Optimism, with substage interactional strategies Engaging Positively and Offering Verbal Commendations. Offering Verbal Commendations exemplifies the strength-based orientation advocated in the McGill model. Capturing strengths, I discovered, regardless of how minute they may seem, is pivotal to relational development. PHNs told me that from the very outset they look for reasons to praise the mother, sometimes as simple as the colour of hair barrettes chosen for her child. This, then, gives the PHN reasons to make explicit her admiration of the mother's creativity and joy associated with dressing her child. Or PHNs might point to the

[6] The McGill model of nursing has since been modified to better reflect the environmental influence on health, coping and development (Gottlieb & Gottlieb, 2007).

way that the child bonds with his or her mother, with commendations aimed at the nature and quality of mother-child attachment.

Identifying strengths enhances maternal self-efficacy appraisals and opens channels of communication for connection according to the study's emergent Targeting Essence model. In keeping with the McGill model, strengths are the means by which the practitioner can collaborate in "health work" and are drawn out after lengthy engagement with the family (Feeley & Gottlieb, 2000). The family's abilities to solve problems in the past are brought to light to form the basis for resolution of current issues and are incorporated as part of nursing planning and intervention. Family members might be asked, What do you think you do well? Do other people ever tell you that you are good at doing something?

Underlying motives are not entirely at cross-purposes with the PHN's intentions when guided by the Targeting Essence model, the difference being that the practice goals of problem identification and problem resolution are secondary in the Targeting Essence model. PHNs, when working with lower income lone-parent mothers, must attempt to locate, identify, and acknowledge strengths as a tool to help establish the relationship. Strengths feedback precedes engagement, and the PHN is not overly concerned with the mother's strengths being embedded in, or a reflection of, the mother's former and present problem-solving potential. The PHN, unlike the directives within the McGill model, does not have to mine out family-identified strengths. Clinician-identified strengths will work just as well. The choice of strengths for the PHN is incidental as long as they contribute to penetrating the mother's wall of defensiveness.

The Calgary Family Assessment Model

Other widely adopted family practice tools are the Calgary Family Assessment Model and the Calgary Family Intervention Model (Wright & Leahey, 2000, 2005). These models equip nurses with the theory and practice skills for assessment and collaborative working relationships to promote family health or diminish emotional, physical, and spiritual suffering from illness. They are designed to focus on families facing health issues such as life-threatening illness, psychosocial problems, and chronic illness. These versatile models can be applied in nursing practice, education, and research.

The internationally adopted Calgary Family Assessment Model (CFAM) is a comprehensive three-pronged structural, developmental and functional family assessment framework. The nurse may be required to conduct a thorough, comprehensive family assessment using a series of questions. Topic areas include, for example, family composition, quantity and quality of support from extended family members, religious affiliation, family life cycle events, extent of affectional bonds and attachments between family members, and determination of family roles and tasks (Wright & Leahey, 2000). The Calgary Family Intervention Model (CFIM) is a strengths- and resiliency-oriented model. Nurses use their skills during therapeutic conversations and interviews to enable change in the family's affective, cognitive, and behavioural dimensions (Wright & Leahey, 2005).

If the family nursing context involved a lower income lone-parent mother who is coping with her chronically ill child, I expect that learnings from my study would still be applicable. For example, posing several questions, as argued

previously, could prove threatening, especially if the mother harbours suspicions and fears. In fact, I do not think that the nurse can transfer the CFAM from the home of a client who is a two-parent, middle-income family to the apartment of a lone-parent mother who is living on public assistance (or implement the CFIM) without ample prerequisite preparation. I outline recommendations to assist nurses with their preparation in the ensuing section.

I advise that prerequisite preparation start with Wright and Leahey's (2000, 2005) comprehensive textbook guides to family practice, which encompass the theoretical foundation and core competencies necessary for working with families. However, the authors acknowledge that they cannot cover the entire range of family nursing practice. The onus is on nurses to make adjustments to accommodate their practice domains. Among the authors' guidelines are three types of family interviewing skills: conceptual, perceptual, and executive. I have selected the three skill sets as scaffolding for recommendations (see below) to assist nurses who are seeking to establish collaborative working relationships with lower income families and who are wishing to fulfill the requirements of CFAM and CFIM.

1. Supplement the nurse's conceptual foundation. Wright and Leahey (2000, 2005) underline family diversity in terms of ethnicity, race, culture, sexual orientation, gender, and class. The authors identify "social class" distinctions between the "low-income" family and the "professional" family in terms of family life cycle stages. For example, they cite claims that in contrast to the professional family, pregnancy and parenting responsibilities could begin early

within low-income families, when individuals are teenagers and young adults. Other social class differences, mentioned briefly against a backdrop of dated American poverty research and statistics, are that nurses are to consider the influence of the family's cultural, social, and economic context on healthcare beliefs and utilization of healthcare services as each "class has its own clustering" (Wright & Leahey, 2000, p. 83) of values, lifestyles, and behaviours.

Wright and Leahey (2005) have defined *conceptual skills* as the nurse's ability to make sense of her observations of the family as a system and as a family in context. PHNs in my study were able to interact effectively with lower income families because PHNs had a sound working knowledge and understanding of the lived experiences of family poverty. I recommend that nurses could best prepare to use the CFAM to assist lower income families to cope with illness if they were exposed to the exigencies of lower income families' everyday realities.

Case studies of Canadian female-led families, for example, who survive on incomes below the LICOs could be sources of learning and contribute to the nurse's conceptual foundation, from which she could draw meaningful insights about what she sees. If I were to relate the "common" story of the lower income mother, I would base my description of the daily challenges on a composite profile of the 21 mothers whom I interviewed. Hence, the case study would

include a mother who

- lives alone with her children in subsidized housing, a costly nonsubsidized rental suite, or a safe house;
- visits the foodbank and food co-op regularly or restricts her own food consumption to feed her children;
- depends on public transportation;
- is estranged from partner, friends, and extended family members;
- has experienced domestic violence;
- keeps to herself to avoid conflict with neighbours and to shield her family from potential dangers in the community;
- retreats occasionally to addictions to cope with stressors;
- suffers at times from organic or situational depression, anxiety, and psychological distress; and
- tends to be suspicious, distrusting, and insecure with health and social service professionals.

Having to cope with an ill child would intensify the mother's daily struggles and would most likely exacerbate her unrelenting stress.

Wright and Leahey (2005) appreciate that each family is unique in terms of composition, functioning, and beliefs about health and illness. Nurses are advised to operate from a stance of respectful curiosity to avoid imposing expert opinions and assumptions on the family and to use hypothesizing as a technique to begin thinking about the family and its health problems well in advance of the first meeting. The nurse is to use "who," "what," "why," "where," "when," and

"how" questions to focus her cognitive resources and to formulate hypotheses. Augmenting the nurse's conceptual base with lower income family case studies could evoke preinterview curiosity and hypothesis generation. For example, the nurse may come to realize that the informal and formal social network connections of the lower income lone-parent mother are generally sparse in comparison to those of higher income mothers. She might then be prompted to hypothesize about how social isolation and lack of social support are affecting the lower income mother's ability to cope with her newly diagnosed chronically ill child.

2. Concentrate perceptual skills on nonverbal cues. Social class[7] is examined as one of CFAM's subcategories of the family's internal structure. Nurses are to consider how living standards and access to employment, income, and housing, have meaning for families) and the implications for caring for ill family members. Nurses are to ask questions, and possibilities suggested by the authors relate to how many times the family has relocated, how their financial income influences their use of healthcare resources, and the impact of shift work on the family's stress level (Wright & Leahey, 2005).

According to my study findings the lower income lone-parent mother might possess heighten sensitivities and could possibly interpret the above questions as not entirely relevant or too personal and, hence, threatening. It is

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[7] Ideally CFAM should be embedded in the unique archetype of the lower income family; that is, social class would no longer be a subcategory but the enveloping context of CFAM.

critical that nurses attain the perceptual skills to know what kinds of questions to pose and to know when during the interaction is the most appropriate time. The nurse's conceptual base could inform her perceptual skills. If, for example, the nurse has learned how stressors of poverty are manifest emotionally, then she might be more apt to purposely observe for any nonverbal cues of distress and resistance, and can alter her inquiry accordingly. Because the nurse is looking, she will be able to perceive overt as well as fleeting expressions, and subsequently use this information to decide the appropriate focus and timing of her inquiry. She might detect signs of apprehension or anxiety, for example, and decide to pose open-ended questions to ascertain the "family's meaning." In this way, the nurse puts the mother more at ease by giving the mother control of the conversation in terms of subject matter and the freedom to decline from disclosing private (i.e., what the mother considers private) information.

3. Make strengths identification the nurse's priority executive skill. The nurse's conceptual foundation and perceptual skills enable her to strategically tailor her executive skills. Executive skills are what constitute therapeutic conversation with the family, particularly during implementation of CFIM.

Wright and Leahey (2005) have cautioned that if family members believe that the nurse is an employee of an institution sent out to assess the family, then carrying out a thorough assessment, such as CFAM, might be contraindicated. I infer that the authors are exemplifying consideration for the family's concerns and that family suspicion could preclude the nurse's attempts to pursue assessment and intervention. It is highly likely that this cohort of mothers will be suspicious

and will safeguard themselves and their children from any professionals, whether agency personnel or not. However, my study findings indicate that the nurse does not have to resign her efforts. Approaching the mother with a warm smile and opening the conversation with verbal commendations, especially praise of maternal strengths, might offset the mother's fears that the nurse's sole purpose is to judge her or to find reasons to condemn her parenting effectiveness. Interactional strategies such as Engaging Positively and Offering Verbal Commendations (located in the emergent first stage, Projecting Optimism) may overcome fears induced by underlying feelings of inadequacy about her mothering capabilities.

In fact, Offering Verbal Commendations correlates well with the strengths-based approach advocated by Wright and Leahey (2005). Nurses are to be "strengths detectives" (p. 163). Preinterview hypothesis generation should incorporate the nurse's curiosity about the family's resilience and resourcefulness. Similarly, commendations are important facets of the process of intervening with families and instrumental to CFIM's effectiveness. Nurses are directed to make positive statements about family competence (big or small) a regular component of their sessions with families. Also, the authors distinguish between compliments about what family members have said to promote a working alliance with the family, and commendations about observations of how family members react to one another, spoken to cultivate hope and optimism. Strengths feedback is intended to reframe perspectives of defeat and to encourage families to mobilize their problem-solving skills. According to the authors, if families think that they

have the potential to overcome, they will approach problems differently and discover their own solutions.

Wright and Leahey (2000) contend that families confronted with chronic illness experience a "commendation-deficit-disorder." This "disorder" might pervade female-led lone-parent families who are coping with a chronically ill child and also dealing with the complex poverty web of adverse living conditions, social exclusion, and disparagement by others for relying on welfare. I recommend that nurses focus first and foremost on the mother's presenting disposition and, if necessary, deploy strengths to address potential feelings of maternal inadequacy and to assuage their fears and suspicions. In so doing, nurses will invite engagement, and the ensuing rapport will foster openness to their opinions and ideas. As the nurse continues to identify strengths, the mother will likely become more trusting and receptive, and the important goals for cognitive, affective, and behavioural coping and management can be achieved.

Summarizing the Interpersonal Communication Essentials

In this final section of the Discussion I summarize the salient steps and ingredients of establishing therapeutic relationship. The PHN seeks rapport with the lower income lone-parent mother within relatively short time frames yet is able to home in on burdening concerns. Moreover, she does not threaten the mother's sense of self; rather, she promotes the mother's positive identity. I explore the PHN's interactional strategies embedded in the emergent theoretical model Targeting Essence: Pragmatic Variation of the Therapeutic Relationship. As mentioned under Summation, relational development evolves through stages

that I have categorized as the icebreakers, the catalysts, and the sustainers. The icebreakers (Projecting Optimism and Child as Mediating Presence) forge through walls of defensiveness by means of the PHN's friendly disposition and verbal praise. The catalysts (Ascertaining Motives and Exercising Social Facility) solidify trust and equip the PHN to detect signals of distress and anxiety, and to know when and how to probe into sensitive subject matter. The sustainers (Concerted Intentionality and Redrawing Professional Boundaries) promise a deeper level of connection as they privilege the personal identity and concerns of the mother and facilitate her innate capacity to pursue self-determined goals.

The Icebreakers

Projecting Optimism and Child as Mediating Presence are the critical first stages of the process and are described as the icebreakers. Analogous to cutting through ice, the PHN implements substage interactional strategies to bring down walls of defensiveness. The walls are erected as self-protective mechanisms (Crocker & Garcia, 2006) precipitated by low levels of self esteem and elevated levels of stigma consciousness. Evident from my study is the tenuous nature of relational development when the PHN is in interaction with mothers who are vulnerable and also subjected to stigmatization (e.g., recall the professional interactions involving mothers Lillian and Esther).[8] The roots of low self-esteem and high levels of stigma consciousness can be traced back to the mothers'

[8] See Study Illustrations.

primary social systems, which incited negative self-judgments as opposed to nurturing healthy positive identities.

PHNs had an in-depth understanding of the vulnerabilities of lower income mothers by virtue of mothers' stories of deprivation and abuse as children. The mothers were wounded psychologically as they were left with the mental imprint that they were not loveable and that they "would not amount to anything." Confounding their life trajectory are the multiple social identities held by many of the mothers: Recall Kelly's affiliation with more than one marginal group (see under The Therapeutic Relationship in Context). The cumulative effects of being identified with more than one socially disadvantaged group heighten stigma consciousness (Greene, 2007).

As adults, lower income lone parent mothers endure psychological distress and anxiety as they face financial hardship and the strain of caring for their children alone. Stigmatization as mediated through negative discursive interactions in their social world has only exacerbated their state of vulnerability. They are left to feel sad, upset, angry, humiliated, and depressed. They are possibly even made to feel, in Goffman's (1963) terms, like the "discredible citizen" (p. 3). Stigmatization fuels their preexistent negative self-judgments, poor self-concept, and low self-esteem.

PHNs with advanced relational capacities recognized the implications of low self esteem on interactional behaviours. As they related their relationship experiences, it became apparent that they were aware of the sensibilities of mothers with heightened levels of stigma consciousness. PHNs could refer to

distinct behavioural markers to identify the walls of defensiveness, such as "averting your gaze," "responding with very short, brief answers," "very flat affect," and disconnection: "not seeming to care about her surroundings." The PHN purposely employs verbal and nonverbal communicative behaviours to mitigate threat.

During the first stage (Projecting Optimism) the PHN breaks through walls of defensiveness by exuding a friendly, gentle, heartening disposition. The mother is receptive but baffled as she ponders: "Is this health nurse happy to see me? She is interested and happy for me and my baby?" The PHN is conscious of her own clothing, an important foundation of nonverbal communication (DeSole, Nelson, & Young, 2006) and dresses informally. If mothers had their wish, the PHN would remind them of an "old hippie women in a skirt." The PHN's analogic communication (Watzalick et al., 1967) conveys enthusiasm and interest through her use of good eye contact, facial smiles, square body posture, and an "upbeat" voice inflection. Sincerity is crucial. The PHN will not be able to conceal from mothers a forced mechanical, spurious, "crocodile" smile. The effectual PHN is genuinely happy to see the mother and her newborn because she believes that all women want to be good mothers. Regardless of income bracket, the euphoria does not wane: "It doesn't matter how wealthy you are or how poor you are, you love your baby the same."

Supplementing positive nonverbal behaviours is verbal praise, or, as some described, the practitioner's language of gifts. PHNs focus their every word and deed on finding the good in the mother and her mothering behaviour. Many of the

mothers whom I interviewed had not received positive reinforcement. In fact, one PHN indicated that "caring for a child well, may be the only thing that they have done right in their eyes, [and] in society's eyes." Mothers acknowledged their appreciation with comments such as, "It feels good when you get compliments. I used to be just put down and you feel like you are nothing." As such, the mothering role and maternal self-efficacy are domains on which many have staked their self-esteem. Cognitions and feelings about self are focused on her role as mother. Imputations of the PHN's responses towards her in terms of her parenting performance have implications for improving her transsituational core self (Turner, 2002). By implementing a strengths-based approach (Feeley & Gottlieb, 2000), the PHN is influencing the mother's cognitions and feelings about her self in the role of mother and potentially, enhancing her core self; that is, how she feels about herself as a person. Social and personality psychologists posit that we all enter into face-to-face interaction with one or more interpersonal motives (Fiske, 2003). Of the five core motives (belonging, understanding, controlling, trusting others and enhancing self) and based on what I know about the mothers participating in the study, I speculate that Offering Verbal Commendations is an effective relational tool because it addresses the mother's motive to enhance her sense of self. Mother participants were exceptionally responsive to positive affirmation, most likely because their maternal role was firmly attached to their identity and hence produced stronger feelings (Turner, 2002) of pride, confidence, and happiness. Simultaneously, the PHN cultivates rich potential for engagement and rapport.

Child as Mediating Presence is the second icebreaking stage and the second stage of the relational development process. The PHN directs her full attention to the child. For mothers who remain standoffish, the PHN can put the mother at ease by shifting her professional gaze off the mother and onto the child. Anxieties dissipate, and walls of defensiveness crumble.

Children are the embodiment of life for this cohort of mothers, and mothers who participated in my study were devoted to their children. Bergum's (1997) poignant reflections of maternal love as "child on her mind" resonate with the sentiments of mothers interviewed. Transition into motherhood "is not merely a cerebral, cognitive notion" but "penetrates the heart, the soul, and the spirit" (p. 14). Children were their source of purpose, direction, and meaning. "Hope is looking at him every day," commented one of the mothers. It is vital that the PHN not overlook this important relational opportunity. The risk is great that if the child is dismissed, all chances for rapport are lost. The child poses as the bridge, or mediator, between initial contact between the PHN and the mother, and the promise of establishing therapeutic relationship.

One fascinating discovery is that the children were endowed with advanced sensitivities. Children ostensibly became uncomfortable when his or her mother was engaged in a negative interaction. "My kid really likes her," claimed a mother of an infant. "He can tell whom I'm comfortable with." Might this be an indicator of the infant's social radar in relation to the spectrum of social intelligence? Psychoanalytic references might shed some light, but it was beyond the purview of my research objectives to ascertain whether mothers were

demonstrating transference. Were mothers transferring their attitudes and repressed anxiety and conflicts towards helping professionals onto their children as a result of former negative experiences? In line with grounded theory's pragmatist principles, I asked myself, Would stages of relationship-building or interactional strategies have been altered if PHNs were witnessing transference? I concluded that, no, they would have remained the same. Transference is possibly another psychological coping mechanism of lower income lone-parent mothers, and if so, it further legitimizes the role of Child as Mediating Presence for engagement and rapport.

The Catalysts

The propensity for mistrust among lower income mothers (Dodson & Schmalzbauer, 2005) contributes to the challenges of establishing relationship. Deeply entrenched mistrust and fear mean that despite the efforts of the icebreakers to affirm maternal self-efficacy and to build the mother's pride through focused child admiration, the PHN will have to undergo the mother's scrutiny before there is further relational development. The mother must ensure that she can trust the PHN. Symbolic interactionists would explain that the PHN is a symbolic representation (Blumer, 1969). The mother's interpretive meaning of the person of the PHN is through the mother's lens of a particular longstanding prototype that determines the attributes of the PHN. Possibly, mothers perceive the PHN, or any professional stranger, as representative of or responsible for all the injustices inflicted on them by the "system" or by their own family members.

Mothers judge the "real" motives of strangers. Recall the insights of the outreach worker whom I interviewed: "They are very judgmental and so they will read you as soon as you walk in the door. You know… where you are, where you have come from, what you do… whatever."[9] During this third stage (Ascertaining Motives) the mother becomes the "judge and jury." Mothers want to verify that the PHN can be trusted not to judge her. The mother decides that she has been unable to sufficiently verify her assumptions about the grounds of the PHN's actions and is left with only her perceptions and imagination. She cannot explicitly inquire about the PHN's thoughts and feelings, including, What are her innermost feelings concerning me? In addition, she is finding it difficult to decipher the PHN's expressive gestures, so she employs the litmus test. This entails strategic questions posed by the mother to the PHN. The mother then conducts her motivational assessment (Strauss, 1959) based on the PHN's replies. Included in the criteria is the observation that the PHN does not react in punitive judgment or assume expert control over the topic matter. If the PHN scores well on the litmus test, the mother will delve into personal issues, and the interaction will catapult into a deeper level of engagement beyond polite, conventional discourse. The mother's validation of trust is the catalyst into the next stage.

As discussed at length under Revisiting Nursing Communication, the PHN possesses advanced social intelligence capacities that enable her to know what to say and when to say it. During the fourth stage (Exercising Social Facility

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[9] See comments by outreach worker under Ascertaining Motives: To Trust or Mistrust.

substages of Empathic Accuracy and Responding Strategically) the PHN demonstrates her astute social detective skills. The PHN's social decisions are driven by high-road social cognitions and low-road noncognitive abilities (Goleman, 2006). The noncognitive abilities are categorized under the substage interactional strategy Empathic Accuracy, which encompasses the PHN's spontaneous detection of the mother's fleeting expressions and emotions, and awareness of the mother's thoughts and feelings. Responding Strategically, the other substage interactional strategy, constitutes high-road social cognitions that build on Empathic Accuracy and equip the PHN to suspend judgment attitudinally, affectively, and behaviourally. Consequently, the PHN mitigates threat and is able to pose personal questions but not sabotage rapport. Without going into extensive elaboration, I draw from my findings certain salient ingredients that warrant mention.

Empathic Accuracy is instrumental to the PHN's ability to read facial displays of apprehension when probing for information. The PHN is able to, in social psychologists' terms, save face. The PHN shields the mother's inner self (O'Keefe, 1991), which is an identity that the mother fears would accrue negative social judgment if ever exposed. The PHN watches the mother's signals of distress when posing questions about drug and alcohol histories, for example, and adjusts accordingly how she will proceed with further inquiry. The self the mother wants represented publicly may be a new "face," a life and identity apart from her former self. Perhaps her new self-identity is that of a proud, competent mother, an

identity that she might believe to be assigned high social value by society (Goffman, 2005).

The PHNs are unable to capture emotions without visually and mentally tuning in to the mothers' verbal and nonverbal communicative behaviours (Egan, 2007). The PHN wonders to herself, What is the mother experiencing in terms of inner emotions and feelings? She immerses herself in the social cognitive process of listening with her ears and her *eyes*, her ears to the content of her story and her eyes to her facial displays of emotion. The PHN's level of listening is characterized as extremely deep and consuming. Counsellor Carl Rogers (1980) described it as empathic listening. All that matters is drawing close to the mother's felt meaning, and when the PHN does detect something amiss, she clarifies with the mother: "Something else going on that you would like to talk about?" PHNs can hear emotions with their eyes and use active listening techniques (Williams & Davis, 2005) to gain clarification of what the mother is feeling and thinking behind her facial and verbal expressions. In addition, the PHN's insights into the mothers' lived experiences and grasp of what might be the continuum of their thoughts and feelings undergird the PHN's powerful capacity for intuitive recognition.

The PHN's exposure to mothers' stories is pivotal to the effectiveness of Empathic Accuracy. New understanding and an insider's perspective of the mother's social embeddedness (SmithBattle, Drake, & Diekemper, 1997) enable her to subsequently see herself through the eyes of the mother. Empathic Accuracy is important groundwork to Responding Strategically, which enables

the PHN to control impulsive emotions and to express nonjudgment. Suspending judgment is a critical ingredient in the overall relational development process. It derives from earned respect, which speaks to the PHN's tremendous regard for the mother's capacity to endure the daily hardships and stressors brought on by economic disadvantage. Suspending judgment requires the PHN's command of her emotions. Here she uses her repertoire of social techniques to fulfill certain self-presentation (Argyle & Kendon, 1972) outcomes, chiefly to appear "neutral" under all situations and circumstances: to maintain a poker face. This facilitates evolvement of the relationship to the sustaining fifth stage, Concerted Intentionality.

The Sustainers

The intensity and quality of exchange between the PHN and mother as dyad members produces the interdependency required for genuine evolvement of the relationship (Strauss, 1959). The successive stages have solidified the mother's confidence in the trustworthiness of the PHN, who can now exert her efforts to ascertain concrete factual information from the mother. The PHN can relax for the moment her need for hypervigilance concerning her indexical information. In the substage interactional strategies Painting a New Canvas, Eliciting the Client's Agenda, and Building Capacity, the PHN seeks understanding of the particular mother and her particular lifeworld, situation, circumstances, goals, and dreams. She starts a new slate and paints on fresh canvas the personhood of the mother before her.

Using a person-centred approach (MacIntyre & Fink, 1997; Rogers, 1989), the PHN poses questions with wonderment and curiosity. The questions are as simple as, How are you? PHNs conceptualize their practice goals as tapping into the "human being first" and privileging "the human and emotional side" of practice that are so often lost in the paperwork. Mothers so wanted and needed to be asked about their human emotions, thoughts, and feelings. Some desperately wanted to be asked about life at home. However, they were not forthcoming without encouragement. They waited for the PHN to approach first and to ask before they would turn on their taps of disclosure.

The person-centred approach entails subjugating the PHN's professional agenda and privileging a client-driven agenda. As much as possible, the goals, objectives, and activities are guided by the client. One of the PHNs exemplifies client "control" with her statement, "Pick me up and put me down wherever you think it is you want me." Client autonomy, however, is not without the necessary capacity-building measures. Peplau (1989) theorized that contact with clients helps that "person to stretch his or her capabilities… and exercise innate capacities" (p. 44). Capacity refers to the "power, ability or faculty for anything in particular" (Simpson & Weiner, 1996, p. 857). Maternal capacity is the mother's perception and performance as an effectual parent. Mothers early on in the relationship-building process will have been recognized for their strengths in terms of maternal competencies. Building capacity calls forth earlier allusions of self-efficacy to enhance and to optimize her competence and positive functioning.

The positive psychology movement promotes listening for the client's innate resources as opposed to listening for problems so that there is hope, optimism, coping, and other virtues for future struggles (Egan, 2007). The PHN has instilled in the mother hope and optimism, and their relationship is strengthened to the point that the PHN actively takes on subroles to assist with resolution of the mother's concerns during the sixth and final stage, Redrawing Professional Boundaries, during which the PHN assumes pseudo-roles of social worker, advocate, mentor, and coach. In addition, the mother perceives the PHN as her surrogate friend, mother, and confidante. The sixth stage is ostensibly the last stage of the relationship-building process but is not considered the final stage of the therapeutic relationship. Unlike Peplau's seminal phases and the CFAM and CFIM models presented for comparison earlier in this chapter, the study's emergent Targeting Essence model is without clear demarcation of closure. Continuity of relational rapport resumes in the event of a crisis or the need to talk, to solicit an honest opinion, or to gain support or for the proud mother to showcase her child's healthy growth and development.

In brief, key junctures and pivotal ingredients that are instrumental to the relational development process have been identified. The icebreakers prepare the way by assuaging threat. The PHN's awareness and accommodation of the mother's heightened sensitivities associated with stigma consciousness are prerequisite to relational development. Gifts of verbal commendation raise self-efficacy appraisals and mediate engagement potential. The catalysts are responsible for strengthening trust and contribute relational opportunity and

momentum. Key ingredients for catapulting the interaction into interdependence include saving face, visually and mentally tuning in, earned respect, and suspending judgment. The sustainers embody person-centredness, a client-driven agenda, and capacity building. The mother experiences incremental self-enhancement throughout the process and recognition of her innate capacities. The final stage is not a point of departure for dyad members but a point of redefinition of role expectations on the part of the PHN and a renewed commitment to life ambitions on the part of the mother prompted by the unconditional support rendered during therapeutic rapport. Of course, relationship building is not without several challenges, as made evident in the next section.

Barriers to Therapeutic Relationship

As I explored the relational development process, I compiled memoranda about the roadblocks that PHNs have experienced establishing therapeutic relationships with lower income lone-parent mothers. I have selected the roadblocks that are predominantly systemic in origin, such as organizational structures, policies, and protocols. These system-level forces influence public health nursing praxis and sometimes hinder relational opportunities. The *generic services delivery system*, *practice habitus*, *team nursing approach*, *diminished face-to-face contact*, and *scope of practice* are five system-level factors that I infer from my data to be major sources of relationship barriers.

Generic Services Delivery System

The generic services delivery system perpetuates the universal truism that one should treat everyone the same. When PHNs treat everyone in their caseload

the same through standardized programs, services, and assessment tools, the risk is great that they will grow immune to salient differences, become insensitive, and then overlook the need to modify their relational practice approach with lower income mothers. When presenting my research intentions to a staff of PHNs during the recruitment stage of my study, I noticed that some listened with interest and others, who seemed less interested, stated after the presentation, "We treat everybody the same. There is no need to focus on these mothers. They aren't treated any differently than any other mother." This unwarranted assumption of similarity (Trenholm, 2008) leads PHNs to miss the need to adjust their communicative behaviours because they are not mindful of differences and are not seeking differences.

With respect to generic services delivery system, it is my impression that PHNs are less motivated or compelled to seek to know mothers as persons first and clients second, yet it is this person-centred approach, and not so much the actual services and programs in and of themselves, that invites, fosters, and sustains engagement. Comments from one of the participants illuminate the tensions:

> Like, everybody is different, right? Even though we are different from everybody else, we are still the same. But I think it is that understanding, and knowing, and really the respect that you can give them that they are going to appreciate that more.

Some mother participants complained that they were unable to schedule immunization appointments with the same PHN. These mothers even appreciated the mere fact that when a familiar PHN walked by them in the waiting room, she recognized them, knew their children, and remembered their names.

Client-centred delivery systems and person-centredness are topics of philosophical discourse in nursing and healthcare ethics (Bergum & Dosseter, 2005; Kendrick, 2000; McCormack, 2003). In the nursing literature person-centredness entails acknowledging an individual's humanness through privileging his or her values, beliefs, and assumptions. When PHNs deliberately attend to the personhood of lower income lone-parent mothers, they are recognizing their clients as unique human beings and, more important, are conveying to mothers that they are special, prized, and accepted and have much to offer. One mother participant, when asked what it meant to be treated as an individual, remarked,

> Well it helps me to appreciate my own self worth and then I come up with a bit more ideas. It helps me be more relaxed about myself and not be uptight like nobody loves me [and] nobody wants me around, and all this kind of stuff.

Practice Habitus

PHNs are not unlike most health and social service professionals, who are quickly socialized within their community of practice (Brown & Duguid, 1991) as to how to think about and do their work. Eventually, everyday, habitual routines enable PHNs to perform their responsibilities in timely, efficient fashion. Although routinization is rewarded for its cost-effectiveness, however, the disadvantages outweigh the advantages for a PHN hoping to connect with lower income mothers. A perfunctory manner sends messages to these mothers that the PHN is more interested in completing tasks and less interested in the mother's personal concerns. My research findings cite mothers reacting strongly to impersonal inattentiveness. For example, the interpretations of one mother, in

particular, included, “She [the PHN] was just trying to do her job,” “They’re just doing it for the money,” and “There is more stuff to do with their job than just a job because you have to interact.” I also became aware that the lower income mother might think herself unworthy of this PHN’s time and attention. The relational window is then sealed tight because the PHN did not take the time to regard the mother or to listen to her. Trenholm (2008) expounds:

> Listening is also essential in creating and maintaining relationships. One of the major characteristics that attracts us to others in the first place is their willingness to listen. When people refuse to listen, they send a message that they don’t care about us, that we don’t exist for them. (p. 47)

Moreover, mothers personalize curt and dismissive approaches of administrative staff with statements such as, “She was rude to me,” “Others have been snotty towards me,” or “I felt like they thought I was some dumb mother.” Some mother participants believed that the married mothers who come into the waiting room with their husbands “are treated differently.”

Communication theorists posit a person dwells on self during face-to-face interaction in the following manner: “ ‘This is how I see myself… this is how I see you… this is how I see you seeing me’… and so forth in theoretically infinite regress” (Watzlawick et al., 1967, p. 52). A mother is prone to internalize what she interprets as negative reactions towards her because she is overly conscious of self and watches for mirrored attitudes of disapproval. In contrast, other clients entering the community health centre, who may not be concerned with impressions of self on others or who pay little attention to the responses of others, would interpret seemingly normative office practices differently. Moreover, mothers participating in this study were possibly hypersensitive to what social-

cognitive psychologists refer to as rejection cues (Pietrzak, Downey, & Ayduk, 2005), which can originate from early rejection experiences as children. The mothers posses a lowered threshold for perception of negativity and will react out of anger, anxiety, or defensiveness.

Team Nursing Approach

Some of the PHNs whom I interviewed spoke proudly about their team nursing approach. Preceding each response to my questions about their relational practice efforts was the plural "we." Whether the participant was discussing roles, approaches, or activities, each sentence began with "we" as opposed to "I" or reference to "my practice." The team approach, however, impedes rather than fosters relational development with lower income lone-parent mothers. Repeatedly mothers voiced their frustrations about having to explain their situation over and over again to different PHNs. Moreover, those with heightened levels of stigma consciousness could never reach a point of trust and establish rapport. Conversely, when mothers are able to visit with the same nurse, their interpersonal relationship evolves because each interaction has a cumulative effect on the quality of the next interaction (Strauss, 1959) in terms of engendering trust, and eliciting details and understanding about the mother's life and her concerns.

Diminished Face-to-Face Contact

Face-to-face contact is a much more effective medium for targeting real concerns than telephone conversations. PHNs told me that they are able to "read much more of what is really going on." They can assess, for example, the

mother's level of stress and anxiety by watching how she handles her baby. Mothers admitted that they have often told the PHN on the other end of the telephone that they are "fine" when many of them really wanted and needed to talk to someone. I uncovered story after story of missed opportunities to connect with mothers because they were contacted solely by telephone. "Talk is not an entirely adequate substitute for human contact, despite what telephone company slogans would have us believe. When people have something emotionally important to say, they need the full range of nonverbal channels" (Trenholm, 2008, p. 112). This communication theorist could be describing the sentiments of the mother participants. Mothers much preferred human-to-human contact to disclose intense emotions and feelings.

Mothers could also assess and test the trustworthiness of the PHN through face-to-face interaction. PHNs cannot wait for the mothers to telephone for assistance if the walls of defensiveness have never been penetrated. One PHN insisted that eventually mothers will "get more comfortable about calling us." However, according to participants, the PHNs are unlikely to gain the mother's trust with the occasional telephone conversation. Furthermore, relational development depends on the PHN's immediate and continued feedback of concern and care for a deeper level of connection.

In the same vein, the PHN learns so much more from visiting the mother in her home setting. The effectiveness of home visit for establishing trusting relationships is well documented in the nursing and early intervention literature. Home visits put mothers in their own realities and can be a more comfortable

location for mothers. If mothers have more than one child, the home setting enhances her convenience and meets transportation needs. As mentioned previously, I unveiled missed opportunities on the part of the PHN to detect concerns and to address both emotional and tangible needs because the PHN was not aware or not made aware. There was no opportunity for her to read the mothers, to read their facial expressions, and to pick up on the socioenvironmental cues that human and material resources were needed. It is up to the PHN to facilitate relationship building through reaching out to the mother, appeasing her distrust, and promoting maternal self-efficacy and capacity potential.

Scope of Practice

In 2004 the Canadian Nurses Association recognized public health nursing as a specialty practice within the field of community health nursing. PHNs espouse several values, including equity and the fundamental right of all humans to the essential determinants of health and to accessible, competent health care. As new employees PHNs are introduced to *The Canadian Community Health Nursing Standards of Practice*, which define the knowledge, skills, and attitudes specific to their practice, education, administration, and research (Community Health Nurses Association of Canada, 2008). During formal orientation sessions, several standards are reviewed, including the mandate to develop connective caring relationships in support of the physical, spiritual, emotional, and cognitive dimensions of individuals, families, groups, and communities. Consultants and managers with whom I spoke during the study indicated that the following core

standards are the topics of deliberation during orientation:

1. promoting health of individuals, families and communities (health is influenced by socioenvironmental influences),
2. building individual/community capacity (applies community development principles),
3. building relationships with clients and/or with organizations/stakeholders (includes principles of connecting, caring, mutual trust and understanding),
4. facilitating access and equity, and
5. demonstrating professional responsibility and accountability.

The above standards promote and direct the PHN's professional role and serve as benchmarks for the desired and expected levels of performance and competencies.

PHNs participating in my study stated that they have not been able to practice within the full scope and expectations of the standards. For example, there is less-than-favourable opportunity to build relationships, especially therapeutic relationships with vulnerable and potentially stigmatized clients. Professional praxis was characterized by some PHNs as constraining. Time-limited immunization appointments, especially, pose a major obstacle. Notwithstanding the critical public health mandate of communicable disease control, and the pressures exerted on the system by workforce shortages and higher than national average birth rates in Alberta, I learned that there is an ever-increasing volume of content to be covered during the immunization visit. Little time is allotted for mothers to discuss psychosocial issues.

Several families every day of the week visit the community health centre for child vaccination. Some of the PHNs whom I observed during immunization clinics stated that they find themselves day in and day out seeing new and different mothers, which they likened to an assembly line. They lamented their former generalist roles, when their office drawers contained their caseload of families whom they knew intimately. However, PHNs related during interview sessions how they have become technically proficient as well as masterful at imparting the important information about risks, benefits, and contraindications and at conducting developmental assessments. Consequently, they are able to create the relational space for rapport and to plant the seeds for later meaningful connection.

Furthermore, some informed that they are afforded the professional discretion and autonomy to make arrangements for follow-up with at-risk mothers if they deem that circumstances warrant further exploration. Esther (a single mother already mentioned) alluded to planting seeds of opportunity as she talked about wishing that the PHN had asked her about matters that were troubling her. She explained that when the PHN inquires about a mother's welfare, it "helps plant a seed, gets the person thinking, 'This nurse is here, maybe I should take advantage of that help,' instead of like holding it all in and waiting for it to explode."

Some PHNs spoke of their interest in fulfilling the full breadth of their professional practice role such as leading group- and community-level health promotion activities. They commented that they would find their job more

satisfying if they could spearhead parenting groups, preventive health teaching sessions, and community outreach initiatives targeting lower income lone-parent mothers and their socioenvironmental living conditions. Community-level education and outreach programs are major components of health promotion.

Health promotion is defined in the watershed document *Achieving Health for All: A Framework for Health Promotion*, as the

> process of enabling people to increase control over, and to improve, their health… a commitment to dealing with the challenges of reducing inequities, extending the scope of prevention, and helping people to cope with their circumstances… creating environments conducive to health, in which people are better able to take care of themselves. (Epp, 1986, p. 422)

It is apparent that the framework inspires more than implementation of educational strategies to promote and enforce health-enhancing behaviours and lifestyles. The framework diverges from health promotion models (Pender et al., 2006) aimed at examining the effects of interpersonal interaction on soliciting engagement in certain health-related behaviours. For example, the use of motivational interviewing techniques to address risky health behaviours (e.g., tobacco cessation programs) is designed to target lifestyle choices.

Within the *new* paradigm of Canadian health promotion, the goal is to eradicate the *causes* of unhealthy behaviours and lifestyles (Labonte, 1994; Marmot & Wilkinson, 2006). The health inequities among lower income lone-parent mothers and other economic groups underscore the influence of underlying social, political, and economic determinants of health, as opposed to individual lifestyles. PHNs have been criticized for not doing enough beyond individual-level interventions and for not addressing socioenvironmental level factors by

lobbying for policy reform and other displays of activism. PHNs have not been "pushed" by nurse theorists to recognize that apart from epidemiological statistics and precipitators of disease is an environment, a social landscape affecting the individual and the family (Butterfield, 2002; Reutter, 2000). On the other hand, nurse researchers have documented the "messy" complexities and demanding expectations when PHNs must respond to individual-level concerns and, simultaneously, attempt to connect at aggregate levels to address sociopolitical factors (SmithBattle, Drake, et al., 1997). In the next and final chapter I put forth recommendations associated with the PHNs' practice scope and expectations. However, before proceeding, a brief synopsis of the main points of the Discussion above is in order, beginning with Peplau's (1989) seminal model.

Peplau (1989) asserted that the nurse-patient relationship is growth provoking. The study's emergent theoretical model substantiates her claims. PHNs who participated in my study knew firsthand the implications of therapeutic rapport for enhancement of self, particularly when interacting with lower income lone-parent mothers. Calling forth strengths is just one of several interactional strategies devoted to elevating the mother's self appraisal. Peplau's seminal phases and the more contemporary Calgary-based models also advocate a strengths-based approach. However, a slight but critical departure from the emergent Targeting Essence model is the operationalization of strengths. The Targeting Essence model places greater emphasis on employing strengths to assuage fear and mistrust, and to forge through walls of defensiveness in pursuit

of relational goals. Identifying and storing up strengths to assist problem-solving are secondary goals and occur once trusting connection has been nurtured.

Also unique to the emergent theoretical model are the requisite social intelligence competencies to manoeuvre through the interaction with astute, keen, and empathic sensitivity. The PHN's advanced social skill set (powered by a collective force of intuition, experience, and cognitive insights) enables her to win and to sustain the mother's trust that the PHN will not render judgment. The PHN must be decidedly deliberate about the self she brings to the relational space. For example, the mother might be somewhat guarded and tentative at first, but anxiety and mistrust are mitigated by the PHN's warm optimism and verbal gifts of praise, which she projects during Projecting Optimism. Projecting Optimism is only the initial stage, however. The PHN-mother dyad will take on characteristics of its own as their interaction evolves through five more stages. Each stage and the substage interactional strategies and components serve unique, pivotal roles in development of the quality of their interpersonal dynamic and also the overall nature, mode, and pace of relationship building. Some of the stages play the role of icebreaker, catalyst, or sustainer, and all are inextricably linked to the PHN's appropriate and strategic responsiveness to the mother's sensibilities. When dyad members reach the sixth and final stage, the mother will have already begun reframing her sense of self and actualizing internal resources to address personal goals with a mindset of hope and possibility.

CHAPTER SIX: CONCLUSIONS

Targeting Essence: Pragmatic Variation of the Therapeutic Relationship has the potential to inform nursing communication curriculum; to advance undergraduate, novice, and veteran relational intervention efforts; to enrich practitioner-client rapport; and to promote maternal/child health and well-being. First, the compelling discoveries of high levels of social intelligence, required to establish rapport, legitimize the need for comprehensive teaching-learning approaches to encompass communication theory and techniques as well as innovative assistive technologies to develop the student's perceptual skills. Second, the Targeting Essence model resonates with several interpersonal constructs in the nursing literature (e.g., strengths-based approach and capacity building), extending the model's relevance to, and practice application in, other fields of nursing and can serve as fodder for professional development and continuing education. Third, depicted in the emergent theoretical model is the PHN's therapeutic use of self throughout the process. Mothers are particularly receptive to the PHN's gifts of praise and other self-affirming interactional strategies and components. The relationship-building process offers mothers opportunities to reap tremendous mental health benefits and witness the positive domino effects on their parenting behaviours. In this final chapter I discuss the implications of the Targeting Essence model for public health nursing practice, nursing communication curriculum, administration, and research, in tandem with explicit recommendations.

Implications for Public Health Nursing Practice

Novice PHNs state that they are inadequately prepared with the prerequisite interpersonal competencies to meet the challenges of relational practice (SmithBattle, Diekemper, & Leander, 2004). PHNs share the feelings of relational inadequacy conveyed by nurses in other fields. The results of a recent interpersonal skills survey of practitioners in diverse areas of nursing indicate that nurses believe that they are better at offering benign, impersonal information then drawing out emotions and consoling clients/patients (Burnard & Morrison, 2005). Targeting Essence: Pragmatic Variation of the Therapeutic Relationship addresses the call for the orientation of novice PHNs to the interpersonal cognitive, attitudinal, and behavioural abilities required in work with vulnerable families in the community.

Proposing a Practice Framework

The proposed practice framework (see Figure 2) outlines in an accessible, succinct fashion the expressive actions of the PHN that are necessary to convey certain interpersonal strategies and components identified in the emergent model, Targeting Essence: Pragmatic Variation of the Therapeutic Relationship. Construction of the practice framework began once the grounded theory model of the relational development process was completed. The first draft was produced in collaboration with PHNs and mothers during their participation in the study and with PHNs whom I had consulted outside of the study.

The framework is a preliminary heuristic tool that can be adopted for public health nursing practice. In the framework's first column, the PHN is to

consider his or her biases and prejudices. It is critical that deeply rooted latent thoughts, feelings, and attitudes are brought to the surface long before initial interaction, or they can arise through nonverbal channels of communication (Egan, 2007) and possibly sabotage relational development. The eight interactional directives in the centre column are drawn from the salient goals and behaviours of the six stages of the emergent model. The last column of the framework emphasizes the key communicative behaviours.

Before Interaction	**WHEN INTERACTING WITH THE MOTHER AND HER CHILD**	**During Interaction**
What are my **thoughts** about poverty in Canada? What are my **attitudes** towards Albertans living on public assistance? What are my **feelings** towards single mothers living on public assistance in Edmonton? What am I expressing in my **verbal and nonverbal behaviours** towards lower income single mothers?	1. Appear **HAPPY** to see her. Be sincere. No "crocodile smiles." 2. Get down to eye level with **HER CHILD** and talk to her child. 3. **PRAISE** her for how well she is raising her child. 4. Say the right thing at the ***RIGHT TIME**. ---------- ***Barrier**: The PHN posing questions about smoking, drug abuse and other health behaviours, or pointing out home safety concerns, and proceeding with health teaching messages, before rapport. ---------- 5. Be conscious of what your nonverbal responses are **MIRRORING BACK** to her. 6. *Begin the conversation with the mother's questions. Fully respond to her questions with options from which **SHE CHOOSES** the solutions. ---------- ***Barrier**: The PHN focusing on her agenda (e.g., checklist) before mother's concerns. ---------- 7. Finish painting the picture in your head of who **IS THIS** mother and what does she need to keep going. 8. Decide how available you will be as **SURROGATE** social support if she tells you she is alienated from family and friends.	Approach the mother and her child with a **welcoming smile**. Face the mother and/or child squarely with a **relaxed, open posture**. Maintain good **eye contact**. Be **fully attentive** to the mother's behaviours, emotions, experiences, and thoughts. **Lean forward** to convey full interest. **Listen** to the mother first; then talk. Let her know you **care** before probing with agenda items.

Figure 2. The proposed practice framework (i.e., a work-in-progress) for PHNs working with lower income lone-parent mothers.

Reflective practice is of paramount importance in all fields of nursing (Freshwater, 2008). I propose that the framework could stimulate greater reflection among PHNs about their relational practice efforts and suggest that PHNs broaden their reflection to include their experiential, theoretical, personal (Phenix, 1964), and aesthetic knowledge (Morse, Miles, Clark, & Doberneck, (1994). *Experiential knowledge* includes thoughts about former relational interventions among vulnerable and potentially stigmatized clients: What lessons can be gleaned? *Theoretical knowledge* entails delving into the principles of primary health care, conceptualizations of poverty, and therapeutic communication. *Personal knowledge* relates to insights gained by subjective acquaintance with the concerns and coping behaviours unique to lower income mothers: What are their life experiences as lone parents who live on public assistance? What are their fundamental issues? Personal knowledge also encompasses reflection about one's professional self in relation to others: What are my interactional strengths? How do I present myself? How do I affect vulnerable and potentially stigmatized clients? *Aesthetic knowledge* refers to the "art" of nursing (Carper, 1978) and would correspond with Empathic Accuracy from the study's emergent theoretical model in terms of the PHN's empathic understanding of the lower income mother's feelings and emotions. Reflection could include hypothesizing about the mother's possible worries, anxieties, and fears.

Drawing on my study findings, I propose that the PHN tap into one or all forms of knowing, and at points *before*, *during*, and *after* the interaction with the

lower income mother. Prior to the interaction, the PHN should reflect on how she thinks about poverty and welfare discourse, as specified in the framework's first column, as part of her *prerelationship reflection*. Then it is advisable that while thinking about her specific client, the PHN determine in advance how she can ensure that the mother will perceive her as trustworthy and caring. While the PHN is interacting, she is *reflecting-in-relationship* so that she is consciously in control of both verbal and nonverbal communicative behaviours and is attentive to the mother's cues. While observing the mother, the PHN might contemplate:

- How did the mother react when I posed that question?
- Is this subject matter too personal?
- Is she averting my gaze because I have touched a "raw nerve"?
- Do I need to preface my questions with care and concern to provide reassurance?
- Should I be silent now and listen intently?

After the interaction the PHN should conduct *reflection-on-relationship* to critically examine facilitating and inhibiting behaviours. What seemed to work well with this mother? Is this the same as or different from the reactions of other mothers? Why did this not work? What did I say? What messages did my body language convey? Do I need to go back and be honest with the mother and tell her

that I "put my foot in my mouth"?[10] This activity enables the PHN to deconstruct and reconstruct the interaction to enhance self-awareness of social literacy levels and to improve interpersonal competencies.

Interpersonal Communication Workshops

The practice framework remains a work-in-progress, and consultation with PHNs will resume during dissemination of my research findings through scheduled meetings at each of the participating community health centre sites. Primarily I want to verify that I have correctly identified the principles and the cognitive, affective, and behavioural postures that best emulate the relational elements embedded in the theoretical model. Suspending judgment, for example, emerged as integral to establishing therapeutic relationships. PHNs will be asked to validate underlying thought patterns and explicit verbal and nonverbal communicative behaviours required to convey absence of judgment, which, in turn, will become part of the framework's reconstruction.

I would like to use the dissemination sessions, mentioned above, as opportunities for professional development. Deliberation over the accuracy of the practice framework will simultaneously convey knowledge and understanding in a nonthreatening environment and enhance practitioner awareness of the complexity and significance of interpersonal communication for their working effectiveness with lower income lone-parent mothers. I hope to solicit the interest

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[10] One of the PHNs I interviewed related an incident during which she returned to the young mother's home and apologized for being so immersed in her professional agenda that she failed to notice that the mother was distraught.

of PHNs and their managers in workshops designed to enhance their relational capacity. Although I know that the PHNs are interpersonally competent, the skills of interpersonal communication competence advocated in the Targeting Essence model and the practice framework can be learned and/or improved on. Interested PHNs could collaborate with me to both complete the framework and be part of the planning, development and delivery of resources, activities, and exercises for ongoing in-services for novice and veteran PHNs.

Recommendations for Interpersonal Communication Curriculum

Nursing curriculum assists nursing students to develop an appropriate repertoire of communication theory, skills, and principles for professional practice. Instructors will impress on nursing students the complex, dynamic nature of interpersonal communication (Boggs, 2003). I recommend that when students interact with vulnerable and potentially stigmatized clients/patients, their instructors highlight the pervasive impact of nonverbal channels of communication. Empathic responses, for example, are facilitative and therapeutic communication techniques (Reiter, 2008), but how are students taught to project empathy so that their verbal empathic content is congruent with their nonverbal messages? How well are the student's acts of empathy being received? In this context it is crucial that students learn to recognize the visual acts of meaning as reflected in the facial displays of those in their care as well as conveyed by their own communicative behaviours. Bearing this in mind, baccalaureate interpersonal communication curriculum could be enhanced by recommendations based on findings of this study and outlined below, in Table 5. Also portrayed are the

stages of the study's emergent Targeting Essence model in conjunction with the prerequisite social skills (i.e., the interpersonal communication competencies).

Table 5

Recommendations for Interpersonal Communication Curriculum

Emergent Model	**Social Skills**	**Communication Curriculum**
Stages	***Competencies***	***Recommendations***
Stage 1: **PROJECTING OPTIMISM** • **Engaging positively** • **Offering verbal commendations** **Stage 2:** **CHILD AS MEDIATING PRESENCE** • **Child as focal point** • **Evaluating the practitioner's approach** • **Attributing advanced child sensitivity** **Stage 3:** **ASCERTAINING MOTIVES** • **To trust or mistrust** • **The litmus test**	a. Verbal and nonverbal behaviours convey: • enthusiasm for mothering role • praise of parenting • adoration of child b. Can listen for, observe, and identify client strengths c. Acknowledges spontaneous impulses and evoked feelings d. Controls expression of untoward responses e. Conveys nonjudgment f. Listens intently with ears and	1. Fundamental communication theory, principles and skills are taught at entry-level and subsequent years with advancing progression of content and competencies (Antai-Otong, 2007). 2. Students learn facilitative verbal communication and techniques including open-ended questions, paraphrasing, reflecting skills, seeking clarification, and so forth (Craven & Hirnle, 2007). 3. Students learn nonverbal attending behaviours (e.g., body position, gestures, eye contact, facial expressions, paralanguage, and so forth). 4. "Hands-on" opportunities include role-playing, role-modeling, and self-awareness exercises (Wright & Leahey, 2005). 5. Theoretical and practical application is achieved through skills performance in front of video-cameras and two-way mirrors for testing and self-critique (Hood & Leddy, 2006). 6. Case study format and problem-based learning approach stimulate group conversation and

Stage 4: **EXERCISING SOCIAL FACILITY** • **Empathic accuracy** • **Responding strategically** **Stage 5:** **CONCERTED INTENTIONALITY** • **Painting a new canvas** • **Eliciting the client's agenda** • **Building capacity** **Stage 6:** **REDRAWING PROFESSIONAL BOUNDARIES** • **Assuming pseudo-roles** • **Fulfilling surrogate social support**	eyes to client narrative g. Demonstrates caring, empathic, therapeutic rapport h. Probes for information with sensitivity i. Conveys curiosity about the client's life circumstances j. Privileges client's prioritizing of problems and solutions k. Builds capacity potential, motivation and hope l. Can reconcile professional boundaries with client need for instrumental and emotional surrogate support	critical thinking regarding challenges of interpersonal communication with vulnerable and potentially stigmatized patients/clients. 7. Self-reflection is a major curricula component to promote awareness and acknowledgement of stereotypical viewpoints and pejorative attitudes (Gorman, Sultan, & Luna-Raines, 1989; Stevenson, Grieves, & Stein-Parbury, 2004). 8. Live supervised clinical practice with clients and patients are provided throughout the undergraduate program. 9. Self-monitoring through videotaping enables students to gain objective views of their verbal and nonverbal communicative behaviours and impact on clients/patients. 10. Curriculum includes social intelligence vernacular and the accompanying science (Goleman, 2006). 11. Social intelligence training commences following comprehension of the fundamentals of communication. 12. Instructors teach students to attune to, and to interpret verbal and nonverbal expressions of emotion. 13. Standardized patients (i.e., real-life patient actors) simulate interpersonal scenarios to train students to gain emotional

	competence. 14. Emotional competencies entail awareness of autonomic physiological responses (e.g., quickened breathing and blushing); control over affective responses; and, modulation of negative and intense emotions. 15. Students apply interdisciplinary counselling principles and techniques from psychology, psychiatry, mental health, marriage and family therapy, and clinical social work, to improve therapeutic communication. 16. Clinical preceptors, clients/patients and family members are given opportunities to evaluate quality of therapeutic interactions. 17. Incremental interpersonal therapeutic cognitive/psychomotor/affective competencies are demonstrated each year through evaluation of student performance in both acute and community care practica rotations.

Recommendations to Administration

The recommendations to administration are set against the backdrop of the standards of public health nursing practice instituted by the Community Health Nurses Association of Canada (2008). As mentioned previously, organizational-level factors seem closely associated with barriers to establishing therapeutic relationships with vulnerable and potentially stigmatized clients. The five core standards and values are listed below. My accompanying recommendations are intended to promote effectual engagement with lower income mothers in order to optimize maternal/child health and well-being.

Standard 1: Promoting health (specifies health promotion, prevention and health protection, health maintenance, restoration and palliation). PHNs are directed to collaborate with individuals/families/communities and other stakeholders to conduct a holistic assessment of needs, assets, and resources. Health promotion strategies include building healthy public policy, creating supportive environments, strengthening community action, and developing personal skills.

Health promotion strategies that are focused on strengthening personal skills to facilitate control in one's life closely align with constructs emerging from my study. Capacity building and advocacy are depicted in stages 5 and 6 (i.e., Concerted Intentionality and Redrawing Professional Boundaries), for example, and are carried out by the PHN once trusting rapport has been established. It became apparent that regardless of how genuine and laudable are the PHN's intentions, certain objectives and subrole activities rely, fundamentally, on the

quality of engagement. Evident from my research is the relational groundwork needed first before the PHN can collaborate with the lower income mother to draw out innate capacities or to assume an advocacy role. It is advisable that administration supports professional development of the PHN's interpersonal competencies to ensure that the PHN has the ability to secure strong alliances with individual members (e.g., the lower income mother) of the community first, before attempting connection/collaboration at group and community levels.

Also, in accordance with this standard, the PHN assists individuals/communities in making informed choices about protective and preventive health measures, such as immunization and breastfeeding. Problematic for establishing rapport is the heavy emphasis on epidemiological indicators, immunization rates, harm reduction, screening, and surveillance. Health assessment tools do not incorporate extensive assessment of psychosocial needs of the vulnerable and potentially stigmatized client. Psychosocial needs, in particular a higher prevalence rate of depression associated with stress and inadequate support, are prevalent among young lone-parent mothers during the first year of the baby's life (Keating-Lefler & Wilson, 2004). Monitoring and episodic screening for depression will identify concerns; however, mothers want a PHN to whom they can turn for emotional and tangible support throughout their journey. The medicalization of the immunization visit may inhibit disclosure of personal issues and overlook the need for one-to-one interpersonal counselling and support. It is advisable that PHNs strategize to address the organizational structures and mechanisms responsible for perpetuating time-limited

immunization visits and other barriers to establishing rapport and ascertaining psychosocial needs of clients.

Standard 2: Build individual/community capacity. PHNs are directed to work collaboratively with the individual, the community, and other professionals, agencies, and sectors and use supportive and empowering strategies to move individuals and communities toward maximum autonomy. The PHN supports individual/group/community action for policy change in support of healthier living environments.

Clark (2000) has defined capacity building as enabling an individual to secure the "tools" (i.e., perspectives, values, and skills) to pursue the quality of life that he or she desires. The PHN should be interested in all three tool sets but concentrate her professional efforts first on perspectives. My study findings indicate that lower income mothers might need to secure *reframed* perspectives of the self before they can work on the skill sets required to optimize their capacity potential. The mother's reframed perspective of self includes her beliefs that she is worthy and valuable and has the capacity to overcome. To this end, I offer the following recommendations.

- PHNs should employ the strengths-based approach embedded in the stages of the Targeting Essence model to promote the mother's positive sense of self and to facilitate the mother's identification of innate capacities.
- PHNs should foster individual-level capacity through establishing therapeutic relationships (guided by the Targeting Essence model) and

then progress to facilitate community-level capacity through broader linkages with other individuals and grassroots groups (Labonte, 2005).

- Community development strategies should include coalition building, intersectoral partnerships, and networking. As facilitators PHNs should assists community members (e.g., a group of lower income mothers) to identify their strengths and available resources and to take action to improve their quality of life.

Standard 3: Building relationship. PHNs are directed to establish nurturing relationships and promote environments to maximize participation and self-determination of the individual, family, and community. Caring incorporates empowerment and the preservation, protection, and enhancement of human dignity. PHNs build caring relationships based on mutual respect and build a network of partnerships with groups, communities, and organizations. To establish relationships at individual and community levels, I recommend the following.

- PHNs and community health centre personnel should recognize personal beliefs, attitudes, assumptions, feelings, and values with regard to poverty/welfare discourse and implications for establishing relationships.
- PHNs and community health personnel should identify complex health issues associated with the stressors of living in poverty.
- All PHNs, regardless of assignment (immunization clinics, postpartum home visits, or at-risk prenatal programs), should be made fully aware of potential psychosocial stressors and the implications for relational

development through interdisciplinary and interagency in-services and workshops. Outreach workers and lower income mothers should share their stories to expose personnel to the everyday realities. Financial hardship takes its toll on lower income mothers especially lone-parents living on public assistance, and formal sessions exposing practitioners to the effects of poverty have proven effectual for enhancing understanding (Stewart, Reutter, Veenstra, Love, & Raphael, 2007).

- PHNs should work with lower income mothers through therapeutic relationships (guided by the Targeting Essence model) to identify needs, issues, and resources.
- "Critical companionship" should be incorporated into the PHN's orientation, mentorship, and continuing education. Critical companionship (Titchen & McGinley, 2003) is the pairing of PHNs with colleagues of equal or greater nursing experience. Peers observe each other's interpersonal approach with lower income mothers to become aware of the self they bring to the relationship and the forms of knowing that inform their relational practice approach. Following interactions, peers exchange reflections about each other's performance with consideration of inferential observations of client receptivity and reaction for the purposes of training and development of interpersonal communication competencies.
- PHNs should be afforded debriefing sessions for venting emotions and feelings arising from relationship experiences with lower income mothers.

- PHNs should meet during trouble-shooting sessions to resolve complex relationship issues.
- PHNs should establish connective and collaborative relationships with health professionals, community agency services (housing, drop-in programs, emergency food services, outreach, counselling), and other sectors to address holistic health concerns of lower income mothers.

Standard 4: Facilitating access and equity. Public health nursing practice is founded on the seminal principles of primary health care (World Health Organization, 1978), which is defined as community-based, essential, and accessible health care. PHNs facilitate universal and equitable access to available services. They collaborate with colleagues to promote comprehensive client care and optimal client care outcomes.

Some of the mothers participating in my study perceived attitudinal access barriers. Community health centre personnel appeared busy, dismissive, and mechanical in their approach with them. I surmise that one problem might be misperceptions on the part of both parties as to the meaning of certain messages exchanged nonverbally. My study findings revealed that people will form opinions of others who are different or unfamiliar. The hospital social worker whom I consulted stated that knowledge and familiarity of one another promote congeniality between diverse groups and preempt pejorative attitudes or discrimination.

With the above in mind, I recommend in-services and workshops to enhance familiarity and understanding of the lived experiences of poverty but, this

time, above and beyond the practitioners. All community health centre personnel (managers, administrative assistants, and professional and paraprofessional health workers) should be presented with real-life accounts of the experiences, struggles, distress, and resilience of lower income mothers.

Furthermore, to promote facilitating access and equity, PHNs should collaborate with individuals from target populations to provide programs and delivery methods that are acceptable to them and responsive to their needs. They should employ strategies such as home visits and outreach to ensure access to services and health-supporting conditions for potential vulnerable populations. Barriers to relationship building include diminishing face-to-face contact and progressively fewer home visits. With this in mind I recommend the following:

- PHNs should assume primary responsibility for caseload of families.
- Continuity of care should be sustained from the antenatal period through to the child's fourth birthday.
- PHNs should be granted professional discretion regarding the frequency and duration of home visits.
- Managers should be commended for their efforts to seek PHN input regarding program/service amendments and for fostering collegial decision making.

Standard 5: Demonstrating responsibility and accountability. The PHN should make decisions using ethical standards and principles, taking into consideration the tension between individual versus societal good and the responsibility to uphold the greater good of all people or the population as a

whole. I refer to this standard as the backdrop for addressing the quality of the work environment and centre space in terms of securing the trust of lower income mothers. Overall values, attitudes, and approaches with client populations can be deemed an ethical issue. Bearing this in mind, I recommend that personnel

- be cognizant of their attitudes and mindful of their communicative behaviours,
- convey patience and understanding when clients are emotionally charged, and
- be willing to accommodate and compassionately listen to clients before reacting instinctively.

Implications for Research

Several implications for research are derived from this study. First, components of the study's emergent model could be examined and tested empirically. Second, the study's design could serve as a template for disciplinary and interdisciplinary relationship research. Third, nurse researchers have proposed the empirical testing of the strengths-based approach for relationship building (e.g., Feeley & Gottlieb, 2000). Finally, given the critical importance of communication curriculum, innovative teaching-learning approaches should be developed, monitored, and evaluated. The implications are fully delineated below.

1. PHNs and lower income mothers participating in this study offered a wealth of knowledge and profound insights about the process of establishing therapeutic relationships. The emergent model, Targeting Essence: Pragmatic Variation of the Therapeutic Relationship, and the proposed practice framework

have prompted questions for further investigation and deductive experimental research:

- Can the model's stages of relationship building be tested for their level of efficacy?
- How would PHNs evaluate the applicability of the proposed practice framework in everyday public health nursing practice?
- How edifying is the process of establishing therapeutic relationship for professional morale, job satisfaction and scope of practice among PHNs in current work contexts?
- How edifying is the process of establishing therapeutic relationship for the lower income lone-parent mother's sense of well-being?
- How do mothers judge the relative importance of PHNs assuaging their fears and mistrust? What weight of importance do mothers assign?
- How is the mother's enhanced self-efficacy a function of her interaction with the PHN? Can we measure how much it is due to the relational building blocks of establishing therapeutic relationship?

2. The Targeting Essence model as a stand-alone entity is not generalizable to settings outside the substantive area of public health nursing practice and clients who are lower income lone-parent mothers. However, certain constructs such as trust, emerging during the third stage (Ascertaining Motives), and respect, depicted in the fourth stage (Exercising Social Facility), are applicable to other fields of nursing. Home care nurses, for example, strive to establish trusting, caring relationships to promote client self-care. Trust intensifies

during engagement with elderly clients as dyad members move through initial trusting, connecting, negotiating, and helping stages.

Nurse researchers have identified a*ccepting* and *respecting* as themes of initial trusting (Trojan &Yonge, 1993). I suggest that Trojan and Yonge have limited their investigation with the identification of themes, whereas application of their findings could be extended by exploring antecedents, consequences, properties, and dimensions of the themes of accepting and respecting. Moreover, nursing praxis and curricula instruction would benefit from their findings if their research design had afforded explication of initial trusting, connecting, and the other stages of building trust with the elderly client. What are the explicit communicative behaviours comprising each stage? Spiers (2002), for example, was able to explicate how trust is transacted, describing a complex interplay of verbal and nonverbal behaviours during which home care nurses and their clients sustain a particular social presentation including autonomy, competence, and esteem. Spiers's (2002) use of videography could be replicated by other nurse researchers in various fields of nursing to uncover unseen interactional aspects between nurses and clients/patients and enhance disciplinary awareness of significant conscious and unconscious communicative behaviours, particularly those that enhance participation or create resistance.

3. The inquiry and design process of my study could also be a catalyst for research involving other helping professionals and stigmatized clients to understand interactional messages and the implications of thoughts, feelings, and emotions for fostering professional engagement and alliance. Moreover,

Projecting Optimism, Ascertaining Motives, and Exercising Social Facility are three of the six stages of the relationship-building process that possibly transcend public health nursing praxis to medicine, psychotherapy, counselling psychology, and social work, whose practitioners work with patients and clients who are in various states of vulnerability and who are representative of both stigmatized and nonstigmatized populations. Some of the substage interactional strategies could be variables for direct application and testing. For example, with regard to The Litmus Test (from the third stage, Ascertaining Motives), are there similar tests that other vulnerable clients or patients implement to verify that the professional has their best interests at heart and to ensure that they are in good hands?

4. The findings from this study support the recommendations of Feeley and Gottlieb (2000) for empirical studies to test the relationship outcomes of the strengths-based approach:

> Further study and development of this construct is clearly required in theory, practice, and research. Future avenues to pursue might include an examination of the mechanisms and processes that might account for the link between strengths and positive outcomes for families. For example, does a strengths-based approach facilitate the development of a more effective nurse-family relationship that leads to the desired change? Do nurses who operationalize a s-b approach collaborate more effectively with families than nurses who do not use this approach? With whom, and under what conditions, does this approach work? (p. 22)

Their questions could be adopted to examine early strengths identification for engagement potential among lower income lone-parent mothers. In addition, their line of inquiry could be used to test the strengths-based approach among a sample of lower income mothers living in other jurisdictions and among other special groups who are assigned a stigmatizing label.

5. Finally, how can one know with certainty that recommendations for interpersonal communication curriculum will advance student recognition, appreciation, self-awareness, and performance of social skills without summative evaluation? Rigorous evaluation research is warranted to test and validate modes of instruction, educational tools, and assistive technologies, including the efficacy of investing in video monitoring and standardized patients for enhancing levels of social intelligence.

Limitations

Notwithstanding the rich data obtained, several limitations of this research endeavour have been identified and they are detailed below.

1. Because of participant self-selection, this study involved a certain cohort of PHNs and mothers. For the most part, the PHNs were practitioners who possessed good interpersonal skills and the mothers were individuals who possessed the confidence necessary to volunteer to speak with a researcher, suggesting perhaps higher levels of self-esteem. I was unable to recruit PHNs who were unfamiliar or uncomfortable working with lower income mothers. Also excluded from my interview and observational data, albeit unintentionally, are perspectives of (or dyads consisting of) mothers who were overly stressed, sullen, or distraught.

2. It was not possible to observe interpersonal behaviours of all the PHNs whom I interviewed (only one PHN was both interviewed and observed), and thus I had to base my analysis on self-reports. I could not corroborate mothers' stories and had to rely on their accounts. There were only two PHNs whose relational

capacities were substantiated through interviews with mothers who had been their clients. However given the timing of the study and the system of scheduled visits between these PHNs and mothers, I was unable to observe these particular PHN-mother dyads.

3. I could not capture dyad members interacting in what could be characterized as a high-quality relationship. The majority of the dyadic observations consisted of PHNs and mothers who were interacting for the first time. I tried to arrange dyadic observations outside the community health centre, but PHNs were unable to make arrangements in advance for early-discharge postpartum home visits. Arrangements were also made difficult by the fact that PHNs did not know ahead of time the economic status of the family. On the occasions when I did schedule home visits with the PHNs, various circumstances caused us to have to postpone or cancel the visits. I also attempted without success to accompany PHNs on follow-up home visits but again was unsuccessful because of their infrequent occurrence.

4. If I had recruited several dyads, videography would have been ideal in terms of recording and capturing true interdependence. True interdependence between the PHN and the mother would have been indicated by the presence of expressive actions on the part of the PHN, the conscious or unconscious perception of such expressive actions by the mother, and the return observation by the PHN that such expressive actions were perceived (Ruesch, 1968/1987b). I would have preferred to have witnessed this back-and-forth loop of action and reaction, and then conducted an interview follow-up with each dyad member to

obtain their perceptions, cognitive motivations, and reactionary comments. It would also have been intriguing and insightful to have tracked the qualitative changes of an evolving therapeutic relationship. However, videography with members of this population would have been difficult given their trust issues. PHNs, too, might have been inhibited, thinking perhaps that they were participating in an employee performance appraisal.

5. I was unable to recruit, interview, or observe new PHNs but was informed about their skill set by other participants. Novice PHNs could have contributed to further understanding, elaboration, and saturation of some of my key conceptual categories. I did, however, recruit the participation of PHNs with only 2 to 3 years' experience in public health nursing practice.

6. This was a grounded theory study of practitioners and their clients in a circumscribed context. Unlike a formal theory (e.g., a theory of suffering), the emergent model, as a single entity, cannot be categorically recontextualized and applied to other situations. However, the mothers represented diverse demographic characteristics such that the findings have relevance for PHNs working with lower income lone parent mothers within other provincial and national jurisdictions. The theoretical model and practice framework could still enhance their practitioner awareness and inform their working relationships. Stigmatization outside this particular study context is of no less concern, and thus PHNs will still need to focus their attention on ensuring that threat is mitigated in order to accomplish efficacious assessment, intervention, and referral through the medium of relationship.

Dissemination Strategies

I plan to disseminate my research findings and to promote knowledge utilization by

1. communicating findings through internal (e.g., Faculty of Nursing undergraduate, post-basic, after-degree and graduate nursing programs; the Community-University Partnership for the Study of Children, Youth, and Families; and Health Sciences Council Education and Research Commons) and external networks (e.g., Alberta Centre for Child, Family, and Community Research) associated with the University of Alberta and other academic communities as well as linking with educational institutions electronically to achieve provincial and national circulation;
2. sharing findings with nursing staff at community health centres and hospitals within the Alberta Health Services jurisdiction through lecture format, seminars, workshops, conferences, newsletters, and brochures;
3. filing a copy of my completed doctoral dissertation at the University of Alberta library;
4. submitting papers to peer-reviewed journals and practice-based periodicals;
5. presenting findings as guest speaker at professional association (e.g., the College of Alberta Registered Nurses Association and the Community Health Nurses Association of Canada) meetings, information sessions, and symposia; and
6. establishing two-way transaction with Alberta's deputy ministers of Alberta Health and Wellness, and the Edmonton and Area Child and Family

Services Authority to deliberate policy implications of my findings. The literature is replete with pronouncements that strengthening researcher-policymaker interaction will influence policy research use (Landry, Amara, & Lamary, 2001; Lomas, 2000; Ross, Lavis, Rodriguez, Woodside, & Denis, 2003).

Concluding Remarks

> We have lived for too long in a society which pays lip service to our social, emotional and aesthetic needs and reduces welfare to a simple matter of consumption. The idea the gift and the desire to give, the capacity for concern, the idea of the gift that seeks no return, the processes of gift exchange and the affirmation and celebration of social relationships as an end in themselves rather than a means to an end. All of these are central to the idea of society as an interdependent community of friends and strangers. I would argue that it is this that brings out the best in us.
>
> –P. Hoggett, 2000, p. 209

I concur with Hoggett (2000) that one could choose to view social interaction, symbolically, as a form of gift exchange between strangers. I believe that many gifts were exchanged during the course of this research study. Stories were honest, reflective gifts imparted by participants. Lower income lone-parent mothers spoke about relationship experiences with their health nurses and also alluded to their maternal gifts of selfless love and sacrifice for their children. These mothers were phenomenal in terms of their resilience and commitment to their mothering role. PHNs who volunteered to participate in this study exemplified exceptional dedication and interpersonal competencies within their nursing role. Their gifts to their clients include mindful attentiveness, empathic understanding, and strategic responsiveness. Grounded theory methodology provided the gift of empirical design and inquiry. I was able to glean relationship perspectives and experiences of both practitioner and client, and respond to our

practice call for greater understanding of how dyad members from vastly different sociocultural backgrounds and circumstances establish therapeutic rapport. The professional discipline of nursing has been given the gifts of new learnings and insights about establishing therapeutic rapport with vulnerable and potentially stigmatized clients. Embedded in the study's emergent theoretical model are the PHN's advanced social competencies, powered by a collective force of intuition, experience, and cognitive insights. The social intelligence spectrum is a gift to the PHN in terms of giving her the language to make explicit what she knows implicitly.

Targeting Essence: Pragmatic Variation of the Therapeutic Relationship reflects a complex, dynamic interpersonal process of action, reaction, and accommodation. Given the immediacy of face-to-face interpersonal communication, it is critical that the PHN be aware of heartfelt thoughts, beliefs, and values, and be able to control what is transacted. Lower income lone-parent mothers are particularly attentive to messages conveyed by the PHNs' facial expressions and body language. Mothers know the signs of stigma enactment and can detect even the most fleeting emotional expressions. However, the PHN is a socially astute practitioner who can employ interactional strategies to respond to overt and subtle sensibilities of the lower income lone-parent mother. Interactional strategies include the inextricably linked communicative behaviours of listening, the spoken language, and the accompanying unspoken, nonverbal acts.

Also critical for relational capacity is congruence between cognition, attitude, and behaviours. When seeking to establish rapport, the PHN "learns" the mother. Relational capacities are enhanced by the PHN's prerelationship reflection. She imagines herself as the mother. PHNs attain capacity to perceive emotions, thoughts, and feelings incrementally as they become well versed in the daily realities of mothers and are able to listen intently and to understand with both their ears and their eyes. Subsequently, gifts of earned respect and suspending judgment prevail, and the PHN and mother move into greater interdependence and meaningful rapport. Admittedly, PHNs cannot remove the stressors of poverty and immediately alter dominant societal ideologies; however, as made evident during this study, the very process of establishing therapeutic relationship could potentially promote maternal mental well-being and optimize child health outcomes.

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APPENDIX A: Interview Guide

Q1. INITIAL QUESTIONS FOR MOTHERS

I would like to talk with you about how you find your visits with the health nurse. There are no right or wrong answers to any questions I ask. I want to learn about what you think, feel, like, and maybe dislike about your visits.

Q1.1 Please begin by telling me about the last appointment you had with a health nurse? How did it go from your point of view?

Q1.2 Tell me about the kinds of expectations or impressions you have about your visits with the health nurse.

Q1.3 How does the health nurse interact with you?

Probe: Is the interaction what you expected?

Probe: What do you like about the interaction?

Probe: What do you not like about the interaction?

Q1.4 How do you think the health nurse sees you, in your opinion?

Probe: Does she/he make you feel any different about yourself, your situation?

Q1.5 Before I end our session, is there anything else I should know that I didn't ask about? Perhaps there are other comments or concerns that you would like to mention?

Note: Questions will change in subsequent interviews with mothers according to the discovery of relational concepts and constructs during ongoing analysis of data.

Q2. INITIAL QUESTIONS FOR NURSES

Q2.1 Describe for me your role and responsibilities pertaining to single mothers whom you know are living at or below the poverty line (either working in low-paying jobs and/or receiving social assistance).

Probe: What do you believe are their issues and concerns?

Q2.2 What role does the professional-client relationship play in your work with lower income single mothers?

Q2.3 Please tell me about a visit that went well from your point of view.

Q2.4 What contributes to your relationship with lower income single mothers?

Probe: Is successful relationship related to what you say? Or, how you say it?

Q2.5 Please tell me about a visit that did not go well from your point of view?

Q2.6 What hinders your relationship with lower income single mothers?

Q2.7 Before I end our session, are there other comments or concerns that you would like to mention?

Note. Questions will change in subsequent interviews with participants according to the discovery of relational concepts and constructs during ongoing analysis of data.

APPENDIX B: Recruitment Poster

An Exploration of Therapeutic Relationships
In the Context of Public Health Nursing Practice

ARE YOU A SINGLE MOM?

DO YOU HAVE ANY KIDS UNDER 5 YEARS?

DO YOU LIVE ON A LOW INCOME?

If you answered YES to all these questions then I would like to talk to you.

I AM LOOKING FOR MOTHERS TO BE INVOLVED IN A STUDY

THE STUDY IS ABOUT THE RELATIONSHIP
BETWEEN MOTHERS AND HEALTH NURSES

EXPENSES AND TIME COMPENSATED

My name is Caroline Porr. I am a nurse in the doctoral nursing program at the University of Alberta.

If you would like to talk to me for about an hour about your visits with the health nurses, please phone me. My telephone number is: (780) 492-6410.

Study	Study	Study	Study	Study	Study	Study	Study	Study
492-6410	492-6410	492-6410	492-6410	492-6410	492-6410	492-6410	492-6410	492-6410

APPENDIX C: Study Invitation (Mothers)

An Exploration of the Therapeutic Relationship
In the Context of Public Health Nursing Practice

My name is Caroline Porr. I am asking *single* mothers to get involved in this study who:

- are on income assistance, or
- are working for very low wages, or
- are on assistance and also are working for low wages;
- have at least one child under 5; and
- have visited with health nurses.

One purpose of this study is to learn more about how single mothers living on a low income and health nurses interact with each other. A second purpose is to find out what mothers think is helpful about this relationship with health nurses. I hope that the results of this study will show health nurses how to be more helpful.

This study is my PhD research project in nursing at the University of Alberta. It is completely up to you to decide if you want to take part in this study. All mothers who agree to participate in my study will be given a gift certificate for their time.

I want you to understand all about this study so I have included some information for you in the *Study Information Letter*.

Please call me or send me an e-mail if you have questions. Thank you so much for taking the time to think about taking part in this study.

Research team members:

Caroline Porr (doctoral candidate)
Faculty of Nursing

University of Alberta
(780) 492-6410
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Dr. Jane Drummond (supervisor)
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APPENDIX D: Study Invitation (Nurses)

An Exploration of the Therapeutic Relationship
In the Context of Public Health Nursing Practice

My name is Caroline Porr. I am conducting a study as part of my PhD research project in nursing at the University of Alberta.

The purpose of the study is to learn how community/public health nurses establish relationship with lone-parent mothers who are economically disadvantaged. It is anticipated that the study results will enhance understanding about the importance of the professional-client relationship when working with lower income families.

Your decision to participate in this study is completely voluntary. I include some important details in the *Study Information Letter* that I hope will assist you to decide whether or not you would like to be a participant. I very much appreciate your attention and consideration.

Research team members:

Caroline Porr (doctoral candidate)
Faculty of Nursing

University of Alberta
(780) 492-6410
caroline.porr@ualberta.ca

Dr. Jane Drummond (supervisor)
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jane.drummond@ualberta

APPENDIX E: Study Information Letter (Mothers)

An Exploration of the Therapeutic Relationship
In the Context of Public Health Nursing Practice

Study team:

Caroline Porr (doctoral candidate)
Faculty of Nursing

University of Alberta
(780) 492-6410
cporr@ualberta.ca

Dr. Jane Drummond (supervisor)
Vice-Provost, Health Sciences Council
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What is the reason for the study?

My name is Caroline Porr. This study is my PhD research project in nursing at the University of Alberta. One purpose of this study is to learn more about how single mothers living on a low income and health nurses interact with each other. A second purpose is to find out what mothers think is helpful about this relationship with health nurses. I hope that the results of this study will show health nurses how to be more helpful.

What will happen:

I would like to talk to about 15 single mothers who have young children and who have been living on assistance or working for low wages. You will be interviewed once or twice with a tape recorder in your own home or somewhere else, it's up to you. I will ask you to talk to me for no more than an hour or so, about how it has been for you raising your children and what you think about your visits with health nurses. At any time you can refuse to answer my questions or talk about certain things, and you have the right to ask to turn off the tape recorder.

I will also ask some mothers if it is okay for me to just sit in on their visits with health nurses and take notes. If I need to use a tape recorder I will first get your permission.

All mothers who agree to participate in my study will be given a gift certificate for their time.

I might need to talk with my supervisor and members of my committee at the University of Alberta from time to time about the information I am gathering from you and other mothers. However there will be no names mentioned during our discussions or attached to any of my work.

Benefits and/or risks:

There are no direct benefits or risks. However, what we find out from the study will be used to help health nurses to improve the ways they work with people living on very low incomes. Also, we hope to use the information from the study to change programs so that they are more helpful for single mothers living on very low incomes.

It may be difficult to find a quiet time to talk with me. I will make sure that we meet only at a time that works best for you and your children.

Sometimes talking about your experiences could be stressful. I want you to know that if you do feel uncomfortable that I will end the interview at any time you wish.

Privacy and confidentiality:

Everything that you say will be kept confidential (or private) except when professional codes of ethics or legislation (or the law) requires reporting. Any information that you provide will not be given back to the health nurses. Nobody will know about that information or listen to our recorded conversations except me and my supervisor. Your name or any other information that identifies you will not be attached to our recorded conversations. Names are not used in any part of the study. The information you give will be kept in a safe place (a locked filing cabinet and a password protected computer file) for at least five years after the study is done.

If I have your permission, I will be using the information to teach health nurses and other health professionals by publishing the study findings or discussing them during presentations.

If I decide to do another study later in the future I might be looking again at the information from this study. The Ethics Board will first go over my plans to make sure that the information will be used appropriately and ethically.

Freedom to not take part in the study:

It is up to you to decide to take part in the study. If you do agree to participate then I will first get your signed consent. When you sign the consent you are saying that you understand what the study is all about and that you want to be a part of it.

There is no risk to you if you do not want to participate and the services provided to you by the health nurses will not change in any way. You have the right to stop being in the study at any time without any questions asked. If you want to stop part way through the study, your information will not be used.

In Case of Concerns:

If you have any questions or concerns about any part of the study, please contact Dr. Christine Newburn-Cook, the Associate Dean of Research in the Faculty of Nursing, by e-mail at Christine.Newburn-Cook@ualberta.ca or by telephone at 1-780-492-6764. She does not have any involvement with this study.

APPENDIX F: Study Information Letter (Nurses)

An Exploration of the Therapeutic Relationship
In the Context of Public Health Nursing Practice

Principal investigators:

Caroline Porr (doctoral candidate)
Faculty of Nursing

University of Alberta
(780) 492-6410
cporr@ualberta.ca

Dr. Jane Drummond (supervisor)
Vice-Provost, Health Sciences Council
University of Alberta
(780) 492-2841
jane.drummond@ualberta

Background:

My name is Caroline Porr. I am conducting a study as part of my PhD research project in nursing at the University of Alberta. The purpose of the study is to learn how community/public health nurses establish relationship with lone-parent mothers who are economically disadvantaged. It is anticipated that the study results will enhance understanding about the importance of the professional-client relationship when working with lower income families.

Procedure:

I would like to interview approximately 15 to 20 public health nurses. During a face-to-face interview I will explore your interaction and relationship experiences with lower income lone-parent mothers who are working and/or recipients of social assistance. You will be interviewed during one or two audiotaped sessions for no more than 60 minutes each session.

As the study progresses, I will want to observe the interactions between public health nurses and lower income lone-parent mothers. At that time, I may seek your consent to allow me to quietly sit and observe one of your interactions with a lower income lone-parent mother for no more than 20 minutes. Should I require an audiotape recorder to assist with note-taking, I will seek your permission in advance.

Benefits and/or risks:

There will be no direct or immediate benefits to you for your participation. Your contribution to this study may benefit lower income families locally as well as provincially and nationally as I plan for widespread dissemination of the findings. Also, professional bodies and policy decision-makers might welcome your

information and any recommendations when considering future programs and initiatives.

I realize your time commitment should you agree to one or more interview sessions. I will attempt to ensure that the date and setting are arranged according to your convenience. I anticipate that interviews will be scheduled during your regular office hours and within your office setting.

Your employer may be aware of your participation in the study. However, the fact that you are a participant in this study, or your decision to withdraw at any time for any reason, will bear no impact on your job performance and evaluation.

Statement of confidentiality:

All information that you provide will be kept confidential except when professional codes of ethics or legislation requires reporting. The audiotaped interviews will be transcribed for the purposes of analysis of the data. Audiocassettes and transcriptions will be assigned a code number and kept in a safe place (a locked filing cabinet and a password protected computer file) for at least five years after completion of the study. Participant names are not attached to any aspects of the research and are absent from all study findings whether for publication, teaching or presentations.

During the study there will be times when I will need to consult with my professors and colleagues at the University of Alberta. Again, confidentiality will be ensured; there will no names attached to any of my work or mentioned in our discussions.

If I carry out another related study in the future I might be looking again at the information from this study. The Ethics Board will first review my plans to ensure that the information will be used ethically.

Freedom to withdraw:

I remind you that your decision to participate in this study is completely voluntary. If you decide to participate, I will ask that you first sign a consent form. Your signature on the consent form indicates that you understand the information regarding participation in the research study and that you agree to be a participant.

There is no risk to you if you decline from participating in this study. You have the right to turn off the tape recorder at any time and withdraw your involvement.

Additional contact:

If you have any questions or concerns about any part of the study, please contact Dr. Christine Newburn-Cook, the Associate Dean of Research in the Faculty of Nursing, by e-mail at Christine.Newburn-Cook@ualberta.ca or by telephone at 1-780-492-6764. She does not have any involvement with this study.

APPENDIX G: Consent Form (Mothers)

Title of Project: *An Exploration of the Therapeutic Relationship in the Context of Public Health Nursing Practice*
Part 1: Researcher Information
Name of Principal Investigator: Dr. Jane Drummond Affiliation: Vice-Provost, Health Sciences Council, University of Alberta Contact Information: tel 1 (780) 492-2841; e-mail jane.drummond@ualberta.ca
Name of Co-Investigator: Caroline Porr (doctoral candidate) Affiliation: Faculty of Nursing, University of Alberta Contact Information: tel 1 (780) 492-6410; e-mail caroline.porr@ualberta.ca
Part 2: Consent of Subject (Mothers)

	Yes	**No**
Do you understand that you have been asked to be in a research study?		
Have you read and received a copy of the attached information sheet?		
Do you understand the benefits and risks involved in taking part in this research study?		
Have you had an opportunity to ask questions and discuss the study?		
Do you understand that you are free to refuse to participate or withdraw from the study at any time? You do not have to give a reason and your care and services will not be affected in any way.		
Has the issue of confidentiality been explained to you? Do you understand who will have access to your records/information?		

Part 3: Signatures
This study was explained to me by: _____ Date: _____
I agree to take part in this study. Signature of Research Participant: _____ Printed Name: _____
I believe that the person signing this form understands what is involved in the study and voluntarily agrees to participate. Researcher: _____ Printed Name: _____
* A copy of this consent form must be given to the subject.

APPENDIX H: Consent Form (Nurses)

Title of Project: *An Exploration of the Therapeutic Relationship in the Context of Public Health Nursing Practice*
Part 1: Researcher Information
Name of Principal Investigator: Dr. Jane Drummond Affiliation: Vice-Provost, Health Sciences Council, University of Alberta Contact Information: tel 1 (780) 492-2841; e-mail jane.drummond@ualberta.ca
Name of Co-Investigator: Caroline Porr (doctoral candidate) Affiliation: Faculty of Nursing, University of Alberta Contact Information: tel 1 (780) 492-6410; e-mail caroline.porr@ualberta.ca
Part 2: Consent of Subject (Nurses)

	Yes	**No**
Do you understand that you have been asked to be in a research study?		
Have you read and received a copy of the attached information sheet?		
Do you understand the benefits and risks involved in taking part in this research study?		
Have you had an opportunity to ask questions and discuss the study?		
Do you understand that you are free to refuse to participate or withdraw from the study at any time? You do not have to give a reason and it will not affect you in any way; there will be no consequences whatsoever.		
Has the issue of confidentiality been explained to you? Do you understand who will have access to your records/information?		

Part 3: Signatures
This study was explained to me by: _____ Date: _____
I agree to take part in this study. Signature of Research Participant: _____ Printed Name: _____
I believe that the person signing this form understands what is involved in the study and voluntarily agrees to participate. Researcher: _____ Printed Name: _____
* A copy of this consent form must be given to the subject.

APPENDIX I: Sociodemographic Data Record

Code #: ____

Date: _____

1. Number of children in the family? _____
2. Age of child (if more than one, from youngest to oldest)?

   _____

3. Age of mother? _____ years
4. Educational level of mother?

   a. less than high school
   b. some high school
   c. high school graduate
   d. some university or college
   e. university or college graduate
   f. some post graduate courses
   g. master's degree or higher

5. Ethnicity? _____
6. On social assistance? No?____ Yes?____ If yes, how long recipient of assistance in Edmonton? _____
7. Working for low wages (less than $33,000 a year)? _____ If yes, how long?

   _____

8. Household annual income level?
   a. <$10,000
   b. $10,000–19,000
   c. $20,000–29,000
   d. $30,000–36,000

e. Other? _____

9. How long a lone-parent mother?

_____

10. Mother describes her sense of well-being as generally:

very poor poor good excellent

11. Receiving medical attention for *very poor* or *poor* sense of well-being?

_____

12. On medications? No?_____ Yes?_____ If yes, for what?

_____